

The Australian Psychological Society Ltd

Submission

To the
Senate Finance and Public Administration
Committee Inquiry
into
COAG reforms relating to health and hospitals

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About the APS

The Australian Psychological Society (APS) is the peak national body for the profession of psychology, with around 18,900 members, representing over 60% of registered psychologists. As the representative body for psychologists, the APS has access to a vast pool of psychological expertise from both academic and professional service delivery perspectives. The APS has responsibility for setting professional practice standards, providing ongoing professional development and accrediting university psychology training programs across Australia. It is represented on a number of advisory groups involved in the planning, implementation and ongoing monitoring of Government policy initiatives.

Constant communication with its members, plus access to high level psychological expertise and detailed involvement in Government initiatives, enables the APS to significantly influence the psychology workforce to ensure best practice in health service delivery.

The APS has a proud history of working in collaboration with Australian Government departments and other organisations in the successful delivery of policies and programs aimed at improving the health outcomes of Australians.

Context of Submission

The Australian Psychological Society (APS) has made various submissions to Government regarding the health and hospital reforms. The general thrust of these submissions has been supportive of the major initiatives around health reform and the APS is observing the developments with keen anticipation. There are, however, four elements that continue to concern the APS and these are:

1. Considerable focus of the reform proposals, and the funding that is associated with those reforms, on the hospital and tertiary end of the health system and the less clear commitment to the essential primary health care part;
2. That even the discussion regarding “primary health care” is largely expressed in terms of medical services (particularly GPs) and the organisations and structures that support these medical services;
3. Lack of any clear integration between primary health care and acute care service delivery;
4. The low and inequitable amount of the health dollar investment into mental health despite the high prevalence of such disorders in the community.

The APS believes that it is a misrepresentation of primary health care in the Australian community to describe it solely in terms of GPs, nurses and GP clinics. An analysis of the health workforce will show that as least as many as 30,000 allied health practitioners conduct private practices and support community health care organisations. Such practitioners are part of primary health care and are integral to its success in meeting the needs of the Australian community. The recognition that much of primary health care occurs alongside general practice and the networks that support GPs is a vital step in understanding the appropriate allocation of funds. There needs to be a creation of structures within primary health care that can ensure equitable and best practice allocation of the limited resources available. Efficiency in acute care will never be realised without effective integration with primary health care service providers to prevent people entering into hospital

too early and staying in too long. It is in this context that the APS makes a submission to the Senate Committee and addresses the specific terms of reference.

Terms of Reference (TOR)

1 TOR B and C

The APS shares with the Senate concerns about a clear analysis of the funding committed by the Commonwealth to these health reforms.

A good example of this new focus is the recent decision announced in the May budget that removed social workers and occupational therapists out of the Medicare funded Better Access initiative and redirected them to provide services under a block funded model that would incur considerable administrative costs that were previously incurred by the provider. This will result in less services being provided because they are more expensive. There are concerns that this will become the model for further redirection of funding away from fee for service towards managed care arrangements that funds an administrative role to coordinate and deliver services. It doesn't make any economic sense to move to this model yet there is increasing evidence that more of the health dollar will be directed to support bureaucratic structures to administer service delivery.

In addition to concerns regarding a distinction to be made between redirected and new/additional funding, there is an overriding concern as to how these funds will be distributed between acute and primary health care programs. But even more worrying from the perspective of best practice and the most cost-effective interventions in primary health care is the concern that *even* those funds that will be directed to non-acute services may be totally absorbed by medical services and medical organisations.

This process occurs repeatedly in policy and financial funding processes in chronic disease management (CDM). There is a clear understanding on the part of both government and community organisations that chronic disease will dominate costs in health over the next few decades. There is now considerable evidence both within Australia and from reputable overseas organisations that the management of chronic disease is best achieved by multidisciplinary care.

