FINAL REPORT

WA Sustainable Health Review
Consumer Engagement

Prepared by
Luke van der Beeke, Marketing for Change
Pip Brennan, Health Consumers Council of WA

Email: luke@marketingforchange.com.au
Web: www.marketingforchange.com.au

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Acknowledgements

The Health Consumers Council of WA and Marketing for Change would like to acknowledge the following individuals and organisations for their contributions to the SHR consumer engagement work program.

Rehab Ahmed, ISHAR

Louise Ford and Tania Harris, Health Consumers' Council

Angela Ryder, Langford Aboriginal Association, Relationships Australia WA

Jane Chilcott and Joanna Murphy, Linkwest

Lynn Malm, Tuna Blue

Manjit Kaur

The SHR Secretariat

The SHR Consumer and Carer Reference Group

Participating Community Resource Centres

Tom Price Senior High School

Most importantly, we'd like to thank the 350 West Australian health consumers who completed the public survey or took the time to meet with us face-to-face at CRC's and community venues across the State. We value your insights. Your willingness to share lived experiences and hopes for the future of WA health is greatly appreciated.

1.0 Background and purpose

This report provides an overview of consumer engagement activities undertaken by the Health Consumers Council of WA (HCC) and Marketing for Change in support of the state government's Sustainable Health Review (SHR).

Following the completion of the first round of public consultation in November 2017, the Department of Health (DoH) and the SHR Panel recognised that the consumer voice had not been heard.

HCC and Marketing for Change were commissioned to undertake further community consultation and then develop a consumer engagement plan for the SHR. The plan was endorsed by DoH in March 2018 and HCC and Marketing for Change were re-commissioned to oversee its implementation.

Initially, emphasis was placed on ensuring that the following 'at risk' consumer groups were provided with further opportunities to engage and comment on the SHR's Interim Report:

- Aboriginal health consumers
- Culturally and Linguistically Diverse (CaLD) health consumers
- Mental health consumers and their carers
- People with disabilities and their carers
- Aged and elderly populations and their carers
- Young health consumers
- LGBTIQ health consumers

However, during the project initiation phase DoH decided that mental health consumers, youth and LGBTIQ health consumers would be engaged through different mechanisms. These groups were therefore not directly targeted.

The key consumer engagement activities undertaken were comprised of four key activity domains, namely:

1. Metro community conversations
2. Regional community conversations
3. A consumer survey
4. Web conferencing with regional consumers

In total, 350 health consumers were meaningfully engaged across these 4 activity domains. These consumers were afforded opportunities to directly speak with facilitators and provide their views or responded to the online consumer survey (n140). We estimate that at least ten times this number were 'reached' by advertising and promotions but chose not to directly engage with the Review.

This report provides an overview of feedback received across each of these activity domains distilled into key themes.

Recommendations from attendees have been included without alteration. We've also included our own recommendations based on what we heard from consumers and what we know to be within the scope of the SHR.

This report doesn't provide a full account of everything we heard. We've synthesised the information collected at each session and endeavoured to report findings that are of practical use to the SHR Panel as it finalises its recommendations to government.

2.0 Key findings

The key findings outlined below have been included because they reflect the most commonly cited challenges and opportunities cited by health consumers. Most sit within one or more of the strategic directions outlined in the Interim Report.

1. *Acknowledgement of culture*, **and greater sensitivity and awareness** of Aboriginal people's beliefs and values would lead to marked improvements in the health outcomes.

2. *Culturally and Linguistically Diverse (CaLD*) consumers are not a homogenous group. Health services should be designed and targeted accordingly.

3. Acknowledging and addressing the *social determinants of health* will lead to improved health outcomes for disadvantaged health consumers, and a more sustainable health system in the future.

4. *Access to healthy food* (and in some cases clean *drinking water*) remains a problem for a small proportion of the WA population.

5. A lack of *cohesion and communication between service providers* was another common theme of this consultation. More "joined up" service, and procurement policy that encourages greater collaboration between providers would be beneficial.

6. *Health literacy* is relatively low across the entire population, and particularly low in socio-economically disadvantaged, aged and CaLD populations.

7. Affordable *transport and accommodation* was the most oft cited barrier to service access for Aboriginal, CaLD, regional and aged health consumers.

8. There is public support for the adoption of *digital and technological innovation* in the health sector. However, it is important to ensure that alternate options are provided, particularly to those facing structural barriers to access such as unreliable internet, phone networks and power.

9. *Digital* solutions may not be appropriate for all health consumers, such as those experiencing mental illness, people with a history of drug use, a diagnosis of a blood borne virus etc.

10. *Digital literacy* is relatively low among certain segments of the WA population, including socio-economically disadvantaged and aged health consumers. It is therefore necessary to ensure that any roll-out of digital technologies is appropriately targeted, and that where a lack of knowledge exists, suitable supports and/or alternatives to service access are provided.

11. The need for a greater focus on *prevention*, including health promotion, was a recurring theme during our consultation. Many of the regional communities we spoke to expressed a strong desire to work in partnership with health service providers to increase efficiency and access.

12. The health of *'at risk' populations*, particularly in regional WA was one of the main issues identified during our consultation. This included mental health consumers, people with disabilities and the aged.

13. *Social isolation* is high across most population segments in regional WA and prevalent amongst CaLD and aged health consumers, carers, and people with disabilities. A focus on building community cohesion and developing other approaches to address social isolation would be beneficial.

14. Many of the regional communities are highly dependent on grant funding to run health promotion events and activities. There are concerns that *fiscal tightening across government* will lead to less of these sorts of activities which in turn will increase the burden on the health system.

15. Links between *general practice, AOD and mental health* services need strengthening.

16. The heavy reliance on *volunteers* isn't sustainable. Many are ageing and there is a real sense that they are over-burdened. Some vi are engaged in three or four different voluntary activities, often because they feel compelled to do so. With more young families leaving smaller regional towns for work and/or schooling the volunteer pool is shrinking.

17. Many consumers have a negative perception of *Health Direct*. There is a perceived lack of value, particularly for regional consumers.

18. The lack of *access to GP's*, particularly those who bulk bill, is a concern for many health consumers.

19. Many of the communities we spoke to were keen to work with health service providers to *co-create solutions* to health-related challenges. Many consumers are keen to engage, but that engagement needs to be 'meaningful.'

3.0 Recommendations

During the course of our consultation we heard from 350 health consumers, including 260 face-to-face.

We received many ideas and recommendations, a large number of which are included in this report. They are *highlighted in orange*.

In this section, we highlight our own recommendations which are based solely on what we heard during the engagement process. Recommendations are listed in the order they appear in the main body of this report where they can be viewed in context.

1. DoH to co-design a new, more comprehensive cultural competency training framework with Aboriginal community members.

2. Cultural competency training to be made mandatory for all health service professionals working in government, and for staff working in health services that receive government funding.

3. Cultural competency training to include a stronger emphasis on the role of family in Aboriginal culture and how health services might better respond to the need for family to visit.

4. DoH to work with health service providers and other relevant stakeholders to (a) identify gaps in interpreter services, and underlying reasons for lack of availability, and (b) implement measures to ensure interpreter services are available to any health consumer who requires them – these may include legislative measures, targeted education and training, attitudinal and behaviour change program design and rollout.

5. Co-design and implement a place-based pilot where community prioritised holistic health services augment existing delivery mechanisms. A collective impact approach should be considered.

6. All WA hospitals to be part of Close the Gap PBS Co-payment measure.

7. Regular information sessions for Aboriginal and CaLD populations to update them on health-related matters that impact them.

8. Review of discharge policy and procedures to ensure that all at-risk patients have access to safe accommodation or a means of transport home prior to discharge.

9. Review of discharge procedures to also include follow-up mechanisms with at-risk patients.

10. Conduct a qualitative research project to better understand attitudinal and practical barriers to CaLD communities current and future access to telehealth and virtual health offerings.

11. Based on research outlined in 11 (above), develop an insight based public education campaign specifically targeting CaLD communities to address negative attitudes toward telehealth and virtual health offerings.

12. Conduct a feasibility analysis of delivering appropriate mental health related online training services. Online training might include e-learning modules, remote mentoring and supervision. Training could be delivered through the CRCs and other appropriate venues where internet access in the home is not always reliable.

13. Commission the development of mental health promotion kits for use in regional communities. In addition to promotional collateral, the kits could include tools and resources necessary for would-be community champions to develop and run small community events, and ideas for activities that support wellbeing. Begin by speaking with Act-Belong-Commit and WA Local Government Association to see what's already being done and what might be improved.

14. Work with relevant stakeholders to scope the potentiality of beaming wi-fi directly into local communities from town centres.

15. All WA Aboriginal communities have access to safe drinking water.

16. Conduct a high-level audit of at risk health consumer's access to fresh food (distance needed to travel) for the purpose of then co-designing local strategies to improve access for at-risk groups.

17. Establish a cross-departmental working group to develop outcome focused performance indicators to improve social determinants of health for regional health consumers. Each department to be accountable to the DPC for achieving agreed outcomes.

18. Consider using one Perth hospital as a trial site to create a regional booking window (e.g. between 11 and 1pm) for patients living an agreed distance from the hospital.

19. Establish community mechanisms (e.g. Facebook page or physical noticeboard) where community members can flag that they're travelling to an appointment and allow others to request a lift (if for example they don't have access to PATS).

20. Explore social enterprise model based on Airbnb and Uber to facilitate movement and accommodation for people without access to PATS.

21. Conduct a feasibility analysis around "if" and "how" the cost of PATS to taxpayers could be reduced by transporting more than one patient at a time. Data management and IT systems are readily able to cross-reference patient locations (even real time geo-data) with appointment times and locations. The challenge would likely be integrating different systems and barriers to information/data sharing. Consider a small pilot program involving two or three health service providers with a view to scaling-up over time.

22. Consult with Western Power and other key stakeholders to identify and implement improvements to back-up power options for rural and remote communities.

23. Commission research to map community attitudes on health equity in the regions, with a particular emphasis on what key improvements could be made to reduce health inequalities between metropolitan and regional health consumers.

24. Increased emphasis on the development and evaluation of community initiatives to maintain and improve health and wellbeing in the regions.

25. Further public education and media messaging regarding the unsustainability of WA's health system is needed.

26. Work with the AMA, WA Primary Health Alliance and other key stakeholders to increase the proportion of GP's asking patients if they're a smoker, how much they exercise and how much they drink. The question itself serves as a behavioural prompt, and depending on the answer, additional support and/or referrals could be provided.

27. Continued use of the full suite of health promotion strategies to educate the public about the need for regular physical activity and maintenance of a healthy diet.

28. Design and implement a place-based social marketing program to address the barrier of 'time' to physical activity. This barrier is both perceived and actual and a consumer insight-based behaviour change initiative to address it amongst identified market segments may be beneficial.

29. Develop targeted guidance for identified health consumers segments on how to distinguish between credible and non-credible sources of health information online.

30. Increased adoption of targeted, behaviourally focused approaches like social marketing, behavioural economics and behavioural design to augment existing health promotion activities.

31. Increase the amount of after-hours care available in local communities to reduce the burden on hospital Accident & Emergency (A&E) departments.

32. Develop and implement a targeted public awareness campaign that informs health consumers where they can access help other than A&E Segmentation should include those who only feel comfortable seeing their own GP.

33. Continue to work with the AMA, WA Primary Health Alliance and other key stakeholders to improve GP availability, particularly after-hours.

34. Strategic communications/behavioural insight work to be undertaken to address the relatively high proportion of respondents who believe service levels should be the same in the regions. There is clearly a difference between quantity and quality of services, and this may be a point of emphasis when engaging in public discourse on regional health services.

35. Continued public education about web-based GP appointments. Face-to-face demonstrations of the technology in local community venues would be a good option.

36. State government to consider what role it should play in notifying health consumers about the changes to the default settings, which will move to opt-out for all Australians by the end of 2018. Given the lack of knowledge about My Health Record, there is potentially a risk for adverse public reaction when the changes are made which could be mitigated by informing the public of the benefits and the impeding changes upfront.

37. Commission targeted education and training for segments of the population with ‘moderate confidence’ in their ability to use mobile phones, tablets and computers.

4.0 Metro Community Conversations

4.1 Background

The primary purpose of the metro community conversations was to test the 12 key future directions outlined in the SHR Interim Report with Aboriginal and CaLD health consumers. Particular emphasis was placed on exploring people's thoughts and experiences with respect to the following four directions given the nature and anticipated interests of participants:

Direction 1:	Keep people healthy and get serious about prevention and health promotion.
Direction 3:	Better use of resources with more care in the community.
Direction 5:	New ways to support equity in country health
Direction 8:	Greater use of technology, data and innovation to support consumers, clinicians and drive change.

The key output sought through the metro community conversations was to provide the SHR Panel with ideas and insights that can be used to inform recommendations as to how the WA health system can continue to deliver patient-centred healthcare to Aboriginal and CaLD consumers in a culturally appropriate and sustainable manner.

4.2 Method of engagement

The method of engagement used differed slightly for the Aboriginal and CaLD sessions to ensure that the engagement mechanism was culturally appropriate.

Langford Aboriginal Association

Location: Langford Aboriginal Association.

Attendance: 20 attendees in total, including 16 from the local Aboriginal community. Five attendees were male, 15 female. With one or two exceptions, most attendees were over-45 years of age, with approximately 20% over-60 years of age. The group included several male and female community elders.

Facilitated by: Pip Brennan, Tania Harris and Luke van der Beeke.

Duration: 3 hours including pre and post informal yarning.

The community conversation held at the Langford Aboriginal Association was a semi-structured yarning circle.

An agenda was prepared and provided to participants (Appendix 1), as was a copy of the Interim Report's Executive Summary.

The session commenced with the sharing of a home-cooked meal which afforded attendees and facilitators an excellent opportunity to talk and get to know each other.

The sharing of a meal was followed by a traditional welcome to country and then Pip Brennan provided a short presentation to attendees (some of whom had attended the November session) with an update regarding the progress of the SHR and a summary of the key directions outlined in the Interim Report.

Ishar Multicultural Womens’ Health Services

Locations: Bentley Library 12th June & 20th June 2018.

Attendance: Total attendance – 38 women (52 if including attendees who arrived after lunch at session 2).
Bentley - 14 women, mainly mature aged, including one self-reporting depression and two carers. An interpreter also attended but is not included in this number.

Mirrabooka - 24 women, mostly mature aged. Three interpreters plus a bi-lingual and bi-cultural ISHAR staff member. Languages spoken were Vietnamese, Macedonian, Arabic and Persian. The attendee number increased to 39 after the lunch break and they contributed to discussion on digital health.

Facilitated by: Bentley - Louise Ford and Luke van der Beeke.

Mirrabooka - Louise Ford and Manjit Kaur.

Duration: 1 hour for each session.

The two community conversations hosted by Ishar were also semi-structured and relatively informal. Given the cultural diversity of the people attending, considerable care was taken to ensure that the women felt safe and comfortable enough to provide feedback.

Additional steps taken to this end included:

- Extensive consultation with persons experienced working with CaLD populations on the appropriate format of the session.
- Consultation with persons experienced working with CaLD populations regarding the way in which questions were structured and asked by facilitators. Questions were framed very simply and included contextual and cultural prompts where applicable.
- Checks with Ishar and attendees that they were comfortable with Luke van der Beeke attending the session in Bentley.

An agenda was prepared prior to each session and provided to attendees on the day. Copies of the Interim Report Executive Summary were also made available.

The conversation was led by Louise Ford who has considerable experience engaging with CaLD communities. Discussion was had over tea and light refreshments, and every effort was made to ensure that all participants, including those with interpreters, were fully included and given opportunities to input.

Across all sessions there was a tendency for attendees to speak about their negative experiences with the health system. This was understandable and anticipated. Our approach was to actively listen to the participants’ concerns before endeavouring to steer conversation back to ways in which those concerns might be overcome in the future.

The experiences and views of Aboriginal people and members of what we call CaLD health consumers differ considerably for a myriad of reasons. This is also the case for the large range of important and identifying cultural differences that exist within and between CaLD consumer groups and/or communities.

However, it is also true that some of the challenges facing Australia's traditional land owners are similar to those experienced by members of CaLD communities, many of whom may have only arrived in Australia within the last one or two generations.

So, while it's important to note the experiences and challenges facing Aboriginal and CaLD consumers are not identical, we have been able to group feedback into five thematic areas which cut across both groups.

1. Cultural sensitivity, awareness and sensitivity
2. Social determinants of health
3. Health literacy
4. Transport and accommodation
5. Digital literacy

Again, in keeping with the intent and scope of the work program commissioned by the DoH, challenges will be noted as will the suggestions and recommendations we heard about how they might be remedied.

Consumer recommendations and suggestions are *highlighted in orange* throughout this report.

4.3 Metro conversations with Aboriginal and CaLD consumers – what we heard

4.3.1 Cultural competency, awareness and sensitivity

Factors linked to cultural competency were amongst the most commonly cited challenges facing Aboriginal and CaLD communities. Attendees at the Langford session also noted that there was a considerable difference between cultural competency and cultural awareness.
The systems' perceived lack cultural competency was seen as a barrier to service access at all stages of the continuum – that is, from prevention to cure. Logically then, improving cultural competency across the system should lead to improved access, improved prevention (and early intervention) and ultimately, a more sustainable, equitable, person-centred health service.

4.3.1.1 Acknowledgement

A lack of acknowledgment of Aboriginal people at hospitals and health centres was cited as an ongoing barrier to service access. It is also an area where improvements can be made with relative ease.

"All public hospitals should acknowledge Aboriginal patients. We need respect. Look us in the eye." (LAA Session)

There was a strong view amongst all attendees that the *employment of more Aboriginal staff in hospital and other health care settings* would lead to better outcomes for Aboriginal patients. The employment of Aboriginal staff was also seen to be an important form of acknowledgement.

"There are very few Aboriginal people working in mental health services at hospitals. This is one reason why there are few Aboriginal people turning up for the support they need." (LAA Session)

4.3.1.2 Cultural competency training

"We need to go back to go forward." (Frank – LAA Session)

Attendees felt that existing cultural competency training for health services staff was inadequate. *Features of an improved cultural competency offering might include:*

- *Ongoing training that is not delivered online*
- *Shadowing and walking with Aboriginal health service providers be included as a key part of the process*
- *Co-delivery by Aboriginal and non-Aboriginal trainers*
- *Co-delivery by male and female trainers*

Recommendation 1: DoH to co-design a new cultural competency training program with Aboriginal community members.

Recommendation 2: Cultural competency training to be made mandatory for all health service professionals working in government, and for staff working in health services that receive government funding.

4.3.1.3 Food in hospitals

Another relatively simple way to demonstrate cultural sensitivity would be to *"provide better access to traditional Aboriginal foods and nutrition in hospitals."*

4.3.1.4 Understanding of family

The Aboriginal family system is an extended family structure, as opposed to the nuclear or immediate family structure which is common in Western society. This extended family concept is rarely endorsed or understood by government authorities with adverse consequences for affected families.

"There is a lack of awareness and/or service responsiveness to the roles and responsibilities of family." (LAA Session)

"The family's heartache and stress and strain is considerable – large numbers of family turn up and get moved on." (LAA Session)

This is also important when dealing with bereaved Aboriginal families. *"In Aboriginal culture family is different. There are family obligations that must be met."*

Recommendation 3: Cultural competency training to include a stronger emphasis on the role of family in Aboriginal culture and how health services might better respond to the need for family to visit.

