5 QUESTIONS THAT WILL MAKE OR BREAK AUSTRALIAN HEALTHCARE

Alex Holderness for Health Facilities Design and Development

Produced by:

Healthcare iQ
a division of IQPC

IQPC
International Quality & Productivity Centre

In association with:

HEALTH FACILITIES DESIGN & DEVELOPMENT VICTORIA 2014

Alex Holderness for Health Facilities Design and Development

I've been working in the Australian healthcare industry for a few years now, and in all honesty, it's slow progress. When it comes to tackling the critical long term challenges to fix some major holes in the healthcare system, it starts from the ground up.

During Australian Healthcare Week 2014, we thought it was time to get some of the Australian healthcare leaders in a room to discuss some of the key burning questions on everyone's lips.

Several clear areas stood out, so here they are – the five questions that everyone in healthcare should be thinking about to revolutionise our system and drive real positive change.

SO WHO WAS INVOLVED?

Leonie Hobbs (Chair)
Senior Consultant
Carramar Consulting

Kathy Campbell
ICT Manager
VCCC

Debra Barbas
Clinical Services Manager, St John of God Murdoch Hospital

Claire Groonbridge
Facility Planner
Hunter New England Local Health District

Ian Mitchell
Principal
Conrad Gargett Riddel

Mark Halpin
Director – Infrastructure Management
The Townsville Hospital

John Goodchap
National Manager – Health
Hansen Yuncken

Steve Trevenar
Head of Business & Strategy Healthcare & Scientific Research, Lend Lease

Stanton Kroenert
Manager
Woods Bagot

Damien Crough
Business Development Manager
Hickory Group

Don Garner
Group Leader – Health
Sinclair Knight Merz

David Johnston
eHealth Consultant

Rob Clarke
WSP Independent

Sandra Roggeveen
CEO
Dzhon

Rohan Wilson
Architectural Director
DesignInc

WHERE SHOULD THE MONEY BE GOING?

IT DOESN'T GROW ON TREES

The Australian dollar is limited; nationally we spend **$130 billion dollars a year on healthcare, which is 10 per cent of GDP**. With substantial cuts announced in the Budget, it's clear the pot isn't getting any bigger. So where should we be spending the money? And perhaps more importantly – where are we going to get it from?

One of the biggest challenges is making sure the funds go where they will have the most benefit; it's not necessarily the specialist treatments and big exciting stuff. There are two sides to this coin. Firstly, who should get treatment and who shouldn't; secondly, we need to stop focusing on sickness and focus on health.

The table discussion centred primarily on the last 10 per cent of people's lives and those that lead an unhealthy lifestyle, leaving the two intrinsically linked.

We're currently spending 90 per cent of funding on that last 10 per cent. We're also focusing on funding facilities, with not enough action being taken to manage demand.

The simple truth is, the growth rate is unsustainable and people's lifestyle choices are smashing acute health services.

Some major reform is needed to incentivise people to stay healthy. Our current spend needs to be shifted; all agree that it's currently imbalanced. Chronic Disease management was also thrown into the mix as a better way to spend money, with more of a focus on long term quality life.

Whether this starts with taxes on unhealthy foods, in a similar manner to cigarettes and alcohol, or wider initiatives around the planning and development stages of community – building in the opportunity for healthy lifestyles.

SHIFTING PUBLIC PERCEPTION

The general consensus is that people have the wrong perception of healthcare.

We all enjoy and expect good quality healthcare in Australia, but as we know, it's not sustainable.

Although the national reform agenda is seeing small amounts of change, it's nowhere near where we need to be.

One of the potential solutions comes in the form of private health and private insurance. More competition in the area enables it to be available at a reasonable cost. Previously seen as a luxury for the wealthy, few have a realistic concept of the cost.

GETTING MONEY INTO THE SYSTEM

As announced in the Budget, the Federal Government could potentially widen the gap to accessible healthcare with confirmation that patients will be charged with a GP tax.

The Government confirmed in its Budget announcement that the much speculated and controversial general practice co-payment model will be implemented.

