Health Consumers Queensland…. your voice in health

Health Consumers Queensland: Submission on the Commonwealth Government's proposed National Health and Hospitals Network

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ABOUT HEALTH CONSUMERS QUEENSLAND

Health Consumers Queensland (HCQ) comprises a 12-member Ministerial Consumer Advisory Committee (Committee) and a Secretariat supported by the Office of the Director-General, Queensland Health. HCQ's statewide Committee was appointed in August 2008 for a two-year term from 1 September 2008. The Committee is comprised of a mix of health consumers from a broad range of health populations and social groupings.

HCQ's Terms of Reference and Mission are to support the voices of Queensland consumers to achieve better health outcomes. HCQ contributes to the continued development and reform of health systems and services in Queensland, by providing the Deputy Premier and Minister for Health with information and advice from a consumer perspective and by supporting and promoting consumer engagement and advocacy.

HCQ aims to strengthen the consumer perspective in health policy development and system reform and improvement.

ABOUT HCQ'S SUBMISSION

HCQ's submission on the Commonwealth Government's National Health Reform Plan, as detailed in the, *A National Health and Hospitals Network for Australia's Future* paper reflects Queensland health consumers' perspectives to date, which were gathered through feedback from:

- A forum with 35 key state-wide health consumers around the National Health and Hospitals Network in Brisbane on 29 March 2010
- HCQ's state-wide Consumer Network comprising 133 individual consumers and 33 key consumer and community organisations
- HCQ's Ministerial Consumer Advisory Committee

HCQ sought feedback from consumers and their representatives around four key areas which HCQ identified from the reform paper:

- National Health and Hospitals Network
- Local Hospital Networks
- National Standards, Performance and Accountability
- General Practice and Primary Health Care

These four areas were of considerable interest to our Committee, Network members and forum participants, reflecting respondents' aspirations for a reformed Australian health system which delivers health services across the board that are consumer-focused, safe, quality, affordable, accessible, timely and responsive to the needs and interests of the diversity of Queensland health consumers.

HCQ perceives health consumers and their representatives have an ongoing role in the management of their health care and the decisions being made which influence the health and wellbeing of their communities.

In line with our role as a Queensland peak health consumer body, HCQ has developed its submission to inform the Honourable Paul Lucas MP, Queensland Deputy Premier and Minister for Health, for his information and consideration, prior to discussions at the Council of Australian Government's meeting on 19 April 2010. A copy of the submission is also being forwarded to the Honourable Nicola Roxon MP, the Commonwealth Minister for Health and Ageing.

OVERVIEW

In principle, HCQ broadly supports the overall direction of the proposed reforms and would encourage the Commonwealth Government to press forward with its reform agenda for better health outcomes for Queenslanders and their fellow Australian citizens. HCQ also believes there are not sufficient details in the reform paper to form an informed final opinion around a number of matters.

However, feedback to HCQ indicated that Queensland consumers want greater clarity and public transparency around the roles and responsibilities of the Commonwealth and State/Territory Governments in regard to the proposed National Health and Hospitals Network. Given the continued involvement by both levels of government in the funding, governance, accountability and performance of key components of the networks under the current reform proposals, greater clarity and public transparency will contribute to public confidence that the proposed reforms will *end the blame game* between jurisdictions.

HCQ also looks forward to further details on the proposed reforms, particularly around rural and remote health initiatives, mental health, aged care and e-health. We are keen to be involved in further consultations on upcoming national health reform initiatives which may impact on the health and wellbeing of Queenslanders. We believe it is vital that health consumers' perspectives are heard and woven into quality health decision-making.

HCQ especially commends the Commonwealth Government on its commitment to 100 per cent funding of primary health care and aged care. We look forward to further details on these matters, particularly in relation to a number of equity groups currently experiencing poorer health, low functional health literacy, and concerns about service access and satisfaction compared to the general community. These inequities need to be addressed and not exacerbated by the intended reforms.

