HCQ HEALTH CONSUMERS QUEENSLAND

28 May 2020

QH funding priorities 2020/2021

A perfect storm: Consumers keen for major transformations

Two Consumer Conversations were held this week to discuss different aspects of QH Funding Priorities for 2020/2021. In all 42 consumers were involved in the conversations and 12 of these same consumers completed an on-line survey. We asked them to provide feedback on the drafted QH funding priorities. The following is a summary of the key themes raised:

An appetite for major change

While talking about priorities for the next financial year, it was clear that health consumers are ready for some major changes in health. The recent Queensland Clinical Senate meeting also demonstrated a parallel appetite for change by clinicians in the health system too.

Consumers have suggested major reforms to long-held traditions and ways of addressing health care. The identified reforms are:

- to the way patients are categorized for care
- re-imagining HHS borders
- funding healthcare
- collaborating with consumers to design new models of care, service improvements and funding models as well as when providing them with individual care
- to actively address the social and cultural determinants of health and the systems barriers that keep some people in a cycle of poverty and ill-health

This is best encapsulated by an experienced consumer representative:

“This unprecedented crisis is a catalyst for unprecedented innovation in care delivery in Australia including the private / public system. This includes revolutionising reward systems in health so that patient outcomes, not volume, are where payment is earned and also further incentivised. Successfully treating a patient should be what is rewarded and not where it is delivered (public facility / private).

We need to start rewarding the behaviours we want to see and disincentivize the ones we don't. How can you encourage Doctors to provide virtual care when the financial payments (e.g. bulk billed) deter this? This will require a huge cultural shift in health too, which will be more difficult than the system changes... Another example of this is the action of "shared information with primary care to support coordinated and streamlined patient journeys". This is very important, however even MORE important is shared information with the patient. This just does not happen. We do not get automatically copied in on correspondence between specialists or a GP or given even summaries. The Covid19 pandemic has shown how health literate the Australian public is and how that health literacy can improve and increase when supported with reliable and trusted information. It is time our healthcare system moved on from a paternalistic approach to communication and decision making to truly support care WITH patients and not to patients.”

Fair, equitable and enable maximum access to health care services for all

Most consumers thought the proposed priorities were fair. To achieve these objectives there needs to be an explicit statement that the care will be patient focused and coordinated by the appropriate clinician.

Consumers agreed that **First Nations peoples** need to be part of the priority Queensland populations. In particular, one First Nations consumer representative wrote:

"First Nations consumers are taking steps to engage with the University's "of the real world" to ensure the practicalities and lived circumstances of Qld's First Peoples are understood by both academia and graduates. A similar approach is needed in the health arena... while numbers of First Nations health graduates are increasing, there's still a minority of older First Nations consumer advocates who are holding back the swift tide of post-COVID adaptive healthcare. HCQ is a key ally in ensuring community-led decision-making and place-based changes in HHS responses become the new norm so as not to cause "virtual" harm to: - cultural connectedness- family relationships- learning and/or earning- individual wellbeing - community safety. All critical elements in Socio-cultural health and well-being particularly in regional and remote settings."

It is critical that **people with disability** are considered a priority population. During COVID-19 there has been a significant amount of focus and work to develop national and state plans for health for people with disability because of the significant issues this cohort experience in accessing quality, safe and affordable health services and the additional barriers to care. It is critical that this work is foundational in continuing to build responsive health system for people with disability.

There is concern about how the priority on vulnerable Queenslanders, along with all of the others, will look in detail and in practice. One consumer wrote *"what does 'making the most of our acute capacity in the right setting' really mean? I think the intent is there, but unpacking the words and how they will affect the community is vital."* Consumers warned about the implications of how this would work in practice. One consumer wrote: *"Some that are of concern to me are: Virtual care as the preferred service delivery model for non-admitted care. How will 13HEALTH be reimagined? Targeted strategies to improve health and wellbeing in the first 2000 days of life for Qld children with outcomes that have long been priorities without much improvement. Models of care which push more consumers back to GPs."*

Co-design, accountability, public reporting

Understanding patients' journeys, co-designing care and services with consumers, along with funding proposals, policies and communications was all very important to health consumers to ensure that the changes result in improvements to health outcomes and experiences (not a worsening of care). This theme runs through to public accountability of money spent, health outcomes achieved etc similar to the way consumers have access to COVID-19 data, they would like to see this continue.

Categorization of healthcare – triage

Consumers are not involved in determining their priority for surgery or specialist care at the moment (Cat 1-3) and based on a triage system developed on the battlefield. Surely we can use a more nuanced system in 2020? It is typically based on their clinical needs only and doesn't assess the whole person's needs and the patient does not get to be involved in their own categorization. A 7-year-old child in need of grommits is listed as category 3 but runs the risk of being left behind in education which is critical to their on-going health and wellbeing. A physical labourer in need of a hernia operation and whose household income is already low, may spiral into deeper financial stress causing an exacerbation of mental health conditions and an erosion of all they hold dear.

