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

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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.

Sustainable Health Review

Dear Panel,

I am a retired psychiatrist and former employee of the Health Department of WA (HDWA). As I am also a senior, I can also count myself as an occasional patient in our health care system which has served me well. I commenced working as a medical officer at RPH in 1957, and experienced a range of health care services in WA, interstate, and overseas since. My special interest has been the delivery of health care in whatever setting I was engaged.

Health costs continue to rise

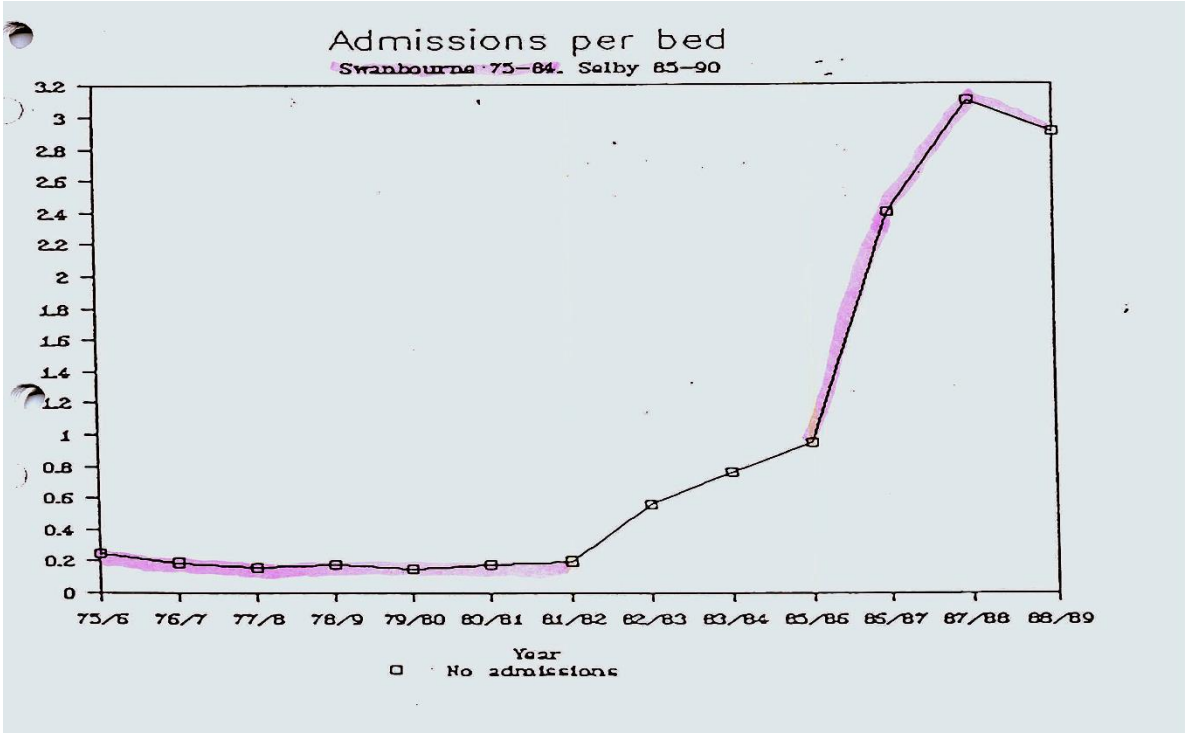
I commenced a posting to Claremont Hospital in 1964 and was immediately aware of the gross disparity between resources at a major general hospital, and a secondary one. It was very clear that to provide basic personal needs, and a humane environment, was firstly a financial hurdle. In my registrar post in England I published a short study in 1968, demonstrating that medication was often given when not clinically essential, and that cost savings could be redirected to providing better care. My desire to ensure that health funds were spent thoughtfully and efficiently, remained with me throughout my employment. Repeatedly it was clear that, unless one could be fully informed on financial decisions affecting every aspect of patient care, then waste and poor services could result. Yet these decisions were often hidden, remote or entirely unknown to staff, including senior clinical care staff.

