Submission No 30

INQUIRY INTO SERVICE COORDINATION IN COMMUNITIES WITH HIGH SOCIAL NEEDS

Organisation: Australian Medical Association

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Parliament of New South Wales
Legislative Council
Standing Committee on Social Issues

Inquiry into service coordination in communities with high social needs

Submission by

Australian Medical Association (NSW) Limited

AMA is a medico-political organisation that represents over eight thousand doctors in training, career medical officers, staff specialists, visiting medical officers and specialists and general practitioners in private practice.

AMA (NSW) welcomes the opportunity to make a submission on the important issue of improving the delivery of coordinated services in communities with high social needs.

Any questions regarding this submission should be directed to:

1. Terms of reference to the inquiry

1. That the Standing Committee on Social Issues inquire into and report on service coordination in communities with high social needs, including:

    a) The extent to which government and non-government service providers are identifying the needs of clients and providing a coordinated response which ensures access to services both within and outside of their particular area of responsibility

    b) Barriers to the effective coordination of services, including lack of client awareness of services and any legislative provisions such as privacy law

    c) Consideration of initiatives such as the Dubbo Minister's Action Group and best practice models for the coordination of services

2. That the Committee report by 11 December 2015.

2. Introduction

It is well established that disadvantaged groups within society, by virtue of their socioeconomic status, are often grappling with a variety of needs such as health, financial, employment, housing and educational needs, as well as typically being the demographic most vulnerable to severe and multiple legal problems. The intertwined nature of the needs of many disadvantaged groups mean that a coordinated response involving a combination of services working together is required to deliver a comprehensive solution to the concurrent and bidirectional problems present in these groups.[1]

The AMA (NSW) recognises the need for more efficient arrangements to support the provision of well-coordinated multidisciplinary care to communities with high social needs, particularly groups vulnerable to chronic and complex health care needs. Many AMA members are involved in delivering health services to patients who would benefit from a coordinated approach to provide them with access to other health and social services in a seamless and integrated response. If access to coordinated multidisciplinary health and social care is improved, then patients will benefit, the number of avoidable hospital admissions can be reduced, and long-term savings to the public system will be generated.

The AMA (NSW) also supports the rights of patient privacy. The AMA (NSW) recognises the sensitive balance between coordination of service delivery, which requires information sharing, and patient privacy with respect to their health and personal information.

3. Effective practices for service delivery coordination

> *"Integrated care is care that crosses boundaries between primary, community, allied health and hospital care and extends beyond health into social care and support too. Providing integrated care is a goal of health systems around the world and is a way of optimising the outcomes for patient, provider and system so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money."*
> - Dr Frank Jones, President of the RACGP

There is a strong business case for integration to improve the interface between general practice and other health and social services.[2] Australian and international evidence demonstrates that structured, integrated GP led primary care reduces hospital presentations, admissions and length of hospital stay in the range of 16-40%.[3]

[1] Coumarelos, C, Macourt, D, People, J, MacDonald, HM, Wei, Z, Iriana, R & Ramsey, S 2012, Legal Australia-Wide Survey: legal need in Australia, Law and Justice Foundation of NSW, Sydney.
[2] Dr Frank R Jones, An Integrated Primary Care sector: a view from the front line.
[3] Grumbach K and Grundy P. Outcomes of implementing patient centred medical home interventions: A review of the evidence from prospective studies in the United States. Patient-Centred Primary Care Collaborative. November 16 2010. Available from: http://www/pcpcc.net; Gilfillan R, Tomcavage J, Rosenthal M, Davis D, Graham J, and Roy, J. E.Value and the Medical Home: Effects of Transformed Primary Care. American Journal of Managed Care 2010;16(8):607-614; Steiner BD, Denham AC, Ashkin E, Newton WP, Wroth T, Dobson LA Jr. Community care of North Carolina: improving care through community health networks. Ann Fam Med

Emergency department presentations have been steadily increasing and the acuity of patient health is worsening.[4] Why do patients present at hospital? Research cites the reasons as a) the complexity of management of chronic disease, particularly for patients with multiple needs, and b) the fragmentation of care which contributes to overuse, underuse and/or misuse of health resources, and ultimately mismanaged patient care because no one is responsible for coordinating that care. Early intervention is proven to prevent deterioration of health and promotes the active management of chronic disease. Centralised coordination of patients with complex needs also reduces the risk of an adverse event leading to hospitalisation, which has public cost benefits.[5]

Government costs for GP care per person per year in real dollar terms have remained relatively steady for 15 years while hospital costs per person have increased by approximately 50% over a similar period.[6] General practice therefore represents an efficient component of the health care system, as well as being centrally placed to deliver preventive and coordinated health care. General practice also has unrivalled capacity and population reach, with over 134 million consultations per year, and 89% of the Australian population visiting their GP at least once a year.[7]

