Delivering quality care more efficiently inquiry

Questionnaire response 48

Name: Health Consumers' Council WA

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Participant background

1. For the purposes of this consultation, which of the following best describes you:

   I am an industry or advocacy organisation, professional association or peak body

2. Which of the following care sectors will your feedback relate to? Please select all that apply.

   Aboriginal Community Controlled; Aboriginal Community Controlled Health Organisations; Aged care; Disability; Early childhood education and care; Health

3. What kind of care supports, services and programs do you have experience with, and in what jurisdictions?

   The participant did not respond to this question.

1. Reform of quality and safety regulation to support a more cohesive care economy

1. To what extent do differences in quality and safety regulation make it costly or complex to provide or access care services?

   Somewhat

2. What are the reasons for your answer?

   As an organisation responsible for amplifying the voices and views of consumers, we don’t have significant insight into the cost side of safety and quality regulation. We are, however, very interested in any outcomes that can enhance patient choice, availability of suitably qualified practitioners and improvements in transparency of safety and quality reporting.

   We know that the need for healthcare staff to undergo mandatory training in more than one facility in the same state takes up valuable staff time that could be spent providing care to patients.

3. To what extent should quality and safety regulations be more aligned across the different care service sectors and jurisdictions?

   Somewhat

4. What are the reasons for your answer?

   We can certainly see the cost and efficiency benefits of aligning regulations, but it is important to ensure that if these are aligned they are not done so at the expense of transparency or patient outcomes.

   We would like to see which jurisdiction and which sector have the best record in safety and the most transparent reporting of safety and quality issues, and would recommend that these standards be the absolute minimum standard adopted across an aligned regulatory system.

Individual independent patient advocacy contributes to better safety and quality and should also be an important point of consideration in examining how safety and quality regulations are aligned. Identifying a safety and quality mechanism that embeds individual independent advocacy as a means of driving good patient outcomes would see improvements across the sector.

2. Embed collaborative commissioning to increase the integration of care services

1. What is your experience with collaborative commissioning

We are involved in the Joint Statement WA Collaborative Commissioning Partnership, which is an initiative between the Australian Government Department of Health and Aged Care (DoHAC), the WA Department of Health, and WA Primary Health Alliance, aimed at strengthening health service integration across Western Australia.

At this stage this collaborative commissioning project is in its infancy, but the intent is to:

Use governance frameworks, funding models and collaborative planning to ensure equity of access for priority populations, including:
• Aboriginal people
• Homeless people
• LGBTIQA+ people
• Older people
• People experiencing economic hardship
• People from culturally and linguistically diverse (CALD) backgrounds
• People living in rural and remote areas
• People living with disability
Improve Care in the Community through:
• Targeted support of the primary care workforce (thin and failed markets)
• Promotion and support of team-based multidisciplinary care for complex and chronic conditions, through early intervention and management in primary care
Data and ICT use to:
• drive an innovative and integrated approach to meeting the complex health needs of priority populations across the primary, acute and community care-based sectors

2. What are the benefits of pursuing greater collaborative commissioning?

Collaborative commissioning works to break down silos in health service provision and should lead to better patient outcomes. Right now, across the health system we see a situation where – in economic terms – every actor in the health system is acting completely rationally and in their interests. However, this means that the “system” as experienced by the consumer or carer who is trying to access care, and achieve their health goals is highly fragmented with the opportunities for failure and unsafe poor quality care at the point of transition between these various elements being very high. Consumers are at the receiving end of service segregation and sometimes experience poorer outcomes as a consequence.

We see this particularly in patients who would be well served by seeing GP but have instead presented to an emergency department either because they were unable to get an appointment with a GP, couldn’t afford the upfront and/or out of pocket costs, or

because the GP is closed. Having a GP service as part of an emergency department would be a significant benefit to patients and would also reduce the load on the hospital system in addressing urgent but not emergent matters, particularly after hours. However, because GPs are part of the Medicare/Federal system and hospitals are part of the state system, this is not easy to achieve without concerns being raised around cost shifting.

The same argument applies to referrals from GPs into the hospital system. A lack of collaboration means that GPs have no useful insight into the expected waiting time for an outpatients appointment and are therefore limited in the advice they can give their patients about their options.

Collaborative commissioning has the potential to allow for a flexible health system with person centred health funding instead of the system-centered funding model we currently see.

Speaking to diverse consumers and people with lived experience will show decision-makers that these sorts of reforms are highly desirable across the sector, as they would more closely meet the needs of consumers, particularly vulnerable or marginalised consumers.

3. What are the barriers to collaborative commissioning, and do you have any suggestions for solutions that would lead to better collaboration in the commissioning of care services?

There are barriers to collaborative commissioning in the differing and sometimes contradictory ways that different parts of the health and social care system currently work. While there might be excellent intent and good will around collaborative commissioning, it would be a cultural and organisational change that would require extensive training, work, cooperation and consultation.

The political nature of health and social care, and the perceived need for politicians and political parties to be able to point to activities and achievements of which they can claim ownership, means that true collaboration where no one partner can take the glory can be challenging. The need to move to a radically different way of commissioning is becoming increasingly urgent as can be seen by the significant pressure in our public hospital system, alongside the current and looming workforce and demographic changes.

We advocate that collaborative commissioning should not be seen as a partnership between Federal and State governments, but that the collaboration includes community from the outset – not as a group to be consulted, but as leaders of and partners in change.