I was the psychiatrist-superintendent of Swanbourne Hospital from 1980 onwards until its closure in 1985. As such I was responsible not only for clinical and mental health care, but also for the ***welfare*** of all patients. This gave me insight into the operations of an entire hospital service, which at the time was grossly neglected, compared with standards of today. Each month I was provided with an itemised account of expenditure on all medications, which I signed as approved. This was an excellent opportunity to illustrate the interplay of clinical and financial prudence. Any untoward expenditure on medication could be promptly reviewed and corrected if necessary. I doubt this still occurs. The role of psychiatrist-superintendent was discontinued.

I had the good fortune to be engaged at a time when WA Mental Health Services (MHS) was an independent organisation, whose Director reported to the Minister for Health, with no intermediaries. With great staff assistance and cooperation, Swanbourne Hospital was closed and all patients relocated into new community based services. These offered a ***range*** of different forms of care previously unavailable.[1]

[1] Hills, NF, Asylum to Mainstream, Personally published booklet, February 1996.

One of the few indicators of the growth in service provision achieved is attached below.



Admissions per bed, Swanbourne Hospital (1975 - 1982, All units, Psychogeriatric services (1982 – 1986), and Selby Lodge (1986 – 1989).

The chart illustrates that until the Campbell-Miller report in 1981-2 the admission rate to Swanbourne remained low and steady. At the time there had been one psychiatrist superintendent responsible for around 400 patients at Swanbourne. The arrival of a second qualified and experienced psychiatrist made initial gains possible from 1982 onwards, and these increased as additional psychiatrists were appointed and new service models developed.

It is important to note that these figures are of patients seen and discharged, not numbers of beds, which subsequently were reduced substantially. Data collection of this type was discontinued around 1986, so the 86-89 results are based on Selby Lodge alone.

In 1984 the MHS was absorbed into what became the HDWA, and almost immediately the breakdown of carefully planned State-wide services for older people occurred. Although most services were based around general hospitals, local unit

management teams were directed by hospital managers with little comprehension of efficient service delivery in mental health. Resources placed into the community for older people were commandeered or misused in various ways.

Central to this change has been the loss of basic financial information and long-term planning. My final experience was as Executive Director of the Selby-Lemnos Hospital, where we had a well-established multidisciplinary management team. However, with successive government and HDWA changes, the ability to manage and plan service delivery and future development was largely lost.

A serious problem was lack of timely and accurate financial details. I could contrast this with my experience as a Councillor at the City of Nedlands, where I was a member of the finance committee and other committees. Although Local Government is often criticised for various reasons, I learned a considerable amount about how an efficient small bureaucracy should operate. As an example, once the budget was approved, Council staff could proceed the very next day to commit funds and resources to agreed projects. At every monthly meeting of the Council finance committee we were provided with itemised accounts of expenditure down to dollars and cents. The total budget for the City was close to the total budget for Selby-Lemnos Hospital, around $6M.

Our management team at Selby-Lemnos consistently received their budget information months after the State budget was handed down. We could be many months sailing blindly into the next financial year before we knew our position. Savings that had been made were spirited away, and we were faced with finding even more savings, rather than planning for new and better services by utilising efficiencies.

As only one example of the bureaucratic problems faced, I mention the Koolyara Mobile Day Hospital which was initiated by our staff, operating from the Selby-Lemnos base. This provided a basic outreach mental health service, for older people in the Northern suburbs near Joondalup. No service for mental health of older people was available there at that time. We mounted this from a shop-front base in Wanneroo Rd., in leased premises costing around $12,000 per annum of our budget allocation. The program was later directed to move into offices at Joondalup Health Campus, where no information on anticipated budget or operating costs could be obtained.

The arcane, inaccurate, and hidden costs of providing a government health service are kept in a “black hole”, which no-one -- clinicians, patients, or politicians can penetrate. It is this absence of elementary financial data which I believe is at the heart of the gross over-expenditure which government is experiencing. I have long believed that many problems are not due simply to insufficient funds, but to lack of transparency and control at the coalface. Health services are expected to operate in a manner expected of corporate businesses, yet are blindfolded and have one hand tied while attempting to do so.

I have been impressed with the writing of EF Schumaker, whose book was titled, "Small is Beautiful; The Study of Economics as if People Mattered".[2] As the HDWA has grown, in common with many other large government corporate bodies, it has taken responsibility for decision-making away from those people closest to the community and patients, shifting it further from sight. Health care does not rest wholly with the major hospital centres, vitally important as they are, but it starts in the community, in patient's homes. Unless this is appreciated and acted upon, claims that health aims are "patient centred" are meaningless.

