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SUB 203A

HUNTER AREA HEALTH SERVICE SUBMISSION TO THE SENATE SELECT COMMITTEE ON MEDICARE

JULY 2003

SENATE SELECT COMMITTEE ON MEDICARE

HUNTER HEALTH SUBMISSION

INTRODUCTION

Hunter Health is funded by the NSW Government through NSW Health to provide health services to the people of the Hunter.

Hunter Health:

- provides services to over 521,000 people living in a 24,800km² area (8.4% of the NSW population)
- provides public health, health promotion, community health, acute hospital, aged, mental health, rehabilitation and palliative care services
- has an operating budget of more than $560 million
- is the largest employer in the Hunter with over 7,200 full-time equivalent staff.

The Hunter Urban and Hunter Rural Divisions of General Practice fall within the catchment area of Hunter Health.

BACKGROUND

There are 405 GPs in the Hunter Urban Division of General Practice (HUDGP). Only about 10% of GPs in the HUDGP bulk-bill 90-100% of their patients and the majority bulk-bill 0-30% of their patients. The trend in reduced bulk-billing is expected to continue. It is estimated that there are vacancies for 40 GPs in HUDGP. There are 97 GPs in the Hunter Rural Division of General Practice (HRDGP) practising in the Hunter Health area. There is relatively little bulk-billing in the rural Division. Concession card holders may be bulk-billed however as the majority of GPs have closed their books, all new patients will pay an additional fee. It is estimated that there is an under supply of 30 GPs in the HRDGP. At the moment 29 GP Registrars are alleviating the number of GP vacancies. Registrars however, place additional constraints on general practice in terms of supervision time and physical space within a practice that could be utilised by other GPs. Area of Need applications have been made for the communities of Karuah, Cessnock, East Gresford/Dungog, Denman, Scone and Nelson Bay.

The GP workforce in the Hunter Health region is ageing and the number of retirements is expected to increase significantly in the next 5 years. This aspect, together with medical

indemnity issues, means that the number of GPs in the region is teetering on the brink of a crisis situation.

The declining number of GPs, the decrease in the number of GPs who bulk bill, and other Commonwealth healthcare reforms has impacted significantly on Hunter Health services.

IMPACTS ON HUNTER HEALTH

EMERGENCY DEPARTMENTS

The consequence of increased co-payments for GP services has been increased attendances at Emergency Departments (EDs) as evidenced by presentations to The Maitland Hospital (see Table 1 for presentations 1996-1999). The impact of an alternative arrangement (Maitland After Hours GP Service (MAGS) whereby GP services after hours could be accessed free of charge is demonstrated in Table 2. This shows a substantial reduction in attendances to the ED for ambulatory patients in triage categories 4 and 5. It should be noted that these categories account for over 60 % of all ED attendances. Patients self-select whether they attend the ED or the GP service after hours and thus this data confirms that the increasing attendances at The Maitland Hospital were as a result of the cost of GP services provided via locum or surgery after hours arrangements.

Table 1. Presentations to The Maitland Hospital Emergency Department by triage category by financial year

Year	Triage Category	
	4	5
1996/97	9286	4868
1997/98	14879	5006
1998/99	16800	3589

In the first 11 months of MAGS, the ED treated approximately 5800 fewer triage category 4 and 5 patients. See Table 2 for further detail on attendance rates.

