event transcript

CEDA
COMMITTEE FOR ECONOMIC DEVELOPMENT OF AUSTRALIA

Health Delivery in South Australia

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Thank you very much Byron. Thank you for those kind words. Before I start I'd like to acknowledge this land that we meet on today as the traditional land of the Kaurna people and we respect their spiritual relationship with their country. We also acknowledge the Kaurna people as the custodians of the Greater Adelaide region and that their cultural and heritage beliefs are still as important as the living Kaurna people today.

Thank you very much it's a pleasure to be here. Before I talk about some of the challenges in health care delivery in South Australia, it's actually probably working about my background. I've been in general practice about 25 years now. I have worked in urban and rural environments and basically have done almost everything you could do in general practice either here or in Papua New Guinea, on Kangaroo Island, or across the system. So I think I've got something to say that may be relevant to this debate as we move forward.

What I'd like to do today is to talk through, I think, some of the priorities we're facing. Basically if there's not a change in the way we deliver health care in the state, with the challenges outlined on this slide, we probably won't be able to do it in 10 or 15 years, and the quote of 'delivering equitable care in an efficient manner and with quality' will be compromised as we move forward. That's a huge statement and I just want to in the next 20 to 25 minutes give you some background and evidence of where I think this can be built on. I want to talk about the aging of the South Australian population and the consequent chronic disease burden we're suffering. The fact that we don't have an illness prevention focus, or a healthy lifestyle system – it's still very reactive. I want to talk about the workforce issues that are going to hit us fairly squarely over the next ten years, what I call the imbalances in the health care system and the priorities that don't seem to be built in a balanced sense. I want to talk about the social determinants of health and then something that's really dear to all our hearts, is what we want as consumers in the next 25 years – and I think that's probably something that we're losing track of as we move forward with the debate around the hospital name.

So to start the debate running, if we look at the age pyramid in South Australia, the blue lines and the red – the brighter lines of blue and red are basically where we are at the moment with the group in the middle, the highest group in the 25-49. Importantly in health care system planning, the group I've circled at the top are the group that are going to impact somewhat substantially on the system. South Australia has the oldest population in Australia with greater than one in six older than 65. In the next 15 years that's likely to double and actually what that means for us also is the younger population will get less and less. So they'll be less people working in the system to make it look after the older people. Now where it affects us as health care practitioners is, if you're 65-75 you are twice as likely to be

admitted to hospital and if you're greater than 85, it's six times more likely. So the pressure in the system will begin to increase.

This is an interesting graph that comes from the Australian Health and Medical Workforce papers. If you look up here, this is the commonest conditions that we confront – arthritis, hearing disorders, hypertension and heart disease, and if you look at the 65 and over age group, the green bars here, they're triple or double what we expect for under 65. So as we move forward with the aging population, the chronic illness epidemic that we're currently facing will grow and double and triple.

What also happens is some of the diseases we deal with and diabetes is the classic, the one that we've often talked about and close to a million people in Australia have already got diabetes, half of those are undiagnosed. Again, the impact of age across the bottom and prevalence across the top, will begin to double and escalate and with the complications that come with diabetes, will triple and give us more problems in the system to manage.

So we've got an aging population with a set of chronic illnesses that are growing in prevalence. If you then look at the chronic disease burden and look at where we're going, it's even more apparent when you map it out. This graph is taken from the recent health care plan release – admissions on the left hand side and growth in chronic illnesses along the bottom. Age where we are is about here, so this projection, is about to escalate and double and go up by 30 and 40 percent, will hit us through into 2021. So the epidemic with chronic illness is something that we actually aren't planning to manage particularly well and the system needs to change. That's fine, I'm saying something that's fairly obvious, but what does it mean in a financial sense? This is actually data taken from Bruce [Whitby] from the Department of Health and this is data from 2002. The red are the most important areas. If you look at chronic disease as a primary and secondary diagnosis regarding possible public hospital separations – 36 percent of the total of hospital separations would deal with the chronic illness and 34 percent were bed days were taken up with people with chronic illness. Now if you go back to the last graph, that is going to double or triple where 70 or 80 percent of the care will be built around chronic illness. What that means is we have a system that's responding and not actually moving forward in a constructive manner.

If I go back to general practice and look at the seven commonest conditions in general practice and understanding that there's 90 million consultations in general practice a year, which is huge. If you look at these figures, five out of the seven commonest conditions are chronic illnesses. Now if you work that through and extrapolate, that's about 20-25 percent of those 90 million consultations. So you've got a further burgeoning problem of management in primary care as well as the hospitals and unfortunately what we don't have is the structure to make that work.

