GOVERNMENT OF WESTERN AUSTRALIA

Sustainable Health Review

Public Submission Cover Sheet

Please complete this sheet and submit with any attachments to the Sustainable Health Review Secretariat

Your Personal Details

This information will be used only for contacting you in relation to this submission

Title	[redacted]
Organisation	[redacted]
First Name(s)	[redacted]
Surname	[redacted]
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Publication of Submissions

Please note all Public Submissions will be published unless otherwise selected below

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Submission Guidance

You are encouraged to address the following question:

In the context of the Sustainable Health Review Terms of Reference listed below, what is needed to develop a more sustainable, patient centred health system in WA?

- Leveraging existing investment in Primary, Secondary and Tertiary healthcare, as well as new initiatives to improve patient centred service delivery, pathways and transition;
- The mix of services provided across the system, including gaps in service provision, sub-acute, step-down, community and other out-of-hospital services across WA to deliver care in the most appropriate setting and to maximise health outcomes and value to the public;
- Ways to encourage and drive digital innovation, the use of new technology, research and data to support patient centred care and improved performance;
- Opportunities to drive partnerships across sectors and all levels of government to reduce duplication and to deliver integrated and coordinated care;
- Ways to drive improvements in safety and quality for patients, value and financial sustainability, including cost drivers, allocative and technical efficiencies;
- The key enablers of new efficiencies and change, including, research, productivity, teaching and training, culture, leadership development, procurement and improved performance monitoring;
- Any further opportunities concerning patient centred service delivery and the sustainability of the WA health system.

Submissions Response Field

Please type your response into the field below. Alternatively you may provide your submissions as a separate attachment (Suggested Maximum 5 pages).

Thank you for the opportunity to provide feedback on the direction of the WA health system for the future. The following comments are my own, and do not represent the views of any organisation I am involved with.

Health versus healthcare

A successful healthcare system will achieve three aims: "healthy people,… superior care, meaning care that is effective, safe, timely, patient-centered, equitable, and efficient; and fairness, meaning that treatment is applied without discrimination or disparities to all individuals and families, regardless of age, group identity, or place, and that the system is fair to the health professionals, institutions, and businesses supporting and delivering care." [1]

It is important to point out that the ultimate outcome of interest, is "health", and the solutions needed to achieve this will come from not only the healthcare system. Prevention of disease and maintaining independence when living with chronic disease are other essential ingredients of health that the "healthcare system" is not well placed to achieve. Any future planning to improve the health of the WA community should invest strongly in prevention of life style diseases (such as obesity), and provision of strong community based services to assist people to live independently. This will require cross government involvement from sectors such as aged care and education.

Challenges

The challenges for WA health are well known. Population wise, we are relatively small in number, but the geographic distances are vast.

A report by the World Economic Forum put the reasons for a growing demand for healthcare being driven primarily by four factors: an ageing population, an explosion of so-called lifestyle diseases, a rise in public expectations, and a lack of value-consciousness among healthcare consumers. Their reasons, pertinent to WA health, are that a lack of data on outcome measures, and poor allocation of resources due to historical reasons or vested interests are significant barriers to improvement. [2]

The other challenges are that there are potentially significant uncertainties in the future. These include infectious epidemics, climate change associated health problems (change in diseases, disasters) and the rise of private sector solutions that may improve and disrupt traditional healthcare delivery.

Data sharing, gathering and outcome measures

The WA public hospital system has already got excellent pathology and radiology access sites (through iSoft and PACS). There are outliers, who are treating public patients - the public-private partnership hospitals (Midland, Peel, Joondalup). These hospitals need to adopt the same systems as the public hospitals, or streamline the data transfer,

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as the repetition of pathology and radiology is costly, and adds extra risk to patients (lack of timely results leads to delays, extra radiation exposure, blood wastage).

The next ICT area of need for WA is electronic prescribing for hospitals. Medication error is a significant cause of adverse events (and many are un-reported), and a lot of time is spent in medication reconciliation between sectors. A streamlined electronic record is urgently needed.

Some of WA health has started using electronic medical records. The overseas experience of EMRs is largely positive, but there are significant costs and obstacles. Ensuring intraoperability between systems (hospital and community sector) should be an essential part of any ongoing solutions.

Finally, in order to truly improve, we need to collect more patient centered variables than current administrative data provides. Patient reported outcome measures (not patient experience) are more useful in understanding whether the treatments provided lead to outcomes that patients value.[3]

Environmental sustainability

The healthcare sector contributes significantly to energy usage (and emissions productions) and disposable waste generation. Given that CO2 emissions, and pollution generation from energy production are significant public health issues, the healthcare sector has a responsibility to assist in reducing their footprint. A discussion about the generation of waste from single use items, and their consequence to the future needs to be had, instead of a narrow focus on a “per-item” cost. Furthermore, looking at ways to shift energy usage to renewables, or to reduce energy usage is also of importance. An example of an association leading this change is https://practicegreenhealth.org/initiatives.