4.3.1.5 Interpreters

For many CaLD consumers, a lack of access to interpreters at the GP and/or A&E was seen to reduce the likelihood of early detection and/or treatment of disease or illness.

"We need more culturally sensitive practice at A&E, …including interpreters are needed to diagnose health issues when they present." (CaLD Session 2)

Some CaLD attendees stated that some GP's and GP practices "actively discouraged" CaLD patients from using interpreters. Such claims, coming as they did from several participants, warrant follow-up.

Similar concerns were raised about the availability of interpreters in several metropolitan hospitals.

"[At] Fiona Stanley, Armadale, RPH, Fremantle - even when requests [are] given on behalf of [the] patient by carer/advocate the interpreters aren't provided by the hospitals when the patient visits on their own without an advocate." (CaLD Session 1)

Recommendation 4: DoH to work with health service providers and other relevant stakeholders to (a) identify gaps in interpreter services, and underlying reasons for lack of availability, and (b) implement measures to ensure interpreter services are available to any health consumer who requires them – these may include legislative measures, targeted education and training, attitudinal and behaviour change program design and rollout.

4.3.1.6 Holistic view of health

Many Aboriginal and CaLD health consumers view health more holistically than has traditionally been the case in Western society. Holistic approaches consider the person as a whole as opposed to a specific ailment. The mind, body and spiritual wellbeing of an individual is believed to contribute to their overall state of wellness.

"The system focuses on illness and symptoms of poor health, but not on working to ensure the spiritual and emotional wellbeing of Aboriginal people." (LAA Session).

"Nurses and doctors look at things clinically, not holistically." (LAA Session)

Thinking more holistically about the health of communities and developing approaches that are responsive to the spiritual and emotional needs of Aboriginal and CaLD populations would likely result in improved mental and physical health outcomes. A more holistic approach to health care might be one of the most impactful prevention measures the system could introduce.

Aboriginal health consumers said that many non-Aboriginal organisations had moved into the area (City of Gosnells) without partnering with local Aboriginal service providers.

"Holistic health and wellbeing approaches should include partnerships with Aboriginally owned and operated health service providers." (LAA Session)

Recommendation 5: Co-design and implement a place-based pilot where community prioritised holistic health services augment existing delivery mechanisms. A collective impact approach should be considered.

4.3.1.7 Aboriginal Liaison Officers

The role of Aboriginal Liaison Officers (ALO) was discussed at length at the LAA Session, with concerns raised about how they are utilised. There was a feeling amongst attendees that the ALO's could be used far more effectively by hospitals.

Questions were also raised about how ALO's were notified when there was an Aboriginal patient in the hospital.

One suggestion was for *"ALO's to do the rounds with the doctor so that patients can see there's an ALO available."* (LAA Session)

Ensuring that ALO's are fully engaged in community care plans was viewed as another relatively simple way of improving Aboriginal health outcomes, and Aboriginal people's experience of health services. *"ALO's are meant to be involved in community care plan – they're meant to sit down 1-1. However, this doesn't happen."* (LAA Session)

4.3.2 Social determinants of health

The need to better address the social determinants of health (SDOH) have been a common thread throughout the community consultation process to date.
In addition to the condition in which people are born, work, live and grow, the social determinants of health include wider socio-economic and political influences that impact individual health outcomes.

Aboriginal men at least a decade less than non-Aboriginal Australians, and the gap for Aboriginal women is 9.5 years.[1] The members of CaLD communities we spoke to were also typically socially disadvantaged.

Many of the challenges discussed when talking to Aboriginal and CaLD health consumers are a function of the SDOH, with financial disadvantage the primary driver of poor health outcomes.

4.3.2.1 Food and nutrition

Amongst the Aboriginal and CaLD community members we spoke to, there was a good understanding of the need for healthy foods in the diet, and high awareness of what did and didn't constitute healthy food choices.

The issue raised by those we spoke to was access. Access to healthy, nutritious food is difficult for many Aboriginal people which in turn results in increased prevalence of chronic illness amongst indigenous populations.

"Diabetes is a real concern and is the result of a lack of money and access to healthy foods." (LAA Session)

4.3.2.2 Access to technology

One Aboriginal consumer told a story of older people sharing their tablets with others *"because there's not enough money." (LAA Session)*

Part of the solution could be *"the provision of computers and internet access at community venues (like Langford Aboriginal Association) and/or places Aboriginal people frequent would be useful."*

4.3.2.3 Medication

Financial hardship reportedly often results in people running out of medications, which in turn results in higher risk of complications, re-admission and ultimately, greater expense to the health system.

We have people running out of medications between pay days." (LAA Session)

Recommendation 6: All WA hospitals to be part of Close the Gap PBS Co-payment measure.

4.3.3 Health Literacy

Health literacy describes the ability of a person to understand essential health information that is required for them to successfully make use of all elements of the health system (preventive, diagnostic, curative and palliative services). It lies at the heart of a person being able to take control of their own health care through making informed health decisions, seeking appropriate and timely care and managing the processes of illness and wellness.[2]

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[1] Australian Institute of Health and Welfare, 2016.

[2] Australian Department of Health [online] Accessed 05.07.18

4.3.3.1 Lack of knowledge about services

Many CaLD and Aboriginal consumers reported not knowing what services are available and/or how to access them.

Attendees across both groups wanted to see more coordination between services. *An audit of services for CaLD consumers was suggested*. (CaLD Session 1)

Attendees were aware that the government provides GP services with an information package for new arrivals. It was suggested that the *GP information package needed to include more information about how to access health services.* (CaLD Session 1)

Most CaLD consumers accessed health information through their GP clinic, which was also the first source of health information for many.

4.3.3.2 English as Second Language (ESL) and Languages Other Than English (LOTE)

For CaLD consumers, a lack of English was a contributing factor to their low level of health literacy.

Attendees suggested that *more English classes be made available* (CaLD Session 1) but noted that older refugees and people who've never been to school may need to be provided with other options.

Most accessed health information through their GP or via pamphlets at community centres. Information in community newspapers was not seen to be effective due to language barriers.

More health information needs to be developed in Languages Other Than English (LOTE). Online services also need more information in LOTE. (CaLD Session 2)

Recommendation 7: Regular information sessions for Aboriginal and CaLD populations to update them on health-related matters that impact them.

4.3.4 Transport and accommodation

A lack of reliable access to transport was unquestionably the most commonly cited reason Aboriginal community members felt unable to access treatment and/or attend appointments. It was also a challenge for many CaLD consumers.

4.3.4.1 PATS

There was considerable frustration regarding PATS and the need for the service to become more attuned to the needs of Aboriginal patients.

"County patients come down on PATS but can't get transport back. Also, if they miss the first flight they don't get another go at it – and they often get it because they didn't get a taxi voucher." (LAA Session)
Many thought *ALO's could be used to transport patients,* particularly those facing chronic illnesses requiring regular treatment such as diabetes patients for dialysis.

"Aboriginal patients have to pay $90 for a taxi-fare from Midland to Fiona Stanley. Why can't the ALO's transport them?" (LAA Session)

4.3.4.2 Accommodation

Accommodation is a key issue facing Aboriginal consumers in Perth for treatment. There were also accounts from CaLD and Aboriginal health consumers of patients being discharged from hospital with no accommodation nor access to transport home. This included at-risk patients discharged after-hours. And even when patients are provided transportation home – *"one patient I know just got sent home to an empty house."*

Recommendation 8: Review of discharge policy and procedures to ensure that all at-risk patients have access to safe accommodation or a means of transport home prior to discharge.
Recommendation 9: Review of discharge procedures to also include follow-up mechanisms with at-risk patients.

4.3.5 Digital literacy

CaLD and Aboriginal health consumers recognised that technology has an important role in health care moving forward. Most of those we spoke to understood how it could be used as a health promotion tool, a means to access services where distance might otherwise be an issue (e.g. telehealth), and to assist with monitoring chronic conditions. However, in general, Aboriginal health consumers we spoke to tended to be more accepting of telehealth and virtual health services than CaLD consumers.

4.3.5.1 Literacy

Notwithstanding broad acceptance of the role of technology in health service provision, attendees at LAA and both CaLD sessions noted that technological and digital literacy is very low in large proportions of their respective communities.

"Tech literacy is very low in the Aboriginal community."

"I don't know how to use my phone [laughs]." (LAA Session 1)

4.3.5.2 Access

Access to digital technologies including internet access, mobile phone networks and even computers is limited for many Aboriginal and CaLD consumers.

At our two CaLD sessions approximately 50% indicated they had access to a smartphone or android. The cost of these devices was a barrier for many, as it was for those living without computers.

"The cost of computer and internet comes on top of everything else." (CaLD Session 1)

Some of those CaLD consumers who stated they were happy to access online services wondered if LOTE would be available. *Greater provision of technologically based services in LOTE was seen to be a good way to increase access and uptake of digital health offerings.*

"Online services also need more information in LOTE." (CaLD Session 2)

Aboriginal health consumers generally agreed that "telehealth is OK if in a GP clinic, but not so sure about individual capacity to access, especially in remote areas." (LAA Session)

4.3.5.3 Acceptance

While some attendees were comfortable using the internet to speak with a GP or other health professional, others preferred personal contact. This was particularly true for many members of the CaLD communities we spoke to, the majority of whom were not generally supportive of technologically based health services.

"Video conferencing with GP or A&E is overwhelmingly unpopular and won't be used." (CaLD Session 1)

Face-to-face engagement was preferred where possible. For many CaLD and Aboriginal health consumers, the personal interaction was an important component of the exchange between health service professional and patient.

There was considerably greater acceptance of wearable devices and their use for ongoing monitoring of chronic conditions (almost 100% across both sessions). However, CaLD consumers again emphasised the need for comprehensive education on how to use the technology when provided with it.

Recommendation 10: Conduct a small qualitative research project to better understand attitudinal and practical barriers to CaLD communities current and future access to telehealth and virtual health offerings.

Recommendation 11: Based on research outlined above, develop an insight based public education campaign specifically targeting CaLD communities to address negative attitudes toward telehealth and virtual health offerings.

5.0 Regional Community Conversations

5.1 Background

As with the metro community conversations, the primary purpose of the regional conversations was to test the 12 key future directions outlined in the SHR Interim Report. Particular emphasis was placed on the following directions.

Direction 1:	Keep people healthy and get serious about prevention and health promotion.
Direction 3:	Better use of resources with more care in the community.
Direction 5:	New ways to support equity in country health
Direction 8:	Greater use of technology, data and innovation to support consumers, clinicians and drive change.

The key output sought was to obtain ideas and insights that can be used to help inform recommendations as to how the WA health system can continue to deliver patient-centred healthcare in a sustainable manner.

Three face-to-face community conversations with regional health consumers were conducted at Boyup Brook, Pingelly and Tom Price. These locations were selected based on advice from Linkwest that they were well managed and situated in communities where good turnouts could be expected.

5.2 Method of engagement

Regional community conversations were held at Boyup Brook, Pingelly and Tom Price.
The same approach was used at each location. An agenda was prepared (see appendix 1) and provided to all participants, as was a copy of the SHR Executive Summary. Most did not pre-read the Executive Summary, but it was a useful reference point for the group discussion.

Sessions commenced with Pip Brennan providing a brief overview of the rationale behind the SHR and what had been done to date. Luke van der Beeke then facilitated group discussion. Attendees at all venues were placed into groups of three or four for the group discussions and Group Map was used to collect feedback from participants.

Following the more structured Group Map sessions, Pip and Luke facilitated a short open discussion with the groups.

There was a tendency for attendees to speak about their negative experiences with the health system. This was understandable and anticipated. Our approach was to actively listen to the participants' concerns before endeavouring to steer conversation back to ways in which those concerns might be overcome in the future, including referrals to the Patient Opinion website.

An additional session was held at Tom Price Senior High School at the request of their Health Education Teacher who had heard we were visiting the town. This session was less formal, comprising a very short presentation about the SHR and then an open conversation with the four teenage girls who attended, two of whom were white Australian, one Aboriginal and one CaLD.

Locations: Boyup Brook, Pingelly, Tom Price

Duration: Each session officially ran for two (2) hours, but tea coffee and refreshments were served prior to commencement and after session to afford attendees further informal opportunities to provide feedback.

Facilitated by: All sessions were facilitated by Pip Brennan and Luke van der Beeke. Group Map technical support was provided by Lyn Malm (Tuna Blue).

Attendance: *Boyup Brook:* 14 in total, 3 of which had heard of the SHR prior to promotional activities for this event. Attendees were predominantly older white Australian's.

Pingelly: 16 in total, 14 of which were over-55 years. One carer also attended.

Tom Price: 3 attended the session at the CRC, with additional written feedback provided by IBN staff who could not attend in person. A further 5 attended a second informal session at Tom Price High school which included four teenagers. Of the three attendees at the CRC, two were Aboriginal women.

Attendees were predominantly female. Although we did not collect data on the following, our estimate is that approximately 10 people who attended were managing an ongoing health issue or disability. There were also at least two carers.

Total attendance: 38.

5.3 Regional conversations – what we heard

5.3.1 Mental health

When we asked community members at each of the three locations *"What are the keys to maintaining good health and wellbeing in your community"* mental health was the most oft cited issue.

Community members expressed concerns about the lack of mental health services and support available to regional West Australians and provided suggestions about what could potentially be done to help address those shortages.

5.3.1.1 Access

One of the most oft cited issues raised by regional health consumers was the lack of availability and/or ease of access to mental health services.

"Mental health services are almost non-existent in country areas." (Pingelly)

"Mental health services are in Newman – that's 2.5 hours away." (Tom Price)

Various suggestions were posited, including: "the *provision of more in-home services*" (Boyup Brook) and/or *more community-based delivery of mental health services where locals are trained to be able to provide support to their own communities.*

One way to deliver this training was potentially through technologies including the internet. "*Community education for users and practitioners using eHealth.*" (Boyup Brook)

Recommendation 12: Conduct a feasibility analysis of delivering appropriate mental health related online training services. Online training might include e-learning modules, remote mentoring and supervision. Training could be delivered through the

CRCs and other appropriate venues where internet access in the home is not always reliable.

5.3.1.2 Prevention

Social isolation was seen to be a significant contributor to some mental health issues for country residents – particularly the elderly and, in Tom Price for any young person who *"doesn't play sport."*

Access to good sport and recreation facilities was seen by many to be an excellent way of keeping physically and mentally healthy.

"*The town needs a recreation centre for sport and to combat social isolation. It needs the facilities for people to come together and connect with each other.*" *(Pingelly)*

While some health promotion programs were conducted in each of the three communities (e.g. Stay on Your Feet), there were little community-based health promotion events of any kind, particularly ones that spoke to mental health, and/or that were specifically geared to prevent it.

Some thought that one way to help reduce social isolation would be to *encourage community members to volunteer to help others with activities*. However, it was noted by others that many people in small towns were already volunteering and, in some cases, "over-volunteering" was contributing to higher levels of stress for some residents.

One group at Boyup Brook suggested: "*help with funding and organising local support groups like mental health support groups*. If everything has to come down to volunteers it won't happen as those with able mind and body become overwhelmed…"

Attendees in all three locations said the *CRC's would be a logical place for people to attend mental health promotion workshops and/or activities*.

"*Enable and support local NFP to run wellness programs*."

More face-to-face visits from health promotion/mental health promotion practitioners was strongly supported. "*They need to come and visit us face-to-face.*" (Boyup Brook)

"*Get a health professional to educate small groups. This also builds networks*." (Pingelly)

And while face-to-face visits were widely supported, many also recognised the potential for the internet and digital applications to be used to provide mental health promotion support to regional communities.

"*Education and prevention should be part of use with technology when appropriate*," (Boyup Brook) and,

"*Use the CRC for digital education sessions using video conferencing*." (Pingelly)

"Would like to see *digital advisors for the elderly and socially isolated at the point of emergency*." (Pingelly)

Recommendation 13: Commission the development of mental health promotion kits for use in regional communities. In addition to promotional collateral, the kits could include tools and resources necessary for would-be community champions to develop and run small community events, and ideas for activities that support wellbeing etc. Begin by speaking with Act-Belong-Commit and WA Local Government Association to see what's already being done and what might be improved.

5.3.2 Digital literacy, access and attitudes toward technology

There was universal agreement across all three sites that technology has an important role in health care moving forward. Most of those we spoke to understood how it could be used as a health promotion tool, a means to access services where distance might otherwise be an issue (e.g. telehealth), and to assist with the monitoring of chronic conditions.

Notably, the use of technology for monitoring chronic conditions was the most widely supported because it was seen as a means of avoiding challenging and costly trips to health service providers that could be hours away.
For example, *"Tech in pacemakers that report back to Perth is very good."* (Pingelly)

5.3.2.1 Digital literacy

Notwithstanding broad acceptance of the role of technology in health service provision, attendees at all sessions noted that technological and digital literacy is very low in large proportions of their respective communities.

Residents in Pingelly and Boyup Brook noted that many older residents didn't know how to use a computer, and certainly not a smart device or tablet.

"Boyup Brook has a high proportion of older consumers who are not necessarily computer literate and there are those who have no wish to use computers." (Boyup Brook)

"It's a great idea for the future, [but] older generation not comfortable or simply don't have tech skills." (Pingelly)

While some residents would have no desire to use computers or other devices to access information or health services, there is a proportion of digitally illiterate health consumers who would be open to training and may embrace the technology if provided with the skills needed to do so.

"*We need services that provide options, but also assistance to use the technology [where there is a will to do so]"*

5.3.2.2 Access

In all three locations, access to internet services was seen as a barrier to the use of online health services. In Tom Price, this was particularly the case for those living outside town and in remote communities.

In Pingelly and Boyup Brook, access to internet and mobile phone networks was the source of considerable frustration.

"Internet access in the country isn't fast and reliable enough to use it extensively to provide health care." (Boyup Brook)

"Many rural areas have no phone or internet service [and] NBN has not solved this problem." (Pingelly)

One suggestion to improve coverage in Tom Price was to *beam internet services/WIFI into the community via the CRC.* One of the attendees at Tom Price mentioned Sky Muster, which are two geostationary communication satellites operated by NBN Co that already provide broadband services to about 400,000 remote homes and businesses.

Recommendation 14: Work with relevant stakeholders to scope the potentiality of beaming wi-fi into local communities from town centres.

Residents in Boyup Brook also noted that the NBN phone needs power, so without power (and there are often outages) there is no access to emergency services. The NBN has also rendered personal alarms in homes inoperative.

5.3.2.3 Attitudes

Attitudes toward the use of digital and technological health care solutions were mixed. This is significant because shifting negative attitudes toward some technological innovations may not be too difficult for some consumer segments.

Almost all attendees across the three sites thought it was important to provide options for health consumers, particularly those at higher levels of risk including (a) the aged (b) mental health consumers (c) people with disabilities (d) Aboriginal and CaLD communities.

"Some services like mental health for young people does often not work via a screen." (Boyup Brook).

This view (posited by an older resident) was in part reinforced by what we heard from three of the four teenagers we spoke to in Tom Price. When we asked how they would prefer to ask a question about a personal health matter, they said they would use an app or text, but would prefer not to use a video link-up. That said, three of them indicated they'd not phone a help line or visit a GP because it would be "too embarrassing."

Several community members pointed to the fact that lots of people simply did not want to engage via digital means. *"Some people prefer human touch and contact, not everything can be done through telehealth and video link."* (Boyup Brook)

However, despite the many concerns and caveats raised, there was also widespread support for several applications of digital and technological innovation in the sector.