This is actually a very busy diagram and it illustrates the evidence base of where chronic illness is going Australia wide and I'll go through this slowly because it defines where the State needs to go to handle what's going to become a bigger and bigger problem. This is based on American data and is really what we call the chronic care model. You actually have to have a whole of system approach for chronic illness where you've got community resources, health care organisations and a health system that understands the issues, you've got self-management programs in place, decision support and guidelines and shared information systems that allow everyone managing a person with chronic illness which may be five to 10 people managing a chronic illness that actually share the same case record. If you put the whole system in place, which we have to do over the next ten years to manage, you will find you'll have an informed patient taking control of their health care, with a proactive primary care practice based team which has to be in primary care. It's quite clear, the evidence is saying increasingly we've got to manage this group of patients in primary care with links back to the hospital, the private sector, local government organisations, but what we don't have at the moment is the model

to move that forward and the biggest problem I think is this shared clinical information systems. We don't have a shared information system to share across the system.

We have a proactive practice based team evolving, there's clear evidence from the Commonwealth with primary care and the medical benefits scheme, that we're starting to develop this, and state government is beginning to link in, but we don't have the whole model integrated in a way that's regionalised and can cope with different distances, both urban and rural and it's something that we have to debate and work through in the next ten years. So that's the second bit – the aging, chronic illness – I want to move onto something and this is a very busy slide about illness prevention. This is something that we don't have right. This is a busy table and I apologise, and I'll come back to it in a minute, but if you look at the determinants of health, we all in the room know, it's multi-causal, it deals with general background factors, socio-economic factors, environmental knowledge and attitudes and health behaviours. If you look at this table and the group I've ringed – the three commonest health behaviours that contribute to the most mortality and morbidity in Australia are the obesity epidemic we're part of, tobacco smoking, high blood pressure and physical inactivity. But we don't actually have a system to manage it. We have a system that reacts to the illnesses at that the endpoint, we don't have a framework to put them in place. For example, the lifestyle coordinators that are beginning to be talked about to be based in general practice are part of the future, but we actually have to train to teach them to do that. We don't have the training structures to make that happen and my argument today, very strongly, that there needs to be a rebalancing of illness prevention, health promotion, mixed up with the direction of the health care system. That's something that I think would do well for the State to move forward on.

Workforce – absolutely dear to my heart and to every other university person in the room – we have an aging workforce, we have inflexible work arrangements, we have a group of young Australians who want quality of life, they don't want to stay in the same job for the rest of their lives – they want to move and change. They don't want to work 24/7 – a lot of us in the room have in the past. The issue of urbanisation and trying to get medical students or health science students to go to the country is like banging your head against a brick wall and the rural work apathy is becoming a bigger issue and the lack of accurate planning, which is actually frightening when you think of the university's link to the planning model.

So where are we going? If you look at the average age of GPs from 2001, that was 48 years there, that's now shifted in five years to 50. Now that's absolutely the biggest issue, is rural health. The rural trainees, the people who have worked many years in the country are all reaching this age group and there's now quite a significant problem for this State and across Australia. Admittedly there are structures in place to manage that, but that's an issue that will not go away. If we look at nurses, the age profile of the nurses has shifted from the commonest of 40-44 in 2002 to 45-49 in 2006. We have an aging nursing workforce and everybody in the room who is a nurse or trained in that area, everyone seems to think nurses can solve all the problems of the system, but we actually – we have to train enough to do that.

The second area than is, if we look at the specialist workforce, and this is across the bottom, psychiatry, O&G, pathology, general medicine – they're all across South Australia, reaching the 50 age group as well. Interestingly for me, the younger specialty of emergency medicine is going to be alright for 10 years. So I suppose that might help us cope with the workloads, but what we have is an aging medical workforce. Now you will have all seen that all the three universities have taken more health science graduates. We're all training more and we're trying to cope with the issues the State's putting on the agenda for us. It's actually not going to solve it, it's actually not going to be solved by the universities training more people because basically the skill base needed for workforce in the future is not about medicine and nursing, dentistry or health science or physiotherapy, it's really about multi-skilled people who have different sets of skills to manage the problems we're facing.