Furthermore, we advocate that collaborative commissioning needs to be managed in a way that decisions are led by “communities in place”, not by “commissioners in cities” and is based on asset-based community development approaches. This means centering communities and their needs, not Government agencies and their structures. This way, we can hope to avoid the situation where communities are invited to endless discussions about key challenges in their communities, hosted by multiple Government agencies, without any resulting action; but rather, communities are resourced to do the hosting of the discussions that matter to them and invite multiple Government agencies to meet with them to explore implementable locally appropriate solutions.

This means that new leadership qualities will be required to lead and sustain collaborative commissioning in the long-term. In addition to the characteristics that have

been valued in public service to date – significant learned experience and knowledge gained over time, objectivity in decision-making, evidence-based decision-making – leaders of collaborative commissioning also need new and emerging skills. These include the ability to develop and foster authentic relationships with diverse people and organisations, including people with diverse lived experiences; the ability to influence without formal authority; the willingness to work beyond their scope in order to "join up" the system; the ability to maintain relationships through disagreements and uncertainty; the ability to draw on knowledge and expertise from non-traditional sources; the ability to sit with the discomfort of "not knowing" all the answers before acting; the ability and willingness to take risks and experiment.

There will also be a need to be investment in capacity building at a place-based level – to enable the conversations to be had, and the relationships to be maintained – to enable true reforms.

3. A national framework to support government investment in prevention

1. What are the main barriers to governments investing in evidence-based prevention programs across the care economy?

Political will: there is strong evidence that the return on investment in preventative programs is significant – and yet, to date, national and state policies relating to preventative health are developed to much fanfare then remain under/un-funded.

Public sector approach to evidence and risk: there is emerging evidence about the benefits of community development as a major contribution to maintaining health and reducing ill-health. But these programs don't fit neatly into the existing procurement mechanisms – for example, there is evidence that a community connector model can reduce hospital use by over 65% but there is no on-going funding for these programs, despite successful pilot programs.

The benefits of investing in evidence-based prevention programs are substantial and long-term, but take some time to be realised. In the meantime, there are still people who are needing medical care and waiting lists leading to long delays. For this reason, an investment in prevention cannot be at the expense of delivery and will therefore require additional substantial investment. Ultimately a considerable investment in evidence-based prevention programs will see savings in the service delivery area, but until those savings are clearly realised there cannot be funding cut from that part of the sector. This means that an investment in evidence-based prevention programs will necessitate more money in the health budget, at least initially.

Need for societal changes to address the social determinants of health making it "too hard to tackle". Obvious prevention programs such as vaccination, screening and health promotion campaigns are well-known, but prevention needs to go deeper, and further upstream, to look at the social determinants of health as well – the things in our lives that make us more or less likely to be healthy. Important conversations need to be had around housing, geographical isolation, poverty, racism and education if we want to get serious about prevention.

In our discussions with health consumers in relation to preventative health activities, it was clear that how we have organised ourselves as a society – where activities which generate an income or profit (such as working full-time, convenience/fast-food, food delivery services) are prioritised and valued over activities which generate health but which have less economic value – i.e. spending time with family and friends; spending time in nature; growing and preparing nutritious food. Rebalancing society towards a

Wellbeing Economy is a complex and significant undertaking which Governments cannot do on their own.

2. What are some examples of successful prevention programs (this could include discontinued programs)?

The plain packaging of cigarettes coupled with a ban on cigarette advertising was a clear success in reducing the appeal of cigarettes, particularly for young people. It also succeeded in correcting the mistaken belief that some brands were less dangerous than others . Of course, we have since seen that while this prevention campaign did lead to a reduction in people taking up cigarette smoking, that space has now been filled with vapes, but the plain packaging project worked to reduce young people taking up smoking.

Another successful prevention program is a combination of the HPV vaccine and cervical cancer screening which has seen a substantial reduction in rates of cervical cancer in Australia, to the point where soon advanced cervical cancer is unlikely to be seen by Australian clinicians.

Broadening the scope of preventative health funding sees the lens turn to homelessness as a key social determinant of health, and the provision of affordable housing as a crucial preventative health investment. Housing First models have been rolled out in various jurisdictions across Australia over the last decade. They are usually a government initiative in partnership with the private sector and not for profit groups that can provide assistance and support to residents. The concept behind such projects is that a person should not be required to qualify for housing, but rather, housing should be provided first, acknowledging that once housing is provided, with built-in support services, then it is considerably easier for a person to find employment and make other changes to their lives. The measurement of non-housing outcomes is crucial to the understanding of Housing First programs as a preventative health measure. Recent research by the University of Western Australia found that on the cost to the hospital system of treating a person who experiences homelessness can be reduced considerably if that person has stable housing, both in terms of reducing the number of emergency department presentations, but also the reduced length of time spent in hospital if admitted.

Compassionate Communities and other models of community connectors, or social prescribing, are also demonstrating positive health outcomes.

3. How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

• By broadening the concept of prevention activities to cover the social determinants of health.
• By recognising that investing in community development is an investment in prevention
• By devolving power and resources to “communities in place”
• By ensuring that the investment is not made at the expense of service delivery
• By building in evaluation and improvement programs to all activities to ensure they are continuing to provide benefits
• By stepping up and regulating the food industry to ensure it delivers health over profit
• By ensuring prevention activities work to address racism and social inequity in access to health care