Sustainable Health Review:

Public Submission

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Introduction

Across the Western world, healthcare systems are being challenged in unprecedented ways due to a mismatch between an ageing population, increasing demands for service delivery and strained finances. Increased health spending is being driven not just by changing demographics but also by chronic disease, health technology, inequities in access and quality of life, workforce fluctuations, and global disease threats.

Despite good performance and results over the last 10 years in quality and safety of care, Western Australia's health system faces huge challenges: health expenditure is growing at an unsustainable rate, public hospitals cost 20 percent more than the national average, and State debt is increasing.

To address all of these complex challenges, over the last decade Murdoch University has enhanced its capabilities in a range of health-related fields such as: biomedical research and development (immunology, infectious diseases, personalised medicine), health workforce, Aboriginal health, health economics, analytics, informatics, leadership, management, policy, governance and regulation.

On the teaching side, Murdoch University delivers high quality and real-world learning experiences to undergraduate, graduate students and healthcare professionals in various areas, such as Nursing, Psychology and Counselling, Public Policy, Biomedical Sciences, Health Administration, Policy and Leadership and Health Communication.

Murdoch's Strategic Plan and Future Horizon 2017-2027 reinforce our commitment "to educate free thinkers who thrive in society and are sought after by employers, and to provide life-changing solutions for the world's big challenges through our outstanding translational research and innovative practice."[i] Three ongoing initiatives evidencing Murdoch's commitment to Human and Animal Health research, teaching and innovation include:

1) Knowledge and Health Precinct
2) 'One Health', the interface of human, animal and environmental health
3) Ngangk Yiri Research Centre for Aboriginal Health and Social Equity

Murdoch's position aligns with *the Strategic Review of Health and Medical Research (2013)* and the *Efficiency in Health: Research Paper (2015)* which reinforce that improvements in healthcare delivery can only be achieved via structural reforms to our health care system based on rigorous evidence-based policy recommendations. This paper draws its recommendations from such projects and were enriched by the discussions that took place in a public policy forum entitled "Sustainable Future for Health" held on 18th July at Murdoch University.

The main topics addressed in this paper are:

1. Policy Development & Service Design
2. Reducing unwarranted variations in healthcare
3. Invisible and Vulnerable Population Groups
4. Health Financing
5. Reform to WA Stimulant Regulatory Processes

Our recommendations to the Review are an opportunity to consolidate and capitalise our interests and expertise to inform health policy reforms in Western Australia.

1. Policy Development & Service Design

The effectiveness of the health policy and service outcomes will be influenced by the quality and extent of engagement processes with key stakeholders; especially health decision makers and service providers responsible for the implementation of policy and services: clinical and non-clinical practitioners, researchers and the ultimate users of services (consumers and carers). Effective stakeholder engagement can lead to greater 'buy-in' from consumers, carers, clinicians and others parties involved in health service delivery. It enables access to expertise and knowledge during policy and service development processes. Conversely, stakeholder disconnect from externally determined priorities can lead to a low level of involvement, collaboration, dissemination, and implementation.

Recommendations for Committee Processes[ii]:
1. Ensure diverse (and where they exist, opposing) views are robustly represented in committee processes. This is particularly important in contested and controversial areas of policy development and service design. Rather than enabling a process of self-selection by like-minded participants with the aim of achieving a consensus outcome, these processes should be open and contested, with a range of views competing to influence outcomes.
2. Monitor the attendance of Group members and report attendance to the organisations (if any) representatives represent- This will emphasise the expectation of active engagement.
3. Identify how items get on the agenda and disclosure and effective management of conflict of interest – *The agenda items* should reflect the consumer experience/interest. Random surveying of consumers using services or with targeted conditions asking them about their experiences and concerns is potentially an invaluable source of information. Potential conflicts of interest should be disclosed and managed, where appropriate by exclusion from decision processes.
4. Ensure that the operation of the committees makes it easy for participation by all representatives. Acronyms, jargon, etc. can be unnecessarily exclusive. Meeting times, locations, durations, etc. can all discourage participation.
5. Ensure an effective engagement of representative participants with third parties*, reporting to the committee and externally, instead of just attending meetings.* If engagement is reduced to passive representation in committee meetings a valuable source of information is effectively ignored.
Recommendations for other forms of engagement:
7. Take it outside committee processes *and sample the views of stakeholders who represent a range of patient and clinician experience* **-** Rather than asking participants to attend quarterly meetings, consider developing new activities that go to where the patient, clinician etc. views are sampled.
8. Incorporate elements of direct and deliberative democratic processes into engagement processes - Randomly chosen (clinician, patient or carer) juries are worth considering as a means of minimising inappropriate bias and conflicts of interest in complex and contentious issues. Stakeholders with particularly views and/or expertise in this model have the opportunity to participate as witnesses, but final decisions are made by participants free from bias who weigh conflicting arguments.
9. Provide external transparency to the public- Unless there is a good reason (individual privacy, commercial sensitivities etc.) documentation should be open to all consumers and other potential stakeholders.
10. Consumers/patients' profile are often limited to their disease conditions – Often single consumers have a limited understanding of the breadth of disease conditions and the experience of people from different gender, age, socio-economic and cultural backgrounds.
11. There is not one common consumer voice or consumer interest leading to conflicting consumer-driven pressure **-** Consumer voices are frequently contradictory. Sometimes this is a result of conflict between opposing legitimate views on what is in the consumer interest.

