The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

College House
254–260 Albert Street
East Melbourne Victoria 3002
Australia
telephone: +61 3 9417 1699
facsimile: +61 3 9419 0672
email: ranzcog@ranzcog.edu.au
www.ranzcog.edu.au
ABN 34 100 268 969

Government of Western Australia

Department of Health

RANZCOG response to the Sustainable Health Review

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) welcomes the opportunity to provide this submission to the Department of Health in response to the call for public submissions to the Sustainable Health Review.

Background

RANZCOG is committed to improving the health and wellbeing of women and their babies. The College is particularly concerned about the gap between the health outcomes of Indigenous and non-Indigenous women and their children, as well as the poorer health outcomes for women and their families living in rural and remote areas.

The purpose of the Sustainable Health Review is to provide an opportunity to all members of the community, including people and organisations within the WA health system, to share their experiences and perspectives on how to ensure that the health system can continue to deliver high-quality healthcare into the future.

This submission is structured according to the six categories in the terms of reference for this review:

1. leveraging existing investment in primary, secondary and tertiary healthcare, as well as new initiatives to improve patient-centred service delivery, pathways and transition
2. 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
3. ways to encourage and drive digital innovation, the use of new technology, research and data to support patient-centred care and improved performance
4. opportunities to drive partnerships across sectors and all levels of government to reduce duplication and to deliver integrated and coordinated care
5. ways to drive improvements in safety and quality for patients, value and financial sustainability, including cost drivers, allocative and technical efficiencies
6. the key enablers of new efficiencies and change, including, research, productivity, teaching and training, culture, leadership development, procurement and improved performance monitoring.

Submission

1. **Leveraging existing investment in primary, secondary and tertiary healthcare, as well as new initiatives to improve patient-centred service delivery, pathways and transition.**

   If WA is to have a truly patient-centred model of care, communication between the primary, secondary and tertiary systems caring for women needs to substantially improve. WA could better use electronic means for communication between general practices and hospitals and between hospitals. Letters generated by doctors in hospitals destined for other hospitals often take months to reach their destination, then several more months to appear in the patient's file.

   There are many means of electronic communication that could be utilised, including voice recognition software, templates for often-performed procedures and admissions, and automatic linkage between general practices and hospitals for transmitting information electronically, to name several that have been used in Victoria for decades. It is difficult to understand why other states and practitioners in the private system can achieve this, but WA government-run organisations, with their complex information technology departments, cannot.

   The health status of women and their fetuses and neonates can change very quickly. The dissemination of this information to general practitioners needs to be prompt in order for care to be continued efficiently and effectively. Not only is this better for patients, it avoids repeating aspects of care, saving health dollars.

   There is a significant problem with access to tertiary hospital care for women living in rural and remote settings. Episodes of care are inadequately coordinated, such that women must visit Perth many more times than would seem necessary to complete their treatment. For example, a patient attending a gynaecological clinic visiting from a remote area will be flown down on an expensive commercial flight, stay in accommodation while awaiting her appointment, attend said appointment, and be sent back home. She may repeat this exercise at a later date for her ultrasound, again to come back to clinic for the results and a fourth time to have surgery. There may even be a fifth visit to see the anaesthetist.

   A nurse or clerk dedicated to the task could coordinate these visits, coalescing them into as few as two episodes, with huge savings in cost and psychosocial disruption. Such coordination could reduce the incidence of patients giving up on the process and not attending. Women from remote communities, particularly Indigenous women, can find separation from familiar people and surroundings frightening, stressful and expensive. Rectifying this situation could go part way towards closing the gap between health outcomes for women living in urban and rural areas. The cost savings would not only accrue to the hospital involved, but to the taxpayer generally.

   Integrating care between primary, secondary and tertiary institutions requires sharing information and communication. The infrastructure for this needs to be improved and its uptake encouraged.