Table 2. Change in numbers of patients presenting to the ED/MAGS site from 1998-99 to 1999-2000

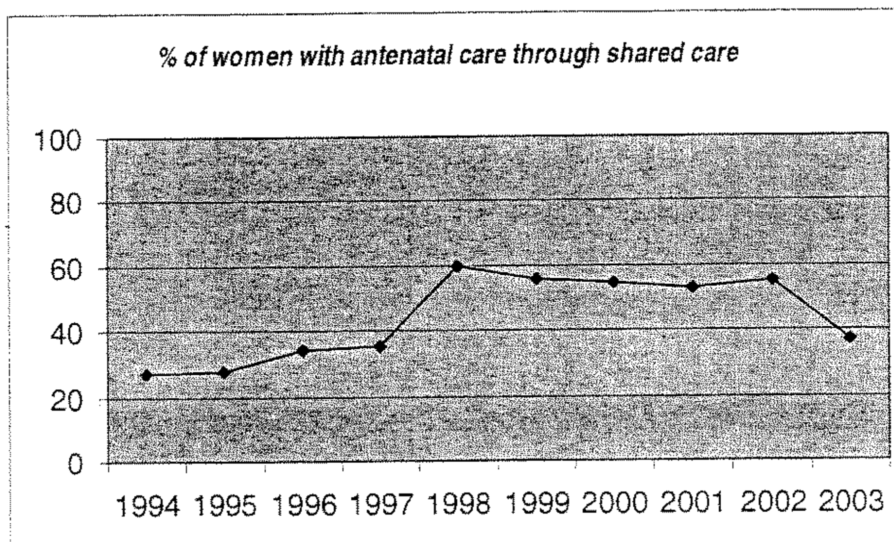
Activity (Triage categories 4 & 5)	Pre MAGS 1998-1999	Post MAGS 2001-2002
Emergency Department	7543	2944
Locum GP Service	6576	-
Local GPs	4000	-
MAGS	-	12207

Total	18119	15151
Triage telephone	-	6416

SHARED ANTENATAL CARE

The concept of shared antenatal care became quite popular in 1996/7 and by 1998 almost 60% of women giving birth in John Hunter Hospital had the majority of their check-ups with their own GP. Recently however, the number of women accessing GPs for shared care has drastically reduced. Anecdotal evidence suggests that out of pocket expenses are a significant factor in this.

Figure 1: Percentage of women with shared antenatal care



Source: JHH Antenatal DOHRS data

Because of a marked reduction in the number of GPs and obstetricians practising obstetrics in the Hunter Health region there has been a 20% increase in the number of women attending the John Hunter Hospital's (JHH) antenatal clinics (ANC). Table 1 provides further data on the increased service provision.

Table 2: JHH Antenatal Clinic Data

Financial Year	**01-02**	**02-03 (y.t.d.)** 9 months	**% Increase (y.t.d.)**
Occasions of Service	29,284	31,100	6
New ANC Bookings	2458	2721	10

Similar patterns have been observed in other Hunter Health facilities. For example, antenatal clinic presentations at The Maitland Hospital have increased from 7, 700 in 2000/01 to 9,600 in 2002/03. This reflects an increase of 300 new patients.

MEDICAL CARE IN AGED CARE FACILITIES

Access to GP care in aged care facilities is an issue, particularly after hours. NSW Health has reported a 25% increase in the number of nursing home patients being treated in public hospital emergency departments between 1998 and 2001. Data for the first year of operation of MAGS indicates that 28% of all home visits provided by the service were to nursing home residents. Hunter Health has, up until recently, run 4 aged care facilities and has found it very difficult to find GPs willing to visit patients within the nursing home. When a GP was unable to attend, the patient was transferred to an acute hospital. The absence of any incentives and sustainable solutions for GPs to provide medical care in these facilities will result in a continued cost-shift to the public hospital system.

MEDICAL SPECIALISTS

There have been significant shifts in the patterns of private and public sector care provided by medical specialists. For instance, the number of obstetricians in private obstetric practice has declined from 16 in 1991 to 7 currently. There are 5 obstetricians who are only working within the public sector. There are also 6 paediatric specialists in the last 3 years who have ceased private practice. These specialists advise that they have made this move because the fees through Medicare no longer cover their practice costs. There is a substantial difference between procedural and consultation fees. Fees for consultations for specialists who do not have procedural items do not cover practice costs and provide a sufficient income.

