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***	
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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

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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.

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).

Introduction

The author of this submission is Matt Burrows, the CEO of Therapy Focus, one of Australia's leading providers of professional therapy services. Matt is a Candidate for the DBA Award at Curtin University with the John Curtin Institute of Public Policy, with the proposed thesis title "An investigation of governance frameworks that empower people with disabilities as consumers of care services". The views contained in this submission are written from the perspective of a CEO managing a medium sized service provider organisation. They are the author's own views and do not necessarily reflect the position of either Therapy Focus or the John Curtin Institute of Public Policy. In forming these views, the author acknowledges the input from the Therapy Focus Chairperson, Fiona Payne, as well as the Executive Manager Clinical Services, Ruth Lee.

This submission raises general layperson issues as well as more specific issues that focus on the interface of mainstream health services with the disability sector. It also recognises that people with disabilities have health needs that are not dependent upon or caused by the disability.

This submission reminds the Review Chairperson of previous work undertaken, including in relation to the National Disability Insurance Scheme (NDIS) and recent Productivity Commission inquiries, as well as Department of Health Clinical Senate publications including the June 2011 "Clinicians - Do you see me?". This review should not be undertaken in isolation of other reviews or other sources of input that have been submitted to government.

A key theme that will be emphasised in this submission is the need for the WA Health Department and all of its employees to have an appreciation of, and an understanding of, supports that are available to be accessed within the community. The Commonwealth Government funds much of the primary health care system in Australia and private providers and health insurers also contribute resources. The WA Government is only one part of the health system that people interact with, albeit a large part.

In writing this submission the focus has been on health. It is assumed that a reference to health includes a reference to mental health. Whilst deserving of its own special mention, the author has decided to include mental health in the broader field of health and assumes more specialised providers will raise the need for integration with and investments in mental health.

Focus areas

Health records

There has been a move to automate health systems for over a decade. Broadband for Health initiatives were in place from 2005 and the advent of the Personally Controlled Electronic Health Record (PCEHR) became a real objective with oversight from the National Electronic Health Transition Authority (NEHTA), or what is now known as the Australian Digital Health Agency.

Some progress was made during the 2005-15 period with platforms developed by Extensia (Recordpoint) in Brisbane and the UWA Centre for Software Practice (Medical Message Exchange – MMeX) in Perth. The latter was used successfully in the Kimberley and other remote regions of WA. In more recent times the registration process for a nationally consistent PCEHR has gone live and the WA Health Department could be doing more to encourage

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people to register for *My Health Record*.

Having people in charge of their own health records is a step in the direction of making people responsible for their own health. It is congruous with the objective of self-management, especially for chronic conditions, and will lead to increased efficiencies. In short, it transforms consumers into citizens. This is in line with other major reforms in disabilities and aged care which promote self-directed supports (or consumer directed care). Doing this well will have a positive impact on people with disabilities as it will enable coordination of care across health-related interventions and ongoing disability related interventions.

Whatever form the PCEHR ends up in, it should be able to cater for data from different sectors, like disabilities and aged care. The Commonwealth Government has introduced the *MyGov* portal and aside from bemoaning its useability, it at least shows an intent to bring everything together and consolidate systems and processes. The WA Government should "plug and play" with the already established *MyGov* portal and should not entertain ideas to duplicate with its own *WANDIS* or *My Place* style portals (for example).

Recommendation 1

Continue to encourage citizens to sign up for My Health Record and ensure WA Health sites are registered and synchronised with My Health Record PCEHR systems, including the management of internal firewalls and permissions to allow genuine data transfer.

Efficient services - technology

Following the theme of electronic health records is the application of the technology for improved efficiencies in health. Lowering health costs per unit of health serviced is paramount for sustainability and technology is a key lever to this end.

Using technology to bridge geography is key. Telemedicine being used to service vast regions without the need for travel is becoming increasingly accepted by both practitioners and consumers alike. The use of electronic health records to transfer information quickly and efficiently is also being used. The Medical Message Exchange (MMeX) was able, with consent, to transfer pathology, radiology as well as records including discharge summaries and medication to a network of practitioners. This meant information was available to the clinician upon presentation of the consumer anywhere in the region.

In using this technology it is still important to respect individual rights. For example, the right of a prisoner to have their treating centre de-identified is paramount to keeping that consumer engaged with the health system following release from prison. The rights also need to be protected during transfer of information through encrypted formats and media (like MMeX). Use of unsecured environments (eg open email or free wifi) should be avoided.

