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	Mr ☐ Miss ☐ Mrs ☐ Ms ☐ Dr x☐ Other ☐
Organisation	RACP representative on & Chair of the Social Determinants of Health Alliance
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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

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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).

Apart from the last TOR item, there is little opportunity to suggest how to develop a more sustainable health system. One reason is that clinical care only contributes about 17% to health according to the latest US estimate.[1] For the health system to be sustainable, greater attention and investment needs to be directed at the contribution from social and economic factors (45.6%), health behaviours (28.9%) and the physical environment (8.3%).

Even if all the recommendations of the SHR are successfully implemented to improve clinical care, failure to influence the 84% - the main determinants of health - will not reduce the demand on the system from the source upstream [2,3] thereby overwhelming the ability to supply adequate quality health services in future.

One of the most important parts of recommendation 64 of the 2004 Reid Review was that *"the role of Area Chief Executives (ACE) should be focussed on improving and maintaining the health of the Area's population…"* In the text (page 95) the following was ignored with a legacy leading to the problems being faced today;

"A more strategic and holistic view of Area Health Service Delivery is likely to come only with some reduction of the Chief Executives tertiary hospital management responsibilities. The preferred option is to separate the management of Area Health Services and tertiary hospitals… A separate manager would oversee the administration of the tertiary hospital." The time is overdue to properly implement recommendation 64, but a preferable option is for the Director General to live up to the title and to *"…be focussed on improving and maintaining the health of the …* [West Australian] *population"* and for *"…a separate manager* [to] *oversee the administration of … tertiary hospital*[s]*."*

As the main determinants of health are beyond the scope of the TOR and expertise of the panel, a recommendation emanating from this review is for a Determinants of Health Task Force to be established. There are many examples overseas. Here is recent evidence of the trend in the US where they recommend *"Interventions that target multiple determinants of health must take place along the continuum of care and at the same time as traditional medical care is provided."*

As it will take time for a Task Force to be established, preferably within Premier and Cabinet which has power over the determinants of health, it is recommended that, in the interim, the Human Services Directors General group be reconvened but this time including CEOs of relevant NGOs. This will enable the group to tackle the main health and societal issues that do not fit neatly into their portfolios and to explore the "greater than sum of the individual parts" opportunities to promote health. The agency with the greatest potential to promote health, especially amongst the most disadvantaged, is education.[4] This potential prompted Dr Jonathan Fielding, Commissioner of Public Health in Los Angeles to say, *"If modern medicine wanted to do one thing to save lives it would be to deal with the high school dropout problem."*

The Task Force should consider and make relevant to WA the report of the National Centre for Social and Economic Modelling to estimate the Cost of Inaction on the Social Determinants of Health (SDOH) commissioned in 2012 by Catholic Health Australia.[5] NATSEM estimated that if the WHO's recommendations from the Closing the gap in a generation report were adopted within Australia: 500,000 Australians could avoid suffering a chronic illness; 170,000 extra Australians could enter the workforce generating $8 billion in extra earnings; Annual savings of $4 billion in welfare support payments could be made; 60,000 fewer people would need to be admitted to hospital annually resulting in savings of $2.3 billion in hospital expenditure; 5.5 million fewer Medicare services would be needed each year resulting in annual savings of $273 million; 5.3 million fewer Pharmaceutical Benefit Scheme scripts would be filled each year resulting in annual savings of $184.5 million each year. How these savings can be made at a national level is outlined in an Implementation Plan endorsed by about sixty

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organisations that constitute the Social Determinants of Health Alliance (available on request). Again the strategies can be adapted for State level application.

For those who seek evidence of the impact of action of SDOH, the trend is to look to the UK where significant activity has occurred especially when Labour was in power (1997 -2010). But the outcomes are disappointing with five main reasons identified in a comprehensive analysis by Prof K Smith,[6] paraphrased as follows: 1) Despite initially developing relevant SDOH policies, the emphasis shifted over time to interventions to attempt to change people's lifestyle behaviours and/or reduce their health risks i.e. 'lifestyle drift'.[7] 2) Interventions were too limited in time, reach, scope, or intensity to make a difference. 3) Whilst the policies aimed to reduce poverty, they did not seek to reduce income inequalities – a major SDOH. 4) Health inequality policies were subservient to broader social and economic policies. 5) Not enough time may have passed to realise the benefits of attempting to implement SDOH policies.

