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	Mrs
Organisation	Health Facilities Planner, Ph.D. Candidate in Health Economics, Curtin University, W.A
First Name(s)	Rhonda
Surname	Kerr
Contact Details	[redacted]

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).

SUSTAINABLE HEALTH REVIEW

The 2017-18 WA Budget noted that Western Australia "is under is under sustained pressure as the demand for health services continues to grow at a rate that exceeds sustainable capacity". Provoking the questions- what is sustainable health care and how should we understand and express capacity? But also how do we make sustainable services for the future?

SUSTAINABLE HEALTHCARE

Sustainable healthcare has two important components- financial sustainability and environmental sustainability.

FINANCIAL SUSTAINABILITY

At the core of a sustainable system is meeting the expectations of Western Australians as:

- potential or actual consumers of health treatment services (requiring access),
- as Australians with strong expectations of public health and safety (appropriate services), and,
- as taxpayers funding the public health system (allocative and productive efficiency).

ACCESS

National standards affirm that all Australians are entitled to access safe, high quality health care and that patients have the right to respect, timely communication and participation in decisions about their healthcare(Australian Commission on Safety and Quality in Health Care 2009). While equitable access for Western Australians should be considered in terms of access to diagnostic and curative services, access should also be more broadly considered as "provision of health services in a way that provides an equal opportunity for all citizens to achieve maximum health"(Bowen 2000)

Disparate health outcomes across rural and regional Western Australia identify that not all patients have acceptable access to diagnostic and curative services(Coory M D 2013; Ho K M 2008; Tomlin 2013; Hall 2004) (Blokker BM. Janssen JH. van Beeck E. 2010; Hall SE. Holman CD. Platell C. Sheiner H. Threlfall T. Semmens J. 2005; Lee AH. Yau KK. Wang K. 2004) This is particularly distressing for children where:

• Hospitalization rates for Gastroenteritis for all children, but particularly those aged between 6 and 11months, were higher in rural and remote regions. For aboriginal children the rates were 259.3 per 1,000 children, and for non-aboriginal children were 22.7 per 1,000 children. (Moore HC. Manoharan KR. Lim FJ. Shellam G. Lehmann D. 2013)

• Reviewing the survival of Australian children with cancer, a Dutch study team found that "Aboriginal children present with a somewhat different pattern of cancer, are less likely to be enrolled on studies and seem to have increased mortality. There is a need for improvement in

study enrolment, treatment delivery, care coordination and suitably supported residential facilities." Aboriginal children who have cancer seem to be younger, come from more remote areas and have poorer survival rates than other child patients. (Rotte L. Hansford J. Kirby M. Osborn M. Suppiah R. Ritchie P. Tapp H. Rice M. Revesz T. 2013)

These studies show that if we are to address the problem of inequality in health, patients from the country and lower socio-economic areas require better access to high-standard medical facilities and clinical services including preventative, diagnostic and curative services.

The challenge of unequal health due to limited access to appropriate services for country people is compounded by their poor access to primary care, therapies and rehabilitation services. Similarly preventative health services are not achieving desirable outcomes for country Western Australians.

A number of factors influence access to preventative, diagnostic and curative services. Access to primary and secondary health facilities, technology, NBN connection and effectiveness, cost, distance and time are factors. As potential consumers of health services Western Australians are also conscious of increasing out-of-pocket costs for private health care.(AIHW 2017) Transport costs for rural families should also be considered in establishing the total costs for rural people.

For metropolitan patients activity-based funding provides for required public inpatient and outpatient care, supplemented by Commonwealth-funded private medical services. Rural health facilities frequently rely on block funding for recurrent expenditure and priority-based funding for capital for health facilities. Activity-based funding for patients admitted from the country pays for treatment in regional hospitals and Perth. So funding for care of rural people is distributed to a range of providers in an episodic fashion, rather than being patient-centred. Activity-based funding aligns funding with patient outcomes as funding from both the Commonwealth and the State pays for specific patient outcomes. There is an opportunity to consider funding a broader mix of health services to give equal opportunity for all Western Australians 'to achieve maximum health' through better linkages, shared funding and investment.