Commonwealth funding

When planning for the replacement of Swanbourne Hospital, it was an opportunity to redirect the provision of services for mental health of older people. This was detailed in the Campbell-Miller reports of 1981-2.[3] The plans envisaged a range of care options that were community based and dispersed in the first place around the metropolitan area, to be followed with coverage for rural and remote regions.

The plans provided for four 24 bed Joint Psychogeriatric/Geriatric Assessment Units (JAU) at each of the three Teaching Hospitals. This plan was based on documented evidence that each hospital was already catering to this number of patients, although not in purpose built facilities. The fourth facility was a MHS managed unit, the Bentley Hospital JAU. This was the only JAU built, but was shortly taken over for other purposes while in the charge of RPH. Note, I am not referring to the 48 bed Lodge unit built at Bentley on the East side of Mills St. which was already in operation.

Five psychogeriatric extended care units (PECU's), named Lodges were purpose built. It is extremely important to recognise that, in keeping with the terminology then in use, this meant ***extension*** of hospital resources ***into*** the community, not length of stay for patients. The architectural design of each PECU had provision for a community team and offices, Day Hospital with treatment facilities, and an inpatient element with special design features. Each PECU was located on a general hospital site, except for Selby lodge in Shenton Park. Selby was only 1 Km from SCGH, and, as I held a joint appointment with that hospital's Extended Care Department, close liaison was encouraged. All referrals from the SCGH wards and local community were accepted daily and handled through Selby-Lemnos.

Based on review of the patient requirements at the time, a hostel type facility was also included. This emerged as a radical concept for the time, comprising eight cottages in a normal suburban street environment at Eden Hill. This unit provided not only step-down step-up care for patients, but also a local community based service

[2]

[3] Campbell C and Miller W, Health Services and Facilities for the Mentally Ill in Western Australia, 1981.

for older person's mental health. Later, mismanaged by the health service responsible, it was abandoned.

These three types of facility were viewed as a suitable model, to progress the development of mental health services for older people into the future. The Campbell-Miller plans envisaged state-wide services for older persons' mental health which have not eventuated. Fly-in fly-out consultations are a limited solution for regional areas which are now major towns. Services have remained Perth-centric and limited in scope despite the much-quoted increase in the aged population.[4]

Beds	2005	1985
Lemnos	closed	88
Selby Lodge	40 beds	48
Osborne Lodge	24 beds	24
Swan Lodge	16 beds	24
Armadale Lodge	8 beds	24
Bentley Lodge	27 beds	48
Bentley JAU	closed	48
Moss St. Lodge	closed	18
Eden Hill Cluster Homes	closed	24
Mercy Hospital	12 beds	
Fremantle Hospital	16 beds	
Total	143	322
Beds closed since 1985		179

Victoria

Around 1985-6 I visited Melbourne and toured one of their new "Psychogeriatric Nursing Homes" at Maribyrnong. This was built as part replacement for Wilsmere Hospital, by an architectural firm which had been involved with the Swanbourne Hospital replacement, and had many similar features. Conspicuous at the entry door was a brass plaque, stating that it was a Commonwealth Approved Nursing Home.

I enquired how they had managed to gain this approval and funding and was told that the local member of Parliament was a close friend of the Prime Minister. A similar arrangement was put in place in Hobart with the Alzheimers Nursing Home, and I gather that the Ritz nursing home in Sydney also operates in this manner.[5] Oakden Hospital in South Australia, subject recently to serious criticism, has also been part Commonwealth funded.[6] This shared funding system has grown without

[4] Hills, NF, Promise and Practice: WA psychiatry for the elderly, Australasian psychiatry, Vol. 3, No 4, August 1995.

[5] https://www.lexology.com/library/detail.aspx?g=37d4b0ff-1aec-44d9-97ad-157401b2697d

[6] Groves A, Thomson D, McKellar D and Procter N. (2017) The Oakden Report. Adelaide, South Australia: SA Health, Department for Health and Ageing.

overall reviews, and there have been reports of problems with oversight. How many such arrangements are in place around Australia I cannot determine, but I suspect there are many more than we may be aware.