The Determinants of Health Task Force would need to cognisant of these challenges and ensure their efforts are not sabotaged. However, rather than look to the UK alone it is important to assess the health benefits of the more longstanding policies of Nordic countries.[8] This year the European Office of WHO published key policies for addressing the social determinants of health and health inequities with respect to meeting the UN Sustainable Development Goals. The evidence gathered indicates that actions within four main themes (early child development, fair employment and decent work, social protection, and the living environment) are likely to have the greatest impact on the social determinants of health and health inequities.[9] The first theme is the most relevant for health from the evidence of the Developmental Origins of Health and Disease - one of the fastest expanding areas of biomedical research today.[4,12,5] Fair employment and decent work is not only dependent upon being healthy but also is influenced by success in education for which preschool health interventions can be crucial to assist with school readiness. In addition, investment in the child health brings a greater return than expenditure in later years when the demand is greater - especially with the demographic shift of baby boomers.[13,14]

The remit of the WHO did not include the role of health systems so it is important to emphasise that the Inverse Care Law[15] has and still is being applied in WA and needs to addressed. In addition the related principle of proportionate universalism needs to be applied i.e. to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.[16]

The following is from this year's special edition of the Lancet on Investing in the foundation of sustainable development: pathways to scale up for early childhood development.[17]

> Failure to scale up has severe personal and social consequences. Children at elevated risk for compromised development due to stunting and poverty are likely to forgo about a quarter of average adult income per year, and the cost of inaction to gross domestic product can be double what some countries currently spend on health. Services and interventions to support early childhood development are essential to realising the vision of the Sustainable Development Goals.

WA's Child Health Services is not in a powerful position to take up this challenge. It has suffered from managerialism. The Child Health Policy position was abolished many years ago leaving the sector "rudderless". I recall this was the word used in Prof Holman's four volume review of Community & Child Health Services in 1990. He also discovered 'psychosocial morbidity' and made many recommendations to explore and address this emerging challenge to child and future health as well as suggestions to overcome the lack of leadership. The recommendations were not accepted with consequences being

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realised by some young adult West Australians today. From being a comprehensive service across the State in the seventies, Community Child Health services, like Public Health, suffered from expensive departmental reorganisations into Areas, Districts, Authorities, etc. with a variety of directors, managers, heads of department coming and going along the way. No wonder there is so much demoralisation in this sector. A Commissioner of Child Health is warranted to give the attention that is deserved to this most vital component of the Department of Health's responsibility with the greatest potential to ensure sustainability of the WA health system.

An emerging approach to funding prevention interventions are social benefit and health impact bonds.[18] However there are the potential risks, drawbacks, benefits and alternatives to explore.[19]

Whilst significant return on investment can be realised by implementing strategies to address SDOH, a recent Productivity Commission report claims, *"… a DRAMATIC overhaul of Australia's health system could boost the economy by $200 billion over two decades."* Many of the suggestions answer several of the issues in the TOR not needing to be duplicated here. But a quick glance of the health section of "Shifting the Dial" Productivity Review seems to have not only overlooked SDOH but it also has not referred to a major potential for savings. The same oversight was made in a review of the UK's National Health Service according to an opinion piece by Molloy; *"*[there is]…*one pot of money that sits curiously unexamined, glistening and untouched. It's the cost of the* [UK National Health Service] *'market' itself. Administering the hugely expensive artificial 'marketplace' created by successive governments to allow both NHS and private 'providers' to compete with each other to offer services to NHS and other 'purchasers'..."* [20]

Since my first employment WA Health System in 1974 the growth in administration and management of the WA health care industry appears to have exceeded the gain in health of West Australians. The law of diminishing returns has been enacted as demonstrated by the slow improvement in the health of the most vulnerable[21] with plenty of challenges for WA remaining as indicated in the recent AIHW report with its comprehensive assessment of SDOH.

Whilst medicine is justifiably evidence based, the proliferation of management has occurred with multiple changes presumably based on theories and ideologies as opposed to evidence requiring ethics approval. The ideas being adopted seem to follow the UK but a few years later when the British are beginning to abandon their failed experiments.[22,23] The consequent frustration generated in the UK led to an amusing rationale for the *"… establishment of ethics committees to review all future redisorganization proposals in order to put a stop to uncontrolled, unplanned experimentation inflicted on providers and users of the health services".*[23] Whilst this 'surrealistic mega-analysis' was conceived in jest, it is no joke that the WA taxpayer has unknowingly supported the exponential growth in the management of its health industry with limited return in relation to health outcomes.

Positive health outcomes can be achieved by going beyond 'patient centred service delivery' to patients as customers becoming owners of their health care service. By adopting this approach rural Alaska's 'Nuka' system of health care has cut hospital emergency room visits by 42%, hospital days by 36%, specialty care by 58% and routine doctor visits by 30%. Additionally binge drinking declined by 30%, suicides fell by 66%, strokes plunged by 62%, all falling along with deaths from heart disease and cancer to about the national average.[24,25] The success has been recognised by health leaders from the UK,[26] Singapore, Canada's British Columbia, but – so far - not Australia. The SHR has the opportunity to learn how Alaska's Sounthcentral Foundation model of care can be implemented in WA thereby reducing costs whilst also improving health. A delegation needs to brave the cold or their leaders can be invited here to share their experience.

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