Strategy and co-ordination

The governance structure of WA health now has several leadership layers. The Department of Health has become the “systems manager” and then each health service has both a board and an executive. It appears that the main reason for this transition was to provide better oversight of each health service. It offers the potential for a better link between the community and the hospital that provides it services. However, the danger is that this creates duplication, distance between the “front line services” and leadership, and uncertainty about roles between the Department of Health and the services. Duplication and uncertainty are the usual culprits when looking for inefficiencies in a system, and it should be discussed as to whether coordination of services could be simplified.

Primary health networks have been charged with conducting community health needs assessments, to truly understand what is required. This should also be part of the larger role of WA health, given that patients move between sectors.[4]

Regional WA

Health outcomes for patients in regional WA are frequently worse, largely due to the time to definitive care, and the regional services and RFDS provide outstanding services to their populations. However, there are many idiosyncrasies to how this occurs.

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As of 2016 there is now an established referral link for unplanned adult inter-hospital patient transfers according to catchment areas. However, WACHS Wheatbelt refers to all three metro links. Visiting outpatient specialists to regional areas are not coordinated, as many are the result of long standing links with specialists (some private, some public) who have performed this service out of their own initiative. Unfortunately this leads to the situation where a patient may be well known to a specialist from one hospital from their visits, but needs to go to a completely different hospital for an acute issue. This is not beneficial for the patient or the receiving medical teams.

The potential solution:

Outpatient and inpatient referral patterns are unified.

Resources/funding to provide these services are shared between the owning "metro health service" and the regional service".

Electronic appointment systems. A central system that enables regional services to book appointments, with the correct specialist, in real time, would help reduce uncertainty about the need for appointments, and who the patient was seeing. From an IT point of view, something similar to Healthengine could be considered (a private provider currently doing this for GP/specialists in Australia).

Small hospitals

Regional WA has a large number of small towns that have small hospitals. It would be useful to have data on this, but anecdotally, often there are large proportions of the beds at the hospitals being used for aged care awaiting placement. If there are other larger towns in the vicinity (which is possible in the Wheatbelt, Southwest WA), then consideration as to whether these hospitals could be re-designated, to use much more of a hub and spoke system. The smaller hospitals may end up having tele-health service with on-site nursing staff, but this may actually allow more funds to be available to the hub hospitals.

Public-private and State-Federal funding structures

There are many inefficiencies as patients move between sectors, but this is an Australia wide issue.

The solution that may have the most likelihood of success for WA is great contribution of (unified) data between the sectors , ideally both episode data (such as discharge summary or pathology results) and outcome data).

Workforce

WA now has three medical schools. There has been a gradual increase in the number of graduates who go to rural posts, but there still remains a large imbalance between the city and regional WA. Furthermore, there are increasing numbers of specialists, which may promote further growth in healthcare costs as doctors are responsible for much of the supply side of healthcare costs. Given the projected large number of junior doctors, thinking about the best ways to use them could be useful (as there is likely to be significant bottlenecks as they await training places). They may have a role in outreach to nursing homes (under supervision of a GP/geriatrician), health promotion activities.

Clinician engagement

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Engagement with improvement initiatives in WA is slowly improving with groups like the Choosing Wisely Champion Hospitals and the High Value Care Collaborative. Nonetheless, there remains a lot of work to make quality improvement a core role within the medical staff as well. In addition, while there are many excellent pilot projects conducted, the ongoing implementation and behaviour change strategies are not well resourced or prioritised. Healthcare delivery solutions / research translation has as much to offer as new medical technologies, but we need a coordinated approach, that is prioritised, across the health services.

Training

Interdisciplinary training remains uncommon, whether undergraduate or in the workforce, and given that health care is increasingly delivered in teams, this should be focused on for the future.

Retention

Regional WA has struggled to retain staff. Greater discussion of organised outreach from the metro area needs to occur.

Conversely the recruitment process across WA Health is often slow and cumbersome. This does not make WA Health "nimble" to respond in times of need.

Intensity and location of care

"Futile care"

There has been much written about the large amount of "futile care" provided to patients at the end of their lives. This is important as it is neither patient centered (surveys show most patients don't want aggressive non-beneficial treatments) and nor efficient (if it is futile, it is not going to work). However merely deciding that we need to stop providing futile care is somewhat problematic for several reasons. First, it is much easier to analyse situations with the benefit of hindsight, namely it is often hard to predict outcomes for individual patients. Second, some treatments may be warranted (analgesia, trial of limited non-aggressive therapies) and be unable to be provided (at least initially) at home or in the community.[5] Third, there remains a lack of uptake of advance care planning within the community.

Potential solutions:

1. The recent goals of care (4 tiers of treatment choices) trial is a useful step forward for in-hospital care
2. There are patient groups are high risk of dying within the next 6-12 months. Namely patients with metastatic cancer, end stage heart, lung or kidney disease, severe frailty. Given the poor community uptake of completion of advance care planning, a strategy that focuses on these high risk groups (and in addition, everyone in residential care), would likely have better results. This could involve outpatients at public hospitals, nursing homes, GP clinics.
3. Any record of advance care planning needs to be easily accessible and available across sites. This could be developed as a stand alone system, or part of the myhealthrecord.