High-dependency units

Flawed logic from the HDWA has perpetuated the concept that removal of a handful of very challenging long-term patients, somehow created more places for acute admissions. Instead of assisting the Lodges to respond quickly and treat more new patients, they provided funds to the NGO sector to duplicate one segment of the existing service. The Commonwealth provisions guarantee that once a placement is made, patients cannot be moved on when appropriate. In effect, they have replaced the slow-stream but steady turnover of a minority of Lodge patients, with permanent care. None of the MHS psychogeriatric units ever maintained a permanent care policy from the outset.

A parallel situation would arise if the Transperth rail service was overcrowded when leaving Perth station, so all passengers on the longer journey to Mandurah were taken off to give priority to those leaving the train at the nearest stations, regardless of their individual needs. This would be a nonsensical solution, yet this has been the approach of HDWA, creating the illusion it was addressing the problem.

In WA, there have been only two similar arrangements to “top up” funding of aged care facilities, to manage long-term older people with challenging behaviours who could not be managed in standard aged care facilities. No evaluation of this program has been conducted to my knowledge. The waiting list for admission to the 16 beds is reported to be two years. I have no reason to doubt that the service provided is of high quality and appreciated by carers. This role was one previously undertaken by the Lodge units without difficulty, units were dispersed around the metropolitan area, patients were reviewed regularly and discharged when possible. The designation of all Lodges as “acute units” under the Mental Health Act, simply increased pressures to place long term patients elsewhere, without addressing the need for prompt community based assessment and admissions. This type of approach has been described as “recreating the mental hospital “back wards”. Reports of Oakden and the Ritz in NSW suggest this may be a correct description. We can learn from other countries and States, but we can also learn from their mistakes.[7]

Even if the top-up funding approach was viable, the Mental Health Commission has been unable get even one 10 bed version up and running in 18 months, since it announced in May 2016 that funds had been provided. In 1982, MHS could give permission to the Eden Hill project in six weeks.

[7] William H. Fisher, Jeffrey L. Geller, Dana L. McMannus, "Same Problem, Different Century: Issues in Recreating the Functions of Public Psychiatric Hospitals in Community-Based Settings" In 50 Years After Deinstitutionalization: Mental Illness in Contemporary Communities. Published online: 04 Jul 2016; 3-25. Permanent link to this document: https://doi.org/10.1108/S1057-629020160000017001

Comparisons with other States

WA Public Hospitals cost 20% more than national average[8]

The source of this contention is not stated, but a page of diagrammatic media grabs offered. I have for many years been suspicious of national statistics. As far as I am aware most, if not all, depend on a variety of voluntary inputs from States. I am not aware of any fully independent audit, to ensure like service model is always compared with like. Service models vary from one State to another, and it is a nonsense to believe that some manipulation does not occur.

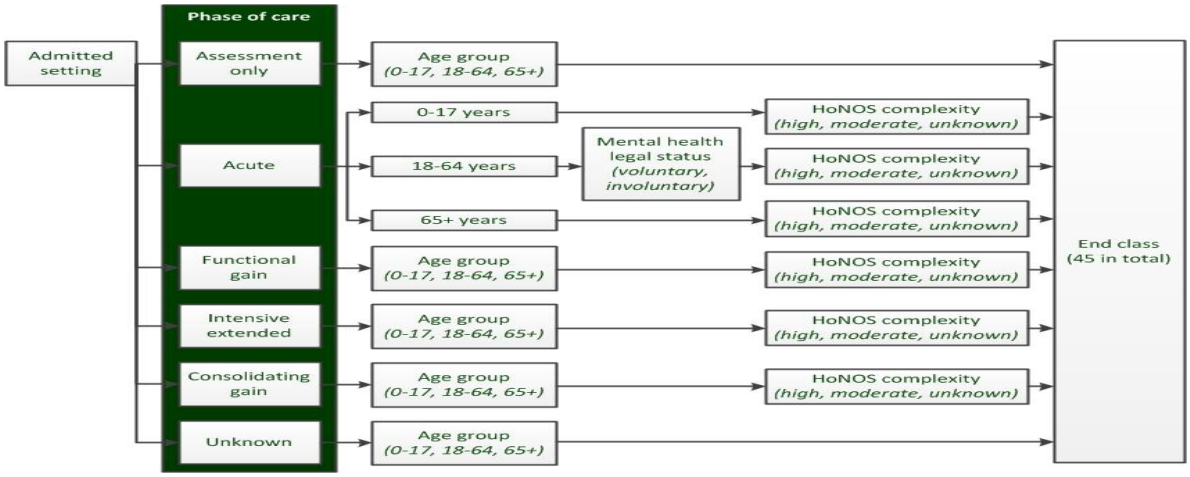
In 1985, I tried to determine just how many beds were provided in Victoria for older people: my request for information was declined. I believe each State protects, or hides from scrutiny, what is provided. Some interstate statistics I have seen were frankly unbelievable. Not that I believe bed counts illustrate the full picture. A bed is just a metaphor, that represents a range of resources from cleaners and gardeners to health professionals and managers. The policies and philosophy behind how beds are utilised are far more relevant.