Capital allocations for facilities, medical equipment, IT and communications technologies however are now entirely state-based. For some rural Western Australians accessing the platforms for information, consultation, diagnosis and treatment is difficult. While capitation systems in health resource distribution have not always proven successful, activity-based funding provides an opportunity to align capital funding for technology and facilities to desired patient, or population, outcomes for rural patients to ameliorate the tyranny of distance. In part, the problem for rural Western Australians may arise, from the poor alignment of funding mechanisms with the outcome of maximising the health of rural people. It also gives the Commonwealth an opportunity to support mutually-desired health improvements for rural Western Australians in an innovative, technology-supportive mechanism.

APPROPRIATE SERVICES

Australian Governments have begun codifying community expectations of health, and particularly hospital services, creating the Australian Charter of Healthcare rights, the Australian Safety and Quality Framework for Health Care and the National Safety and Quality Healthcare Standards.(Council of Australian Governments 2011; Council of Australian Governments(COAG) 2011; Australian Commission on Safety and Quality in Health Care 2011,

2012; WA Parliament 2016) These offer a focus on a respectful, multilayered, integrated approach to the patient, recognising context for the individual and enhancing illness prevention and health promotion.(Stewart 2001) Rather than a hospital-based approach, patient-centred care recognises that patient engagement is vital in effective healthcare and that patients' individual background and experiences are important in delivering safe and effective care.(Australian Commission on Safety and Quality in Health Care 2011) (NSW Clinical Excellence Commission 2013)

Guidelines developed by the NH&MRC with the Australian Commission for Safety and Quality in Healthcare identify appropriate care delivery for a range of patients. Similarly state-based guidelines for the care of specific patient groups have been successfully developed in NSW, Queensland WA and by peak clinical organisations(NSW Agency for Clinical Innovation 2017; Queensland Maternity and Neonatal Clinical Guidelines Program 2012; Acute Coronary Syndrome Guidelines Working Group 2006; CARI 2016; Bannister 2006; Mitchell C 2015; SA Health 2014). The process for assessing guidelines is on-going.(Antioch 2017; Ghersi 2015; Quaseem 2012) Health facility guidelines have been extensively used in Australia for more than two decades(Australasian Health Infrastructure Alliance 2004-2015).

The level of appropriate care for Western Australians can be identified using clinical pathways based on certified practice guidelines built on the platform of national and state guidelines, similar to Healthpathways. Funding should fund appropriate standards, now, and for building future service delivery. Clinical pathways for chronic disease based on guidelines offer a platform for the full range of services from preventative, diagnostic and treatment services to include monitoring and management. However IT funding and communications system development remain project-based rather than embedded systemic funding for 'the way we do health care' now and in the future. Connectedness, real-time data and patient-centred data analysis require investment to achieve safety and quality standards and improve efficiencies in service delivery.

ALLOCATIVE, PRODUCTIVE AND DYNAMIC EFFICIENCY

Financial sustainability for the WA health sector requires allocative, productive efficiency and embed dynamic efficiency. The optimal distribution of assets to achieve the greatest community wellbeing or outcomes for that use of the money (allocative efficiency) is a key component of achieving distributional efficiency. But so is maximising the productive efficiency of hospitals by providing appropriate capital resources to maximise the productivity of skilled labour for the level of funding. The return on public investment in hospitals is over many years so Western Australians expect capital expenditure to be able to manage changing environments (dynamic efficiency)(Abel et al. 1989; Productivity Commission 2015; Rumbold 2015; Hollingsworth 2003; Duckett 2008; Duckett 2014; Productivity Commission 2009, 2017). A component of dynamic efficiency is an expectation of environmental sustainability.