Wearable emergency devices for high risk patients well particularly well supported, as were innovations that supported people to stay in their homes for longer. "*Create simple, cost-effective installations for monitoring aged, dementia etc to [help people] stay in [their] home longer*." (Pingelly)

The role of CRC's as local IT hubs was also championed. One resident in Pingelly suggested "*using CRC's to host video conferencing link-ups for pre-op and post-op to save travel, time and money for brief tick box [medical] appointments*."

5.3.3 Social determinants of health

The need to better address the social determinants of health (SDOH) have been a common thread throughout the community consultation process to date. Our definition encompasses cultural, environmental and structural determinants in addition to social determinants as defined by the World Health Organisation.
Social, structural and financial determinants of health were significant issues for people living in Boyup Brook and Pingelly. In Tom Price, cultural and environmental determinants were also at play.

5.3.3.1 Food and nutrition

Obtaining access to fresh food was problematical for many of the community members we spoke to.

In Pingelly, the recent closure of the local IGA meant that there was no longer anywhere for many local residents to access fresh food without a lengthy drive. The result has been that: *"There is no access to food for older residents, no fresh grocery store. They eat bread and butter."*

According to residents, funding cuts to the Meals on Wheels program has exacerbated the problem.

For many Aboriginal people living in communities surrounding Tom Price, access to basic necessities such as safe drinking water is limited. Water was reportedly dropped off at some houses, but not enough to last the week.

"Environmental health issues are a big thing. Water is not clean in some communities. Everyone knows but nothing is done." (Tom Price)

Recommendation 15: All WA Aboriginal communities have access to safe drinking water.
Recommendation 16: Conduct a high-level audit of at risk health consumer's access to fresh food (distance needed to travel) for the purpose of then co-designing local strategies to improve access for at-risk groups.

5.3.3.2 Financial

Many of the older residents in Boyup Brook and Pingelly survive on limited fixed incomes, and many Aboriginal people living in remote communities outside Tom Price live in poverty. Unemployment and underemployment rates are also higher in regional WA.

This in conjunction with higher costs of accessing health care services (including GPs), allied health services, transport and IT infrastructure means that financial determinants have a profound effect on people's ability to stay healthy.

"It's expensive to see a doctor." (Tom Price)

One participant said it was *"cheaper to fly to Perth to get her glasses than to purchase them in Tom Price."*

Given the high cost of accessing GP's, one group in Boyup Brook suggested "*extending the role of the nurse practitioner as a continued role in the community*."

Community budgeting was suggested by residents in Pingelly to allow local residents a greater say in how money is spent locally so that what limited funds there are better meet local needs.

Housing was another issue for Aboriginal Tom Price residents: *"Housing is inadequate. There's overcrowding."*

5.3.3.3 Cultural

Discussions around the social determinants of health tend to be negatively framed. They are typically spoken of as barriers which disadvantaged populations need to overcome to attain optimum personal health and wellbeing.

The cultural determinants of health as they relate to Aboriginal and Torres Strait Islanders should be viewed as enablers of good health and wellbeing.

"Cultural determinants originate from and promote a strength-based perspective, acknowledging that stronger connections to a cultural and country build stronger individual and collective identities, a sense of self-esteem, resilience, and improved outcomes across the other determinants of health…"[3]

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[3] NACCHO "Promoting a social and cultural determinants approach to Aboriginal and Torres Strait Islander Affairs" accessed [online]

In our community conversations in Tom Price there was considerable emphasis on the need for greater cultural awareness and understanding of how cultural determinants could be leveraged upon.

Suggestions included "developing core informal ways to engage with Aboriginal communities on health" and "recognise that a one size fits all approach doesn't work."

Rather than simply funding services, community members suggested that the government "invest" in communities and "empower them to develop culturally appropriate solutions from the grassroots up."

"Help Indigenous patients be on country during their treatment."

Recommendation 17: Establish a cross-departmental working group to develop outcome focused performance indicators to improve social determinants of health for regional health consumers. Each department to be accountable to the DPC for achieving agreed outcomes.

5.3.4 Transport and accommodation

For all of the regional communities we spoke to, travel and accommodation for travelling patients and/or their carers was a key theme. Notably, discussions at each venue initially focused on challenges and issues, and then moved to potential solutions.
There was a strong sense among many of those we spoke to that there is a lack of understanding amongst city-based health service staff just what's involved i4n travel for regional health consumers.

5.3.4.1 Bookings

There was a view amongst most consumers we spoke to that a lot of the travel they needed to make to reach appointments was unnecessary and overly burdensome.

Several groups noted that *"there is no consideration to be able to match up different appointments"* so as to reduce the travel burden for patients. *A review of booking procedures* was suggested as was the need for *providers to be able to exchange basic information to allow for said 'matching up' of appointments*.

"Consideration of travel time. Often multiple appointments [are needed] and are unable to be made on the same day causing the need to travel more often than necessary. People are old and sick, and travel is exhausting. More consideration of the cost involved." (Pingelly)

Digital and telecommunications-based approaches were seen to be a potential solution. For example. *"Travel for appointments is a major issue… X-ray taken by the local GP and could not diagnose the issue so had to travel to Perth to get an opinion. Why can't this be done online?"* (Pingelly)

With all the travel issues of seeing specialists, "*why not have a rotation of visiting ones?*" (Pingelly)

In addition to the need for improved coordination, it was suggested that not requiring somebody who lives five hours from Perth to attend an 8.30am appointment would help considerably.

"*Appointments priority needs to exist for those that travel to make allowance for time on the road and travel time after – if you're not well 4am starts or night return trips are dangerous*." (Pingelly)

Recommendation 18: Consider using one Perth hospital as a trial site to create a regional booking window (e.g. between 11 and 1pm) for patients living an agreed distance from the hospital.

5.3.4.2 Access to and cost of transport

Many patients are heavily reliant on PATS and/or St John's Ambulance (which is run by volunteers) to reach appointments. However, access is limited, and several suggestions were made on how access might be improved.

- "*We need a community car to get people around. It should be funded by local council*."
- "*Better utilise existing vehicles* – a HACC bus sits idle in town which could be used by the community but there are too many insurance and policy issues."
- "The need for partnership are essential. *Pingelly bought a community car with fundraising money and volunteers drive clients to appointments*."
- *"Free parking at public hospitals."*
- *"Conduct a hackathon using PATS data."*

Recommendation 19: Establish community mechanisms (e.g. Facebook page or physical noticeboard) where community members can flag that they're travelling to an appointment and allow others to request a lift (if for example they don't have access to PATS).

Recommendation 20: Explore social enterprise model based on Airbnb and Uber to facilitate movement and accommodation for people without access to PATS.

Recommendation 21: Conduct a feasibility analysis around "if" and "how" the cost of PATS to taxpayers could be reduced by transporting more than one patient at a time. Data management and IT systems are readily able to cross-reference patient locations (even real time geo-data) with appointment times and locations. The challenge would likely be integrating different systems and barriers to information/data sharing. Consider a small pilot program involving two or three health service providers with a view to scaling-up over time.

5.3.4.3 Safety

There were several reports of patients (including elderly and at-risk patients) being discharged at night without any regard for how they would get home.

"Hospitals are discharging people late at night with no means of transport to get home."

Patients are sent to Bunbury, discharged from hospital with no way to get home." (Boyup Brook)

In Tom Price, the quality of roads between major centres was also a significant safety issue. *"It's a long drive to Karratha because half of it is gravel road – they're getting a new hospital."*

Many felt that there is an assumption made upon discharge that patients are returning home with access to plenty of care and with support services close by. This is not the case for many. *The discharging staff member should ensure that adequate supports are in place, and if they're not, seek to mitigate risk.*

5.3.4.4 Compliance

One of the most universally supported suggestions with respect to reducing costs associated with transport and the burden placed on patients was to avoid unnecessary compliance that requires people to be driven out of town to receive services.

"There should be more trust in the local health service providers. If GP's state they can look after a patient locally [why] then are they still transported out of town for compliance issues?"

"This compliance driven transport issue is hugely expensive to the health care budget and it will exhaust our valuable volunteers." (Boyup Brook)

5.3.5 Community education, engagement and partnerships

Community members across all three locations were supportive of increased community education, better community engagement and partnerships.

5.3.5.1 Education

The need for greater community education was cited by participants in all locations. References to education were typically focused on two key aspects:

1. Greater education (and therefore awareness) about what services are available (from health service providers and community supports) and
2. Increased health education around general health and wellbeing, mental health and health literacy.

"Ongoing education about existing services – what is available. Promotion within the community of existing services." (Pingelly)

"Health literacy is also low." (Tom Price)

One of the groups in Pingelly noted that many people aren't aware of symptoms of many non-communicable diseases which makes early diagnosis and treatment more difficult. The same was also true for mental health conditions.

Participants also wanted: "*access to information, competent communication between health authorities and the public. Presentational workshops on nutrition, exercise etc."* (Pingelly)

"We need more education on health and wellbeing [from] on the ground workers." (Tom Price)

5.3.5.2 Engagement

Attendees in Tom Price believed there was a disconnect between what the health system upstream wants, and what people in the community actually need. Community conversations with Aboriginal people were seen to be "woefully inadequate." *Work needs to be done with the local community to ensure services are delivered in ways that work for them (culturally).*

How about having an *informal event at the community hall where health providers come and provide information in a fun and engaging way (interactive stalls etc).* This may reduce the "scary part" of engaging with providers for some Aboriginal people.

It was noted by attendees in Tom Price that *engagement would also be improved by ensuring that "specific learning and training for persons working with Aboriginal populations" is provided*.

Participants in Pingelly also strongly believed that more meaningful engagement was needed, and that by doing so, government and other service providers would reduce costs and improve outcomes.

"There's a lack of authentic communication and collaboration (co-design) with the community."

"*Community budgeting*." (Pingelly)

"The health department needs to liaise and consult much better with local stakeholders and community groups." (Boyup Brook)

Finally, the concept of *engaging consumers in procurement strategy* was strongly advocated in Tom Price. *"If people in the community get together and work with what is strong to tackle what is wrong, then they will identify low cost/no cost solutions to work together on. Then, out of that approach ideas that do cost must be invested in."*

This was ostensibly a push for 'social procurement' which involves not just health consumers, but non-health organisations who might be involved in the solution.

5.3.5.3 Partnerships

Partnerships between health service providers, community organisations and consumers were cited as a means of improving patient experiences as well as reducing reliance on government funded services.

An excellent suggestion from Boyup Brook was to *allow community members to access current facilities outside regular operating hours. For example, school gymnasiums could be used when not in use by school students (before 8am and after 3.30pm).*

"Partnerships are essential…" (Pingelly)

The need for improved communication between health service providers themselves, and between providers and the wider community was a common suggestion.

There was a sense amongst many participants we spoke to that if organisations worked in partnership rather than in competition there would be an improved experience for patients, and far less waste.

6.0 Webinars

6.1 Background

The SHR Panel has been firmly committed to ensuring the voices of regional West Australian's are heard as it formulates its final recommendations for government. The use of web conferencing is a cost-effective means of reaching more regional consumers than would have been possible face-to-face.

The primary purpose of the regional video conferences was to test key future directions outlined in the SHR Interim Report with regional health consumers.

Particular emphasis was placed on the following two directions:

Direction 1:	Keep people healthy and get serious about prevention and health promotion.
Direction 8:	Greater use of technology, data and innovation to support consumers, clinicians and drive change.

The key output sought through the regional video conferences has been to obtain ideas and insights that can be used to help inform recommendations as to how the WA health system can continue to deliver patient-centred healthcare in a sustainable manner.

6.2 Method of engagement

Linkwest has an extensive network of CRC's throughout Western Australia, all of which have internet connections and video conferencing capabilities. They were sub-contracted to provide operational support which comprised:

- Promotional support, primarily dissemination of advertising collateral through its regional networks
- Administration of an EOI process through which CRCs throughout the State lodged their interest in booking one of the 16 available video conferencing slots
- Facilitation of the web conferencing sessions themselves, at its head offices in Nedlands and at each of the 16 regional locations involved.

Dates: Web conference 1: 10am on Wednesday 20 June 2018

Web conference 2: 2pm on Wednesday 20 June 2018

Web conference 3: 10am on Thursday 21 June 2018

Web conference 4: 2pm on Thursday 21 June 2018

Locations: An EOI process was conducted by Linkwest which then selected which CRCs would participate based on their knowledge of the CRC and their expectations about numbers likely to attend.

There were four CRCs booked in on each of the four conferences.

- Web conference 1: Meekatharra, Nannup, Wagin and Kalannie
- Web conference 2:*Bremer Bay, Merredin, Denmark
- Web conference 3: Brunswick Junction, Lancelin, Jerramungup, Williams
- Web conference 4: Jurien Bay, Dalwallinu, Gingin, Dowerin

** The fourth CRC was a late cancellation due to insufficient community interest.*

Pip Brennan providing a brief overview of the rationale behind the SHR and what had been done to date. Luke van der Beeke then facilitated group discussion.

As with the other engagement sessions there was a tendency for attendees to speak about their negative experiences with the health system. Our approach was to actively listen to the participants' concerns before endeavouring to steer conversation back to ways in which those concerns might be overcome in the future.

Duration: Each session ran for one (1) hour, though in the case of video conference 3 there were a large number of technical issues resulting in a shortened session.

Facilitators: Pip Brennan and Luke van der Beeke.
Group Map technical support was provided by Lyn Malm (Tuna Blue).

Attendance: Session 1 – 15 attendees

Session 2 – 35 attendees

Session 3 – 20 attendees

Session 4 – 30 attendees **Total attendees: 100**

Demographics: We did not instruct Linkwest to ask attendees to indicate their age, cultural background, disability status etc. Therefore, the demographic of attendees could only be estimated based on our own perceptions of age, cultural background or disability, and/or where people self-identified.

Estimates as follows:

- Participants under 30 years (5%)
- Participants 30-45 years (25%)
- Participants 46-65 years (40%)
- Participants 65 years and over (30%)
- People with disabilities (10%)
- Carers (5-10%)
- People living with a mental health issue (less than 5%)
- Aboriginal health consumers (5-10%)
- CaLD consumers (5-10%)
- LGBTIQ (unknown)

6.3 What we heard

The majority of views obtained were those of middle-aged and older West Australians. Perhaps unsurprisingly, the themes identified in the video conferencing sessions were similar to those identified across the three face-to-face regional community conversations. These themes were:

1. Health of at-risk individuals
2. Digital literacy, access to and attitudes toward technology
3. Health equity
4. Transport
5. Health promotion

Again, in keeping with the intent and scope of the work program commissioned by DoH, challenges will be noted as will the suggestions and recommendations we heard about how they might be remedied.

6.3.1 Health of at risk populations

Community members expressed concerns about the lack of services and support available to at-risk populations and provided suggestions about what could potentially be done to help address those shortages.

At-risk individuals include those who have disabilities; are living with mental health conditions, who live in institutionalized settings; who are elderly; who are children; who are from diverse cultures; who have limited English proficiency or are non-English speaking; or who are transportation disadvantaged.

These are populations who have additional needs including maintaining independence, communication, transportation, supervision, and medical care.

6.3.1.1 Access

There were several accounts of at-risk individuals falling through the cracks between services, and/or being bounced between different services.

One consumer with a disability said there HACC services had been cut and handed to Silver Chain but they'd not been in touch. They wanted to know if this was an issue with NDIS. They felt there was a need for "*better coordination between services*." (VC2)

The need for better coordination (and communication) between services was also needed in mental health. *"There is a breakdown between the GP clinic and mental health services."* (VC4)

A lack of health literacy amongst at-risk groups was also cited as a barrier to accessing services.

"*Health promotion needs to account for the relatively low health literacy among older and disadvantaged residents in country areas*." (VC1)

6.3.1.2 Social isolation

Residents in several towns we spoke to were very positive about the inclusive and caring nature of their local communities. *"We have lots of people on the street who have life experience in the town. People care for each other."* (VC2)

However, social isolation was regularly flagged as an issue facing various at-risk groups.

"Loneliness and social isolation are rife, particularly amongst the elderly and those caring for loved ones." (VC3)

"*We need more conversations about mental health in our communities*." (VC2)

Concern for the ongoing mental health of elderly residents and their ability to access services was particularly high. There was a strong sense that it was the community's responsibility to ensure they (and other at-risk individuals) did not become too isolated.

"People need to visit old people in town, perhaps weekly. It needs to be more proactive. More regular." (VC2)

Examples of community-based supports included Dowerin's Companion Club which is run by volunteers that takes people out to socialise. Nannup has a community kitchen, and Brunswick Junction is in the process of starting up a Men's Shed.

Concerns about social isolation were also expressed for people with disabilities. *"People with disabilities without social networks can't cope. All the NDIS has done is turn us into a financial commodity."* (VC2)

Participants wanted to see *more mental health services, and more information on topics including drug abuse and depression.*

Counselling for young people was viewed as a high priority, as was the need for *services targeting people who are in the gap between middle-age and aged-care*.

The ***provision of more face-to-face services and support for at-risk groups*** was strongly supported.

"There's nothing better than face-to-face. There are struggling people out there that don't feel connected. (VC1)

However, despite a general preference for face-to-face contact, many people recognised the important role digital technologies could play in helping to reach socially isolated individuals.

One participant favourably mentioned a trial aimed at providing counselling to kids using digital called Youth Focus. (It is possible this was a reference to the organisation rather than an app).

6.3.2 Digital literacy, access to and attitudes toward technology

There was universal agreement that technology has an important role in health care moving forward. Most of those we spoke to understood how it could be used as a health promotion tool, a means to access services where distance might otherwise be an issue (e.g. telehealth), and to assist with the monitoring of chronic conditions.

The use of technology for monitoring chronic conditions was well supported application, mirroring the sentiment we heard during our regional community conversations in Pingelly, Boyup Brook and Tom Price. However, telehealth services were seen to be the most useful technology-based application by the majority of participants.

6.3.2.1 Digital literacy

Notwithstanding broad acceptance of the role of technology in health service provision, attendees at all sessions noted that technological and digital literacy is very low amongst large proportions of their respective communities.

"Many members of the community aren't computer literate so putting everything online won't work." (VC1)

"Not everyone is computer literate." (VC4)

Participants also noted that the population make-up of country towns was often quite diverse. In many towns there was a significant number of people from non-English speaking backgrounds (e.g. Dalwallinu).

"There is a need for cultural sensitivity in the digital world." (VC4)

Participants believed that options should be provided for those who were unable to access technology-based health services and applications. *Training for those who lacked confidence and/or the ability to use digital and tech-based services was also recommended*.

“*We need education about how to use them.*” (VC3)

“*We need to provide seniors with support to use the health system and devices.”* (VC3)

6.3.2.2 Access

During each of the four conference calls a lack of reliable access to internet services was seen as a barrier to the use of online health services.

“The quality of bandwidth is poor.” (VC3)

“*We need improved internet access*.” (VC4)

Notably, on two of the four conference calls, we experienced major technical challenges as a result of bandwidth issues and/or faults on the network. The irony was not lost on participants who cited the challenges we were having as a prime example of low service reliability.

“We’re very positive about telehealth but look at our experience today – the sound keeps dropping out.” (VC1)

There were also concerns that poor-quality connections may lead to patients receiving a lower standard of care.