Countering this trend to public hospital work has been a marked decrease in procedural specialists who are willing to work in the public sector because the fees in the private sector are more attractive. This particularly affects specialists such as anaesthetists and surgeons. These specialists have either stopped or reduced the number of public hospital sessions in favour of private practice. There is also a dearth of general physicians in both the public and private sector.

The consequence of these shifts has been particularly marked in rural and regional areas due to overall shortages in medical workforce.

HUNTER HEALTH SOLUTIONS

In response to the pressures on a number of its services, Hunter Health has been involved in number of innovative service developments with Commonwealth funded services such as

Home And Community Care, the Hunter Urban Division of General Practice and Community Options.

AFTER HOURS MEDICAL CARE

GP Access After Hours

Hunter Health has been working collaboratively with the Hunter Urban Division of General Practice to achieve an improved system of after hours medical care. After extensive research and consultation, a model was developed, and the first stage of implementation of the model commenced with the opening of the Maitland After Hours GP Service (MAGS) in October 1999. From July 2003, the regional after hours service called GP Access After Hours (GPAAH) commenced.

GP Access After Hours provides a comprehensive system of after hours care incorporating the following elements:

- An after hours telephone triage service
- GP clinics situated within John Hunter Hospital, Maitland Hospital, Toronto Poly Clinic, Newcastle Community Health Centre and Belmont Hospital.
- A funded transport service using a local taxi provider for patients with problems getting to the clinic
- A home visit service for those whose needs cannot be met by the above

In the first 10 days of operation, the service saw 829 patients and received 614 calls to its call centre.

PRIMARY CARE SERVICES

Community, Aged Care, Rehabilitation and Extended Care Network

Hunter Health community based services are major providers of primary care services. In conjunction with an organisational re-structure to integrate Community Health with Aged Care and Rehabilitation Services to create the Community, Aged Care, Rehabilitation and Extended Care (CARE) Network, a process re-engineering exercise was undertaken. By conceptualising the delivery of community-based services from a patient perspective and utilising an evidence-based approach, a number of new initiatives have been proposed. These include:

- Central intake and service directory
- Common assessment form
- Care plans and care coordination
- Rapid Response Acute Community Care
- Pro-active management of wait-lists
- Expansion of rehabilitation model
- Integration of key information management systems

A number of performance measures have been identified for the Network including: % patients first seen for assessment within benchmark, % at risk patients who are targeted for risk reduction (smoking, alcohol and falls), potentially avoidable hospitalisations for ambulatory care sensitive conditions, and % staff performance management plans in place.

Medical Services at Allandale Aged Care Facility

In response to the lack of GP services to residents at this facility (with 330 beds) Hunter Health proposed the employment of a Career Medical Officer to provide medical care. Medicare would fund the medical services via the allocation of a provider number to the aged care facility. The Commonwealth rejected this proposal and the facility has had to employ a primary care nurse, at their own expense, in an effort to facilitate GP attendance.

Services for socially deprived groups who cannot afford to access GP care.

Hunter Health has established new models to provide primary care for groups unable to access GP services.

Coachstop Caravan Park Outreach Service

The project commenced as a pilot in 2001, as members of the Community Nursing Team recognised the health & social needs of a socioeconomically disadvantaged group, resident within a caravan park, situated on the fringes of the Maitland community. These residents were unable to afford GP services and were regular attendees at The Maitland Emergency Department. Key aims & objectives of the service are to improve access for the women & children to diverse existing social & health services & to develop support networks that will help to achieve improved maternal & child outcomes. Utilising a van borrowed from the Aboriginal Health Service, the project team commenced on-site outreach clinics, targeting issues identified by the women residents themselves.

After 2 years of intervention, there is growing evidence for positive evaluation. The list of "collaborators in care" (see Table 2) has grown, thus ensuring resident's access to diverse services. More importantly, a number of key services have adjusted their service delivery model to better meet the needs of the residents.