As the APS wrote in a previous submission to government:

“One of the main challenges of new PHCPs [Primary Health Care Practice: expansions of General Practice] will be to address chronic disease. This requires the provision of an appropriate model of chronic disease management... The model of “best practice” for a comprehensive approach to chronic conditions prevention and self-management (CCPSM) indicates the need for a Primary Health Care Practice workforce that covers interventions across three areas of need: disease related treatment; health behaviour change strategies development; and psychosocial interventions (Lindner et al., 2003). The evidence-based application of this model has been reviewed by a large number of investigations into chronic conditions prevention and self-management.

The World Health Organisation (2003) stresses that CCPSM needs to be viewed and implemented as a “team” approach with an adherence to health care recommendations. For

example, the medical practitioner plays a fundamental role in diagnosis and treatment recommendations for the physical condition and nursing and allied health professionals need to be involved in the assessment and treatment of health behaviour change difficulties associated with recommended treatments for CCPSM and associated psychological and social problems.

The adoption of this type of model will inform decisions in determining the most effective combination of primary health care providers and minimum staffing and standards for what would constitute a PCHP.”

When it is realised that CDM is only one (but a major one) of a range of conditions where multidisciplinary care is considered best practice, the appropriate funding of a broader range of health providers is vital.

2 TOR D

The very same concerns expressed regarding the allocation of the \$5.4 billion considered in TOR B need to be applied to the \$15.6 billion top-up payments. A significant portion of these funds should be dedicated to primary health care and with GP services as only one component of the expenditure.

It may be of assistance to the committee in defence of this proposal to briefly refer to the extensive literature that reports on the research now available on effective and cost-effective psychosocial interventions for a range of chronic diseases. The APS has previously written to Government and reported the following:

Chronic disease. *A substantial amount of research exists demonstrating the cost-effectiveness of psychological interventions for physical health problems such as heart disease and obesity, and for non-adherence to recommended treatments. Psychological interventions have been estimated to cost between 10%-50% less than medical treatments. Following effective psychological interventions, patients tend to have low relapse rates and fewer GP visits and hospital admissions leading to ongoing cost savings within the health care system.*

While recent programs such as the Better Access to Mental Health Care initiative recognises the importance and cost effectiveness of psychological interventions for mental health conditions, the effectiveness of psychological interventions for physical conditions is equally well documented however not yet recognised by policy makers.

In one study by Schlesinger, Mumford, Glass, Patrick, & Sharfstein, (1983), 700 patients with heart disease, hypertension and diabetes receiving psychological services were tracked for a three-year period and compared to a group of 1300 patients who did not receive psychological treatment. Patients who received psychological treatment showed a 40% reduction in annual medical costs when compared to patients who were not given psychological services. Once the cost of psychological intervention was taken into account there was still a 5% net saving.

Further research on psychological treatments for chronic pain conditions found that every dollar spent on psychological treatment led to a five dollar saving in medical costs (Gonick, Farrow, Meier, Ostmand & Frolick, 1981). In addition, one year after psychological treatment

for chronic pain, patients had reduced their need for inpatient services by 72-81% and outpatient services by 41-50%.

The capacity for psychological intervention to reduce the incidence, recurrence and overall costs of chronic disease has yet to be fully explored and deserves support and endorsement.

Aged Care. *Numerous other studies have also highlighted the importance of psychological interventions among the elderly. Research surrounding mood disorders among the elderly has not only confirmed the alarming level of depression in both residential and community populations, but also the effectiveness of psychological therapies and their benefits in avoiding the complications that drug therapies can produce. Psychological interventions are also important and effective for behaviour disturbances (such as wandering, verbal outbursts, physical aggression and calling out) an outcome that can significantly improve the quality of life for other patients, carers and staff.*

Mental Health. In addition, the APS would like to highlight the role of psychological interventions in mental health. The vital point, of which the Committee needs be aware, is that there is considerable evidence that supports these interventions as not only effective but cost-effective. With depression, for example, it is now considered best practice for GPs to refer for psychological interventions in place of (or, at least, as well as) prescribing antidepressant medication. What is even more important is that this can lead to a significantly smaller cost in the long term. This lies at the foundation of the concern of the APS that health reform funding for hospitals and primary care underfunds mental health services and interventions generally and is so medically focused specifically.

While the concerns of the committee are focused on fiscal arrangements and details, it is vital that the broader policy and community outcomes of this discussion and recommendations are fully acknowledged.