“There needs to be good reliable technology in place to ensure a focus on the consult.” (VC1)

6.3.2.3 Power

Linked to ‘access’, a lack of reliable supply of electricity was raised regularly. Many participants believed that unreliable power supply to regional communities was a much larger barrier to adoption of internet and/or phone-based health services than poor bandwidths and mobile coverage.

“If we lose power, the battery runs out on Telstra power and then there’s no network.” (VC2)

“When you’re out for hours on end you also don’t have access to a landline.” (VC2)

However, power outages posed more than a small inconvenience to regional health consumers. For many remote communities’ power outages represent a tangible risk to life.

We heard that on one occasion power went out for days resulting in boom gates going down (blocking roads), no landlines, no mobiles and no internet access.

Power outages also impacted medical alert technology. One carer noted “if she has a fall in a power cut – nothing.” (VC2)

Also, the Royal Flying Doctors Service won’t land or take-off without power to landing strips. One suggestion was solar energy being used to power all regional landing strips, or at the very least, runway lighting.

We also heard that despite there being generators in several communities, “Western Power won’t light it when the wind is on or there’s heavy rain.”

Recommendation 22: Consult with Western Power and other key stakeholders to identify and implement improvements to back-up power options for rural and remote communities.

6.3.2.4 Attitudes

Attitudes toward the use of digital and technological health care solutions were mixed. Participants generally thought it was important to provide options for health consumers, particularly at-risk individuals.

"A huge proportion of people in Meeka [sic] are indigenous. They're not computer literate and don't want to be." (VC1)

But on the other hand, *"Telehealth has been fantastic for Merredin."*

"When you only need a five-minute chat, to drive 500km is ludicrous." (VC2)

"Emergency telehealth services into the clinic saves lives." (VC2)

"Talking over the screen is better than having to travel." (VC1)

Community Resource Centres were championed by some as another potential location that the community could access telehealth services. "*Telehealth should be provided through CRC's, not just WACHS sites."* (VC1)

Several participants also saw potential for digital to extend the reach of existing services, and or be used to support health promotion initiatives.

"I'd like to see digital being used to deliver education services." (VC4)

6.3.2.5 Awareness

Notwithstanding the perceived barriers to access many people believed technological solutions were under-utilised.

"Telehealth is under-utilised. *GP's should notify patients that they can access telehealth.*" (VC2)

"Seniors don't know what's out there." (VC3)

6.3.3 Health equity

"Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. Health inequities therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes".[4]

While the need to better address the social determinants of health (SDOH) have been a common thread throughout the engagement process, in the web conferences the concepts of equity and fairness came to the fore.

There was a strong view amongst the majority of people we engaged with that they were not seen to be as important as those living in the city.

"People in Perth are concerned about what happens in the city, not what happens in the country." (VC3)

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[4] 'Equity'- World Health Organisation, [online].

For the most part participants accepted the logistical and financial challenges of delivering health services to such a widely spread regional population. But there was also a view that many of the barriers to accessing services were avoidable and could be remedied if there was sufficient will to do so.

6.3.3.1 Access to services

While it was generally accepted that services in smaller regional communities could never mirror those available to people living in larger population centres, an almost complete lack of access to GP's, dental health services, allied health and mental health services was seen to be a health equity issue for many participants.

"We're only asking for basic healthcare." (VC1)

"People in Meeka [sic] have to travel two days to see a specialist." (VC1)

"When they look at mapping out where they send health professionals, they only see a few people. It's a waste of money." (VC1)

According to one participant, the solution is simple. *"It will cost more to deliver services in the country. Everyone has to be OK with this."* (VC1)

6.3.3.2 Bulk billing

Participants in Jerramungup noted that a new GP had arrived in town, but he/she doesn't provide bulk billing. This was a common issue for many regional participants.

The lack of access to bulk billing GP's and the higher cost of medicines in country areas was viewed by many as unfair and inequitable. The trend for private practices to replace public clinics and medical centres was also concerning to residents who felt it restricted choice and accessibility.

6.3.3.3 Transport

Transport was also flagged as an equity issue.

"People are travelling from Bremer Bay to Albany to access basic services. The time and financial cost burden for regional health consumers is too much for many to bear." (VC2)

Notwithstanding their concerns and perceptions around 'fairness', many participants were pragmatic and recognised that digital and technological innovations were already improving access to services.

For some, services like telehealth were paradigm changers. Rather than demanding more GP's *"we need to educate our communities to demand telehealth."* (VC1)

Addressing people's attitudes and beliefs about a perceived lack of equity in WA's health system is a challenging task for government. Values-based discussion around issues like 'fairness' and 'rights' are difficult to navigate. However, notwithstanding the long-held concerns around equity that were raised during this consultation, our view is that many people living in regional areas are cautiously optimistic that innovations such as telehealth will improve access.

Recommendation 23: Commission research to map community attitudes on health equity in the regions, with a particular emphasis on what key improvements could be made to reduce health inequalities between metropolitan and regional health consumers.

6.3.4 Transport

Transport and accommodation were amongst the most commonly cited challenges for regional health consumers across all 15 communities.

As we identified during conversations at Boyup Brook, Pingelly and Tom Price, there was a strong sense among those we spoke to that there is a distinct lack of understanding amongst city-based health staff about what's involved in travel for regional health consumers.

6.3.4.1 Access

Attendees in Dowerin said they had no access to any medical services, so transport was the only option. However, for many this was difficult – including elderly people and mothers with young children. "Many people in town don't have people to transport them." (VC4)

HACC used to have volunteer drivers that would take elderly people to Perth, but the service no longer operates. "They got rid of the cars. Now you have to organise an ambulance to do patient transfers." (VC2) *Reinstatement of the HACC volunteer transport service* was recommended.

One participant noted that many towns are limited in where they can go for PATS funding and suggested that "*there is a need to increase the flexibility of the PATS system."*

6.3.4.2 Safety

We heard the story of a 90-year-old man who fell in Merredin and had to wait for an hour with a broken eye-socket while an ambulance was sourced from Nangarin.

This was a common theme and although we witnessed a few shaking heads there was seemingly acceptance of the long wait being a function of distances between locations. The concerns stemmed around the strain now placed on volunteers who drive the ambulances, and frustration that the local police are no longer able to drive patients to hospital.

We also heard the story of a patient who collapsed in Bremmer Bay. When the patient collapsed her husband was told to drive her in their own car to Albany hospital. This because the medical centre isn't staffed 24/7. Many attendees believed *medical centres should be staffed 24/7*.

6.3.4.3 Waste

While access and safety concerns dominated discussions about transport, there was also considerable discourse about the amount of money wasted on unnecessary patient transport.

For example: *"We fly people to Perth for a suspected heart attack!"* (VC1)

There were several accounts of people being transported to major regional centres at considerable cost to the taxpayer or themselves for appointments that most felt could have been adequately addressed locally.

Telehealth services were again seen as part of the solution. *"Telehealth services are needed rather than transporting people to Perth."* (VC1)

"Talking over the screen is better than having to travel." (VC1)

6.3.5 Health promotion

Community members across all three locations were supportive of increased health promotion activities that educated people about what services were available and how to stay healthy. Mental health promotion was also seen to be a priority.
Participants also recognised the important role the community itself plays in creating an ecology in which residents can live healthy and fulfilling lives.

6.3.5.1 Education about service availability

The need for communities to be educated about what services are available was a recurring theme across all sites.

"Education. You can't fix something if people don't know about something." (VC1)

One mum in Dowerin relayed her experience prior to the birth of her child.

"I didn't know where to go, or what assistance was available. Even the GP didn't know. I got it through word of mouth." (VC4)

Community Resource Centres were seen by many to be excellent portals for community education and health promotion activities.

"Information through the CRC and a weekly paper though the CRC." (VC4)

"*More video conferencing through the CRC. More mental health activities [prevention] through the CRC.*" (VC4)

However, some noted that "CRCs are not equipped to move into health" and believed *the best place for the distribution of health information was at nurse's stations and GP clinics.*

One community was using an app called *Local Hero* (http://mylocalheroapp.com/). Although initially set-up as a community safety application, it can also be used to let other community members know what's available in the area. *It could be used to tell people where they can go to access primary or allied health services.*

And while there was general agreement that health information could be delivered in many ways, "*someone coming and delivering information on what they've got and what they can do*" remained the most useful approach for many.

A need for *more mental health promotion activities* was widely supported by health consumers.

"*Information around drug abuse*. More counselling, especially for young people." (VC4)

6.3.5.2 Appropriate targeting

Websites and apps were also cited as being good ways for many health consumers to access information about service availability, though there were caveats attached with regard to the ability of at-risk populations to do so. *For at-risk groups, participants suggested face-to-face information sessions which could potentially be hosted by the local council and non-profits.*

It was also noted that health promotion collateral targeting CaLD and Aboriginal health consumers needs to account for language barriers.

"Sometimes people get put off by the terminology that's used. Think about who the target audience is and use appropriate language." (VC4)

6.3.5.3 Community initiatives

The important of community-led initiatives was well understood by most participants. Many regarded community cohesion as a real strength of country towns - one that could be leveraged upon.

Examples of community led programs included a lady in Dalwallinu running local health and fitness programs, in part because: *"Most of our community spends their day sitting on tractors."*

Recommendation 24: Increased emphasis on the development and evaluation of community initiatives to maintain and improve health and wellbeing in the regions.

7.0 Consumer survey

7.1 Background

In addition to the face-to-face sessions and webinars, a public survey was developed and disseminated through existing and newly established consumer networks. This survey was open to the public from 4 June to 6 July 2018 and 140 responses were collected at a completion rate of 86%.

This section provides survey data, findings and recommendations for consideration by the SHR Panel and Secretariat. A basic commentary on the results is provided, but a comprehensive statistical analysis of findings was not within the scope of this project. Furthermore, while care was taken with the survey design, this was informal research designed to generate insight from health consumers about certain aspects of the SHR's key directions.

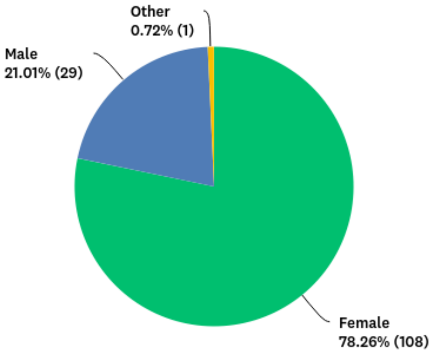
Consumer networks, peak bodies and service providers were the primary promotional channels leveraged, and therefore the proportion of respondents with chronic health conditions, disability and lived experience of mental illness are very high relative to WA population prevalence.

Many organisations were involved in promoting and disseminating links to the survey, including:

- Council of the Ageing
- Cancer Council
- Heartkids
- PWD
- Holyoake
- Mercy Care
- Curtin School of Public Health
- SIREN
- Injury Matters
- Australian Health Promotion Assoc.
- Telethon Speech and Hearing
- JDRF
- Linkwest

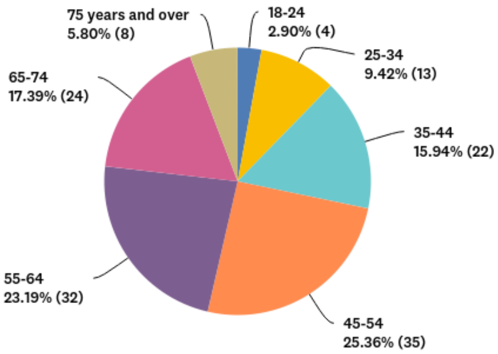
7.2 Results – classification questions

7.2.1 Gender (n138)



Females were over-represented, comprising 78% of respondents. This is likely the result of the channels through which the survey was promoted and mirrors the results of the first consumer survey conducted for the SHR in February 2018.

7.2.2 Age (n138)



The survey was completed by a broad range of age groups, with 64% aged between 35 and 64 years of age. Twenty three percent of respondents were over 65 years of age which is pleasing since older Western Australian's were a key target group.

7.2.3 Cultural background (n138)

	Percentage of total	Total responses
White Australian	71.74	99
Aboriginal Australian	1.45	2
British or Irish	16.67	23
North-West European	2.17	3
Southern or Eastern European	2.90	4
South East Asian	2.17	3
Southern and Central Asian	0.72	1
North, Central or South American	2.17	3
TOTALS	100.00	138

Aboriginal people were under-represented in the survey, as were persons from CaLD backgrounds. This was expected and one of the key reasons for face-to-face engagement mechanisms being used to seek feedback on the SHR from those groups.

7.2.4 Postcode (n138)

Regional WA was over-represented in the sample accounting for 23% of respondents. 2016 ABS estimates[5] put WA's regional population at 13.4% of total residents. This is likely the result of the consumer networks leveraged, and the fact that the survey was promoted through regional Community Resource Centres. Seventy-four percent of respondents resided in the greater metropolitan area, and two responses (1%) were received from people living in South Australia.

For the purposes of this breakdown, greater metropolitan boundaries were classified as follows:

- SOUTH - Peel region

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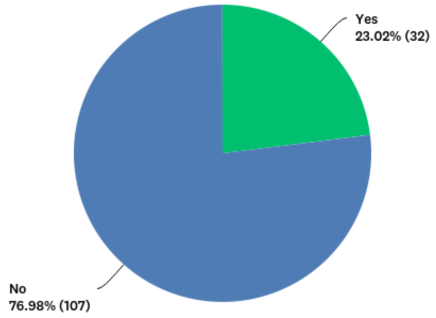
[5] Estimated Resident Population, States and Territories, Australian Bureau of Statistics, 30 June 2016, [online]

- EAST – Gidgegannup/Chidlow
- NORTH – Yanchep

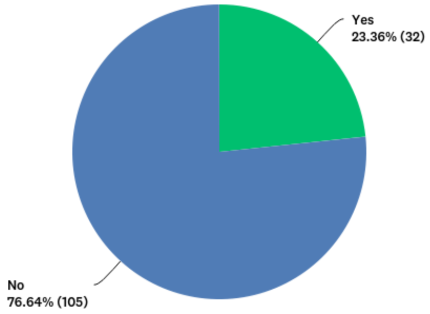
Any suburb that fell outside these boundaries were classed as regional.

7.2.5 Disability status (n139)



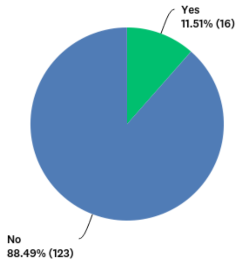
Almost one in four respondents indicated they were living with a disability which is higher than the national figure of 18.3%[6] People with disabilities (PWD) and their carers are a priority target group for this piece of work, so this level of representation likely indicative of effective targeting.

7.2.6 Mental health status (n137)



Twenty-three percent of respondents indicated that they were currently living with a mental health condition. Although not a priority target segment for this work program, mental health consumers are a primary target group for the SHR.

7.2.7 Are you a paid or unpaid carer? (n139)



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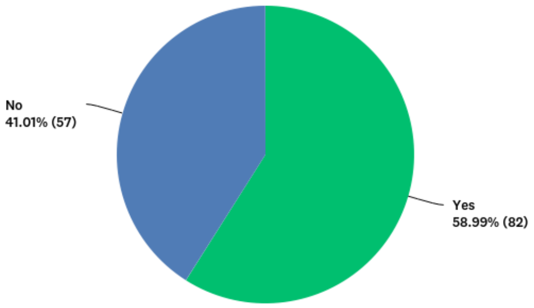
[6] 2015 Survey of Disability, Ageing and Carers (SDAC), Australian Bureau of Statistics [online]

The percentage of respondents who were carers was 11.51% which mirrors the national figure of 11.6%, or 2.7 million.[7]

7.2.8 Chronic illness (n139)



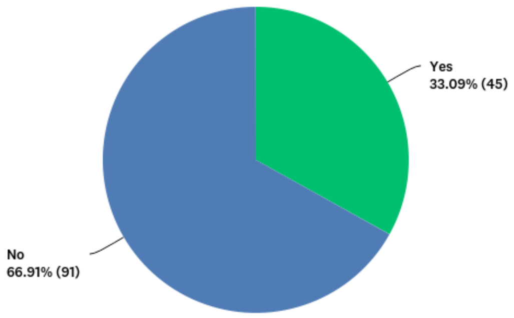
Almost 60% of respondents said they currently had a chronic illness or condition. This is a high number and is likely a result of the channels used to promote the survey.

7.3 Results – attitudes and awareness

7.3.1 Awareness of the SHR (n138)

Almost half (49%) of all respondents had heard of the SHR. This is a very high number and is likely the result of respondents being health consumers who were either targeted by HCC for the first consumer survey conducted in February 2018 and/or are more likely to have seen SHR related content as a function of their being linked to health consumer networks.

7.3.2 Do you think WA's health system is sustainable (n136)



One-third (33%) of respondents thought that WA's health system is sustainable. The results indicate that there is still considerable work to be done to convince the public that the system is not in fact sustainable.

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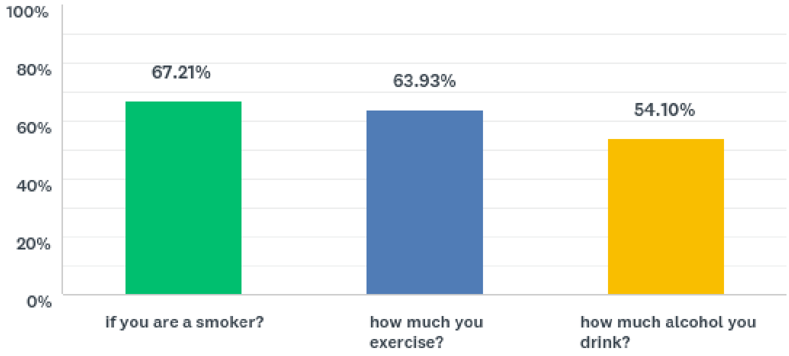
[7] ABS Survey on Disability, Ageing and Carers 2015, Carers Australia [online]

Recommendation 25: Further public education and media messaging regarding the unsustainability of WA's health system is needed.

7.4 Results – prevention and promotion

7.4.1 GP visit prompts (n61)



On their last visit to a GP, 67% of respondents said they were asked if they were a smoker. Sixty four percent were asked how much they exercised and only 54% were asked how much alcohol they drank.

Preventing or delaying the onset of ill health is a key future direction for the SHR. Smoking, alcohol physical inactivity comprises three of the four key risk factors for chronic disease and GP's have an important role encouraging patients to take better care of their health. For example, Australian's are more than 4 times more likely to successfully quit smoking with the help of a healthcare professional such as their GP.[8]

While some people might ask for help from their GP, most would benefit from a behavioural 'nudge' every time they visit the doctor.

Notably, respondents were asked considerably less often about their level of alcohol use than their levels of smoking or physical activity yet the social and health related burden associated with alcohol misuse is considerable. Alcohol is a causal factor in over 200 disease and injury conditions including cirrhosis of the liver, cancer, cardio-vascular disease as well as injuries and death resulting from violence and road crashes.[9]

Recommendation 26: Work with the AMA,WA Primary Health Alliance and other key stakeholders to increase the proportion of GP's asking patients if they're a smoker, how much they exercise and how much they drink. The question itself serves as a behavioural prompt, and depending on the answer, additional support and/or referrals could be provided.