Table 3: Collaborators in Care

Collaborating in 2001:	Added in 2002:	Added in 2003:
➢ Dpt Housing ➢ Dpt Community Services ➢ Family Support ➢ ACIR ➢ TMH Maternal & Child Health Services ➢ HAHS Aboriginal Liaison	➢ TAFE ➢ Family Action Group ➢ Maitland Public School ➢ HAHS Dental Services ➢ TMH Emergency Services ➢ Maitland Domestic Violence Committee	➢ TMH Drug & Alcohol Services ➢ Maitland City Council ➢ Families First ➢ Mindaribba ➢ Police Boys Assoc ➢ Attorney General's Dpt ➢ School Counsellors ➢ UNI Law Faculty

Other outcomes of the service include improved attendance at antenatal clinics and an increase in birth weights of babies born to resident mothers, a walking and swimming group, improved literacy rates, improved school attendance rates, completion of stress management courses, and development of personal skills such as parenting and cooking.

Chronic Disease Management Program

With the decrease in bulk-billing rates many people with chronic medical conditions cannot afford access to regular GP care. As part of a NSW Health Government Action Plan initiative, Hunter Health has established programs to improve the primary care management of people with Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and lung cancer. Key components of this program are community-based rehabilitation programs for CHF, COPD and generic chronic disease, along cancer multi-specialty team, a psych-oncology outpatient service, palliative care medical outreach, and workforce development. Outcomes for the first 2 years of activity indicates that completion rates for rehabilitation programs are higher than state benchmarks, improvements in quality of life and functional capacity, and readmission rates are stable. Another outcome has been an increase in the acuity of patients with CHF that are admitted to hospital and longer lengths of stay. This suggests that patients are better able to manage their disease in the community setting and are only admitted when deterioration becomes more serious.

TRANSITIONAL CARE

Previous models have also included a transition care service that provided transitional care between acute facilities and aged care facilities. This was ceased due to Commonwealth concerns about costs shifting. The Commonwealth provided respite level funding whilst Hunter Health provided enablement and rehabilitation services to maximise outcomes in terms of returning home or to a more independent level of residential care. The service was run by a not for profit community service provider, Baptist Community Care.

OBSTETRIC SERVICES

Community Mobile Midwifery Service

The Obstetrics and Gynaecology Department at the John Hunter Hospital is developing a proposal for NSW Health for a Community Mobile Midwifery Service (CMMS). CMMS will be a service team of midwives that

- will provide women with the option of a midwifery-led model of maternity service provision,
- is community-based and framed by the principles of primary health care,
- will provide

    i. antenatal care in community venues, including the family home
    ii. early labour check-up & support at home if required
    iii. labour and birth care in birth centre, delivery suite or home, according to the woman's preference
    iv. postpartum care in the family home.

It is proposed that the service will be available to all women but will focus on the needs of disadvantaged and disaffected women who are at risk of poor physical and psychosocial health outcomes (moderate to high psychosocial risk/social disadvantage; mentally ill, drug or alcohol use, adolescents, Aboriginal or Torres Strait Islanders and women from non-English speaking, culturally diverse backgrounds);

The CMMS will be conducted as a pilot in the Greater Newcastle Sector, co-ordinated using the infrastructure and resources of John Hunter Hospital, and expanded throughout the Upper Hunter and Lower Hunter Sectors dependent on the successful completion of the pilot. Outcome measures for the pilot have been selected for their ability to reflect safety and efficacy in maternity care as well as midwife, medical and consumer satisfaction.

CONCLUSIONS

The solutions to ensuring access to general practice/primary care for all Australians is complex. There is no single solution. The key issues are:

- Workforce distribution
- New models of primary care with greater interface between State and Commonwealth systems to develop integrated, multidisciplinary care teams.
- New models for after hours care
- Work practice redesign to make general practice attractive and supported
- Improved use of technology
- New funding models to support a variety of models of primary care