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 ☐
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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

x☐ 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).

Leveraging existing investment in Primary, Secondary and Tertiary healthcare, as well as new initiatives to improve patient centered service delivery, pathways and transition.

Department of Health has identified populations from South East Asia and Sub Saharan Africa as target population for Chronic Hepatitis B and C. The Western Australian Hepatitis B and Hepatitis C strategies 2015-2018 have provided guidelines to improve health outcomes in people living with chronic hepatitis B and C.

However, in addressing these defined strategies and actively engaging these communities in working with existing healthcare services the transfer of what has been identified as strategies cannot be easily translated into workable and outcome driven strategies especially in working with these communities. In a recently funded program by the Department of health for prevention and treatment of Blood borne viruses with these populations, Multicultural Service Centre (MSCWA) had several experiences that highlighted the need for innovative ways to deliver the required actives of the funding. Through the several challenges experienced and first hand experiences of working with the target communities, MSCWA's team had to take into consideration these challenges to plan activities to achieve the outcomes for these populations. Several hundred people from these population were put through the testing process and that exercise in itself expected innovative ways and "outside the box" planning. Although the health care services exists, accessing them is the main issue. The project identified several barriers to access to services at every level from primary to secondary.

From this project and several other projects run by MSCWA, it is highly recommended that these experiences to be taken into account in delivering not just healthcare for Hepatitis but for several chronic diseases and Mental health.

The objective of this submission is to gain interest of the department in making the population from these countries part of the decision making in any future planning as to date, there is limited involvement of the most vulnerable population in help plan what is most effective for them.

The question: How can we best leverage existing services to make this a more inclusive and effective strategy in addressing the health needs of these target populations?

1. Re-examine and change the way Cross cultural workshops are delivered. They are primarily driven and delivered by main stream agencies and more fitting for main stream population but there is definite gap in employing the expertise of people who come from these communities, work and understand these communities better.
2. Making use of bilingual support workers more accessible and training them to acquire basic knowledge of these health messages as they are more likely to have a more effective and meaning impact than using interpreter service where often the messages are "lost in translation" and the impact definitely questionable. We have repeatedly experienced the inefficiency of the interpreter service and research also confirms the same. The wait time, aviablaity, efficiency etc. are some of the key examples that make the present approach inaccessible.
3. Use of telephone interpreters is not the most effective way in communicating important messages (regarding their health) to these populations. Onsite interpreters would be more effective and strategies have to be developed to make these services more accessible
4. Key barriers are experienced at front desk staff level at medical practices in working with these populations. Combined with the pressures of doctors and patients, the staff need more support and information in helping them work through the barriers and make services easier to access. An important example is how best to communicate simple instructions including filling out forms. The staff do not often speak the language and their main challenge is completing paperwork that most of these populations find difficult to

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understand or complete.

5. Encouraging primary and secondary health providers to be more available to be part of the treatment compliance. Finding some way to create incentives for medical practices to invest time as these vulnerable populations need more than average engagement strategies given their cultural and linguistic barriers. Department of Health has to create incentive programs for these medical practices so that motivation is created at several levels from staff and GPs to be more involved so that good health care can be achieved for patients. The rebate fees at this point appear to be the dispute as they cannot cover the comprehensive session GPs require to attend to this population
6. Employment of Health care nurse practitioners or people from health backgrounds who are bilingual workers need to be encouraged within these medical practices to support the effective translation of information to treatment activities to encouraged enhanced for the doctors.
7. Simpler tools of assessment and checklist may be a way to work with these populations and as most cannot read or write adequacy enough.

Overall :

Chronic hepatitis B and C can be associated with significant morbidity and mortality if untreated. Complications such as decompensated liver disease and liver cancer are health burdens in the healthcare system. These complications can be alleviated or at least reduced with effective treatments. Furthermore preventative strategies such as hepatitis B vaccination and reduction in transmission have been shown to reduce the incidence of viral hepatitis.