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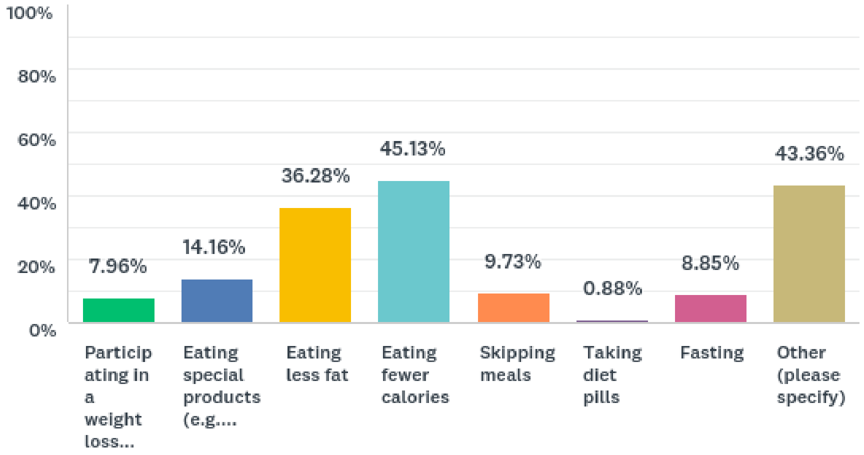
[8] *West R (2012)* Stop smoking services: Increased chances of quitting. NCST Briefing #8. London; National Centre for Smoking Cessation and Training

[9] Key Facts Alcohol, WHO [online]

7.4.2 Staying healthy (n113)



Fifty four percent of respondents said they followed a regular routine of exercise (n113). Eating fewer calories (45%), eating less fat (36%) were the most oft cited people were currently undertaking to control their weight.

For those who said they didn't follow a regular routine of exercise, 25% (22 of 88 respondents) said time was the barrier to them doing so.

Only 2% of respondents 'didn't think exercise was important', 'wouldn't help', were 'worried what others might think' or felt 'there was nowhere to exercise'. For many respondents, a chronic illness or condition was the main reason they didn't regularly exercise.

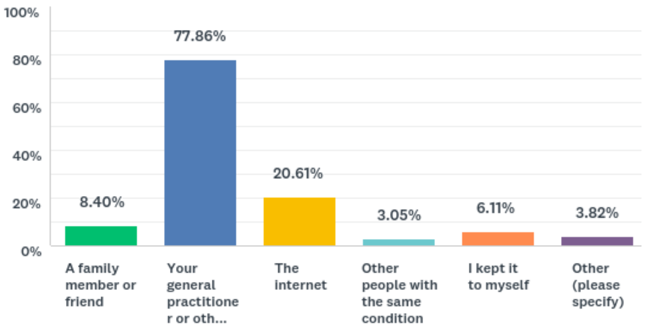
These figures demonstrate the import of health promotion messaging with regard to physical activity and diet. Amongst respondents to this survey there is a relatively high level of awareness about the need to control the number of calories and fat in the diet and the need to exercise regularly.

Recommendation 27: Continued use of the full suite of health promotion strategies to educate the public about the need for regular physical activity and maintenance of a healthy diet.

Recommendation 28: Design and implement a place-based social marketing program to address the barrier of 'time' to physical activity. This barrier is both perceived and actual and a consumer insight-based behaviour change initiative to address it amongst identified market segments may be beneficial.

7.4.3 Help seeking behaviour (n131)

We asked: "the last time you had a health issue where did you go first for help or advice." Seventy-eight percent said they went to their GP or health care provider. The internet was the first source of help or advice for over 20% of respondents which is a significant number given over 40% of respondents were over 55-years of age.

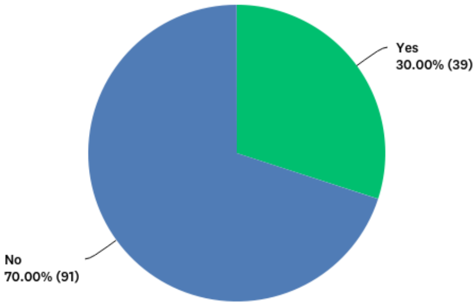


The responses reinforce the important role of GP's in treatment and prevention of ill health, but perhaps more importantly hint at the potential and risks associated posed by information available online.

Recommendation 29: Develop targeted guidance for identified health consumers segments on how to distinguish between credible and non-credible sources of health information online.

7.4.5 Health advertising and self-reported behaviour change (n130)

When asked *"can you think of a health advertisement you've seen that led to a change in your behaviour (e.g. drinking less, quitting smoking or losing weight)"*, 70% of respondents answered 'no."



Advertisements that respondents said had impacted their behaviour included ACT-BELONG-COMMIT, Live Lighter, the Girls Make Your Move campaign, and graphic anti-smoking campaigns and images in general.

The evidence-base clearly demonstrates the importance of health education and advertising, but notwithstanding the inherent biases, this result seemingly reinforces the increasingly recognised need for holistic approaches to influencing health-related behaviours.

Recommendation 30: Increased adoption of targeted, behaviourally focused approaches like social marketing[10], behavioural economics and behavioural design to augment existing health promotion activities.

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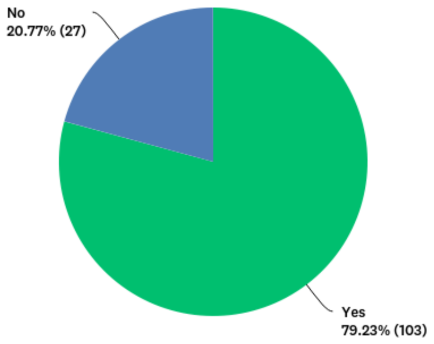
[10] *Social Marketing seeks to develop and integrate marketing concepts with other approaches to influence behaviour that benefit individuals and communities for the greater social good – Australian Association of Social Marketing [online]*

7.5 Results - person-centred services

7.5.1 Patient's confidence to ask for what they want (n130)



We asked: Do you feel confident to tell your GP or healthcare professional what you want from your healthcare?

Almost 80% of respondents felt confident to tell their healthcare professional what they wanted from their healthcare service. At face value this is a very high number and is likely the result of the promotional channels used.

7.5.2 What should patient-centred care look like? (n109)

We received 109 open-ended responses to this question. A text analysis reinforced the need for healthcare professionals (usually doctors) to 'listen' to the patient so that they might better understand the nature of each individual's circumstances.

"A doctor who actually listened." "A doctor that actually hears when listening to you."

A more holistic view of health and an understanding of the whole patient and his/her circumstances was mentioned by many respondents, as was working in partnership with the healthcare professional.

Word Cloud

7.5.3 How can government make healthcare more patient-centred?

We asked – "If the government could do one thing to make healthcare more person-centred, what would it be?" (n126)

Almost 3 in 5 respondents believed better connectivity between services was the single thing government could do to make healthcare more person-centred. The delivery of more services in the local community, and provision of more home-based support were the next most popular choices.

These findings are consistent with feedback we received during our metro and regional community conversations.

Answer choice	Percentage of total	Total responses
Ensure better connectivity between services	58.73	74
Deliver more services in the local community	47.62	60
Deliver more home-based support	32.54	41
Provide better access to transport to and from healthcare	17.46	22
Deliver more services via digital devices	11.90	15
Support more peer-led services	9.52	12

7.5.4 Reasons for Accident & Emergency (A&E) attendance (n75)

A&E attendances have increased by 49% over the past ten years which is putting considerable strain on our hospitals. Many A&E attendances are preventable. We asked respondents if they'd ever attended an A&E department for any of the following reasons:

Answer choice	Percentage of total	Total responses
You were unsure where to go for treatment	14.67	11
You could not get an appointment with your own GP	16.00	12
You could not get an appointment with any GP	12.00	9
A lack of after-hours care in your local area	57.33	43

A lack of availability of local after-hours care was the reason for A&E attendance in 57% of all cases. It's likely that in these instances, the issue was non-life threatening or serious, since respondents would have considered attending local after-hours care if it were available.

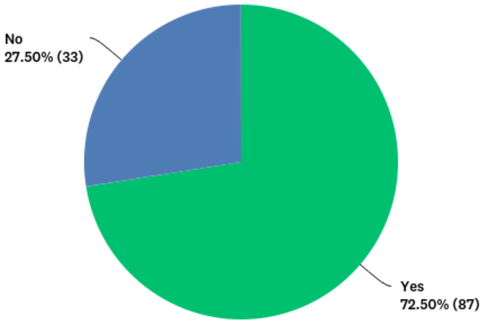
A further 28% of attendances were the result of a lack of GP availability, including 16% who may have been able to get an appointment with another GP but chose not to.

Recommendation 31: Increase the amount of after-hours care available in local communities to reduce the burden on hospital A&E departments.

Recommendation 32: Develop and implement a targeted public awareness campaign that informs health consumers where they can access help other than A&E. Segmentation should include those who only feel comfortable seeing their own GP.

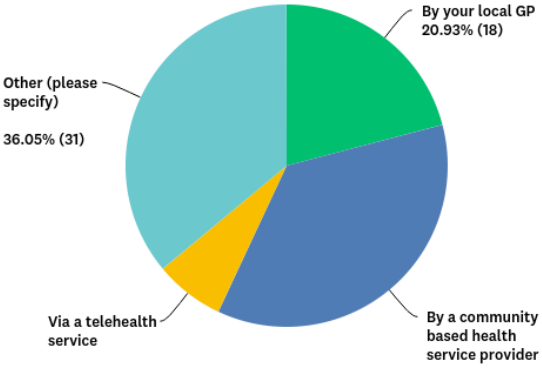
Recommendation 33: Continue to work with the AMA, WA Primary Health Alliance and other key stakeholders to improve GP availability, particularly after-hours.

7.5.5 Have you ever been a hospital outpatient?



7.5.6 How else could the care have been provided? (n86)

We asked the 87 respondents who said they have previously been a hospital outpatient if they thought: “the care you needed could have been provided in any of the following ways – the local GP, via a telehealth service or by a community-based health service provider.”



Thirty-six percent of respondents believed they could have been provided care by a community-based health service provider, and 7 % by a telehealth service.

Of the 36% who responded “other”, 22% said they could not have received their care in any other setting. The most commonly cited reasons were access to specialists and or equipment based at the hospital.

7.5.7 Attitudes toward alternative outpatient treatment options? (n120)

We asked: “If you had the option, how likely is it that as an outpatient you would consider:

- Using your local GP instead of travelling to hospital
- Using a community-based health service instead of travelling to hospital
- Using a telehealth service instead of travelling to hospital

	Using your local GP (n90)	Using a community-based health service (n87)	Using a telehealth service (n75)
Very likely	50 (55%)	31 (35%)	13 (17%)
Likely	14 (15%)	33 (37%)	11 (14%)
Neither likely or unlikely	14 (15%)	11 (12%)	24 (32%)
Unlikely	7 (7%)	7 (8%)	13 (17%)
Very unlikely	5 (5%)	5 (5%)	27 (36%)

The use of GP's and community-based health services would be strongly considered as an alternative to travelling to hospital as an outpatient. Both options were very likely or likely to be considered by 64% or respondents, though using the local GP attracted slightly stronger support.

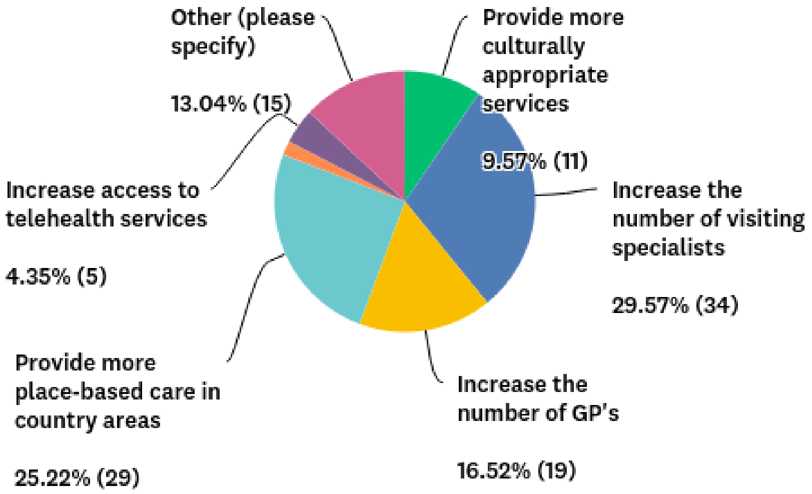
There was considerably less likelihood that respondents would consider the use of telehealth services as an alternative. While 31% said they were very likely or likely to do so, over one-third (36%) of respondents said it was very unlikely they would do so. Deeper analysis might identify whether this is purely attitudinal, or in part a function of the respondents need to attend in person due to their need to access specialist equipment (e.g. dialysis, scans).

Given the existing demands on GP's and the current GP shortage, the use of community-based health services is seemingly a strong option and aligns with current trends toward de-centralised healthcare.

7.6 Results - supporting equity in country health

7.6.1 Improving health equity in the regions (n115)

We asked: *"What is the most important step the government can take to improve health equity in the regions?"* Thirty-percent of respondents believed increasing the number of visiting specialists was the most important, closely followed by the provision of more place-based care in country areas.

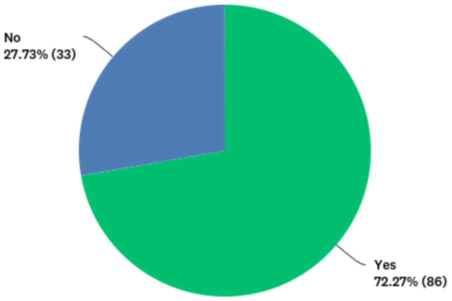


Additional suggestions included several relating to prevention (direction 1) such as: "*Support people to live more healthily and avoid the need for health care services*." And from another respondent: "*Prevention programs in the community that are evidence informed.*"

Other comments touched on addressing structural and social determinants of health inequalities, and improved connection between available services "*so GP's know where to send you or what is available.*"

7.6.2 Acceptance of service levels in the regions (n119)

We asked if respondents accepted that: *"small and remote sites cannot be provided with the same level of service as larger regional and metropolitan centres."* The overwhelming majority (72%) of respondents did so, though a significant proportion (28%) did not.

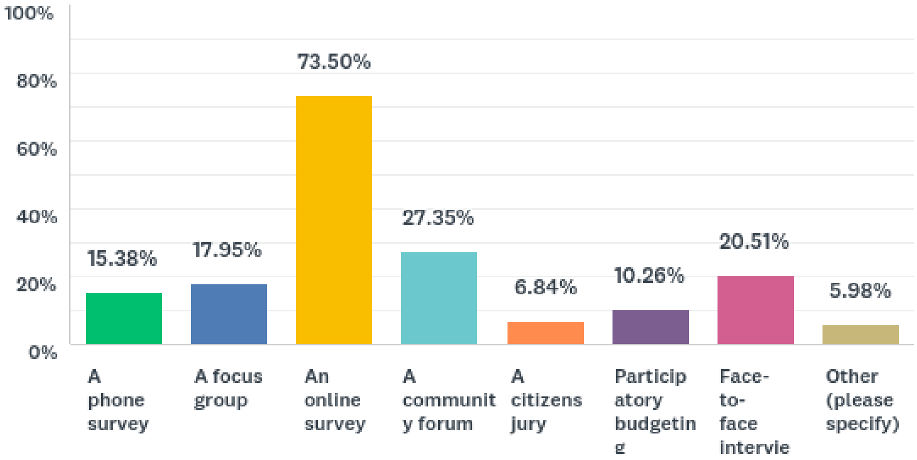


Data has not been cross-tabulated (not in scope), but it's possible that many of those who do not accept this question's premise include a high proportion of 23% of participants who are based in the regions.

Recommendation 34: Strategic communications/behavioural insight work to be undertaken to address the relatively high proportion of respondents who believe service levels should be the same in the regions. There is clearly a difference between quantity and quality of services, and this may be a point of emphasis when engaging in public discourse on regional health services.

7.6.3 Preferred means of engagement (n117)

Consumer engagement is an important component of health care system design, delivery and ongoing improvement. We asked health consumers how they'd rather have their say about what health services get invested in and the vast majority 74% said they prefer to engage via online surveys. NB: Survey participants were allowed to indicate more than one preference.



Again, we have not cross-tabulated any data sets so it's important to note that approximately 87% of respondents indicated their cultural background was *White Australian*, *British* or *Irish*. Attendees at our metro and regional community conversations were overwhelmingly in favour of face-to-face engagement.

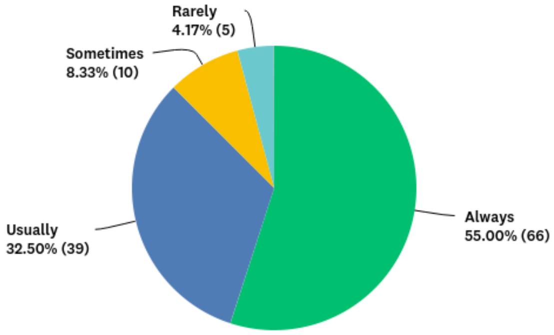
7.7 Results - use of data, technology and innovation

7.7.1 Access to mobile phone networks (n120/n109)

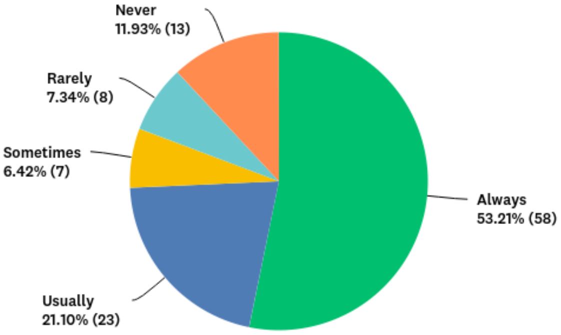
Digital technology and innovation, including applications for mobile phones, iPads etc have been identified as one of the key future directions by the SHR panel.

We asked health consumers *"do you have reliable access to a mobile network at home?"* (n120) and *"do you have access to a reliable phone network at work?" (n109)*

Home



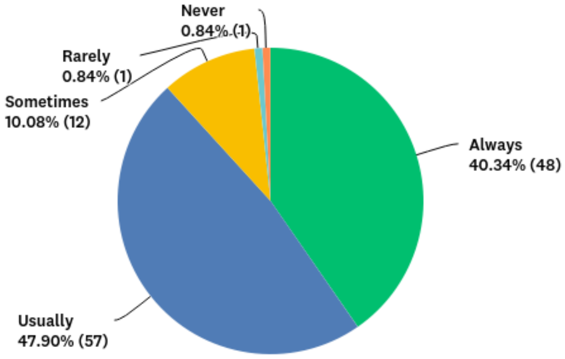
Work



Although 74% of respondents lived in greater metropolitan Perth (where good mobile phone coverage is often assumed), only 55% said they "*Always*" had reliable access to a mobile phone network at home, and only 53% "Always" had reliable access at work.

The extent to which this is a function of (a) not having a mobile phone, and (b) network reliability is not clear. However, these findings reinforce feedback we received at regional and metropolitan forums that until mobile phone coverage is more reliable, mHealth applications will be a practical option for a small majority of the population.

7.7.2 Access to the internet at home?



Access to the internet at home is marginally better than access to mobile phone networks, with 88% of respondents indicating that they *"Always"* or *"Usually"* have reliable access.

For some of those with less reliable access to mobile networks, mHealth and other technologically-based health services could be accessed via the internet on their personal devices instead. Others may choose to use their own personal computers (if they have one).

7.2.3 GP appointments via computer or mobile tablet? (n120)

Almost half of respondents (48%) indicated *"YES",* they would feel comfortable conducting an appointment with their GP using their iPad, tablet or computer.