From **July 1, 2015, visits to the doctor will cost everybody $7 with the introduction of a Medicare co-payment.** The co-payment will be waived for children and those on concessions only after 10 visits a year. The co-payment will raise $3.4 billion in the first four years, while upfront payments and a tightening of eligibility for the **prescription drugs on the Pharmaceutical Benefits Scheme will raise another $1.3 billion**.

It's the continuation of a long debate around co-payment.

Another $1.6 billion will be cut from health by freezing indexation of income thresholds, which determine eligibility for the private health insurance rebate, the Medicare Levy surcharge and other Medicare services.

There are a few problems hindering injections of cash into the health system; inefficiencies from whole-of-regime litigation, excessive tests, limited working hours and supply and demand from private insurers.

The group explored one of the key areas – working hours.

Many facilities are still limited by the 8-5 pool, leaving people with no choice other than to go to hospital. Can we have 24-hour general practices, reducing the demand on hospitals in the same way many health insurers do?

If the health facility functioned on a 7-day-a-week approach with staffing and services, would we be able to provide better care and reap back costs that outweigh operational running fees?

The day public facilities expand the operating hours is the day we can stop building new operating theatres. There's a trend for more 24/7 facilities – let's fund the infrastructure but then use it efficiently. A private facility in Brisbane ran its MRI 24/7 – ends up being cheaper to come after-hours.

Public health is getting better with new targets, but it's some of these efficiency-driving measures that could make the real difference...a little more on that later.

WHAT'S GOING ON IN OUR REGIONAL FACILITIES?

INFRASTRUCTURE BEYOND THE METRO AREAS

Metro areas are big (and vote rich); it wasn't long ago that these facilities were in bad condition, leading to large-scale new builds with the likes of VCCC and QLD Children's. The table had high hopes for seeing improvements to the smaller and more regional facilities in the near future.

Community-based facilities are going to be heavily relied upon to meet the challenge of keeping people out of hospital.
The concern at the moment is the condition of rural facilities; there are 20+ bed facilities in Australia that still require patients to go outside for the toilet and showers.

The need is twofold – better buildings and better services. Nursing is one area coming under the spotlight to alleviate some of the pressure; telehealth and similar services also have the potential fill the void of connect to more rural areas.

New Zealand was discussed as a country to learn from, with huge ranges between facilities, community solutions and use of technology as the key for efficiency.

In terms of the buildings, should we actually have smaller rural hospitals? The opinion among our health experts is that the facilities are currently in voting zones, providing employment. But the right facilities aren't necessarily in the right areas.

Should there be a **small rural hospital within half an hour's drive of another one with some hospitals down to 30 or 40 per cent utilisation?** Should there not just be a group of hospitals that share services between them?

30% - 40%

PRIVATE PROVIDERS

Community facilities are going to be very dependent on private health coming on board. If private health collapses, the whole system will collapse; 46 per cent of people have private insurance.

Some serious altercations in the model of care could see smaller hospitals with telehealth services, but the public sector alone won't be able to achieve this.

We need to entice the privates to go into regional or remote areas.

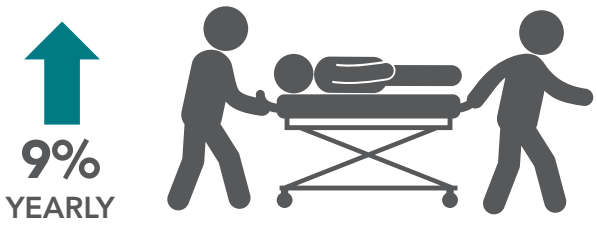
WHY AREN'T WE INVESTING IN OUR PEOPLE?

INSTILLING THE POWER IN OUR PEOPLE

Healthcare seems to think it's different and can't learn from other industries. If you get a company that's not performing well in a business, it gets destabilised to accept change.

Healthcare projects take 5 to 10 years – the debate came from the claim that there was no support from the senior members of the hospital to drive change and empower staff.

With a high, fast turnaround of staff but long, big impact problems, we're probably not spending enough time looking at our people tasked with the job.



Take the emergency department as an example – **with a yearly increase of around 9 per cent in emergency patients**, it's essential people don't stay in hospital longer than they need to. Clinical champions are needed to affect transformational change. Significant resources are spent on top doctors, but perhaps the same priority needs to be given strategic employees.

