HEALTH CONSUMERS' COUNCIL

Delivering quality care more effectively, Interim Report. HCCWA Feedback

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Introduction

The Health Consumers' Council WA Inc. (HCC) was established in 1994 with the purpose of giving a voice to health consumers in Western Australia and improving health outcomes by encouraging and supporting consumer engagement and involvement in health services. HCC also provides an individual advocacy service to support consumers to navigate the WA health system and seek redress.

Executive summary

- Broadly supportive of radically new approaches to the care economy
- It is crucial that productivity changes are done with the intent to ensure that as well as delivering productivity, the changes deliver long lasting and meaningful benefits to people and communities.
- There are some exciting potential benefits to collaborative commissioning and we hope that opening the doors to such an approach will provide good outcomes for consumers who are often forgotten at those pain points where state and commonwealth government funding lead to service segregation and silos
- Good to see a wide lens being applied to the space of preventative health

This feedback represents the views of Health Consumers' Council WA informed by our daily discussions with a wide range of diverse consumers, carers and community members in our role as an independent non-government organisation with extensive experience of advocating for health system improvement at all levels.

General points

Broadly supportive of any new ideas, with conditions

We are acutely aware that the health and care system cannot continue to operate as it currently is – with an ageing and growing population creating pressure on the way the system currently operates, the need for reform is obvious. The need for new ideas on how we can deliver health care in this changing landscape has been clear for some time. The pressure on the hospital system in WA over a particularly brutal period of flu and other seasonal illnesses has many looking for better solutions and better care.

The important thing is that this not become an exercise in productivity for productivity's sake. Simply cutting costs in the name of productivity is not supported. Productivity changes that deliver long lasting, meaningful benefits to people and communities may actually not be cheaper to deliver in the short to medium term, but their longer-term flow on benefits will show long term improvements and more affordable models of care. It is likewise important that there is political support for these changes across the entire parliament and at every level of government. Without bipartisan and interjurisdictional support, radical initiatives start to become political footballs and are at risk of being changed when governments change. When important health initiatives become politicised, we see large amounts of money spent on changes that then go nowhere. The cost to community of short-term pilot projects that are not invested in for the long-term is high – in loss of faith and loss of hope, as well as the missed opportunity to improve health outcomes.

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

Anything that streamlines services and encourages people to use their transferable skills across many in-need industries is supported, on the understanding that there will not be a reduction in the level of scrutiny involved in processing clearances and safety regulations.

We note the national screening clearance suggestion for workers across multiple sectors, which did raise one question. If a person applying for this screening is ineligible to do child related work (for example), but eligible for other work, would this immediately disqualify that applicant as unsuitable for all types of work? Or does the screening take into account the nature of the work that the applicant will be undertaking?

With the entire care sector facing staffing issues, we believe that applying for clearances and registration should be a simple process. Some people find the process of applying for such checks to be too complex and therefore they choose to pursue other employment options. This does not mean there should be no complexity in the assessment process, but the application process itself should not be a barrier. The process to follow to become registered or cleared should be smooth, accessible, simple and achievable for everyone, and any decisions that are made should be communicated clearly and honestly.

All regulation processes should include the requirement for involvement by representatives from the group who will be receiving the care. For example, we note AHPRA's Community Advisory Council – as well as the stated intention of the new AHPRA CEO to strengthen consumer and community involvement in their processes.

Embed collaborative commissioning to increase the integration of care services

The mechanics of how to make this work are not in our area of expertise, however, we are very supportive of any initiatives that help smooth out the pain points between and federal and state funding, and we also encourage that decisions on where these collaborative commissioning programs occur be devolved to local communities, as they know their needs the best. In many cases, "local" means more devolved than "state level". For example, health and social care needs in the Kimberley are quite distinct, and require a deep understanding of local conditions, to the needs in the Perth metro area.

By way of explanation of the "pain points" that we're referring to, here are some scenarios that we have encountered recently where the intersection of state and federal funding leaves consumers missing out on important care. These are some areas that could be addressed with more creative funding solutions such as those that are possible using collaborative commissioning.

NDIS and Hospital care

We have heard from consumers who are National Disability Insurance Scheme (NDIS) clients that when they are admitted to hospital they are not permitted to use their funded support workers while they are inpatients. This does vary for people who self-manage their care, but for others this leads to considerable gaps in care provision. The expectation is that the hospital staff (state funded) will take care of all personal care and complex communication needs for the consumer while they are in hospital. This is simply not realistic in many circumstances, particularly when considering patients who have complex communication needs. Assuming that this care can be managed by the hospital staff puts a burden on the already overworked hospital staff, particularly nurses, and leaves consumers without the appropriate levels of care and support that their NDIS worker would normally provide.

Allowing NDIS support workers to be funded for time in hospital would make a significant difference to the health outcomes and overall experience of consumers with disabilities when they are in hospital, and would actually improve care for all hospital patients as the nursing and support staff at the hospital would not be needing to spend as much time providing additional care for to accommodate the communication requirements of people with complex communication needs.