3 TOR E

The APS response to the structural concerns inherent in this TOR needs to be seen in light of current movements and proposals with national health and hospital networks and primary healthcare organisations with already established medical structures, networks and organisations. While the committee is reviewing the nature and roles of these structures it is important to question the current assumptions and expectations in the funding and governance of these. While the APS endorses the current models being proposed as a change from the general practice model to encompass a broader range of health professionals, it would also challenge the committee to consider alternatives.

Primary health care organisations require the establishment of governance arrangements that include consumers, carers and allied health providers and mirror the commitment to improved collaborative care. Whilst not all patient conditions require a multidisciplinary teamwork response, equitable partnership spreads the responsibilities, financial liabilities, increases accuracy of diagnosis and better informs treatment decisions. Without this fundamental shift in governance, it is unlikely that there will be any significant change in primary health service delivery, resulting in ongoing costs from inefficient and ineffective primary health care

In an earlier submission to Government, the APS wrote with regard to the structure of PHCOs:

“Alternatives to the existing general practice model include the Victorian Community Health Centres approach that brings together service providers under a collaborative arrangement with a representative Board. Ideally CHCs will have a general practitioner providing services from the site but if not they will have working arrangements with local GPs who may be associate members as part of their service delivery. The cost of infrastructure is charged on a percentage of time used in the CHC basis and a single share for each provider that enables them to have an equitable participation in decision making. The expansion of this type of model may require infrastructure investment similar to that of the GP Super Clinics to seed fund new Primary Health Care Practices (PHCPs).

4 TOR G

The APS raises concern about the lack of clarity regarding the interface between Local Hospital Networks and Primary Health Care Organisations (PHCOs). These organisations need to be coordinated to provide effective and integrated governance of the new health system.

In light of the decisions to retain medically focused structures and networks (hospitals and divisions of general practice), it is critical that clear direction is provided as to how other professional groups and organisations will be incorporated and how the governance structure will be revised to achieve this. This will be particularly important to resolve in situations (e.g. Community Health organisations in Victoria) where current structures are working very effectively but may be superseded because of the desire to standardise approaches across the nation. This will have significant implications for funding management and allocation.

The APS is further concerned about the apparent increasing cost to the health system that will be imposed by additional layers of bureaucratic management. The existing Federal, State and Local government layers will be increased to now include Local Hospital Networks and Primary Health Care Organisations. All of these will have boundaries but as yet undetermined and potentially non-aligned. None of these will increase the number of health treatments in their own right as they depend upon assumptions that their establishment will improve pathways between each other resulting in cost savings that can be applied elsewhere in the service system. These assumptions are currently untested.

5 TOR H

The APS has a particular interest in the combination of funding processes that are raised under TOR H. It has been argued elsewhere that the maintenance of block funding for mental health services will be necessary to allow hospital networks to provide services for people who need access other networks, whether this is for patients of acute care (hospital networks) or in the community (PHCOs). This block funding approach should be applied to chronic disease management as well unless there is a revision of the allocation of funds to allied health and other non-medical services.

It is in light of this, the whole question of activity based funding and the accuracy of the measurement of activity by non-medical services needs to be addressed. For many years

allied health professionals have been developing standardised measures of activity for both acute and non-acute settings. These have received very little support from jurisdictional managers of health policy or health services administration. The allocation of funds and the defence for their appropriate distribution will rely on reliable patient-focused activity measurements. The APS recommends that this work be considered for support by the Senate committee as its relationship to defensible funding will be evident.

6 TOR I and J

The APS reiterates the important and cost-effective role that psychologists perform as part of multidisciplinary interventions for both those with mental health disorders and those of the ageing community living independently and in residential aged care facilities. The essential nature of these services and their capacity to impact on costs and effectiveness is discussed above under TOR D. The APS has made separate submissions to Government about the important role that its members can serve in supporting community members in this regard.

Conclusion

The APS would like to highlight once again the need for a review of current funding and funding mechanisms to ensure that best practice and most cost-effective interventions are being supported by the funding processes and mechanisms that are currently being reviewed.