For the 52% of respondents who said no, barriers to uptake were both attitudinal and practical.

Attitudinal barriers were typically based on the respondent's preference to speak in-person with the GP and tended to stem from simple personal preference or concerns that the doctor may not be as fully engaged on a computer screen as they would when speaking to them in person.

"The need for personal connection is important."

"I would want to be 100% sure that they are listening to me and not distracted."

The most commonly cited practical barriers included the GP needing to conduct a physical examination, network reliability and physical impairments such as vision or hearing difficulties.

Some of the responses gathered could indicate a lack of understanding about the mechanics of GP appointments conducted online. For example, some respondents seemed to think they might not actually see the GP and therefore not know if he/she was paying them attention.

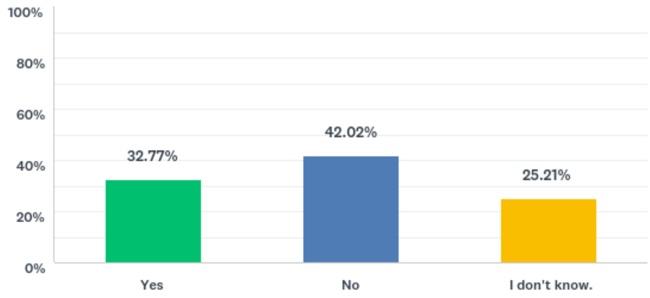
Recommendation 35: Continued public education about web-based GP appointments. Face-to-face demonstrations of the technology in local community venues would be a good option.

7.2.4 My Health Record (n120/n119)[11]

We asked if people thought the expansion of the My Health Record would improve the quality of health care services. Thirty-eight percent thought it would, 22% didn't think it would improve services, and 40% didn't know if it would improve the quality of services.

We also asked people if they currently had a My Health Record. Over one-quarter "*didn't know*" and only one-third (33%) said *"Yes"*.

Do you currently have a myHealth record?



The findings point to a lack of awareness about MyHealth records, including what they are, what they are used for and how they can benefit patients and health service providers.

Recommendation 36: State government to consider what role it should play in notifying health consumers about the changes to the default settings, which will move to opt-out for all Australians by the end of 2018. Given the lack of knowledge about MyHealth records, there is potentially a risk for adverse public reaction when the changes are made which could be mitigated by informing the public of the benefits and the impeding changes upfront.

7.2.5 Confidence in use of personal devices (n120)

We asked respondents: *"how confident are you in your own ability to use the following devices?"*

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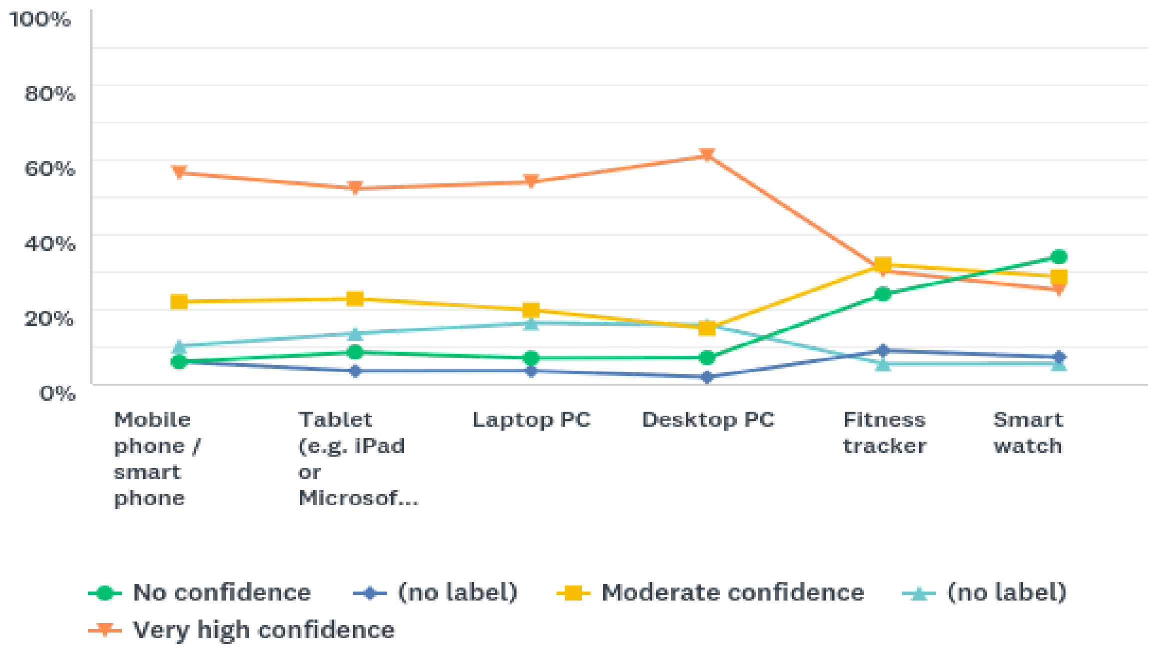
[11] The survey was conducted, and recommendations posited prior to the MyHealth Record receiving considerable adverse publicity in the Australian media in mid-late July.



User confidence in mobile phones, tablets and computers were all relatively high, where-as confidence in the use of devices like fitness trackers and smart watches were quite low.

Personal device raw data

–	NO CONFIDENCE		MODERATE CONFIDENCE		VERY HIGH CONFIDENCE	TOTAL
Mobile phone / smart phone	5.88% 7	5.88% 7	21.85% 26	10.08% 12	56.30% 67	119
Tablet (e.g. iPad or Microsoft surface)	8.40% 10	3.36% 4	22.69% 27	13.45% 16	52.10% 62	119
Laptop PC	6.84% 8	3.42% 4	19.66% 23	16.24% 19	53.85% 63	117
Desktop PC	6.96% 8	1.74% 2	14.78% 17	15.65% 18	60.87% 70	115
Fitness tracker	23.89% 27	8.85% 10	31.86% 36	5.31% 6	30.09% 34	113
Smart watch	33.93% 38	7.14% 8	28.57% 32	5.36% 6	25.00% 28	

Recommendation 37: Commission targeted education and training for segments of the population with ‘moderate confidence’ in their ability to use mobile phones, tablets and computers.

8.0 Appendices

8.1 Additional ad-hoc findings and considerations

1. There is a perception that when government providers map outreach services, they identify hotspots according to where people demand services and not necessarily where services are most needed. That is, the more vocal communities get more services. Consumers and community members are not sure what the data is behind service mapping.

2. Support for carers in country areas is lacking. There were several carers present at each video conferencing session and they consistently spoke of the lack of respite available. Some who were caring for their aged partners were exhausted and socially isolated as a result of no longer being able to spend time with friends.

3. Issues with the NDIS were raised by several participants and echoed concerns raised at our regional site visits. HACC Services are being cut, and many people in need of support were no longer eligible and unclear what might be available in the future.

4. While there is general support for technologically based advances to improve access to services, there is still a strong need for other options to be provided where practicable. Also, until more is done to address the poor reliability of internet, phone and power, the community will continue to have reservations about technology.

5. Prompts about what services are available should be provided to patients by GP's and other health service providers. Professionals should know what's available and pass that information on to patients. While this is being addressed through Health Pathways, there are considerable opportunities to have this information available to the public for easier access.

6. *Develop an app where all health services available to an individual are listed and easily accessible (information and contact details).* (Tom Price)

7. More preventative programs are needed. *"The chronic underinvestment in prevention and early intervention is a crisis in WA."*

8. Affordable access to healthcare for regional health consumers is a key priority. *"Cost of travel for country patients for city appointments and PATS subsidies."*

9. There is a perceived lack of value in private health insurance.

10. Mental health consumers and people with disability need more support. *"Lots of people falling through the cracks really needing support."*

11. More community-based service would be welcomed, and more health professionals in rural areas.

12. Better coordination and coordination between service providers is needed.

13. There are many different cultural barriers to patients accessing services. *"No white walls, no white cars, and no uncaring receptionists."* Keep services simple. Offer a cup of tea. "*Understand what the initial engagement should look like."*

14. Several respondents expressed concerns about health professionals transferring to other areas. "They should work within their own sector and qualifications."

15. Community members wanted community nurses as linkage/liaison between hospitals, GP's etc. These roles were previously funded by local government but it was stopped about 7 years ago. "*How about a home visiting nursing service funded by the Shire?*" (Boyup Brook)

16. *"There needs to be transparency and oversight over recommendations made by the SHR Panel to government."* (Tom Price)

17. *"Clear representation, advocacy and support is needed for those living with mental health and associated health issues."* (Boyup Brook)

18. Considerable concern was raised by community members at all locations about the growing burden placed on volunteers to meet service shortfalls. Examples tended to focus around Ambulance transfers, community-based care for at risk populations, and health promotion activities. It was also noted that the majority of volunteers in the small regional towns were often quite old themselves and 'over-volunteering' could have detrimental health effects.

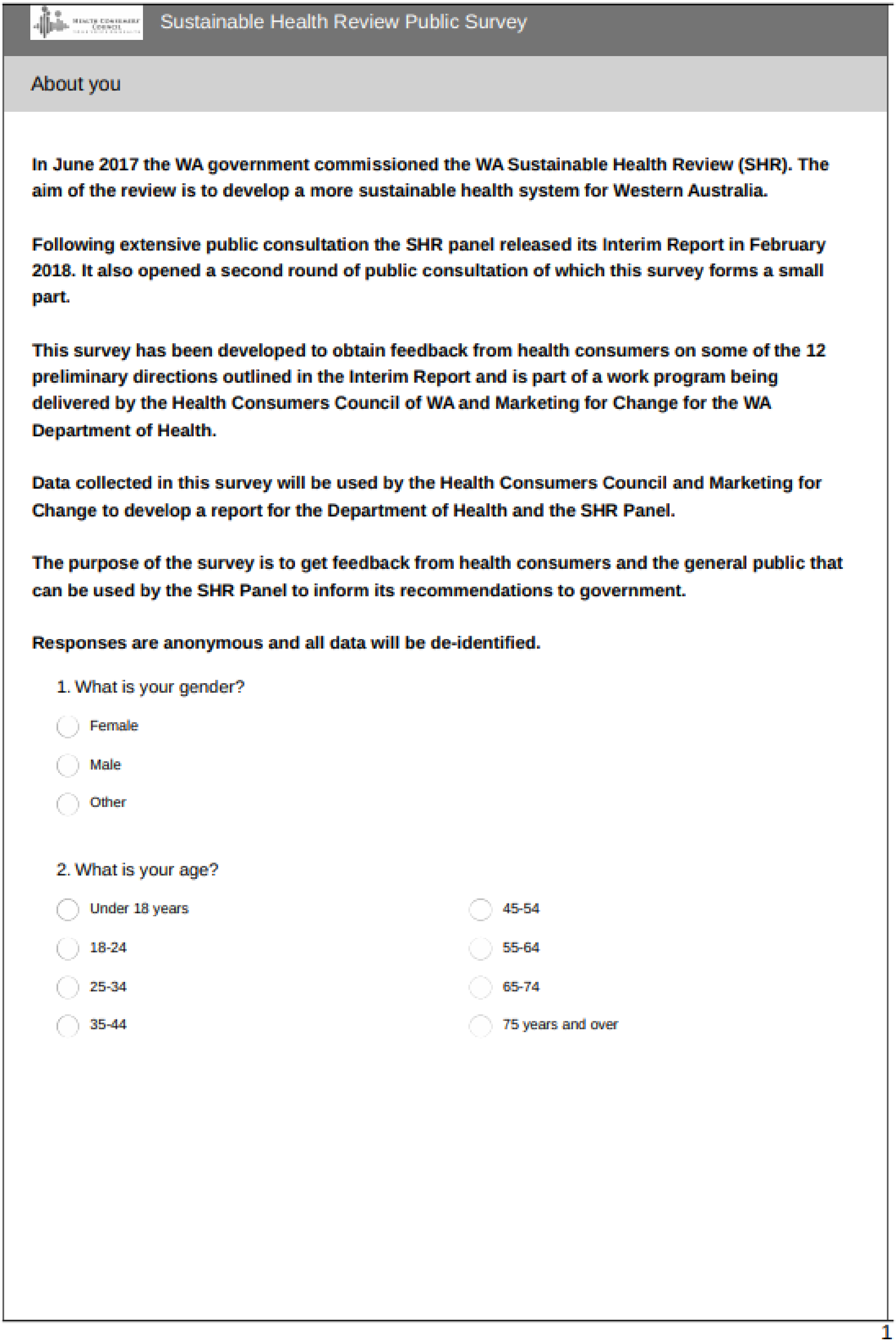
19. Access to healthy food choices was a consistently cited issue across all three locations, particularly Pingelly and Tom Price. Clearly health promotion is critical, but for many of those we spoke to, the issue isn't a lack of awareness about what to eat, the problem is a lack of access to the nutritious foods they need to eat.

20. The lack of access to GP's was a key concern for everyone we spoke to. This was a function of either their not being a full-time GP in town, or that the GP goes home after his/her last appointment which might be early in the afternoon.

21. Inadequate access to allied health services was also cited as a barrier to maintaining health and wellbeing. Visits were neither consistent nor regular, and often people were unaware that a specialist was even in town.

22. Dental services were also difficult to access.

8.2 Survey Questions



Sustainable Health Review Public Survey

About you

In June 2017 the WA government commissioned the WA Sustainable Health Review (SHR). The aim of the review is to develop a more sustainable health system for Western Australia.

Following extensive public consultation the SHR panel released its Interim Report in February 2018. It also opened a second round of public consultation of which this survey forms a small part.

This survey has been developed to obtain feedback from health consumers on some of the 12 preliminary directions outlined in the Interim Report and is part of a work program being delivered by the Health Consumers Council of WA and Marketing for Change for the WA Department of Health.

Data collected in this survey will be used by the Health Consumers Council and Marketing for Change to develop a report for the Department of Health and the SHR Panel.

The purpose of the survey is to get feedback from health consumers and the general public that can be used by the SHR Panel to inform its recommendations to government.

Responses are anonymous and all data will be de-identified.

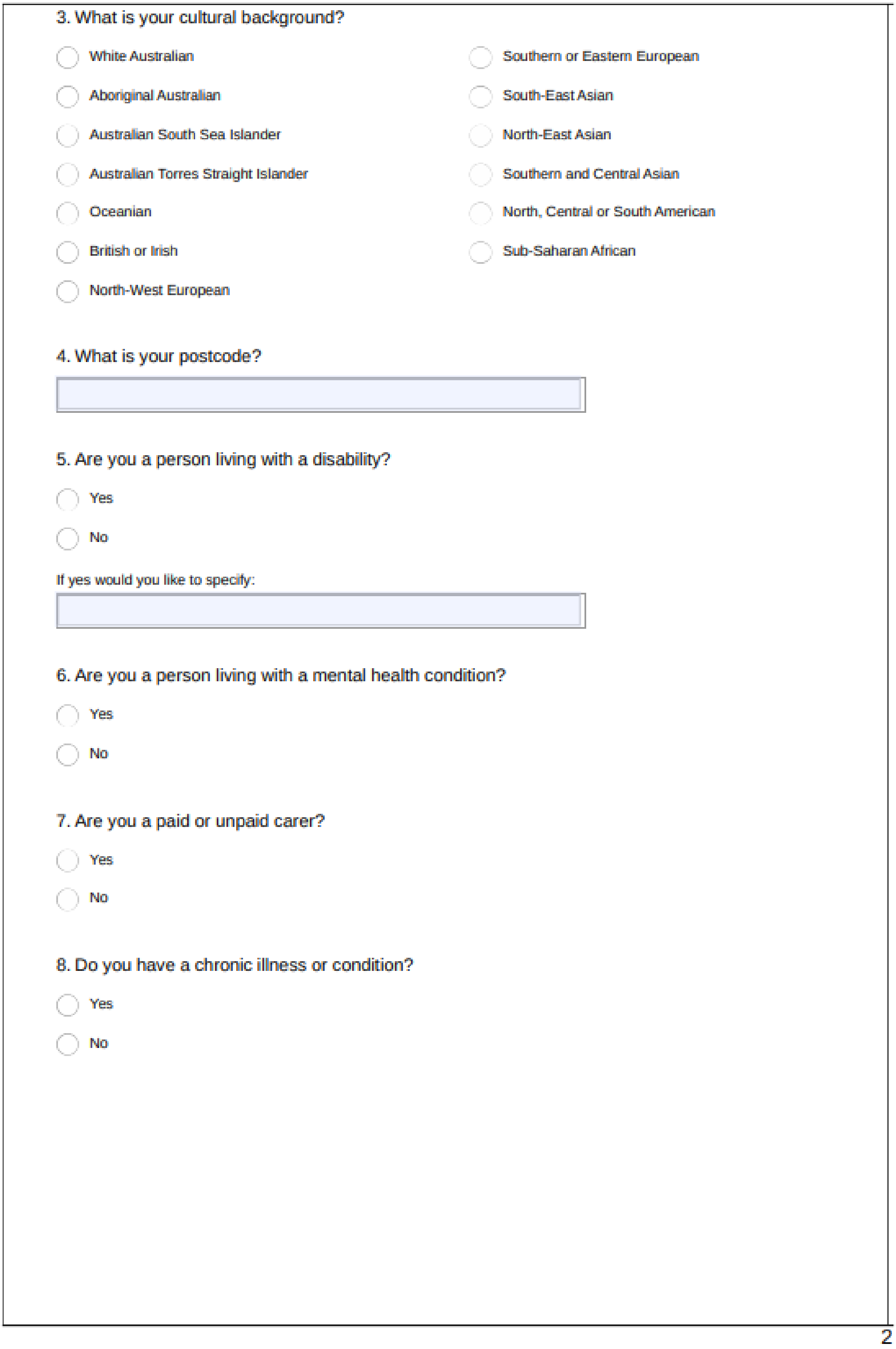
1. What is your gender?