So what we're looking for is basically a different set of working skills to complement those already. There will need to be job redesigning, new ways of working reallocation of tasks and I've given three examples on the bottom. I've recently been in the APY Lands and was struck by the need to plan for the aboriginal health support in those areas, with the local aboriginal people in a way that you take them through a learning curve through their teaching, right through to training. They learn to be multi-skilled and handle prescribing patterns and acute management. We are about to put in place, the State health is about to fund an anaesthetic physician assistants program, where people will be skilled to do low-risk, regular anaesthetic procedures under the supervision of an anaesthetist to see if this can actually relieve the workload. I think one of the biggest issues is primary care chronic disease coordinators. I spend my life dealing with chronic illness and in fact what we're doing is using our practice nurses to coordinate care through a system. I'm not totally convinced that's the best use of their skills and I think it's about coordination, lifestyle planning, a different way of looking at how we do work skilling. I think that's something where the universities have basically struggled and I think are behind where we need to go.

If we then look at the imbalances in the health care system my personal view is that we have an ill-health focused system. It doesn't actually reward positives, it doesn't reward good health – positive behaviours. It's dealing with reactive care that deals with people coming in the door. It's fragmented – in 2002 there were 73 health units plus a hundred other funded agencies who deal with State health. It has nothing to do with general practice and the need to link back into there. There's no real linkage between public and private systems and we've started to explore the issue of teaching in the private hospitals and we need to think through how we do that as a partnership in the State. I've talked about the under-resourced and under-valued primary care and my argument there needs to be a rebalancing of the vision to make sure both groups carry forward. I've talked about the lack of coordination of information technology and everyone knows the appalling gap in our indigenous health indices, with a life expectancy of male aboriginal people of 59, compared to 77 for non-indigenous and female 65 and then 82 for non-indigenous females. I think there's a sleeper in all this from a primary care perspective. There's a growing realisation of the impact of mental health care on our system and that needs to be put into the planning so it's linked and integrated in a manner that's logical. In fact one in ten – 2.1 million people have mental health problems, so we have a burgeoning problem of the interaction of mental health with our chronic illness epidemic.

So what I've done is talk through some of the issues – I just want to move to a slightly more positive model. This is the projected hospital growth, which I've said already, which is where the impact over the next – if you go along the bottom, that's the year along the bottom, this is the projected use of our hospitals. But interestingly for me, if you then look at this diagram, this is actually a very famous diagram for primary care and it's one I love to float because it just shows you where all the patients are seen. On the right hand side is the number of people seen with medical problems. On the bottom, less than one in an academic medical centre, 8 are hospitalised, 13 to the emergency department, 14 were seeing home health, 65 complementary practitioner, 217 visit me, 327 think might go to health care, or maybe they talk to their neighbours and don't go. This is American data, but I think the lesson for me is, what we've got at the moment in the State is a preoccupation with the balance of the hospital and again, 70 percent of the funding goes to the hospitals and I understand that, before hospital people shoot me down in flames, but what I'm also saying is I think there needs to be a rebalancing where most of the care is going to happen in the future, is in primary care.

If you look at the evidence around primary care and look across the world, if you build and support primary care, the health care systems are more efficient and better. There's clear evidence now across the work and what we've got to do is make sure we rebalance that over the next 10 or 15 years. So I was actually putting this talk together and I was trying to find some other reading and the Generational Health Review, which has pre-empted the Health Care Bill was published in 2003. This gestation of

where we are today, as some people know in the room, has been a five to eight year process. The Generational Health Review did some modelling and this is based on some scenarios. If there's no change to the health care system in 2011, hospital admissions will increase by 10 percent, the total beds will increase by 16 percent and the total cost per annum will increase by 9 percent. I think Kevin Foley has made many comments, as has the Minister, about health absorbing all the costs in the future in the city, in the State. So therefore if we just start thinking differently, plan in a different way, look at plan change in patient flows, support new clinical models, hospital and demand strategies in place, community supports in place with capital investment and we decrease the average length of stay in a modelling sense, what you find is that you start to go forward where we need to go. Admissions will increase by 7 percent, not 10 percent, total beds decrease by 7 percent, not increase by 16 percent, total cost decreased by 13 percent, not increased by 9 percent. So it's about appropriate planning from the whole of State perspective where hospitals, primary care and community can be linked together. The moulding is rubbery and there's caveats wrapped up in it, but I think it's beginning to have the debate about what we're trying to deliver.

This is the best quote, I think, as I was trying to develop this talk – this is out of the Generational Health Review. 'The health system is not sustainable into the next generation on the grounds of quality of care, efficiency and equity' and I would add, unless sustained State-wide change is put in place. I think everyone needs to buy into this otherwise I suspect when I go to have my hip done in 20 years time, I won't be able to find a bed. So that's part of what I think we need to think through in the future.

