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 consent to my submission being published

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).

There are few prevention interventions that address the stage between public health awareness campaigns and the time when a person develops a chronic condition. In the case of diabetes 60% of people could avoid or delay diagnosis with targeted intervention: a huge saving to the health system. Working with, for example, WA Health, other Government Departments, Local Government and Health Insurance industry in a joined up approach would allow for reach, impact and shared cost. The Healthy Living programs North and South Metro mostly focus on those newly diagnosed with chronic conditions rather than a strong focus on preventing the conditions. Recently a partnership between Department of Transport, Department of Sport and Rec and Wanneroo Council resulted in 30,000 households being contacted and 10,000 participating households. Results showed significant positive changes in health behaviours. The Let's Prevent Pilot Program will be drawing on successful elements of this program and providing a targeted program intervention to reduce risk of chronic conditions. Shifting funding priority to effective high risk prevention will save money downstream for the State.

Early intervention when a person has developed a chronic condition greatly reduces costs in later life. The cost saving for every person with type 2 diabetes who avoids a complication is over $5000 per year. Stroke costs $12,900 per person in the 1st year; IHD costs $23,000 per person in the 1st year (2 complications of diabetes). Multiple morbidity is common: 67% of people aged under 60 and 91% of people over 60 with diabetes have another chronic condition. We need to work together in chronic disease secondary prevention, especially in conditions with similar risk factors such as Kidney, CVD and Diabetes.

The management of chronic conditions is mostly about self-care or self-management. A person living with diabetes for example, will typically see their GP and other health providers for 8 hours in a year. This leaves around 8,750 hours a year where they are making decisions from day to day in order to best manage their condition. The WA Diabetes Standards of Care 2014 state that on diagnosis, people should be offered structured diabetes self-management education. The National Diabetes Service Scheme (NDSS), funded by the Commonwealth Government and administered by Diabetes WA locally, is leading the country in this area and Diabetes WA has been particularly influential and innovative with cost saving outcomes being actively measured in an ever increasing cohort of consumers. State Health could use the NDSS platform as a leaver and driver of quality service in the State. WA Health should take a systematic approach and utilise this quality platform of National programs with proven outcomes by introducing them as the standard programs for WA. We could then assure many positive outcomes and extend this approach to other chronic conditions.

Fund programs with strong or emerging outcome evidence base. We need to stop doing things that have no evidence or are shown to be ineffective and have the courage to make those decisions. Have commissioning models based on outcomes anticipated and clear quality standards around what is delivered. If we keep doing the same things the same way, we will get the same results. We need to build robust evaluation into any activity undertaken beyond occasions of service measures.

For patient satisfaction, use a validated tool such as the Net Promoter Score so we can start measuring consumer experience consistently. To move patient centred care from a buzz term to reality, measure services delivered with the Health Care Climate Questionnaire, another validated tool which is currently used in all programs across the country via the NDSS and is used for one on one appointments via Diabetes Education Telehealth clinical sessions. Diabetes WA also are currently using the Patient Activation Measure which is validated internationally and can show likelihood of future hospital admission (and reduction in that likelihood post intervention). Diabetes WA would welcome discussion on their evaluation framework and the evaluation tools currently used and their

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potential for application in the current system across all chronic conditions.

Capacity in the workforce to deliver quality self-management and other programs can be achieved through appropriate training and accreditation (quality assessment) of a wide range of health professionals. Too often it is assumed that health professionals can deliver programs with complex behavioural science underpinning them. This is not the case: HP need support and upskilling and peer measurement to ensure they are delivering programs in an effective way. Diabetes WA actively uses these methodologies with great efficacy.

Allow funding within the health sector to be far more flexible to accommodate different models. The funding structures often dictate the types of services which can be delivered instead of the other way around. Even when barriers of coordination and training costs are removed, some health managers put up barriers to engagement due to strict parameters of funding and program delivery structure.

Innovative partnerships and strategies can work well. For example the partnership between Western Australian Country Health Service (WACHS) and Diabetes WA to commence the Diabetes Telehealth Service (the only model of its kind in Australia). Diabetes Educators are upskilling health professionals in the regions and are providing individual consultations to patients all through telehealth technology. The outcomes of this service are very positive and continue to be measured. Diabetes WA are working with Asthma WA to start the process around a chronic conditions hub for telehealth. This type of collaboration should become commonplace (NGO's partnering together and with State to deliver economical scaled up services instead of each NGO developing independent services, all with door opening costs). Health funding models can drive this type of collaboration.

Expansion of telehealth services to outer metro and inner metro consumers. So they can access the right care at the right time and in a way that is convenient to consumers, reduces impact on the workforce, can be scalable if situated in a central location, removes the barriers of distance, reduces cost to PAT and overcomes staffing challenges.

Diabetes WA has recently commenced an Endocrinology service via telehealth . Three clinics and 100% attendance is a testament to both the need and the solution being provided (unprecedented that DNA's are non-existent). The potential is there to fill a very real gap in service in Country WA via Telehealth. Other chronic conditions can follow this model.

Database systems that can move towards integration will greatly improve the efficiency of the health system.

The leadership skill set which will be required to successfully achieve innovative changes in WA Health is a very important resource which should not be overlooked by this review.

Thank you for the opportunity to contribute to the Sustainable Health Review.