2. **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.**

   The promotion and funding of 'hospital in the home' services could be improved, with the expectation of better social and medical outcomes and substantial cost savings. Conditions such as hyperemesis gravidarum, for example, could be managed in an outpatient setting, with less social disruption for the pregnant woman and her family and a cost saving to the community.

   In WA there is no step-down service for post-natal women. Patients delivering in the public sector are usually discharged rapidly after delivery, well before breast feeding is established. Visiting midwifery services offer a daily visit, but this is not frequent enough to substantially benefit a patient struggling with breast feeding her infant. The health, social and psychological benefits of breast feeding to both mother and baby have been long established, but this crucial aspect of perinatal care is distressingly under-resourced.

   A step-down unit would also be useful in the care of preterm babies who are essentially well but still need assisted feeding. These babies stay in the part of the neonatal nursery requiring less intervention, but are still separated from their parents and their siblings are not allowed to visit. A step-down unit where feeding assistance could be provided but where the mother was allowed to room in and other family members interact with them would be of great psychosocial benefit to the family unit.

3. **Ways to encourage and drive digital innovation, the use of new technology, research and data to support patient-centred care and improved performance.**

   While some sites in WA have embraced digital technology, others lag far behind, making effective communication between sites difficult. There may not be a single unifying system that is appropriate across all locations, but an attempt to provide some kind of connectivity would be welcome.

   Digital communication with remote sites is hampered by a lack of reliable and fast internet services. Until that basic deficit is corrected, problems will continue. Once it has been, digital technology will have much to offer in terms of teleconferencing and telehealth. There are many clinic visits where telehealth could be used, either with or without the patient's GP or remote area nurse being present. Examples of where a costly visit to the tertiary centre could be avoided without compromising patient care include:

   - pre-operative discussions
   - post-operative visits
   - antenatal visits where the observations and examination have been performed locally but a discussion about the mode of delivery needs to take place.

4. **Opportunities to drive partnerships across sectors and all levels of government to reduce duplication and to deliver integrated and coordinated care.**

   No response.

5. **Ways to drive improvements in safety and quality for patients, value and financial sustainability, including cost drivers, allocative and technical efficiencies.**

   Improving safety and quality for patients requires a robust, inclusive and accurate system to capture the necessary data. Only from that starting point would it be possible to assess and monitor starting points and look for improvements. Having appropriate technology to access and analyse data is also critical to the success of research into safety and quality. More abstract outcomes, such as patient quality of life and interventions where a large number of participants is required, are examples of research requiring large volumes of accurate data.

   Several reviews of unnecessary and low-value tests and procedures have been published recently. One example is RANZCOG's 'Choosing Wisely' list[1]. Incorporating such recommendations into hospital practice would reduce costs and potential harm to patients.

   A periodic review by hospital staff of their unit's procedures, not just for complications and adverse events but also for procedures of doubtful value, could be instituted.

   Canvassing staff opinions on ways to avoid day-to-day waste in hospitals would likely yield savings.

   While patient safety is possibly improved by mandatory staff participation in the dozens of educational modules that are required in public hospitals, the implementation of these systems is incredibly inefficient. Large amounts of time is wasted in the inefficient organization of compulsory modules.

6. **The key enablers of new efficiencies and change, including research, productivity, teaching and training, culture, leadership development, procurement and improved performance monitoring.**

   There is a problem when the priorities of hospitals, which require a certain number of practitioners to fulfill their workforce requirements, conflict with the training needs of trainees. There is no easy answer to this issue, but open communication between hospital administration bodies and colleges overseeing training is vital. Time for teaching needs to be valued and quarantined, in order to nurture the workforce of the future. Trainees who "grow up" in an environment where learning and leadership are valued are more likely to contribute in like fashion as they progress in their careers.

   Institutions where trainees are undervalued and their educational and rostering needs regarded as a nuisance are likely to find themselves short of locally trained consultants. This situation is the reality at present and is unlikely to change while the attitudes of some medical administrations continue.

[1] <www.ranzcog.edu.au/news/choosing-wisely>