HCQ especially supports enhanced health advocacy opportunities, which align with improved health literacy and patient activation initiatives that promote wellness and resilience in individuals, families and communities; and reforms that promote safe and high quality health services and programs and other initiatives that achieve better health outcomes for consumers.

Queensland consumers also stress the Commonwealth needs to take into account the challenges and complexities posed by the state's geographical spread and the diverse needs of our various health populations and social groups, including the unique needs and circumstances of rural and remote Queenslanders, in further developing the reform proposals.

In recent years the Queensland Government has implemented a number of positive reform initiatives to improve the quality, safety and overall culture of Queensland's health services. A number of these reform initiatives have been driven through centrally located agencies that link with local or district health services to deliver efficient and effective healthcare outcomes. Implementation of the National Health and Hospitals Network proposals need to build upon these state reform initiatives that have improved the safety and quality of health services.

Additionally, Queensland has a rich history of various models of community governance in relation to its public health services at the local or district health level. Lessons about what has worked well and what has worked less well can inform the final structure and governance arrangements of Queensland's Local Hospital Networks and contribute towards nationally consistent approach to their structure, governance, roles and responsibilities.

Further, consideration needs to be given to the health requirements of a growing and ageing population and the dedicated personnel who will deliver those services across Queensland, with appropriate levels of funding, training and resources to enable this to occur in an efficient, person-centred and timely manner.

As such, we welcome further consultation by the Commonwealth and State with key consumer bodies, health consumers and their representatives for greater understanding of the proposed reforms and their likely impact on health consumers who are central to health service delivery.

KEY ISSUES FOR HCQ:

- Given the importance of the recent announcement and its impact on all Queensland health consumers, it is vital consumers' perspectives continue to be heard in relation to this important aspect of the national health reform agenda.
- HCQ is keen to see a strong role for health consumers in the proposed Local Hospital Networks (LHN), particularly in their planning, governance arrangements and consumer and community consultation activities.
- There is a need for close collaboration and common boundaries between the LHN and Primary Health Care Organisations (PHCO) to ensure consumers receive integrated care and a seamless transition between acute and primary healthcare. Towards this, consumers want clarification around the proposed boundaries and relationships between the two bodies.
- Whether the reforms will promote better interlinking between health services and other social determinants of health at the local community level, towards improving health consumers' overall well-being (for example, housing, transport, income support, town planning, healthy food choices).
- The need for a nationally consistent and equitable approach to the funding of the Patient Travel and Accommodation Scheme and the Medical Aids Assistance Scheme, rather than continuing with separate state program and administrative arrangements. Queensland rural and remote consumers particularly want improved program and funding guidelines for both schemes, especially in relation to cross-border issues.
- Public health initiatives (for example, health prevention activities around chronic illness and disability) must be built into funding that is responsive to different community needs.
- HCQ believes LHN will only work if the hospitals are responsive to consumers' current life situations, needs and experiences. These must underpin service improvements. This includes ensuring older Australians health needs are met in the most appropriate and resourced health care environment (for example, acute clinical and treatment needs are provided in a hospital setting rather than a residential aged care facility; and residential support needs are met in a suitable residential aged care setting rather than an inappropriate hospital environment because of the lack of aged care beds).

- A major point of concern for rural and remote Queenslanders is infrastructure spending. What chance, if any, will small communities have for upgrading of facilities or expansion of services as required?

- HCQ would like to be involved in the continuing and ongoing professional development of LHN Governing Council members, to ensure the consumer perspective is included in all matters.

- HCQ believes LHN should have a clearly defined and effective process for complaints handling and management.

- HCQ would like involvement in the development and monitoring of medication safety mechanisms in LHN.

- HCQ suggests the intent of the ‘close the gap’ initiative for Indigenous Australians is incorporated into LHN policy and planning.

- HCQ would like to be involved in core continuous quality improvement processes within the reformed health system.

- The concept of 33 cents out of every dollar collected through the Goods and Service Tax being allocated by the Commonwealth to health and hospitals is a necessary reform.