I want to finish on a couple of final things and you can have your meals, I'm just working this through. I think the big issue for South Australia is the equity issue. This is again out of the Generational Health Review – the yellow bars are the well to do suburbs in the State, these at Gawler, Munno Para, Elizabeth, Port Adelaide and Enfield – these have poorer health status, there are more unemployed, more low income families as a consequence their health behaviours are poorer, they exercise less, they smoke more, there's more alcohol at risk and they have less healthy diets. So whatever system we put in place, whatever we move forward, it has to be identify the gaps and look at where the equity issues are otherwise this is likely to get greater and more significant.

I've talked already about the indigenous health, I can't go past the issue of rural health, and needing to make sure that what we build links urban and rural together in a model that takes us into the future.

This very busy diagram is about the future and the consumer expectations if you read the futuristic books, we will want more and more. We will want our hips done, and just as I go through these diagrammatic pictures. That's a 3D rat brain, and basically what's happening with the burst of neurosciences research, there will be solutions made for our behaviour – dementia will be managed within 10 years, we will have increasing understanding of the neurosciences research as we move forward. This is actually a genetics lab and I'll lay money in 10 years time, most people in this room would have had their DNA profile done, to outline what risk they are for cancer or for future longevity. So the DNA issues are going to get bigger and bigger as we understand our genetic profile.

We'll get more infectious diseases we'll have to manage and that has to be managed within the system and this lovely diagram on the right hand side is about having our hips, knees and fingers done as we try and retain our quality of life. I've no doubt everyone in the room will want to live to the ripe old age of 85 with everything working properly. These are the pressures as technology expands on our system. At the moment, we don't seem to have factored that all in – sorry, we're beginning to factor it in, but at the same time as dealing with the epidemics of chronic illness and the aging population.

So where do I want to be in 2015? I think there needs to be a rebalance around having it more prevention orientated, I think it needs to be future-proofed, so we can cope with new drugs, the impact of stem cells, brain science research, issues of prevention, DNA profiles, technology – so that we can

manage and anticipate where we need to be. We need to be integrated across the hospitals with a shared information system and I think that's one of the next steps over the next five years. What I'm hoping we'll do is that the population health needs will be planned, in an integrated fashion to allow us to move forward together, whether you be Elizabeth or Burnside. I think the workforce that I will train as a university person will need to be incredibly flexible, multi-skilled, can deal with a patient with asthma versus sorting out chronic illness care over the future and fitting them into an aged care model. They need to be adaptable to technological change and importantly for me, it needs to be research informed. It's very dangerous at the moment to get lost in the service issues and not remember that the State thrives and needs a research base to build off and I have had my plug now, which is always nice after Health Partners had their plug, that needs to be underpinned by an affordable teaching model. There is actually no point us training more students if we can't teach them to give quality care and that's something that I think is a priority for this state as we move forward. Safety and quality will be a priority as we become more accountable, and I've talked about equity on population disease groups.

So just to finish, on a couple of positive notes, I actually think we're beginning to move in the direction and I'm sure the Minister will unpack this in a minute. The GP Plus model has got positive steps about linking with local services, there's two established at Aldinga and Woodville and others planned at Elizabeth and other parts of Adelaide – at least the thinking is around partnership and integration which is positive. We have eight clinical networks which are led in the area of rehabilitation, renal, cancer, mental health, maternal and child health and cardiology, which are at least starting to plan from a State-wide perspective as we move forward and it will be important that they become very useful tools for change. The State government has very sensibly funded primary care practice nurses to underpin the development of practice based teams, I have to make a plug for Universal Home Visiting and the value it has for identifying prevention for children – something that I haven't talked about today is the issue of early development and the importance of balancing that at the same time as we deal with age and chronic illness. There's redesigning care models at Flinders and there's lifestyle coordinators being funded in the Central and Northern Adelaide Health Service – so it's going in the right direction.

I think the other thing to say as my final comment from the university's perspective is that I think it's important that we all come behind this. The University of Adelaide has done that, we're talking new training programs around physician assistants, new curricula for our health science graduates, we're talking aligning academic roles with the system as it moves forward, new models of teaching current students and I've talked about expanding into private hospital and into primary care. Underpinning and valuing the importance of research in these changes and not to lose track of it as we build the models forward in basic health services and clinical. I think all the three universities want to be involved in the planning solutions for the system. For example, the Marjory Jackson Nelson Hospital will have three universities involved with the clinical school which is a sign of where we're going in the future which is around partnership and moving forward in the right direction.

Thank you very much, it's been a pleasure to be here and I look forward to further comments.

Thank you very much.

End of transcript