2. Reducing unwarranted variations in healthcare

Understanding the unwarranted healthcare variation is fundamental to improving quality of care (clinical effectiveness and safety), and value for money. Data collection and awareness on variations that are unrelated to patients' needs or preferences is the first step to develop measures to tackle this issue.

Recommendations:
1. Integration of socio-economic inequalities and access to care within a unified framework of analysis.
2. Public reporting of geographic variations in health care.
3. Development and monitoring of clinical guidelines is a key lever to standardise clinical practices.
4. Shared decision making between patients and providers about treatment and patient outcomes measurement are key to reduce unwarranted variations.
5. Comparing patient outcomes across geographic areas or over time helps to assess the appropriateness of care. Overutilization of health care can lead to diminishing health outcomes.
6. Implement a uniform electronic health record system

3. Invisible and Vulnerable Population Groups

By focusing our research on vulnerable and invisible population groups, Murdoch University is expanding the existing scientific knowledge, as well as giving voice to 'hard to reach' population whose health outcomes and patients experiences are often being overlooked by healthcare systems.

a. Rare Diseases

A study published in 2016 showed that rare disease (RD) cohort members accounted for nearly 2% of the Western Australian population but their hospital discharges accounted for 10.5% of the total WA inpatient hospital expenditure[iii]. Adding to this finding, our research looked at the life-cycle costs of aggregate RDs classifications and found a number of patterns: Immune and neoplastic diseases appear to have a constant cost throughout their life-cycle; Renal diseases costs seem to increased towards later stage of life, as is the case with systemic or rheumatologic diseases. Finally, respiratory disease exhibit a slightly inverted U-shape effect with costs higher in early- to mid-adulthood, i.e. ages 15 to 35 years old.

Recommendations:
1. Raise Rare Disease awareness. Each RD alone is rare but all together they have high incidence and large budget impact that is not recognized by the public.
2. Policy discussion should be focused on Group Rare disease, and consequently raising their profile and funding towards their treatment, the same way it has been done with cancer.
3. Service design and standards of care based on the disease life cycle and focusing on the main determinants of service demand (RD and Location);
4. Timely diagnosis enhances patients' and caregivers quality of life, and might reduce service utilization (about a quarter of patients diagnosed with a rare disease can have a diagnostic delay of between 5 and 30 years).

b. Refugees and newly arrived migrants from culturally and linguistically diverse (CaLD) backgrounds

People from multicultural backgrounds and those who have newly arrived in Australia face often multiple health vulnerabilities: in their countries of origin, they might be affected by significant hardships, trauma and mental illness, nutritional deficiencies, and unmonitored clinical care of chronic diseases. On the top of these problems, when arrived in Australia these groups face several barriers, namely: financial inability to pay, language barriers, lack of knowledge and understanding of the healthcare system and rights to care, and troubled settlement experiences.