We hear similar concerns around people who have funded mental health supports when they are admitted to hospital for reasons that do not relate to their mental health, they are not permitted to continue to receive this mental health support while in hospital, with the assumption yet again being that the state will absorb the cost of providing additional care for these consumers while they are in hospital.

This is a perfect example of where the funders involved need to see the journey of the consumer as key, rather than seeing a hospital door as a place where funding commitments transfer to a different level of government.

Rural towns trying to attract and retain GPs

Rural towns across the country find attracting and retaining GPs to be a great challenge, and the Local Governments in those towns often find themselves providing cash subsidies, houses and cars for GPs to try to convince them to make their home and business in their towns – GPs choosing to live and work in these communities also allows the hospitals in these towns to remain open, providing key local health care for the community.

Unfortunately, these local governments have small ratepayer bases and a low rates income, yet are spending well over $100 000 per year in cash incentives plus provision of accommodation to their GPs. Meanwhile, wealthier city-based local governments have no such financial obligations. This leads to regional local governments being less able to fund other important projects in their areas. The pressures on rural communities aren't entirely reflected in the statistics of GPs in rural communities, as these communities have GPs and hospitals, but are facing significant financial pressure in order to keep these GPs.

The state government provides housing for nurses, government dentists, teachers and police officers in rural and regional towns. It would be of great assistance if this housing provision could be extended to GPs who are also working at the local hospital.

The need for small towns to pay cash incentives to GPs puts a great burden on the community, who effectively have to pay for their GP three times – once for the appointment itself, once through their taxes and a third time through their rates. This is an unreasonable burden on community members and local governments. The federal government Financial Assistance Grants for Local Government covers a portion of the cash incentives the local governments are providing, but local governments tell us this is not adequate and nor is it confirmed as being a reliable amount each year. This means that consumers are either left without a reliable doctor or are faced with higher local government rates in order to access a GP. Another pain point in funding bodies not adequately meeting the needs of consumers.

Lack of suitable aged care beds at discharge

Hospitals in WA and across the country are under considerable pressure, not only from increased demand over a troublesome flu season, but at the other end of care, where people who are not able to be discharged home are needing to remain in hospital until an Aged Care bed becomes available. The availability of Aged Care beds is a federal issue, while the management of hospitals is a state issue, and while these two funding arms continue to not quite meet the needs of our communities, the flow on effect from that is multifaceted. People being unable to be discharged to aged care beds means they need to stay in hospital for longer than is necessary, leaving them with a distressing experience that isn't appropriately meeting their needs. It also leads to ambulance ramping and long delays in emergency departments, placing vulnerable and unwell consumers at risk of not receiving the urgent care that they require. Additionally, these delays and ramping lead to a diminishing trust in the health system, which in turn leads to people not attending for care when they do need it, which then leads to people needing a higher level of more urgent care further down the track, increasing potentially preventable hospitalisations and placing even greater burden on ambulances and health staff.

Care in place in the community

Communities often know what it is that they need for community members to live healthy lives. It is also well known that people heal better when they are close to home, country and loved ones. We believe that collaborative commissioning provides an exciting opportunity to devolve decision-making to communities and to seek their knowledge on what works well. We also think this provides an excellent opportunity for primary health networks and public health services to work closely together to deliver adequate and appropriate care in place, on country, close to where people live. The current funding model that means that higher levels of care are only available in large tertiary hospitals that are located in the centre of large cities is particularly unsuitable and unsustainable in a large state such as WA, and telehealth is not always the answer, due to telecommunication connection issues in the bush.

A national framework to support government investment in prevention

We are broadly supportive of the recommendations in this part of the report, particularly since this is recommending that prevention has a wider lens that includes housing, education and justice. We

are also very supportive of the endorsement of Housing First programs as being successful and worth funding.

Similarly, we agree that it is important to recognise that the parts of government that fund preventative health projects may not be the parts that benefit. Therefore the funding needs to be across government and not viewed as costs and savings for only one department or portfolio.

We were also pleased to read the recommendation that evaluation of preventative health funding be flexible, as the benefits from such programs may not be observable in the standard fiscal outlooks and forward estimates periods.

We agree that advisory board decisions on assessing funding applications be made public because public scrutiny of such decisions is crucial to ensuring they are being made in a fair and equitable manner. While we support the formation of an advisory board for assessing applications, we note that there is no mention of consumer participation or community members in this board. We would recommend that community members and consumers be included to ensure a diversity of opinions are available to make the best-informed decisions.

At no point in the report is it explicitly stated that preventative health funding should come from a different budget than the health budget. The risk to service provision if operational health funding is reduced to move money into the preventative health budget is too high at this stage. As mentioned earlier, the cost savings delivered by preventative health will not be seen for some years, so it is crucial that in the first instance the funding that is available for preventative health comes from other sources and does not reduce the funding available to the health system.

Please contact the undersigned for any clarification or further information.

Kind regards,

Clare Mullen
Executive Director