- HCQ asks how the Commonwealth intends coping with the tyranny of distance, particularly in rural and remote areas of Queensland where consumers have to travel extensive kilometres to access even a basic public hospital or community health facility.

QUEENSLAND HEALTH CONSUMERS AND THEIR REPRESENTATIVES HAVE RAISED THE FOLLOWING CONCERNS:

- The need for a ‘no blame’ culture. Some consumers suggest 100 per cent funding of hospitals by the Commonwealth would stop the buck-passing between State/Territory and the Commonwealth Governments.

- Funding should meet local needs.

- The affordability of Local Hospital Networks (LHN).

- The need for seamless health services across all health sectors.

- The need for formal recognised integration of holistic, person-centred health services and practitioners.

- What will be the interface between the roles and responsibilities of all stakeholders?

- How a consumer representative and their required skills set will be universally defined.

- The need for national standards for appointment to LHN.

- National standards and performance monitoring should be a rehabilitative process, not a punitive process for continuous quality improvement.

- There needs to be one national accreditation system for public and private health services across Australia.

- How will the national standards be enforced? Consumers believe there should be no imposition of national standards without Commonwealth-driven solutions.

- How will a federal monitoring system fit into the state system?

- Why will LHN be statutory bodies accountable to their State/Territory Health Ministers?

- Health education to be provided in schools to teach children to become more health literate and be responsible for their preventive health practices.

- Consumers consistently raise the issue of better coordination of aged care services and more available residential aged care places or community health staff to enable older Australians to return safely to their community home of choice with necessary health and community care support. This involves comprehensive discharge and transition planning and rehabilitation services within the hospital environment and community sector.

- When an older Australian is a hospital in-patient, will their health diagnosis rather than just their age and/or frailty be given prime consideration, when determining whether they should remain in hospital or whether they should be discharged to a residential aged care facility? HCQ is keen to see the health care needs of older Australians safeguarded and that they receive the same level of required care in an appropriate health care facility, in a timely and responsive a manner as other Australians across their lifespan.

SUMMARY OF FEEDBACK FROM QUEENSLAND HEALTH CONSUMERS AND THEIR REPRESENTATIVES:

- **National Health and Hospitals Network (NHHN)**

  - Consumers have raised the following concerns:

    - How will eHealth be resourced and operated?

    - Who ultimately is legally and financially accountable for good corporate governance and patient care, quality and safety – the Commonwealth, State/Territory Governments, and/or LHN?

    - Will the National Disability Insurance Scheme link with the NHHN and if so, how?

    - Will Queensland Health departments that monitor quality and safety of services and staff performance (for example, the Patient Safety Centre) be lost in these arrangements? If they are maintained, what will their relationship be with the NHHN?

  - The complexity of the current health system across the States and Territories should be minimised to enable people to better navigate the system.

- Health services should be seamless between hospital, primary and community care, focusing on individual consumer's health needs.
- Health services should be interlinked with other social determinants of health (for example, housing, transport, literacy and health literacy).
- Appropriate models of service (for example, mobile or telehealth services in rural and remote communities) need to be investigated, implemented and evaluated to ensure diverse contexts are addressed.
- There needs to be a clear process to highlight the relationships between the NHHN and LHN.
- A national, centrally coordinated eHealth and telehealth system underpinned by appropriate standards and performance accountability.
- A standardised approach to communication to respond to consumer and community diversity and their functional health literacy.
- Public health initiatives (for example, health prevention activities around chronic illness) must be built into funding that is responsive to different community needs.