○ Female
○ Male
○ Other

2. What is your age?

○ Under 18 years
○ 18-24
○ 25-34
○ 35-44
○ 45-54
○ 55-64
○ 65-74
○ 75 years and over

1



3. What is your cultural background?

○ White Australian
○ Aboriginal Australian
○ Australian South Sea Islander
○ Australian Torres Straight Islander
○ Oceanian
○ British or Irish
○ North-West European
○ Southern or Eastern European
○ South-East Asian
○ North-East Asian
○ Southern and Central Asian
○ North, Central or South American
○ Sub-Saharan African

4. What is your postcode?

5. Are you a person living with a disability?

○ Yes
○ No

If yes would you like to specify:

6. Are you a person living with a mental health condition?

○ Yes
○ No

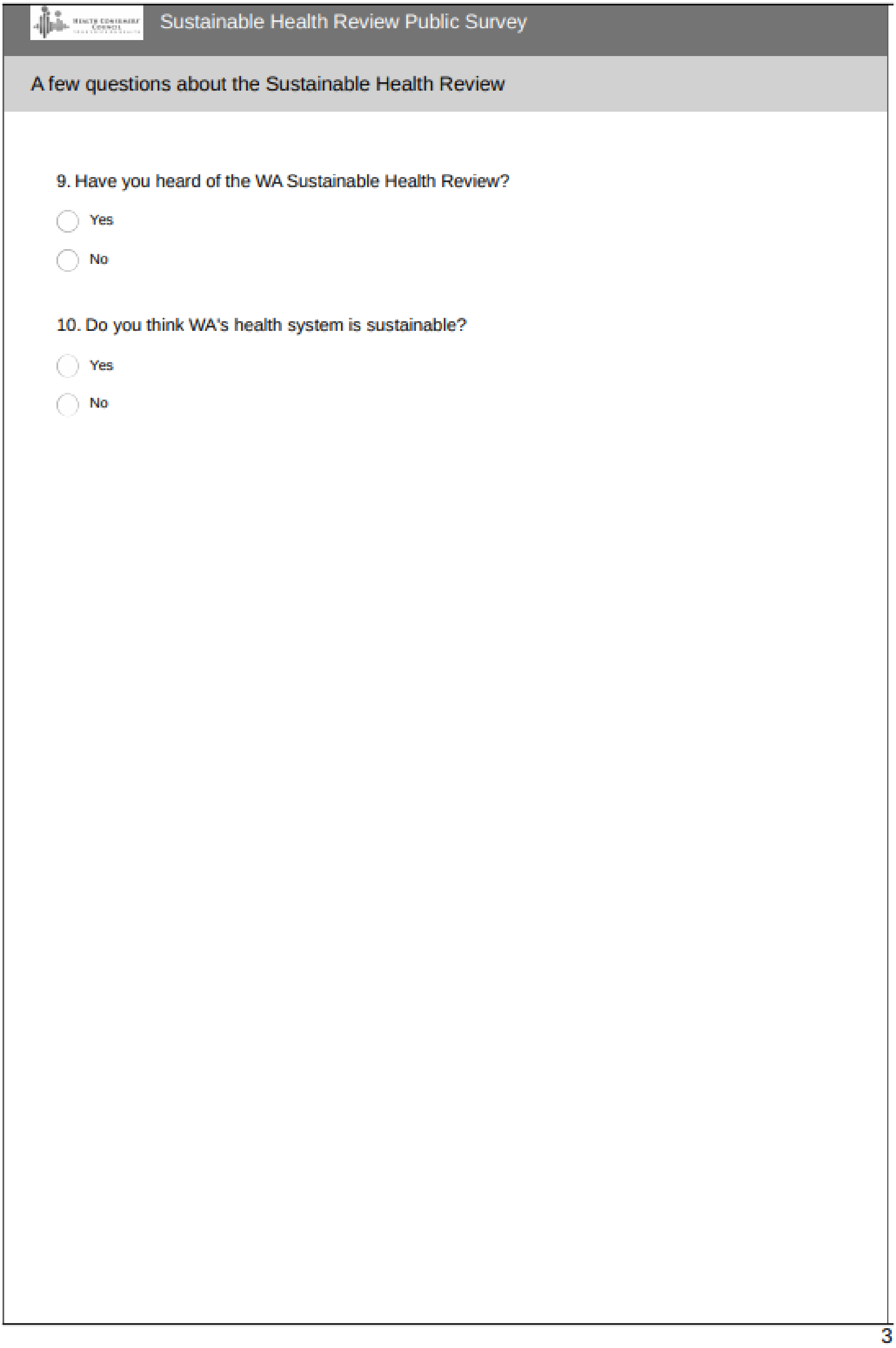
7. Are you a paid or unpaid carer?

○ Yes
○ No

8. Do you have a chronic illness or condition?

○ Yes
○ No

2



Sustainable Health Review Public Survey

A few questions about the Sustainable Health Review

9. Have you heard of the WA Sustainable Health Review?

○ Yes

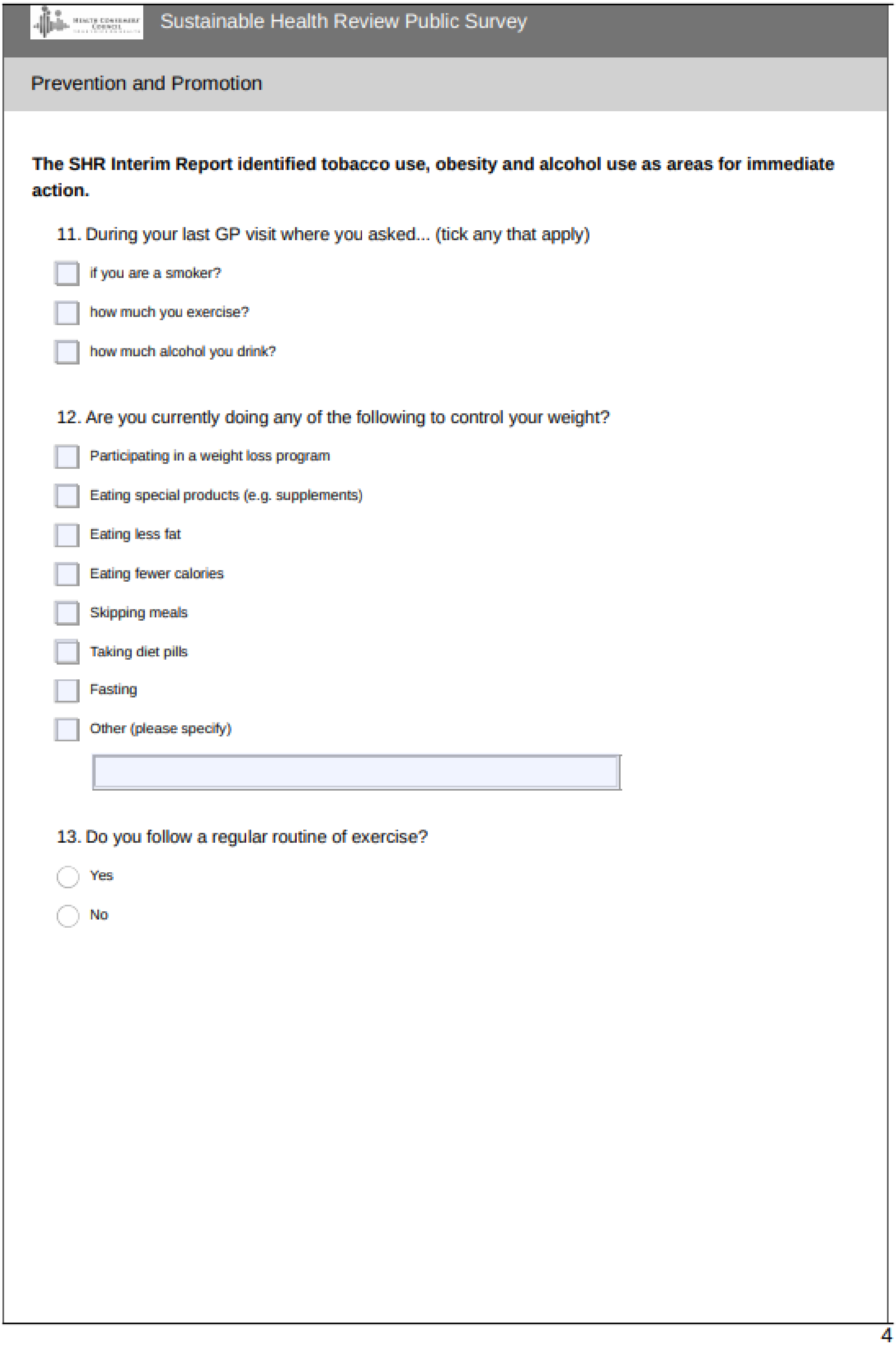
○ No

10. Do you think WA's health system is sustainable?

○ Yes

○ No

3



Sustainable Health Review Public Survey

Prevention and Promotion

The SHR Interim Report identified tobacco use, obesity and alcohol use as areas for immediate action.

11. During your last GP visit where you asked... (tick any that apply)

☐ if you are a smoker?

☐ how much you exercise?

☐ how much alcohol you drink?

12. Are you currently doing any of the following to control your weight?

☐ Participating in a weight loss program

☐ Eating special products (e.g. supplements)

☐ Eating less fat

☐ Eating fewer calories

☐ Skipping meals

☐ Taking diet pills

☐ Fasting

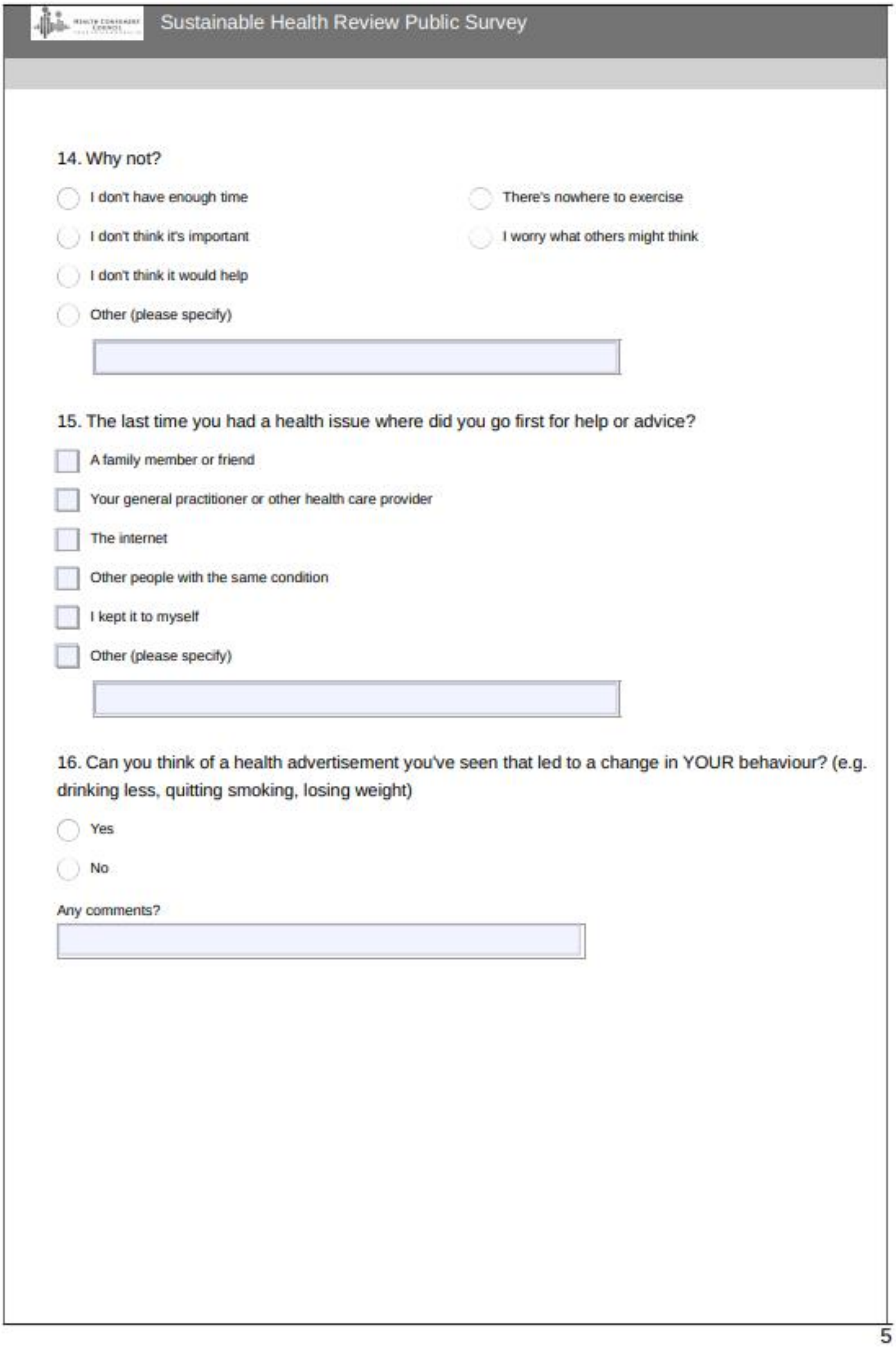
☐ Other (please specify)

13. Do you follow a regular routine of exercise?

○ Yes

○ No

4



Sustainable Health Review Public Survey

14. Why not?

○ I don't have enough time

○ I don't think it's important

○ I don't think it would help

○ Other (please specify)

○ There's nowhere to exercise

○ I worry what others might think

15. The last time you had a health issue where did you go first for help or advice?

☐ A family member or friend

☐ Your general practitioner or other health care provider

☐ The internet

☐ Other people with the same condition

☐ I kept it to myself

☐ Other (please specify)

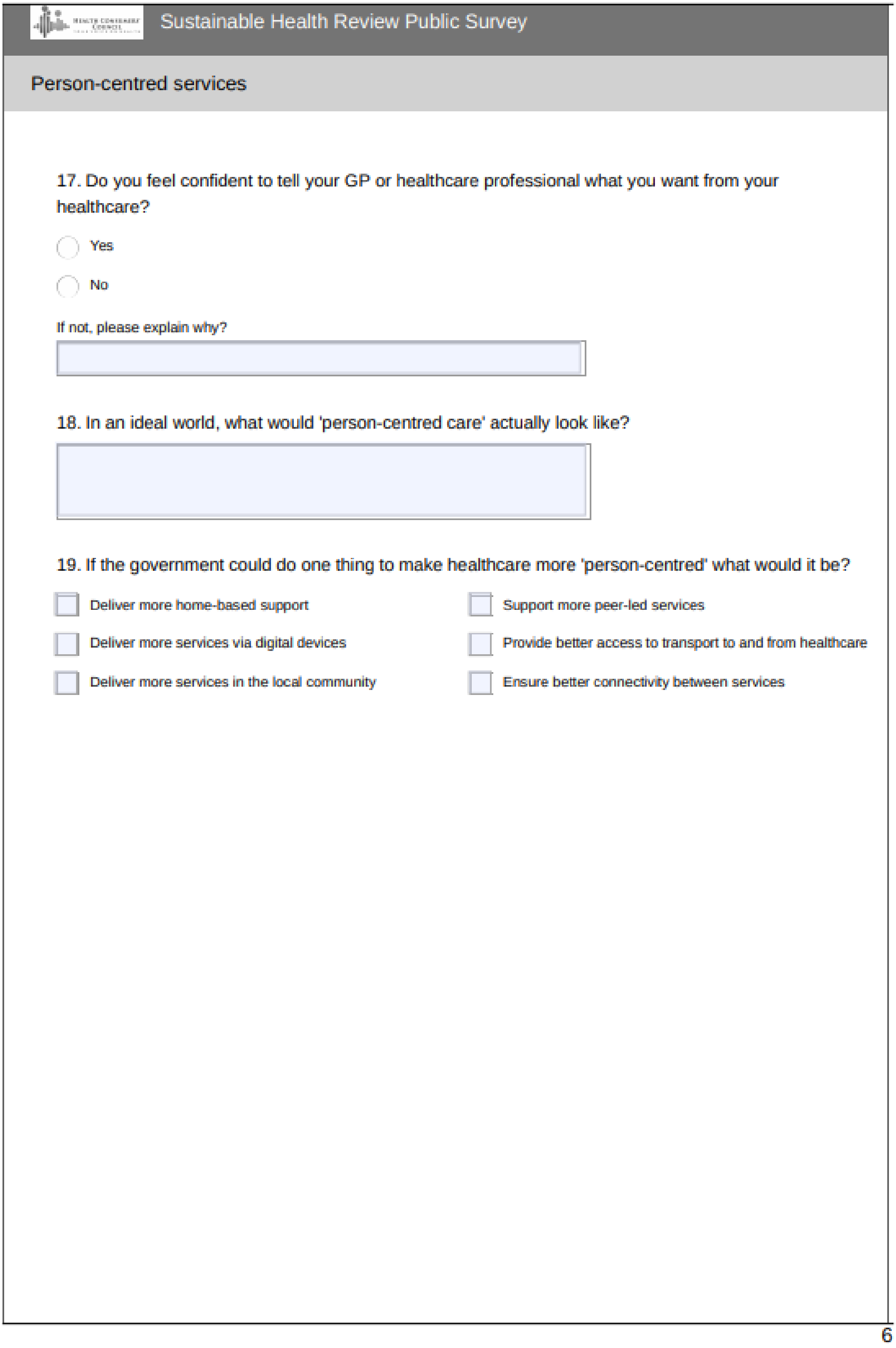
16. Can you think of a health advertisement you've seen that led to a change in YOUR behaviour? (e.g. drinking less, quitting smoking, losing weight)

○ Yes

○ No

Any comments?

5



Sustainable Health Review Public Survey

Person-centred services

17. Do you feel confident to tell your GP or healthcare professional what you want from your healthcare?

○ Yes

○ No

If not, please explain why?

18. In an ideal world, what would 'person-centred care' actually look like?

19. If the government could do one thing to make healthcare more 'person-centred' what would it be?

☐ Deliver more home-based support

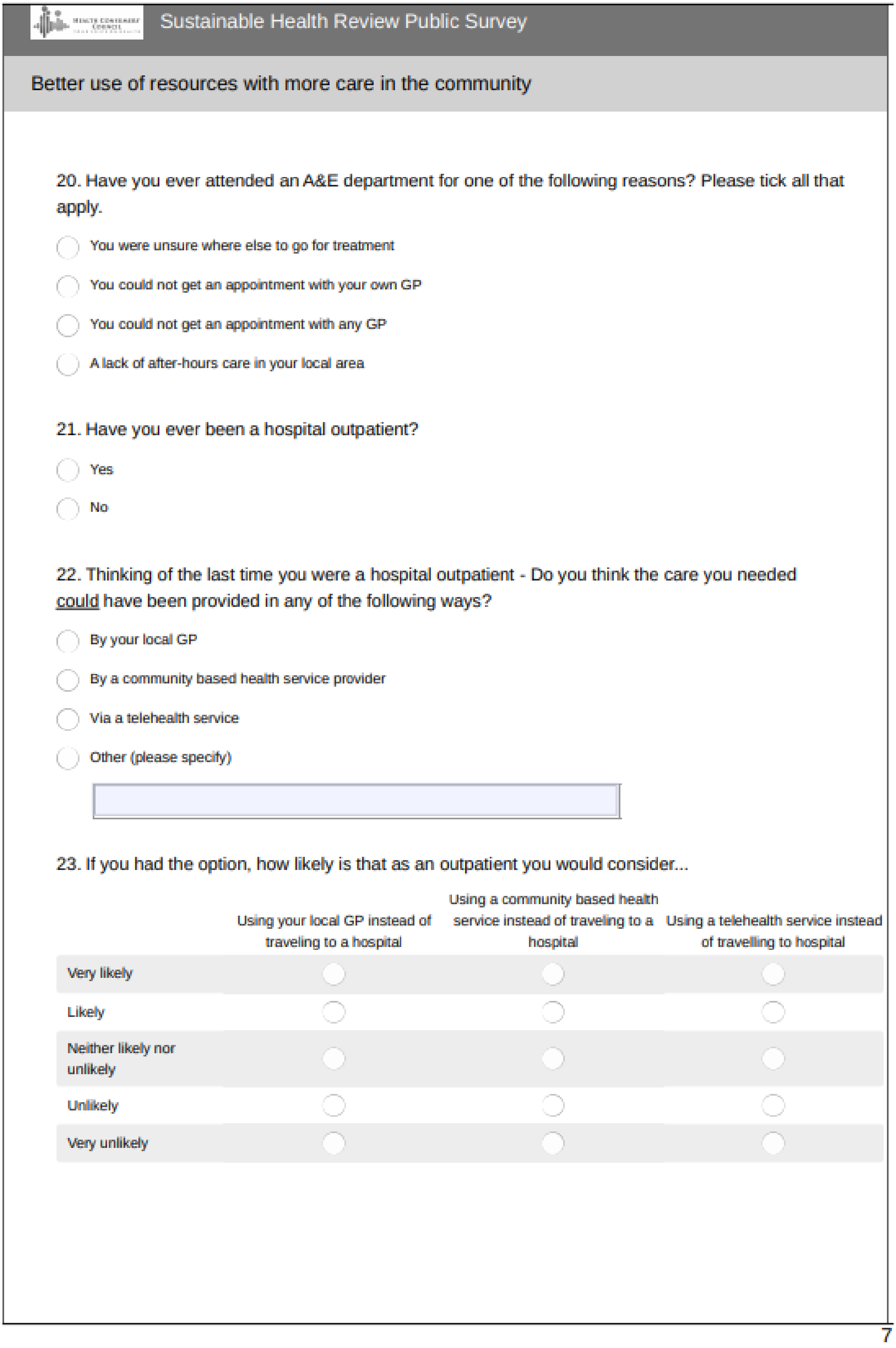
☐ Deliver more services via digital devices

☐ Deliver more services in the local community

☐ Support more peer-led services

☐ Provide better access to transport to and from healthcare

☐ Ensure better connectivity between services



Sustainable Health Review Public Survey

Better use of resources with more care in the community

20. Have you ever attended an A&E department for one of the following reasons? Please tick all that apply.

○ You were unsure where else to go for treatment

○ You could not get an appointment with your own GP

○ You could not get an appointment with any GP

○ A lack of after-hours care in your local area

21. Have you ever been a hospital outpatient?

○ Yes

○ No

22. Thinking of the last time you were a hospital outpatient - Do you think the care you needed could have been provided in any of the following ways?