It is well documented that many factors *outside* of the health sector have an influence on the health outcomes of communities with high social needs. For Aboriginal and Torres Strait Islanders much of the gap in health outcomes can be traced to social determinants of health,[8] which are a confluence of social, economic, geographic and cultural circumstances that have an impact on health. In considering the impact of these factors on the health of Aboriginal and Torres Strait Islanders, one study suggests that between one-third and one-half of the health differences between Indigenous and non-Indigenous Australians may be explained by differences in social determinants of health.[9]

Given this, it is acknowledged that in order to effectively address the health disparities experienced by Aboriginal and Torres Strait Islander people, the health system must be linked to and supported by a range of programs and services that address wider social and economic disadvantage, giving due consideration to social, economic, cultural and spiritual factors to demonstrably and sustainably improve health outcomes for Aboriginal and Torres Strait Islander people.[10]

The evidence base reveals that service delivery coordination initiatives designed with, and for, communities of high social need must;

- Focus on outcomes[11]
- Respond to the distinct social needs and tailored to the particular circumstance faced by communities of interest[12]
- Be culturally appropriate by ensuring that mainstream services are better equipped to be responsive to the needs of Aboriginal and Torres Strait Islander peoples[13]
- Be undertaken by staff who are appropriately skilled, qualified, experienced, supervised and supported[14]
- Apply a strengths-based approach which acknowledges that all communities have strengths and capacities that can be harnessed to engage change- this approach is particularly successful in

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2008;6: 361-367; Geisinger Health System. Presentation at White House Roundtable on Advanced Models of Primary Care:August 10, 2009; Washington DC, United States.

[4] Bureau of Health Information, Hospital Quarterly Report series 2010-2015; Australian Institute of Health and Wlefare, Hospital Statistics 2014.

[5] Dr Frank R Jones, An Integrated Primary Care sector: a view from the front line.

[6] Australian Government Productivity Commission. Report on Government Services 2013. Canberra: Productivity Commission, 2013.

[7] Vos T, Carter R, Barendregt J, Mihalopolous C, Veerman L, Magnus A, Cobiac L, Bertram M and Wallace A. Assessing Cost-Effectiveness in Prevention (ACE-Prevention): Final report. September 2010. University of Queensland, Brisbane and Deakin University, Melbourne.

[8] Marmot, M. 2010. Fair Society Healthy Lives (the Marmot review). UCL Institute of Health Equity.

[9] Booth and Carroll (2005) The health status of Indigenous and non-Indigenous Australians (Centre for Economic and Policy Research ANU).

[10] Investing in Healthy Futures for Generational Change - National Aboriginal Community Controlled Health Organisation (2013) *in:* Australian Healthcare and Hospital Association, 2015. Aboriginal and Torres Strait Islander Health- AHPA Primary Discussion Series, Paper 3.

[11] Australian Government Closing the Gap clearinghouse. Effective practices for service delivery coordination in Indigenous communities (December 2011).

[12] Shergold Peter, *Service Sector Reform. A roadmap for community and human services reform*, Final report, July 2013.

[13] National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 Australian Government Implementation Plan 2007-2013.

[14] Victorian Service Coordination Practice Manual 2012, Primary Care Partnerships Victoria.

engaging clients with complex needs who have negative experiences, or low trust levels with other agencies, to work towards positive outcomes[15]
- Protect privacy[16]
- Support the providers of care[17]
- Be 'joined-up'- recognising that elements of multiple disadvantage are complex and support services should be 'wrapped-around' the individual or community to provide a holistic response[18]
- Be fit for purpose[19]
- Be timely- prevention is a cost-effective way of improving population health[20]
- Be gender-aware, family-sensitive and child-focused- acknowledging that statistics and research clearly indicate that the majority of family violence is perpetrated by men against women and children[21]
- Address the social and environmental determinants of health and wellbeing, such as education and housing, as well as biological and medical factors. This includes the spiritual and family connections that contribute to wellbeing[22]; and
- Be accountable to the public by demonstrating the effective use of funding received to achieve agreed outcomes and by measuring the longer term social impact of programs and services.[23]

To address chronic and complex social and related health needs, we must recognise that massive social change requires massive social investment, sustained over time, which spreads new and existing innovations that are proven effective. The hard work that's necessary to build sustainable institutions that foster justice, opportunity, and health cannot be short-circuited.

4. Barriers to effective service delivery coordination

> *"To create new norms, you have to understand people's existing norms and barriers to change. You have to understand what's getting in their way. So what about just working with health-care workers, one by one, to do just that?"*
> - Atul Gewande[24]

Communities with high social needs require an array of supports. Individual service providers develop the expertise to deliver a very specific service, yet individuals, families and communities with high social needs experience multiple needs and interrelated problems.

Privacy is often cited as a barrier to necessary and appropriate information sharing.[25] The sharing of health information is a key feature of coordinated health care programs. The future availability of electronic health records and electronic communication will greatly assist the sharing of health information amongst all providers of health care.