- **Local Hospital Networks (LHN)**
  - Consumers have raised a number of questions, including:
    - How will the boundaries for LHN be determined? Where possible, the boundaries for LHN and primary health care organisations should be the same with emphasis on integration. This integration should include communication, public perception, media communication and health awareness (for example, mosquito borne viruses in the tropics) and regional, schools-based initiatives, including health champions for a healthy, active and the younger generation.
    - Is there a likely restructure of existing health service districts in Queensland? HCQ proposes, if there is to be a restructure, then LHN and PHCO have the same boundaries/borders. Anomalies around geographical and service provision boundaries are one cause of people falling through the cracks.
    - How the LHN boundaries and structure will align with Queensland's 36 Health Community Councils and 15 Health Service Districts. Given it was publicly announced by the Commonwealth Government that there would be about 150 LHN across Australia, how many LHN will be allocated to Queensland? Health Community Councils have already gone through an alignment process that will probably see much greater geographical service areas and less people appointed to monitor the areas' requirements and the quality and safety of health services.
    - Who will constitute the Governing Council membership of LHN? HCQ believes a blend of diverse working abilities (for example, clinicians; operational and domestic staff; community representatives; two or more health consumers) and base-line level of skills need to be agreed upon across the nation (for example, communication skills,

including awareness of media imperatives; ability to apply strategic thinking and network; consumer experience; empathy; credibility; integrity; and ability to be apolitical).

- HCQ suggests it would not be the role of Governing Council members to engage in the finer details of operational matters associated with each of the hospitals in LHN.

- How will members of the Governing Council be appointed? HCQ believes there should be a nationally consistent process for recruitment and selection of members, based on the principles of transparency, respect and integrity throughout the appointment process and members' incumbency.

- What level of commitment will be required of Governing Council members – full time, part-time, episodic? Given doctors and other health practitioners are extremely busy people and often quite transient in rural and remote areas, and the perceived time consuming nature of membership of a LHN Governing Council, how effective will LHN be?

- What remuneration arrangements will be in place to reimburse professional people and community and consumer representatives for their membership? One of HCQ's consumer engagement principles states that no consumer representative will be financially disadvantaged as a consequence of their involvement in health-related committees. If remuneration is made, will financial coverage come out of the initial LHN funding?

- What is the role of the Chief Executive Officer (CEO) – equal member or principle decision-maker? HCQ asks if the CEO can be a non-executive advisory role. Will the CEO be able to work in partnership with other members of the Governing Council?

- Will LHN have sufficient autonomy to respond to local needs? HCQ believes LHN need to not only be autonomous but be seen to be autonomous (this is where media skills and assistance come into play).

- Will LHN become employers of the staff employed at each of the hospitals in the LHN? HCQ would not support this concept.

- How will direct reporting to State-based Minister under statutory body guidelines operate?

- What will be the indemnity arrangements for the governing council if the LHN become statutory bodies reporting to a State Minister?

- Will there be adequate, quality consumer representation on LHN (for example, at least two or more consumers, representative of the smaller hospitals in the LHN)?

- How will the networks receive their funding?

- Does the Commonwealth propose a cap on service delivery?

- Where will palliative and transitional care sit within the proposed reforms? HCQ believes palliative and transitional care should have exactly the same status and position as primary health care. This is where seamlessness comes in – hospitals and hospital care have a middle role to play. In fact, the more quality care provided during early life stages (for example, prevention and primary health care) and later life stages (for example, palliative, homecare and transition care) then the least likelihood of hospital stays.

- Where will top-up funding come from?

- What chance if any will small areas have in the future for upgrading facilities or expansion of services into communities of need?

- Will the Patient Travel and Accommodation Scheme be run centrally out of Canberra or operate under current State arrangements? HCQ believes the current arrangements are not working – it believes it is process heavy, open to abuse, and not meeting the needs of consumers without transportation.

- How will electronic discharge summaries be resourced and operated?

- What about hospitals with a less than 10-bed allocation? Activity based funding could impact on their continued operation – need for top-up funding to enable local health needs to be met in local communities with local health practitioners.

- HCQ was glad to hear that the Prime Minister stated that *the formula to be developed for the pricing of hospital services will not lead to the closure of any regional, rural or small hospital anywhere in Australia.*

  HCQ believes the current fixation with bed numbers should be changed to 'what services can be delivered'.

- The 'efficient price' funding proposal may be an impost on rural and remote areas. Also, will this arrangement provide sufficient time for health professionals to work with consumers to address their health concerns and needs?

- Consumers believe high level, ongoing training on all aspects of the health system and corporate governance is required for each member of the Governing Council.