○ By your local GP

○ By a community based health service provider

○ Via a telehealth service

○ Other (please specify)

23. If you had the option, how likely is that as an outpatient you would consider...

	Using your local GP instead of traveling to a hospital	Using a community based health service instead of traveling to a hospital	Using a telehealth service instead of travelling to hospital
Very likely	○	○	○
Likely	○	○	○
Neither likely nor unlikely	○	○	○
Unlikely	○	○	○
Very unlikely	○	○	○

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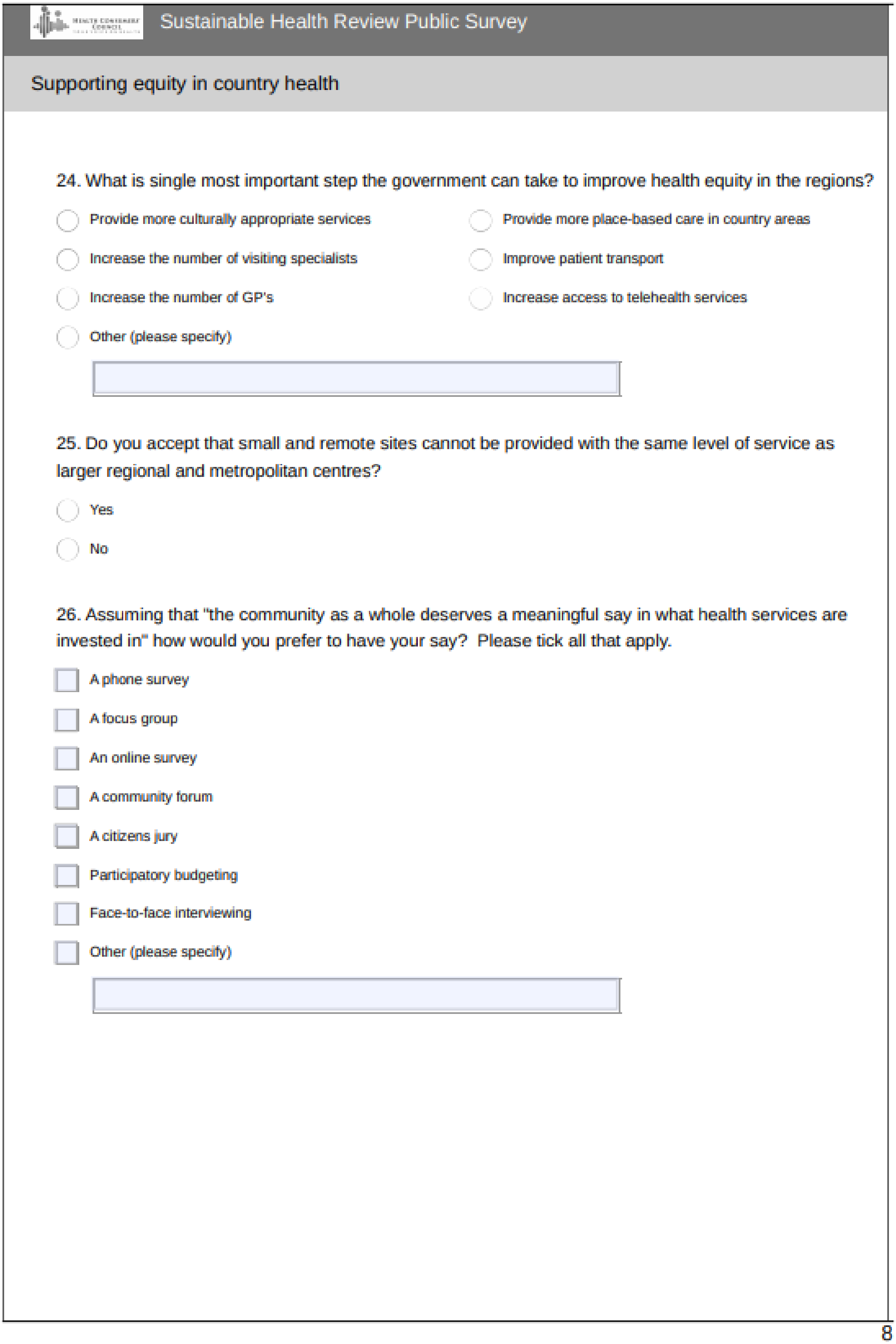


Sustainable Health Review Public Survey

Supporting equity in country health

24. What is single most important step the government can take to improve health equity in the regions?

○ Provide more culturally appropriate services
○ Provide more place-based care in country areas
○ Increase the number of visiting specialists
○ Improve patient transport
○ Increase the number of GP's
○ Increase access to telehealth services
○ Other (please specify)

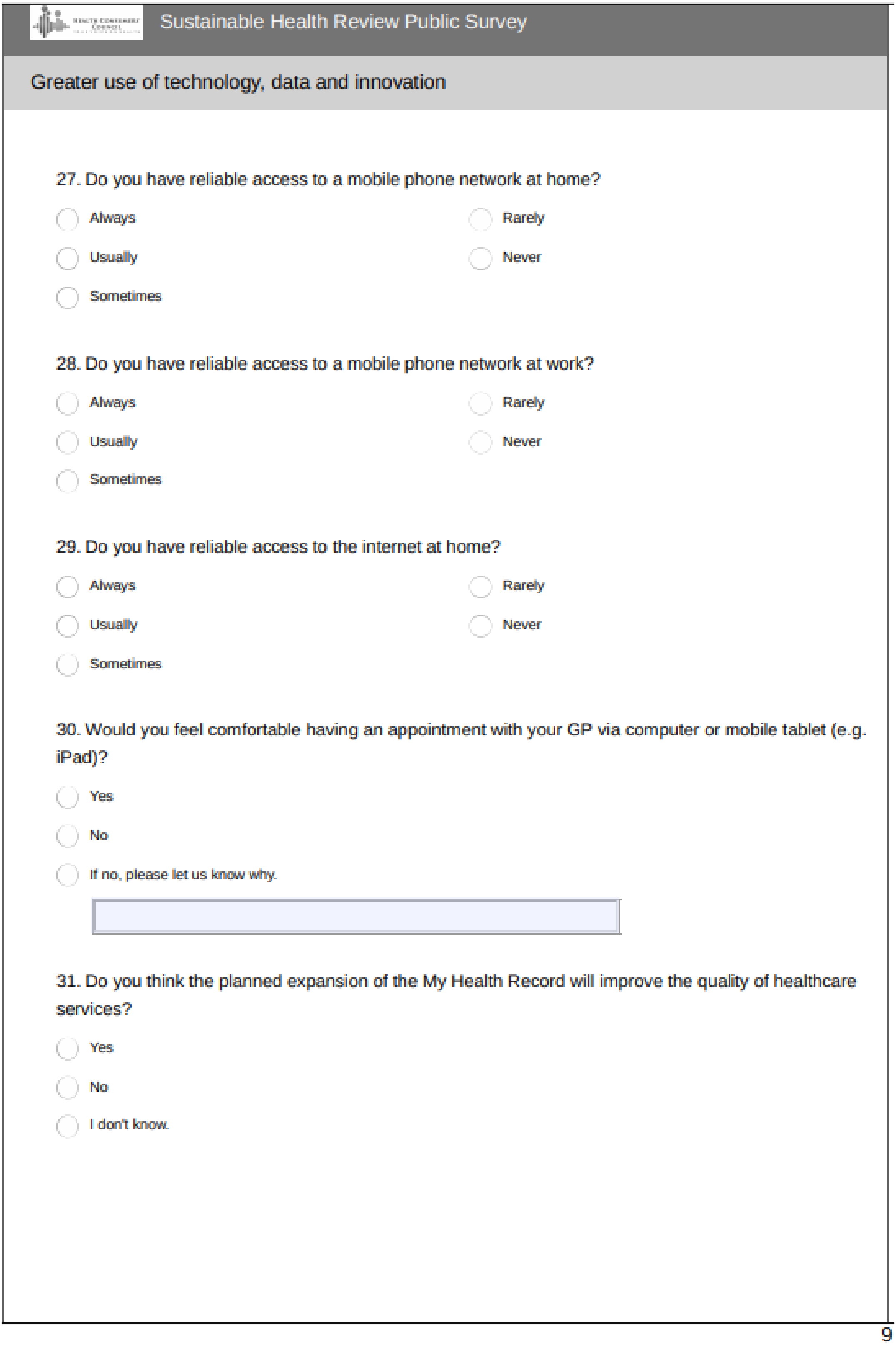
25. Do you accept that small and remote sites cannot be provided with the same level of service as larger regional and metropolitan centres?

○ Yes
○ No

26. Assuming that "the community as a whole deserves a meaningful say in what health services are invested in" how would you prefer to have your say? Please tick all that apply.

☐ A phone survey
☐ A focus group
☐ An online survey
☐ A community forum
☐ A citizens jury
☐ Participatory budgeting
☐ Face-to-face interviewing
☐ Other (please specify)

8



Sustainable Health Review Public Survey

Greater use of technology, data and innovation

27. Do you have reliable access to a mobile phone network at home?

○ Always
○ Usually
○ Sometimes
○ Rarely
○ Never

28. Do you have reliable access to a mobile phone network at work?

○ Always
○ Usually
○ Sometimes
○ Rarely
○ Never

29. Do you have reliable access to the internet at home?

○ Always
○ Usually
○ Sometimes
○ Rarely
○ Never

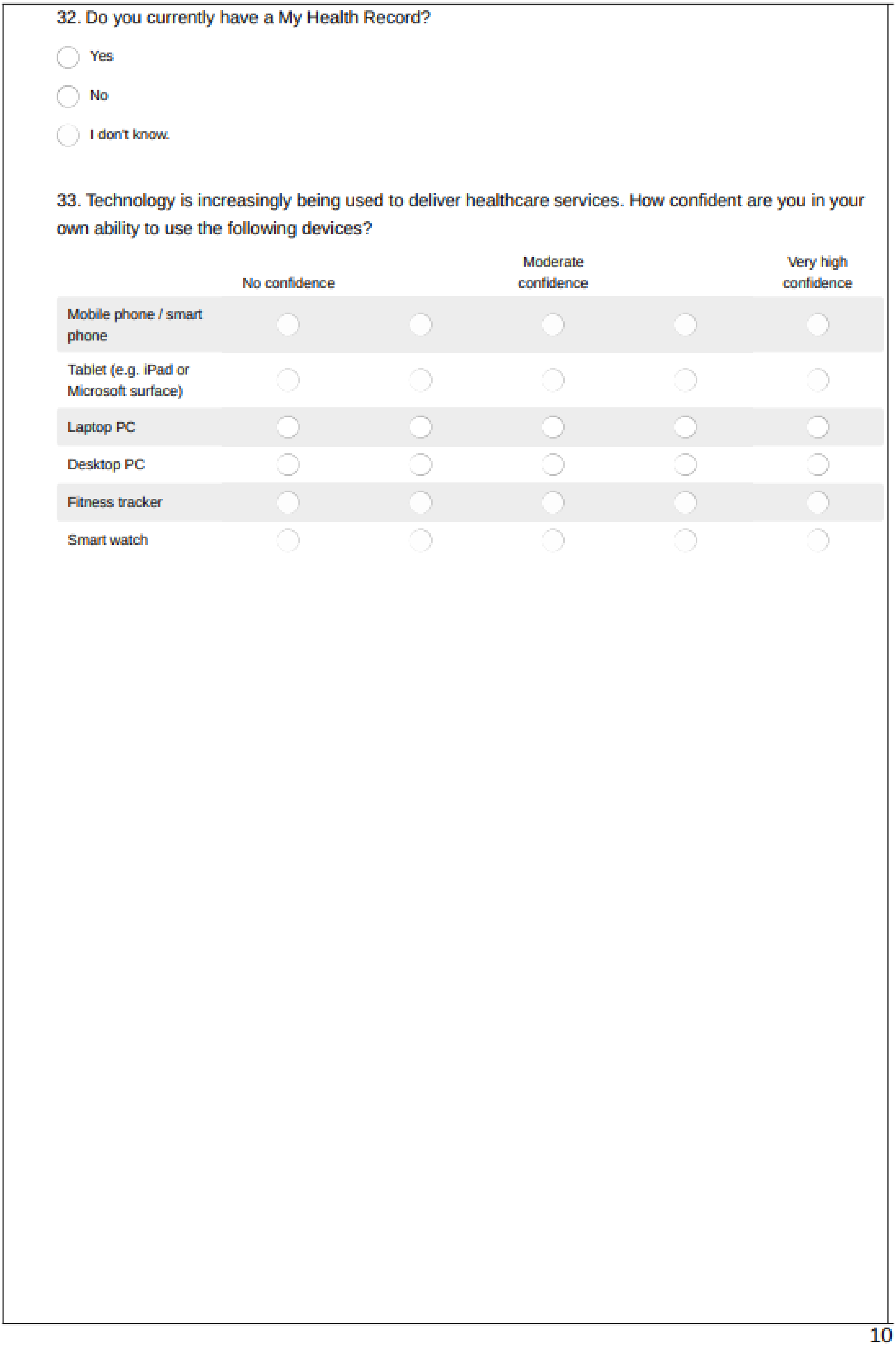
30. Would you feel comfortable having an appointment with your GP via computer or mobile tablet (e.g. iPad)?

○ Yes
○ No
○ If no, please let us know why.

31. Do you think the planned expansion of the My Health Record will improve the quality of healthcare services?

○ Yes
○ No
○ I don't know.

9



32. Do you currently have a My Health Record?

○ Yes

○ No

○ I don't know.

33. Technology is increasingly being used to deliver healthcare services. How confident are you in your own ability to use the following devices?

	No confidence		Moderate confidence		Very high confidence
Mobile phone / smart phone	○	○	○	○	○
Tablet (e.g. iPad or Microsoft surface)	○	○	○	○	○
Laptop PC	○	○	○	○	○
Desktop PC	○	○	○	○	○
Fitness tracker	○	○	○	○	○
Smart watch	○	○	○	○	○

8.3 Sample community conversation agenda

Agenda

Community Conversation on the SHR

TIME	ITEM
11.30-12.00pm	Doors Open Registrations Tea and coffee *(Take food/drink to table)*
12.00 - 12.15pm	Welcome Introductions Overview of the Sustainable Health Review Patient Opinion Group Map instruction
12.15 - 12.40pm	Group Map Question 1 – Direction 5 – Equity in Country Health.
12.40 - 1.05pm	Group Map Question 2 – Direction 1 Keeping People Healthy.
1.05 – 1.30pm	Group Map Question 3 – Direction 8 Better Use of Tech, Digital & Innovation.
1.30 – 1.50pm	Group Map Question 4 - Open comment & Discussion.
1.50 – 2pm	Wrap up.

8.4 Sample webinar run sheet

Questions for VC’s

Direction 1: Keep people healthy and get serious about prevention and promotion

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- ***What are the keys to maintaining good health in your communities?***
- If we were going to implement prevention and promotion strategies, what would work?
- Health literacy – how can we improve it? Have you seen XY ad? What do you think? What do others in your community think?
- How do we build trust?
- How would you like to receive information?
- What would it mean to have a more preventative approach to your health?
- Intro and then talk would work better – how many sessions can we do?

Direction 8: Greater use of technology, data and innovation to support consumers, clinicians drive change.

- **When developing its digital health strategy, what does the government need to consider?**
- How can we use technology, data and innovation to drive positive change in the health system?
- Explore barriers and enablers to engagement via. digital (encompass cultural beliefs, access and competency.
- Would you talk to a doctor via a computer/tablet?
- What would it look like?
- Do you use a mobile phone? Do you (or your community) have reliable phone service? Do you (your community) have reliable internet access?
- Have you got a My Health Record?
- Internet?
- How do you think technology could help you, your family, your community?
- What risks do we need to be aware of? How might we overcome them?

8.5 Langford Aboriginal Association run sheet

12	Welcome, gather your food and take a seat Introductions
12.30pm	Discussion One – Staying Healthy • What do you need to help you stay healthy? • How do you get your health information? • What's the best way to find out what you need to keep you and your loved ones healthy?
1pm	Yarning About Health 1 • Do you feel comfortable giving feedback? If not, why not? • What's the best way for us to engage with you?
1.30pm	Yarning About Health 2 – Going Digital • Do you own a smart phone? Do you own an iPad or tablet? Do you feel comfortable using this technology? • How would you feel about talking to your GP or health service provider over the internet (e.g. video chat direct or with GP/specialist) instead of face-to-face? • What would be good about this? What wouldn't be good about this? • Is there anything about using health care that worries you? How could we help you overcome those worries?
2.00	Cultural Competency Training What should cultural competency training be like?
2.45-3pm	Wrap-up, close, next steps

8.6 Run Sheet for CaLD Sessions

Time	Topic and/or questions
0 – 10 mins	**Setting the scene** • Facilitator(s) introduce themselves • Housekeeping, icebreaker, photo consent taping consent • Overview of Sustainable Health Review • Outline key objectives of the session
10 – 25 mins	**Prevention (prompts)** • What do you need to help you stay healthy? How do you keep yourself or your loved one well? • What do you need from government to not get sick at all? Provide examples of what government currently provides • Where do you get this information?
25 – 40 min	**Engagement (prompts)** • When people in healthcare talk about 'engagement', they mean talking with you, giving you information, and sometimes asking for information from you. How do you feel about this? • How do you give your feedback? Do you feel comfortable giving feedback? If not, why not? • What's the best way for us to talk with you and get your ideas? To find out what you need to keep you and you're loved ones well healthy?
40 – 55 mins	**Digital and innovation (prompts)** • Do you own a smart phone? Do you use your smart phone to get any health information? What about an iPad or tablet? Do you know how to use it to get information? • How would you feel about talking to your GP or health service provider over the internet instead of at an appointment? • What would be good about this? What wouldn't be good about this? • Is there anything about using health care that worries you? How could we help you overcome those worries?