Consumers would like to explore the possibility of using a Patient Reported Outcomes Measure that can be used along with clinical assessment to determine their priority of care. This would enable consumers to include the financial, social, physical, emotional, psychological and cultural impacts on their ability live their life.

One consumer said there are priorities within priorities and this could help to identify those especially in the priority Queensland populations and with an equity lens.

Value based health care and capitalising on private health sector

Consumers would like to see a new funding model as it's a key structural change that is needed. Funding should pay for evidenced based care and focused on patient outcomes (value based healthcare). Did the patient get the outcome they wanted/expected?

Consumers support QH capitalising how things are funded and maximising new models of care. However, there are concerns about building a new surgical hospital when there is real potential to do a lot more in the private sector. If there's capacity in one sector (e.g. private hospitals) why not partner with private hospitals to ensure improve consumer health outcomes and experiences while at the same time reducing wait times.

"Some of these suggestions while beneficial would mean increased costs to the health Service. How practical is this or even achievable in the current financial circumstance? Empty promises cause less confidence in the health service"

Models of care/Virtual care/telehealth

Consumers support new models of care and innovations that are supported by evidence and been designed from the start with consumers.

"… there is a risk in the actions underlying these themes that we may end with low value care that could actually make things worse (even if well intentioned). For example, it will be very important to map and understand the patient journey in the development of virtual healthcare. This means having the right tests or information available prior to a tertiary consultation (so that everybody's time is not wasted) and ensuring that if an "in-person" Outpatient process typically includes a review by a Registrar / Fellow who then discusses with the Consultant who then consults with the patient, then the Telehealth service also must allow for this. Otherwise there is a high risk that a patient may not have questions answered and instead a virtual healthcare appointment is repeated with an in-person appointment, which is a duplication not an efficiency. This is just one example. There are many more that will be mitigated if effort to understand the patient journey is made before any general roll-out."

Consumers suggest that the aim that 50% target outpatient review to be provided through virtual appointments should be based on clear criteria, consumer choice and be clinically appropriate. Hopefully this would be something developed with consumer input eg. Consumer Guidelines for Delivery of Virtual Care. This may need to be issue/needs based by patient groups.

Consideration should be given so it's not a one size fits all approach to virtual care and acute capacity. There are many people with disability who have experienced positive benefits and outcomes during COVID-19 and some people who have found this new environment (virtual care) challenging.

The is real concern that the move to virtual care may create a digital divide and lead to an increased disparity in health outcomes in Queensland. There are also issues with access to data and ICT devices so any strategy going forward will need to consider both system and consumer capability and capacity. Consumers suggest that those who are identified as priority Queensland populations have a targeted education and supported assistance so they can access and use the technology competently. That models of care targeted to support the health outcomes of these people are designed with them, to ensure care is accessible and comfortable and reduce the likelihood of a digital divide occurring. And to recognize that patient choice is important and if a person chooses not to use virtual care that this does not adversely impact their care and health outcomes.

Preventative healthcare

What is missing in these priorities is a large focus on preventative healthcare and early interventions. Do we measure consumers' access to this to ensure minds are focused on a wholistic system of healthcare? We have Cat 1 surgery but could we have a priority 1 for preventative healthcare with streamlined access to a multidisciplinary team led by allied health professionals and/or nurses and midwives? The system focuses on what is measured, and often what is not measured doesn't have the same focused attention. So creating a system that rewards evidence-based preventative healthcare and early interventions is important.

Integration of care

Consumers want a system where care is joined up between different sectors – can this be incentivized through funding? So a consumer can move seamlessly between primary and secondary/tertiary care, community care, private hospital care, disability and aged care supports and care.

Improve communication / keep people informed

Consumers would like to be kept informed about where they are on waiting lists and for an overall improvement in communication. People who have had their surgeries turned 'back on' have received a letter but those who were waiting for surgery have not received any communication.

"The 'unknowingness' needs to be addressed. It doesn't take a lot in this day and age to keep people informed."

Reach out to public, make lay people aware of how the health system works, no one can answer how waiting lists work and the impact on people's overall health.

Involving consumers in the implementation and monitoring

It is critical to include consumers at all points of the rollout in the planning, design, delivery and evaluation of QH funding.

Track the development of these priorities throughout Queensland by involving consumers in the existing Qld HHS consumer advisory groups (CAG). The use of the CAGs would be a readily available means of tracking the development of the implementation of the priorities throughout Queensland. Each CAG is in a position to monitor the local situation and feed that information back to a coordination centre for collation and analysis. This could be by way of each area and/or on of the six designated centres noted on the map, them forwarded to Headquarters for final collation, analysis and evaluation. This is a process in which all consumers could be involved in its design, planning, implementation, monitoring and evaluation

Propose a model of Quality Assessment whereby evaluation is continuous and progressive. It is in contrast to Quality Control where the evaluation takes place at the end of the process. Continuous of Ongoing Quality Assessment allows for the assessment of the process as well as its outcomes and enables the making of adjustments to the process to make it even more effective and efficient.