The extent to which other States have been more successful in cost-shifting to the Commonwealth is unknown.

Policy guides

The Independent Hospital Pricing Authority (IHPA) web page on mental health provides a chart, intended to describe phases of care in mental health inpatient units (see below). The top item is “assessment”, which should not be a priority for inpatient mental health aged care. Assessment should only be undertaken in the patient’s home or place of residence in the first instance, and must be done promptly to avoid referral to acute hospitals and ED. Admitting elderly patients to hospital only for assessment, has been shown to increase risk of iatrogenic and other misadventures in older people. I mention this to highlight the complexity of the task, and the possible unreliability of national views which may not appreciate individual State and service policies.

[8] No reference given in document page.



$7 billion infrastructure investment

I cannot comment on the wisdom or otherwise of a $7Billion investment in infrastructure, except to note that from media reports of problems with commissioning of new general and children's hospitals, there appears little cause for satisfaction. Harking back to Schumaker I suggest "Big may not be better". I visited the well-recognised Maudsley Hospital in London several times, and noted that it has an eclectic mix of new and older facilities on site, where it has been since 1923.

The site of Graylands Hospital carries a considerable range of valuable services, which do not deserve the opprobrium placed on it by politicians of both parties. Description of it as needing to be "blown up", belies the fact that no patients are currently in the original Claremont Hospital buildings. It is thought in some quarters that the sale of the site will be redirected to mental health. A WA Parliament Committee was told this was not possible, as funds would go to general revenue. The same was true regarding the Swanbourne Hospital site, as I found following enquiries through a question in Parliament. Funds redirected to mental health were stated as "Nil".

While some Graylands wards are poorly designed, shifting this role to general hospitals has been only partly successful. In my capacity on the Mental Health Review Board I visited Alma Street unit at Fremantle Hospital, where I considered the detention of some patients in such confining conditions for months at a time to be inhumane, and not in the interests of their mental health and rehabilitation.

The waste of relatively new mental health facilities at Swan Districts Hospital is another example of poor decision-making. In the quest for cost benefits from privatisation it appears that State resources have been lost, and yet cost over-runs are still occurring.

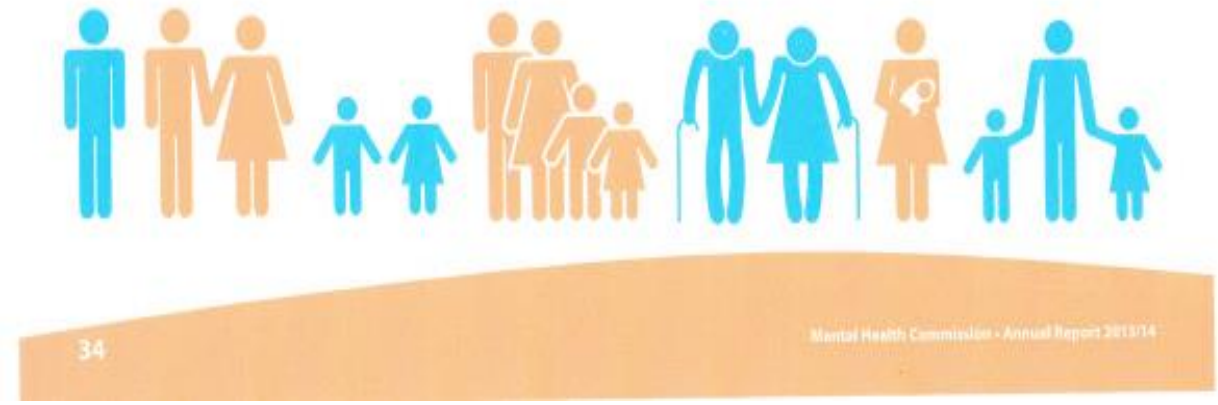
Ageing population

Once again, the ageist HDWA pushes the view that the older population is a problem, and a negative result. In fact, the longer life and good health of most aged