Recommendations:
1. Coordination of care and services with the Department of Social Services, based on patients' outcomes instead of program outputs
2. Expansion of the mental health services available (an exploratory study conducted by Murdoch University shows that the social value generated outweighs significantly the investment[iv]);
3. Culturally competent care from primary to tertiary care

4. Health Financing

Health financing is a key area in any review at the State and Federal level that attempts addressing sustainability in health and healthcare. Although this review is focused on Western Australia, there are underpinning structural governance and financing challenges that cannot be ignored by single States, including WA, while aiming at resolving fundamental inconsistencies and inefficiencies such as:

1) **The paradox in the current public/private mix** in health care financing in Australia. Almost 50% of Australians have two insurances: Medicare and private health insurance, and the out of pocket expenses account for nearly 20% of the total national health expenditure.
2) **Community rating combined with open enrolment**. Insurers must insure anyone who wants coverage and must adopt one price per product. Although these regulations were introduced to mitigate the effects of risk-selection by insurers (keeping or attracting healthy people and getting rid of or discouraging high-risk, unhealthy people), they are ineffective and inefficient, and potentially raise the average premium required to get coverage.
3) **Government subsidies** for private health insurance that are premium-related (such as the rebate) and tax penalties for being uninsured make consumers less price-sensitive. This can lead to premium inflation.

Recommendations:
1. Allow individuals to choose between healthcare purchasers' who prudently buy care for their members. This is to address the fragmentation in purchasing, and to move from passive retrospective to active efficient purchasing.
2. Promote integration of healthcare "insurers", as well as "providers".
3. Introduce risk-adjustment and performance metrics to pay/reimburse providers and funders according to modern incentive-compatible mechanisms utilised in other developed countries (e.g. US, Germany, UK, Holland, Switzerland etc.). This would improve the efficiencies of Activity-based Funding (de facto Activity-based management).
4. Allow private insurers to cover for General Practice to achieve greater coordination of care, and temper the inequality deriving from increasing reliance on out-of-pocket contributions.
5. Strategic purchasing and contracting to be incentivised to increase responsiveness to consumers' preferences and to the shifting burden of disease (from acute to chronic care needs).

5. Reform to WA Stimulant Regulatory Processes

With rapidly increasing WA child and adult stimulant prescribing rates and the potential for the diversion of stimulants for non-medical use, effective regulation is essential. In addition, there is very clear evidence of frequent misdiagnosis of ADHD among WA school children that makes the need for stimulant prescribing oversight more pressing[v].

In August 2003 against a similar background of concerns about misdiagnosis, drug misuse and *rapidly rising prescribing rates* the *Western Australian Stimulant Regulatory Scheme (the Scheme) was established. It held frequent prescribers* accountable for the first time and was followed by a 50% fall in child prescribing rates between 2002 and 2010 that coincided with a 51% fall in self-reported teenage amphetamine abuse rates[vi].

Recommendations:
1. The membership of the Stimulants Panel (established under the Scheme) needs to be reconfigured to ensure balanced representation among specialist clinicians, particularly across the prescribing spectrum.
2. Annual personal prescribing statistics for all the members of the *Stimulants Panel* should be made public in the *Schemes* annual reports as a means of avoiding perceived conflicts of interest.

Conclusion

These evidence-based recommendations represent the practical impact of Murdoch's research projects and areas of expertise of the academic staff at the School of Business and Governance. Murdoch University is available for further engagement with the Review panel to present and debate these recommendations to achieve a sustainable, affordable, equitable and high quality healthcare system for all West Australians.

Attachment

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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

☐ I would like my submission to be published but remain anonymous

[i] Murdoch University (2017) Strategic Plan and Future Horizon 2017-2020: A five year plan with a ten year horizon. http://www.murdoch.edu.au/_document/About-us/strategic_plan_future_horizon_2017-2027.pdf

[ii] Sequeira, A., Whitely, M., Paolucci, F., Murdoch University (May 2017) Final report of the Murdoch University team developing methodologies to monitor, report and evaluate engagement by WA Health Networks and the contribution of Networks to the WA Health System. Unpublished.

[iii] Walker, C. E. et al. The collective impact of rare diseases in Western Australia: an estimate using a population-based cohort. Genet. Med. (2016). doi:10.1038/gim.2016.143.

[iv] Sequeira, A., Whitely, M., Paolucci, P., Murdoch University (August 2017) Ishar Multicultural Women's Health Centre: An Exploratory Study of Ishar's Services in the Perth Metropolitan Area. Unpublished.

[v] Whitely M (et al), Influence of birth month on the probability of Western Australian children being treated for ADHD, Medical Journal of Australia 2017 https://www.mja.com.au/journal/2017/206/2/influence-birth-month-probability-western-australian-children-being-treated-adhd

[vi] Martin Whitely, 2013. ADHD debate clouded by preconceptions and hidden conflicts of interest, Australian and New Zealand Journal of Psychiatry, September 2013. http://anp.sagepub.com/content/early/2013/07/25/0004867413498270.extract