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

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Publication of Submissions

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

☐ I do not want my submission published

☒ I would like my submission to be published but remain anonymous

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).

1) There is a gap in service to uninsured working people who sustain an injury that prevents them from attending work (eg musculoskeletal sprain/strain). These clients are often managed by their GP, but endure long wait times (or are excluded) from public hospital OP Physiotherapy as they are not ABF and are considered a lower clinical priority. They also cannot utilise medicare EPC referrals as it is not a chronic condition. For uninsured, private physiotherapy services are usually cost prohibitive. Even for those with private health insurance, the rebates barely cover a third of the bill. Their recovery is subsequently not optimised and often significantly delayed, they use up their sick leave (or lose their jobs if they are casual), creating a burden on the government and the economy in other sectors outside of health. We need to staff up our public physiotherapy services (which are cheap to operate) and fund them to provide prompt services to these clients to get them back to their paid work asap.

2) Meanwhile, public hospital physiotherapy depts. are being asked by management to run multiple exercise classes to treat subacute and acute OP to maximise income through ABF. In some cases this excessive use of group therapy is suboptimal (a short course of 1:1 therapy would be far more effective), in some cases it is overservicing (many clients can do their exercises at home - they don't need to be coming in to a hospital to exercise), often the practice is over medicalising clients (who then believe it is not safe for them to exercise unless they are in a hospital under the supervision of a physiotherapist), and usually it is going against the contemporary approach of self management support. It does, however, attract a lot of funding under ABF - hence the push to get physio depts to run exercise groups, taking physio resources away from more direct, focussed and effective 1:1 treatments.

I think health should be setting up collaborative arrangements with local government to run a standard range of exercise classes at local government facilities (eg a gym circuit, a hydro class, a cardiac rehab class, a pulm rehab class, a weight loss/management class). Local government is already set up with great facilities, and often a staff of accredited exercise leaders, and a longer term sustainable model of facility membership that encourages healthy lifestyle choices. The collaboration could be a HDWA physiotherapist working with each local government to help transition clients from health to wellness, to help with program design and tweaking to suit client needs and goals, to provide education components for clients and exercise leader staff and to provide expertise for the more unstable or complicated health clients. HDWA could also provide capacity for the local government facility to access dietician, podiatrist, OT to provide education components for their groups and consultation. HDWA could subsidise 12 weeks of attendance for referred (from Physios and GPs and HDWA Doctors) clients at the local government fitness facilities (such that clients only had to pay <$5 per week). At the end of the 12 weeks, clients may then choose to take up a paid membership at the facility, and hence be taking on a self management approach to their ongoing health and wellness (decreasing the chance of health events in the future). All this benefit for the relatively small outlay by health of a paid physiotherapist position (PT) at each local government fitness facility and a 12 week subsidised attendance for referred clients.
This would also then free up the public hospital Physio OP depts to see and hold on to only those clients that really needed 1:1 physiotherapy care.

A big win all around as far as I can see.

3. HDWA should look at the time spent on recruitment when they have so many casual contracts. Casual contracts create instability and movement in the workforce. Senior clinicians are spending so much time each week trying to access staff,; they could be spending that time on clinical tasks instead. Also, fluctuations in daily

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staffing due to the non-binding nature of casual contracts creates a lots of work to reschedule clients, shuffle staff on a daily basis to cover clinical priorities. These work tasks are taking our senior clinicians away from clients and putting them at their desks on the phone for too much time. Also, the orientation and mandatory competencies required for each new starter are so onerous (about 20 hours of mandatory training and countless hours skilling a new starter up to operate the multiple IT platforms we use at the clinincal level). This start up time is compounded may times over when we have very mobile casual workforce and very part time workers. In my section I have 9 staff covering 5 FTE, and I have recruited 5 times over the past 12 months! So 280 hours of clinician time this year to cover mandatory competencies plus a HUGE number of hours orienting new staff (both for the new staff member and the supervising staff member) This is a massive loss of clinical time!

Suggest - avoid casual contracts.
Look at the evidence around some of these annual mandatory competencies (eg does making us repeat hand hygiene online training every 12 months definitely produce outcomes??)