Activity-based funding is an opportunity to align patient outcomes with improvements in efficiency. Driving efficiency through activity–based funding at the hospital level and beyond to the patient level has proved effective in Victoria and NSW and to a lesser extent in Queensland. The labour elements of each diagnosis-related group (DRG) are routinely costed as are the consumables for each DRG. The missing element to determine the level of efficiency is the capital allocated for each patient episode.(IHPA 2011, 2014; NHHRC 2009) This is the topic of my doctoral studies in health economics "Can diagnosis-related capital facilitate more

appropriate, sustainable and innovative acute health facilities?" Early results have identified three key findings of relevance to this review:

- Capital used in contemporary patient care remains valued in terms of old models of care.
- in a time of increasing technological change, capital funding for Australian public hospitals has been below replacement levels for all but two of the last 40 years(Kerr 2014)However the appropriateness of the investment funding for contemporary care is infrequently challenged.(Reid 2004) For example investment in Rockingham Kwinana Hospital stages 1 and 2 were separated by 40 years yet the dynamics of health delivery change more rapidly.
- The NHHRC acknowledged the need for the cost of capital to be included in Activity Based Funding.(NHHRC 2009)
- Duckett and Deeble argue that on efficiency grounds capital responsibility, and therefore information, should be available to health service administrators.(Deeble J 2002; Duckett S 1995)
- The replacement costs for capital consumed providing hospital services are rising substantially and are estimated to be over 9% of recurrent expenditure per annum.(Kerr 2014)
- Scope for translation and innovation (defined as evidence-based improvements in clinical care) is not included in capital funding systems focussed on replacement of past assets.
- Capital is not fully supporting improved productivity in clinical care
- Workforce sustainability is a major concern with an ageing medical and nursing workforce(SCRGSP 2017),
- Opportunities to enhance labour productivity in clinical settings could be enhanced in WA in the way they have been in NSW and Queensland hospitals.
- When the cost of medical labour is 'sticky downwards' with competition from the private sector driving up costs(Boxall 2011) opportunities for clinical redesign(Stokes 2011), innovation and labour substitution are not systemically supported in the capital funding system.
- Health information systems, patient data collection and analysis in real time provide opportunities for improving clinical outcomes, reducing costs (shorter lengths of stay, reductions in unnecessarily repeated tests and telemetry to monitor patients at home or in a medihotel)
- Allocative efficiency has four characteristics that are not evident in Australian investment in public hospitals. Effective funding for establishing better patient-centred communications systems in health care are important to increasing productive efficiency (Productivity Commission 2017)
- Dynamic efficiency is about preparing for the next steps

- environmental sustainability, energy use and carbon footprint are not systemically managed in Australian healthcare.
- It has been estimated that up to 60% of public sector energy costs in Victoria are generated by hospitals.(Burger 2010) Sustainability is a significant issue for acute healthcare with high energy costs and carbon emission particularly in ward areas and surgical services. (Australasian Healthcare Infrastructure Alliance 2011) Lighting, hot water, heating and cooling, 24/7 operations and the requirement to have comprehensive backup power generation place heavy energy requirements on hospitals.(Burger 2010)
- Typically Australian hospitals improve their systems and environmental standards at the time of redevelopment. Many WA hospitals have been redeveloped and improved their standards however lowering energy costs for all hospitals could be strategic focus with environmental and financial benefits.
- A systemic approach to energy use and sustainable policies are required for WA health buildings and services to display dynamic efficiency.
- My research has identified the most effective health systems have developed a different approach to capital allocation that invests in the treatment, the patient and the outcome. As a forthcoming article will identify there are specific qualities of capital aligned to productive and allocative efficiency that can affect improved productivity and improve access for patients. Improved transparency is achieved when patients and the community can identify investment and costs for care in units they can understand such as the diagnosis group. Resilience in difficult economic times has been found in health systems that have:
- adequate levels of public spending on health,
- information on the cost-effectiveness of services
- the political will to address inefficiencies.(Thomson S 2014) Page 160)
- had invested in efficiency, and
- strengthened the design of transparent health financing to be more explicitly linked to population health needs (Thomson S 2014)

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