One of the most important strategies in the management of chronic hepatitis B is vaccination of those at risk, in particular infants borne to hepatitis B infected mothers. Moreover, identification of expectant mothers, especially those with high viral load can help to further reduce maternal-foetal transmission by providing effective and safe antiviral medication in the third trimester of pregnancy.

Treatment of chronic hepatitis B at the current time is aimed at viral suppression rather than viral elimination. However, with viral suppression, it has been shown to reduce complications of chronic hepatitis B, including liver failure and hepatocellular carcinoma in majority of these patients. Unfortunately treatment is often life-long and compliance may be an issue, particularly in young patients. Early phase research studies have shown promise in eliminating the virus.

Recent advances in the management of chronic hepatitis C lead to sustained virological responses (SVR) or cure rates of greater than 95% and yet in Western Australia only about 12% of those infected by chronic hepatitis C have been treated. This can be achieved with 8-12 weeks treatment with oral direct acting antiviral drugs (DAA) which is associated with great efficacy and few side effects. Strategies such as general practitioner (GP) support for community prescribing are attempts to try to increase treatment uptake, particularly in disadvantaged groups such as CaLD, homeless and those incarcerated.

Management of chronic viral hepatitis includes:

A. Identification of those at risk

Chronic hepatitis B

- Vertical (maternal-foetal)
- Parenteral or percutaneous
- Sexual transmission
- Horizontal e.g. in young children
- others

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Chronic hepatitis C

- Intravenous drug users
- Previous transfusion of blood or products (before 1980's)
- Sharing of personal items such as razors or toothbrushes
- Migrants
- Others

Many of above risk factors are present in CaLD population and therorre vulnerable an at Risk population

B. Testing for viral hepatitis

- Counselling before testing - Lack of understand of those infected can be a barrier to testing
- Counselling to reduce transmission
- Needs to be culturally appropriate
- Pre – and post-test counselling
- Stigmatisation and discrimination

C. Treatment:

- Effective treatment is available but most CaLD communities ignorant of this
- Compliance for medication and follow-up (especially hepatitis B – indefinite treatment)
- Lack of resources in tertiary centres
- Reluctance of General Practitioners to take up prescribing or monitoring patients
- Need multimodal approach and models of care to overcome this barrier

D. Monitoring those at risk of hepatocellular carcinoma

- Cirrhosis
- Chronic hepatitis B in the absence of cirrhosis
- Africans < 20 years of age
- Family history of hepatocellular carcinoma

E. Barriers in treatment in tertiary centres

- Lack of resources
- Long waiting time
- Language barriers

Potential strategies

- Dedicated clinics especially for CaLD
- Video call clinics
- On-site clinics
- Support GPs for community prescribing
- GP education – accredited courses and web-based programs
- Accreditation of GPs as prescribers
- Remote consultation referral programs
- Nurses and Nurse Clinics made more available for screening and treatment
- Training of nurses (or practice nurses to identify case in large caseload facilities e.g. GPs' surgery

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- Education for those infected with viral hepatitis
    - Culturally appropriate education
    - Prevention
    - Complications if untreated
    - Treatment

In reference to encouraging and drive digital innovation, the use of new technology, research and data to support patient centered care and improved performance:

This is one area that most of us in this sector (CaLD services) fail to understand how the government cannot see that this is several steps away from the target population's ability to engage in. Even the basic use of the phone is far from their understanding. Most cannot operate the computer other their children and most do not have access to these gadgets or the ability to train adequately enough to participate in this activities. However, every funding round expects us to use these digital platform.

Strategic recommendation: Simpler and pictorial/ visual information works better than written with verbal information sharing exceeding outcomes above all. Investment in these information strategies is more likely to be cost effective in working with any health acre promotion for these target population for now.

The above recommendation will clearly include collaborations between service providers, primary and secondary health care services and most importantly, services that work specifically with CaLD communities and thereby encouraging more community driven interventions rather than just health service provisions