GOVERNMENT OF WESTERN AUSTRALIA

Sustainable Health Review

# Public Submission Form

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

| **Your Personal Details**<br>*This information will be retained and used only for contacting you in relation to this application.* | |
|---|---|
| **Title** | [redacted] |
| **Organisation** | [redacted] |
| **First Names** | [redacted] |
| **Surname** | [redacted] |
| **Postcode** | [redacted] |

| **Publication of Submissions** *Please note that all Public Submissions will be published unless otherwise stated* | |
|---|---|
| **Please advise your preferred option** | ☐ I consent to my submission being published<br>☐ I do not want my submission published<br>☒ I would like my submission to remain anonymous |

## Submission Instructions

**Please address the Question provided in relation to the Sustainable Health Review Terms of Reference (listed below). Any attachments must be summarised within the submission.**
(Suggested maximum 5 pages)

## Terms of Reference

- 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.

## Public Submissions Question

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

1. Question the need for increasing numbers of medical students – hard to make costs less if more doctors are trained who cost money and spend health money! There is no doubt as doctor numbers increase, health costs increase so getting graduate numbers right and making sure those graduates go to where they are needed (rural) is essential. More rural medical school experiences are important as well as choosing rurally minded people.

2. Avoid sending nursing home patients to tertiary/quaternary units, very rarely need these services. They need access to good medical, geriatric, palliative, orthopaedic and general surgical services, but rarely need high level specialty unit care. there needs to be a focus of care around less interventions and less therapies and more focus on symptom control and a gentle care approach. nursing home patients should have NFR forms done on admissions to hospital and receive basic medical therapies when consent is given and never offered higher level interventions (ICU/HDU, major emergency surgeries etc.)

3. Massive amount of overprescribing in the elderly and aged care population. I think there need to be aged care trained GP's who could sort this out and reduce our PBS usage enormously. We currently don't have "aged care specific GPs", ie those who look after a whole nursing home, instead each individual patient has their own GP who they see.

4. Outreaching of junior doctors to community based medicine (eg. nursing homes) to keep people there rather than in hospital.

5. By far and away the biggest change to make health sustainable is getting us to STOP doing interventions and procedures on people at the end of their life/final years. This needs to be looked at by every facet of health and the savings would be stupendous. There are endless examples of when frail elderly demented patients have massive procedures performed on them in an emergency setting because families are scared and doctors no longer recommend common sense therapies for patients in accordance with what is best for the patient, but instead list ALL options and put the onus on families to decide for their loved ones and they invariable choose aggressive intervention as they don't won't to bear the responsibility for causing the death of their loved one.

6. Consider the level of approval required for RFDS patient transfers. If made at a consultant level if may decrease and save large amounts of money.

7. consider charging a nominal fee for emergency department attendance, or incentivising using GPs over EDs. Important for decreasing overcrowding nad bed block in hospitals and improving 4 hour rule targets

8. Abolish "dial a doctor" schemes which is rorting the health system by charging expensive visits to people to write scripts and look in sore throats when the patients are simply too lazy and don't want to pay any gap using after hours GPs. This is a disgrace and needs to be stopped. The doctors are not even GPs and have no specialist qualifications, they are poor doctors who provide minimal service to people but high convenience to patients, which is a recipe for disaster as they will become more and more popular and costly but provide no real help to sick people, as anyone who is remotely sick just gets sent to ED or told to see their GP in the morning, so it actually costs Medicare double. It is astounding that people in health finance cannot see this

| Public Submissions Question |
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| obvious rort.<br><br>9. consider outsourcing junior doctors to private hospitals more and have some of their wages offset by the private system<br><br>10. telehealth expansion to rural and remote areas to provide acute care and reduce RFDS transfers<br><br>11. consider the cost of experimental oncology medications and how these are accessed and paid for (I don't know how this works so may not be an issue)<br><br>12. consider the implant cost of materials into different patient groups……. Does a minimally ambulant/non-ambulant nursing home patient with a fractured neck of femur need a $25,000 ceramic total hip replacement, or can they have a much cheaper alternative?? |