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Other patient groups

For patients not at the end of their lives, there are still options for patients to choose the location where they receive their healthcare (public, private, outpatient, inpatient) and the type of service they require. The WA metro hospital system has increasing become "tertiary heavy", and the provision of lower intensity care to these patients in tertiary hospitals is not efficient (the expertise and staffing mix at these sites is expensive). There is a lack of rehabilitation and community hospital level beds to provide these services. Looking at our smaller hospitals and whether they could be expanded to take on more of these roles may be an effective shift of resources (and patients often want to stay closer to home, if possible). In addition, investment in community care to help provide care at home, out of business hours, would be another alternative solution. The Chemo at Home service now available is one example of an innovation providing care to patients in the place where they want it, out of the tertiary centres.

This would also be applicable for maternal health, as community hospitals can provide a great service for low risk women (Australia has one of the highest caesarean section rates in the world, which can delay breast feeding, mother-child attachment and a midwifery led model for low risk births is shown to have lower interventions). [6]

Prevention

Other countries, planning their health systems, have started thinking about "promoting wellness" – to attempt to prevent many of the problems before they arise.[2] For instance, in Japan, screening for metabolic syndrome is mandatory for ages 40 and 74**.** China is planning on focusing efforts on its top 10 chronic diseases.

Obesity is a rising problem in WA, and there are significant consequences as a result. Testing different solutions is necessary to see whether sugar taxes, easier access to fresh food, easier access to physical activity options may be successful.

Poor sleep has also been identified as a significant health and economic cost issue. A Deloitte report suggest that the total cost of inadequate sleep in Australia is 66.3 billion dollars a year and 7.4 million Australians get inadequate sleep. Recent Busselton health data suggests obstructive sleep apnoea is 20% of adult men and 10% of adult women, and double 1995 data from the US.[7]

Early childhood is an area where promotion of health is likely to achieve significant benefits. For instance, longer maternity leave has been associated with better child health (including mortality), potentially from longer breast feeding.[8] It also promotes attachment.

Early childhood education and care is another area where improved access to childhood education leads to better health outcomes later in life. Like many social factors with health implications, the children most likely to benefit from early childhood education – those from disadvantaged backgrounds – are least likely to participate, and Australia lags well below the OECD average for this.[9] One of the issues in Australia is that overall, 77% of Australian children attend ECEC in private, not-for-profit or community-run services, compared to an OECD average of 32%. All of these services are private entities that receives more than half of their core funding from government, but then the government does not have much control over delivery, quality or pricing.

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Care coordination

A relatively small proportion of the population accounts for a much larger percentage of healthcare usage. These are patients living with significant chronic diseases. In order for them to get the best value from the healthcare system, care coordination is essential. These strategies have been shown overseas to reduce hospital admissions and readmissions. A local example is CoNect (Complex Needs Coordination Team). Evaluation of their success, and also whether potentially the coordinator is better situated in the community, should be considered.

Community

Improved honest dialogue with the community is necessary. Discussions around advance care planning, expectations of what rural hospitals are able to deliver, and whether the government is able to fund emerging chemo/immunotherapies are all difficult discussions to have. However, part of sustainability is determining what mix of services the public feels is reasonable to support, when the trade-offs are reductions in other part of the State's economy (education, infrastructure etc).

Ways to improve the community involvement in decision making, and their health literacy is essential for these discussions to be meaningful. The Choosing Wisely Australia 5 questions is one approach that could be more widely adopted.[10]

Overseas exemplar

Kaiser Permanente in California, USA has several attributes that are worthy of consideration. Kaiser Permanente (KP) is a large integrated health care system, spread across 8 US states and provides care to over 10 million members. In a way it functions like a large public health system, where the doctors are salaried employees, there are distinct regional entities, and patients receive their care only within the Kaiser system. They are well known for their electronic medical record which is available in all parts of the system, and their emphasis of preventive care.

1. Centre for Effectiveness and Safety Research : This centre, separate but collaborative with the researchers within the organisation, asks clinical leaders what are implementation or research questions of importance to the organisation, and then attempts to study them. This gives a rigor to quality improvement, while aligning with organisational clinical priorities.

   Of note, NSW has the Clinical Excellence Commission and AIHI which perform similar roles.

2. EMR and prevention: Every interaction between a Kaiser member (patient) and the system is designed to act as a prompt for preventive health. For instance, if a patient attends a cardiologist appointment, there are flags for immunisation/cancer screening, that the administrative assistants or the doctor are required to act on, to make an appointment for that preventive health opportunity.

3. Community needs assessments: as part of their non-profit status, hospitals undertake community needs assessments to assess what services they may need to support in their community (whether this may be availability of fresh food options, or specific medical services).

4. Innovation Centre – in order to quickly adapt, test new products or mock-up building lay-out, KP has

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an innovation centre. In order to rapidly test new ideas in the changing world of healthcare, having pilot sites for modelling healthcare delivery is important (but doesn't necessarily require a stand-alone innovation centre).

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