

## Care coordination and health sector reform

**THE PRODUCTIVITY COMMISSION** (Productivity Commission 2004) has nominated nationally coordinated health sector reform as one of two top priorities (along with natural resource management) for extending the industry reform agenda under the aegis of National Competition Policy. This is in recognition of the importance of these areas for the wellbeing of Australians, and the level of resources they will require in future years. The Commission states that “an independent review of Australia’s health system as a whole is a critical first step in achieving cooperative solutions to deep-seated structural problems” (p. XI). The fragmentation in health system governance that results from the national–state split is mirrored in the lack of coordinated care at many levels throughout the system. The Commission’s proposal has been welcomed by many in the health industry, no doubt with some nervousness, because of the broad and deep conviction that something has to change in the apparently intractable problem of split funding responsibilities.

“Today’s health-care delivery systems are not organized in ways that promote best quality. Service delivery is largely uncoordinated, requiring steps and patient ‘hand-offs’ that slow down care and decrease rather than improve patient safety” (OECD 2004). Improving care coordination is high on the list of issues to be addressed in any reform of the health sector. This issue of the journal features a collection of papers which address the sometimes jagged ‘seams’ in the current system. They offer insights into some of the consequences of the structural problems the Productivity Commission would like to see addressed, and document an energetic search for methods of enhancing the effectiveness of health care.

There have been many positive contributions to care coordination. Kroemer and colleagues (page 266) explain how a collaborative approach

to rehabilitation for selected older patients (who were otherwise targeted for long-term residential care) succeeded in getting most of them home. Middleton and colleagues (page 255) report that while getting discharge summaries to GPs is still a problem, patients are more informed about how long they’ll stay in hospital and generally feel ready for discharge.

However, other attempts suggest that care coordination and integration may depend on broader structural reform. Brand and co-authors (page 275) found that an intervention aimed at preventing readmissions of patients with chronic disease may have been too small and insufficiently integrated with existing care models to be effective. They urge those who fund experimentation with new models to set aside funding for larger-scale evaluation studies as well. Nagree and colleagues (page 285) demonstrate that a focus on reducing Emergency Department attendances by emergency patients who could have been treated by a GP is unlikely to have a significant impact on ED workloads in Perth hospitals, and may not save money. Dow (page 260) documents the often difficult experiences of carers of patients discharged early as part of a ‘bed substitution’ approach to rehabilitation. In the area of mental health services, Buchan and Boldy (page 292) found that GPs, psychiatrists and administrators suggested that an agreed definition of the scope of primary care psychiatry, methods to improve GP access to mental health services, and better communication and education were required to improve service integration.

These studies illustrate some of the difficulties we have in navigating the largely artificial boundaries created among the various health sectors. There has been mixed success in implementing the required care coordination mechanisms, such as standardised assessment and admission tools, system-wide pathways

and other collaborative initiatives that cross existing service sector boundaries. Perhaps, as suggested by the Productivity Commission, it is time to review and reform these impeding structures.

Planning for effective health service delivery has never been easy. We present a group of papers on planning topics ranging from local priority setting (Mitton and Prout, *page 301*), methods of consulting with non-English speaking communities (Whelan, *page 311*), to a case study on using local intelligence in health planning (Austin, *page 317*). These studies confirm the success of open, participative planning processes, and we would argue that the principle of participative planning should apply at the level of national review and reform of the health care system as well.

### **Other considerations for health sector reform**

The impact of private health insurance policies on people and providers continues as an important area of research and debate, and for consideration in any national reform. In this issue, Sundararajan and co-authors (*page 320*) show that public hospital utilisation continued to increase in Victoria in recent years despite increased PHI coverage; while Hanning (*page 330*) addresses the implied demand on Victorian public hospitals if PHI coverage had continued to decline. Most commentators agree that it is all a question of getting the balance right — there is less consensus on where that balance lies.

Recently policymakers have recognised the importance of addressing workforce issues to improve the delivery system. Two case studies from Australian hospitals (Collette, *page 349*; Kitchener and colleagues, *page 357*) examine a successful strategy for enhancing retention of nursing staff and a successful approach to managing aggression. Cheung (*page 340*) reports on a study of the reasoning of nurses who have left

nursing, with a focus on events at work that challenged the participants' thinking about the values of nursing.

Finally, as we continue to explore ways to manage the risks within the system, Hendrie and co-authors (*page 363*) estimate the cost of falls in Western Australia, and Houghton and co-authors (*page 374*) document the experience of a comprehensive falls assessment and treatment clinic in a hospital setting in South Australia.

### **With thanks and season's greetings**

This issue marks the end of a momentous year for Australian Health Review. We have received much positive feedback from readers about the new format and continuing quality of the journal. The transition to online submission and editorial management has been smooth (mostly!) and we contemplate next year with confidence, heightened by the strong support of the national Australian Healthcare Association office, Council and AHR Editorial Board, and a great working relationship with AMPCo, our publishers. In this issue, we acknowledge the contributions of the many reviewers who assist us in assessing and improving the value of the papers we publish. While their work on individual papers is anonymous, we take advantage of this annual opportunity to record their names as a group, along with our gratitude for their generous and painstaking work.

As we look forward to downing tools for the year, we thank all our contributors and readers for their support, and wish you a happy and restorative holiday break.

**Sandra G Leggat and Judith Dwyer**

**Editors, Australian Health Review**

Productivity Commission 2004, *Review of national competition policy reforms: draft report*, Productivity Commission, Canberra.

OECD 2004, *Towards high-performing health systems*, OECD, Paris. □