Much needs to be done to ensure that the information sharing needs of frontline service delivery workers are clarified and simplified. This needs to occur before an emergency arises through the operationalisation of information sharing procedures which can involve, for example, making available and training frontline staff in standard operating procedures about privacy of patient health information and circumstances where

[15] Department of Health and Human Services, Victorian Government. Services Connect Client support practice framework February 2015. Accessed 12 August 2015 at: http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/client-support-workers-resources/client-support-practice-framework; Australian Government Closing the Gap clearinghouse. Effective practices for service delivery coordination in Indigenous communities (December 2011).
[16] Victorian Service Coordination Practice Manual 2012, Primary Care Partnerships Victoria.
[17] Australian Government Closing the Gap clearinghouse. Effective practices for service delivery coordination in Indigenous communities (December 2011).
[18] Shergold Peter, *Service Sector Reform. A roadmap for community and human services reform*, Final report, July 2013.
[19] Department of Health and Human Services, Victorian Government. Services Connect Client support practice framework February 2015. Accessed 12 August 2015 at: http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/client-support-workers-resources/client-support-practice-framework
[20] The Department of Health, Annual Medicare Statistics 2013-14.
[21] Department of Health and Human Services, Victorian Government. Services Connect Client support practice framework February 2015. Accessed 12 August 2015 at: http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/client-support-workers-resources/client-support-practice-framework.
[22] Victorian Service Coordination Practice Manual 2012, Primary Care Partnerships Victoria.
[23] Shergold Peter, *Service Sector Reform. A roadmap for community and human services reform*, Final report, July 2013.
[24] Sharing Slow Idea's, The New Yorker 29 July 2013.
[25] Commissioner for Privacy and Data Protection Commissioner for Privacy and Data Protection. Response to Royal Commission into Family Violence Issues Paper 31 March 2015.

information can and cannot be shared. Other barriers to effective service delivery coordination as evidenced by research include:

- Fragmentation and duplication of existing services
- Lack of a tailored, targeted response
- Lack of community consultation and engagement
- Government 'silos' and competitive funding
- Inadequate investment
- Lack of skilled program leaders, practitioners and staff
- Inflexible organisational structures or service delivery models
- Collaborative partners that do not share a common purpose or understanding of the objectives, and lack clearly defined roles or responsibilities
- Evidence of outcomes is not communicated
- Inadequate monitoring and communication of outcomes
- Inadequate information technology and privacy issues[26]

5. Recommendations

The benefits of coordinated care are recognised around the world.[27] The GP is the only clinician who operates in the nine levels of care: prevention, pre-symptomatic detection of disease, early diagnosis, diagnosis of established disease, management of disease, management of disease complications, rehabilitation, terminal care and counselling.[28] Funding of general practice that supports integrated, collaborative and coordinated care therefore represents a strategic investment in realising cost savings as well as proven patient and community benefit.

The AMA (NSW) supports a comprehensive approach to the management of chronic and complex health care needs based on a coordinated response that:

1. Provides GP-coordinated access for patients to services based on clinical and social need;
2. Provide a patient's usual GP with the support they need to improve the care they can provide or organise for patients with high or complex socially linked health care needs, in particular, provision in the MBS for the medical practitioner to be able to coordinate care;
3. Supports the coordination and transition of patient care between health care providers and across health care and community sectors;
4. Ensures that funding follows the patient;
5. Leads to better collaboration with existing service providers.[29]

6. Summary

The expectation is that general practice and primary health care will manage the majority of chronic conditions. GPs can assume this role but are not currently supported to facilitate integrated care. It is not possible for GPs to absorb the additional work required without appropriate support. The lack of provision in the MBS and inadequate provision in items AA180-AA210 creates a barrier for GP-led coordination of care. A model of integrated service delivery involving GPs would need to be supported by provision in the MBS for the medical practitioner to be able to coordinate care.

What is also required are programs aimed at promoting and supporting the integration of care between the community and health care providers which will save hospital funds at local, state and national levels.[30]

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[26] NCRVWC, Time for Action: the National Council's plan for Australia to reduce violence against women and their children, 2009–2021: a snapshot, FaHCSIA, Canberra, 2009, pp. 4–5. Accessed 12 August 2015 at: https://www.dss.gov.au/sites/default/files/documents/05_2012/a_snapshot.pdf.

[27] World Medical Association (2011) Global Burden of Chronic Disease, the 62nd WMA General Assembly, Montevideo, Oct 2011; GP Partners, Coordinated Care (2008) Team Care Health II Perspectives, http://www.gppartners.com.au/content/Document/report_teamcare.pdf; Battersby, Malcom W and the SA HealthPlus Team, Health reform through coordinated care: SA Health Plus. BMJ, Vol 330, 19 March 2005; Powell Davies, Gwaine, et. al. (2008) Coordinating primary health care: an analysis of the outcomes of a systematic review. MJA 2008; 188 (8 Suppl): S65-S68; Cosway, Robert et al. (2011) Analysis of Community Care of North Carolina Cost Savings, Millman Report for the North Carolina Division of Medical Assistance, 15 December 2011.

[28] Australian Medical Association. 'Chronic Disease Plan: Improving Care for Patients with Chronic and Complex Care Needs' AMA Canberra, 2012.

[29] Ibid

[30] Dr Frank R Jones, An Integrated Primary Care sector: a view from the front line.