- There must be investment in good governance and the capacity of clinicians to deal with performance and accountability matters. Clinicians need to be aware of these matters.

  (Note – HCQ recommends that agencies invite at least two consumers onto a committee as two consumers participating provide an opportunity for each to support the other during meetings, in preparation and debriefing. Having two consumers involved will facilitate succession planning and safeguard the continuity of the committee should one consumer be unable to fulfil their obligations).

- There needs to be uniform terms of reference across all Australian LHN.

- There needs to be consumer-centred, formally recognised integration across each of the hospitals in the LHN.

- LHN need input into workforce planning and performance management (for example, recruitment; Local Government input in rural and remote areas; collaboration on attraction and retention in rural and remote areas).

- Consumers raised concerns about transient health practitioners, particularly in rural and remote areas of Queensland and the implications for continuity of care and interpersonal relationships.

- Currently hospitals are not retaining information or providing onward referral to other hospitals. This makes it very difficult for people with chronic and complex illnesses, disability, living in regional and remote areas and other marginalised people to have timely access to the health care they need. HCQ asks why this is not happening. Will electronic health records solve this problem? HCQ believes, across the board buy-in of e-health is required beyond just systems and skills.

- Current interstate agreements for cross-border and transient populations (for example, grey nomads travelling north for the winter; Northern Territorians accessing hospital services in Mount Isa; seasonal workers; Aboriginal and Torres Strait Islander populations). Will the redirected funding go directly to the LHN?

- Consumers have raised concerns about the implications on health service delivery in times of natural disasters (for example, floods, bushfires) and emergency funding arrangements. HCQ believes informed consumerism would include dissemination of information about Local Disaster Management (LDM) Plans; the roles and responsibilities of Emergency Management Queensland; Local Government; and Population Health. Quality consumerism would include extensive knowledge of these plans, what happens in the local community and the chain of command (how it all works). There is a case for inclusion of LDM Group membership on LHN.

- Any successful reform to the health and hospitals system must be based around consumers. It is vital that consumers and their representatives have a say in the design and running of LHN.

- Consumers want to see LHN providing quality consumer and community engagement around key health issues in those communities.

- Some consumers have suggested general practices be accommodated in larger rural hospitals to relieve the drain on accident and emergency departments. It was also proposed that the Medicare rebate for general practice services be raised to encourage consumers to attend their local general practice rather than the overburdened accident and emergency department at their local hospital. This would require public education about the availability of such services (for example, for older Australians; tourists; and culturally and linguistically diverse communities).

- **National Standards, Performance and Accountability**

  - There needs to be greater detail about potential standards and performance and accountability processes before consumers and their

representatives will accept that the proposed reforms will deliver person-centred, affordable, accessible, timely and responsive health care for Queenslanders. HCQ proposes consumers play a more active role in the further design of the proposed reforms, rather than just waiting until they are delivered.

- The key areas for national standards seem broad – how will they filter down to clinical guidelines and models of service delivery that are consumer-focused? HCQ requires more detail on these matters.

- The national standards must be levers that can drive reform across the service sector (for example, reforms highlighted in the National Maternity Review need levers on hospitals to increase midwifery models of care). There needs to be an incentive for efficiency and improvement planning via a rehabilitative and reward, not punitive process.

- There needs to be widespread consultation with consumers, their representatives, families and carers and representative from professional organisations during the development of the standards. Accurate data to reflect local needs and intelligence should be included.

- There needs to be one standard across the health sector, not local clinical guidelines to ensure equity of access (for example, for Indigenous, culturally and linguistically diverse, disability and mental health consumers) i.e. a basic standard of person-centred, affordable, accessible, timely and responsive health care.

- Will service providers receive additional funding for national standards implementation and compliance? HCQ believes this could be one of the incentives for standards implementation and compliance.

- Consumers have asked – who would 'watchdog' the national standards? Consumers have suggested either a new, national independent body or enhanced responsibilities for state-based agencies like Queensland's Health Quality and Complaints Commission. If a new national body was formed, what will happen to individual States' standards and their relevant bodies?