Change management has always been a challenge for healthcare. It was discussed that health is a non-compliant culture; the Chief Executive is not in charge according to the senior clinicians. Directives are often ignored.

We're currently in a culture that's non-compliant and unstructured. If change is set to happen, that culture needs to change.

PATIENT CENTRICITY

To be patient-centric you have to be staff-centric.

This starts with the development stage of infrastructure, with unanimous agreement on the importance of consultation with all parties' involved and direct interaction to establish patients' insights.

We're not fully utilising information from previous or similar projects to apply to current ones. There was an example where 55 projects were conducted over the course of 10 years. One project has a lessons-learnt review with 176 points which each had a prevention and mitigation strategy – that was the only review carried out over the 10 years.

The second area is the staff themselves; the table discussed how critical it is to have engaged and motivated staff to achieve patient centricity.

WHERE CAN WE SEE THE VALUE IN TECHNOLOGY?

END TO END SYSTEM

As an industry, health spends very little. If we imagine the health system like a bank, it's primarily text-based information (with the exception of some images that are used). You need a high level of security and a lot of points of contact or care. A bank spends around 8 per cent on ICT. The worst case in health is aged care, which spends 1.5 per cent. The average is just 2.2 to 2.5 per cent. In the words of some of the CIOs in the room: 'We're chronically under spending'.

The healthcare system was estimated to be around 20 per cent inefficient. On $130 billion a year, that's a lot of inefficiency. It's rarely seen as an end to end industry. The focus is generally put on sections of the problem. The speed of the factory, however, will only be the size of the slowest process.

There's currently a lack of strategy, with no look at the full end to end system. It's generally just arguments and solutions around bits and pieces.

The belief is that we're under-spending, and where we do spend, we're not getting value for money. Things get funded chunk to chunk, issue by issue – we need strategic planning.

EFFICIENCY

Technology has the potential to really shine when it comes to enabling efficiency.

eHealth is impacted by this; the general belief is that it's currently very difficult to sign up and there's a lot of misunderstanding of the system, meaning it's not being used to its full potential.

Information is not currently linked as it should be – people aren't necessarily always being identified properly. One of our experts referred to a case in which a patient was identified ten times in one hospital. As aforementioned, the public perceive that the health system has its act together a lot more than it actually does.

Security is clearly a concern for many data-led efficiency initiatives, but if finance can do it, surely health can. Imagine the possibilities of mapping information the same way that spending and tax are done.

Interestingly, the table noted that our facilities are still built with large rooms, purely for file storage. The concept of data rooms was discussed 10 years ago and we're still not quite there.

70%
OF ICT PROJECT
FAILED

ICT wise, statistics were shared that 70 per cent of ICT projects in healthcare fail. Technology is still not always fit for purpose and change management is still an area that needs to be addressed to ensure higher success rates.

Even in the large-scale projects, such as the VCCC, it's a challenge to acknowledge that change managers are needed and bureaucracy often absorbs time and budget.

WHAT IS THE SILVER BULLET?

All of these challenges impact health facilities' design and development well into the future. Our upcoming health conferences will be delving further into the practical solutions being used, starting with **Health Facilities Design and Development Victoria 2014**. But lastly, we sought the insight of every panel member to see what was top of their solution list…

- The pill that 'cures everything' – it may be 20+ years away, but the principle behind it is that our hospitals will only deal with emergency cases and that's relevant today
- A real focus on wellness rather than sickness
- Solve the funding issue – we should be redirecting the use of tobacco and gambling taxes straight back into healthcare
- Take it beyond elections and politics – let's look at the bigger picture and de-politicise
- We need to push for change – public discourse and strong leadership is needed
- There are huge disconnects in communication – we need to pull together and drive some real change
- If you choose to live an unhealthy lifestyle, you shouldn't have access to all the same health benefits
- Improved efficiency – Google and Facebook know more about us than the healthcare system does
- Demand and supply– AMA and colleges can currently milk the system for their own financial outcomes
- Fund health, not illness
- The supply side needs to be broken and competition needs to be brought in
- Leadership – get the big brains in health to sort it out. We pay our doctors millions but not the CEOs