people should be celebrated. The HDWA consistently blames older people for occupying beds in acute hospitals, having discarded the important role of aged care to the Commonwealth wherever possible. Cost shifting to private and NGO aged care has been a deliberate but unstated policy. While that sector has many virtues and advantages, it should not be the basis of abandoning the role of the State services in prevention, treatment, and restoration.

The Mental Health Commission pays little attention at all to older persons mental health, having been seduced by the flawed and misused results of the 1987 ABS survey, which helped shift the focus entirely to younger aged people. ABS surveyed only 12,000 persons in the whole country, for a limited number of diagnostic categories, and did not interview anyone in aged care homes. Organic illness, dementias or delirium were not included. The survey was soundly criticised by Brodaty et al, yet continues to generate misplaced attention.

The attitude of the Mental Health Commission can be illustrated in this diagram from one of their Annual reports.



When I complained to the Commissioner that older people were not typically bandy-legged, hunched and on walking sticks, a media officer defended their position!

Reports

There has been no shortage of reports expressing concern regarding failure to plan and implement adequate services for older people in WA.[9] This last mentioned is only one of many that have been simply ignored.

Technology and innovation

[9] Discussion Paper: The key challenges associated with providing mental health care for older adults.

A submission prepared by the Older Adult Mental Health Planning Advisory Group to inform the development of the State Mental Health Policy and Strategic Plan 2010 – 2020, July 2009.

In 1984-5 the psychogeriatric unit at Swan Lodge was provided with a computer and a research assistant, to monitor the patterns of admissions and discharges to all older adult mental health units. This was funded by MHS, and provided my office, with monthly date data on each unit. Vacancies and referrals could be redirected as needed by fax. The HDWA regionalisation developments resulted in an instruction to Swan Lodge to cease this data collection. At the same time, my office of four staff was effectively stifled from making any further contributions and closed. There has been no comparable data feed-back to clinicians since then, and each has gone its own way. This is despite considerable growth in availability of even better IT resources.

Annual reports from each MHS service were once a regular feature and included financial details. Hospital Superintendents could comment on positive and negative concerns for tabling in WA Parliament. The last such report is available at Graylands Library and dated 1984. Hospitals do not now produce their own Annual Reports, but instead we have glossy HDWA and MHC media approved publications, with carefully managed content.

Recently I found enormous difficulty obtaining basic statistical data, without recourse to FOI applications. No doubt many statistics are kept, but they are not freely available to the public or for research. This contrasts significantly with the ease with which data can be found regarding NHS mental health services in respect of numbers of detained patients, reports of the Care Quality Commission, etc.

Any small business that cannot track their progress on a regular basis, and as often as necessary will soon fail. The same applies to large government services. Clinicians must be able to get feedback on unit performance daily. It was our unit policy at Selby-Lemnos to review the visible waiting list every morning to ensure it remained as short as possible. However, unlike in elective surgery, this appeared to serve as a perverse incentive; absence of a long waiting list for service suggested there was no demand, and any vacant beds were ripe for removal.

Technology can offer considerable benefits, but is not a panacea. If all it does is centralise and remove information from clinicians at huge cost, it is counter-productive. Health care is a human service, and we all lose if that fact is forgotten.

A new approach that addresses a full range of health services from the ground up, instead of putting all resources into the new “cathedrals of health-care” is required. State Government has a primary and historic responsibility to the community, to provide health care to those in most need. This cannot be shifted to the private and NGO sector alone, although close cooperation is essential. State services should match and be at least equal, to any comparable health service, not a poor relation.

The Commonwealth Government has attempted to intervene in dementia care services, largely to address a shortfall in State provision. This should not be a role for a Federal Government, remote and lacking sound policy direction. It is also opening the way to duplication and waste.

Thank you for the opportunity to express myself on this vitally important topic. Best wishes to the panel with their efforts to regain some common sense, to a sector where it has been lacking for several decades.

Dr. Neville Hills

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