- Innovative ways of attracting quality staff underpin the implementation of and support for national standards and performance and accountability activities. HCQ proposes Local Government could be recruited to work collaboratively with LHN, especially in rural and remote areas.

- The process for LHN to feed into the continuous improvement process. Why is responsibility to rest with 'expert' clinicians?

- Consumers questioned why the States should solve performance issues, when they are the minority funders.

- Consumers have asked if the current Queensland Health Patient Safety and Practice Improvement Centres will continue under the proposed NHHN model.

- Issues to be addressed for better consumer health outcomes:

  - Overseas trained doctors should be given an immersion period by being placed in an urban hospital where there is adequate supervision

and better access to resources and training. They should also receive Australian culturally appropriate training before they are sent to rural and remote areas to practise. This should include information on the history and culture of Aboriginal and Torres Strait Islander peoples.

- Consumers suggested overseas trained doctors could do a course, like one run in Victoria where all Language Other Than English Speaking doctors were given training in Australian medical terminology and colloquialisms before they were accredited.

- The qualifications of overseas trained doctors should correlate with the role they will be doing in a rural or remote community. The placement should not simply be based on 'area of need'.

- Overseas trained doctors working in rural and remote areas need ongoing supervision, professional development and appraisal of their competence to practice.

- Consumer-friendly, transparent data collection and review which is linked back to quality improvement systems and 'community wellness' models. This should identify the consumers' whole experience of the health system and consumer liaison officers to facilitate qualitative consumer interviews rather than just the current tick 'n flick consumer satisfaction surveys.

- There is a need for an ongoing education process on clinical guidelines for clinicians, other health professionals and consumers (for example, a national information brochure suitable for all levels of consumers' functional health literacy).

- Need for a national media campaign around the national standards and their implementation.

- **General Practice & Primary Health Care**

  Consumers believe there should be:

  - Strengthened formal mechanisms at hospital, general practice, primary health care, community health, and public housing and transport governance levels.

  - Development and training in specific specialities to direct health practitioners towards primary health care.

  - Multi-disciplinary input is required.

  - Bundled funding and delivery of care to bridge primary and acute care, encouraging continuity of care and person-centred pathways – good communication strategies.

  - Allowance for local flexibility and research to ensure best practice initiatives which will continue the interface between hospitals, general practitioners and community services – map local services to ensure quality service delivery for consumers.

- Effective information technology to support the mapping, with primary health care taking responsibility for the provision of current and relevant information to consumers and their representatives.

- Incentives for general practitioners to deliver targeted health interventions to improve identified groups of consumers' quality of life (for example, Indigenous and people with chronic health conditions).

- Quality of care and patient wellbeing should not be compromised by case mix funding of services.

- Health consumers need to be better supported to be more active in their care arrangements and decision-making. Informed consumerism is one of the pillars of good health service delivery; uninformed consumerism works against even a basic acceptance of service delivery and good health outcomes.

SUMMARY

HCQ welcomes this opportunity to provide the consumer perspective on the Commonwealth Government's proposed National Health and Hospitals Network and corresponding reforms. HCQ is supportive of the Commonwealth's ongoing health reform agenda, having provided submissions on a number of key reform initiatives over the past year.

We acknowledge this initial step in addressing the overwhelming complexity and diversity of the Australian health and hospitals system as it stands today. We also welcome the Commonwealth Government's move to assume majority funding responsibility towards a safer and better quality public hospital system with an integrated private, primary health and community care system.

This holistic approach will ensure the provision of needed care, treatment and support for future health consumers and current health consumers, who have a disability, are frail, aged, live with chronic or mental health conditions, or who are just unwell for a short period of their lives or have experienced a debilitating accident, wherever they live.

In summary, HCQ would suggest that peak consumer bodies and consumers and their representatives have ongoing engagement in further development of the proposed reforms and be key players in LHN governing councils and the development, setting and evaluation of performance measures and service standards.

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