The application of technology is growing exponentially, especially as the age of artificial intelligence dawns. The assumptions underlying the application of artificial intelligence always need to ensure it is for health benefits. And if applied to an individual, for the individual's health benefit and within their rights of privacy. Extra care needs to be taken when considering artificial intelligence applications to the care of people with disabilities to ensure they have an understanding of the assumptions, the application and the impact.

A couple of case studies are listed below to highlight the benefits of technology:

Case Study – Opthalmology in Central Australia

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In the early 2000's the opthalmologist based in Alice Springs embarked on a program to make the visiting service more efficient. Rather than turn up at communities to conduct retinal screenings, he decided to empower the Aboriginal Health Workers to do the screening. With some investment in equipment and training, it saw retinal scans taken in communities and sent electronically to Alice Springs where they were assessed by the opthalmologist. When the opthalmologist did travel, they were able to target their efforts at only those consumers who presented major risks and required treatment.

Case Study – Wound treatment in Western Australia

In the late 2000's the podiatry team in the Kimberley were able to take photographs of foot wounds and send the images to Perth for analysis by Wounds West. A treatment plan could then be communicated back to the regional clinicians who would then implement. This enabled clinicians to access best-practice advice from specialists as well as consumers to access evidence-based treatment quickly and effectively whist remaining on country (or close to) in the region.

These case studies both show the practical benefits of embracing technology and integrating it into problem solving and decision making in health servicing.

Recommendation 2

Invest in technology (and research and development) to support better health servicing, not just better health care. Monitor investments in health servicing and implement continuous improvement strategies to proof returns on investments in innovation, especially if technology related.

Integration of acute care with community care

There is a prevailing assumption in the WA Health Department that all health is delivered by the WA government. This is not unique to WA and is endemic in all public health systems. It is not an individual trait, but rather a cultural one. It manifests in all aspects of engagement and is most easily summed up by referring to the email conversation below:

Health Professional:	*"That's a good point Matt, where can I learn more about that model of service delivery?"*
Me:	*"I can email it to you if you like. What is your email address?"*
Health Professional:	*"Just look me up on the global address list."*
Me:	*"But I don't have access to your global address list."*
Health Professional:	*"Why not? It's global!"*
Me:	*"Because it is only global to those on the same server network, meaning government health employees. I work for a not-for-profit and we have our own, much smaller global address list."*
Health Professional:	*"I never realised!"*

If this conversation happened once, it would be acceptable and able to be corrected. But it is commonplace to have to explain that there are valuable people working outside the (State) government funded public system.

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Whilst the State system acknowledges the Commonwealth has a role to play, especially in the Health Service Agreements and the contribution of funding towards State health servicing, it has very little knowledge of what else the Commonwealth Government funds. This includes knowledge of the work undertaken in the broad primary health care realms. There is some knowledge of the After Hours GP practices, but partly due to their proximity to hospital EDs. There is less knowledge (and appreciation) of the work done by private GPs and the supports available from Medicare (or the Pharmaceutical Benefits Scheme for that matter). There is little knowledge of work done by Aboriginal Medical Services or the newly established Primary Health Networks (ex-Medicare Locals). The question of private health is asked not as an inquiry of what is needed by the patient, but of what can be paid for and if a patient can be transferred to a private facility. This needs to change to reflect a seamless interface between acute care and care in the community.

Recommendation 3

The WA Government initiate a genuine desire to learn more of complementary supports available to citizens and to engage in life cycle planning that takes account of all services and supports that a citizen is likely to engage with across their lifespans, rather than just those provided by the State Government.

Discharge processes

Whilst a subset of the previous focus area, the impact of poor discharge processes means it deserves its own focus area. The process of discharging a patient from acute care to home and the community supports can mean the difference between properly closing that episode of care or just placing a Band-Aid and waiting for the patient to return. This can be the bedrock of the health frequent flyer program. It can also mean the difference between life and death.

Having efficient systems that can distribute discharge summaries and medication lists to numerous points of care (with patient consent) means that the information is accessible where the patient next accesses healthcare. Having it controlled electronically means it can be issued once but accessed multiple times. Having it controlled by the patient means it can be managed and accessed with patient consent at time of need.

Discharge processes are, again, important in the context of caring for people with disabilities. Due to complex conditions associated with the disability, the person's home environment may have a number of unique circumstances (eg home modifications; communication aids; mobility equipment; carer supports) that need to be taken into consideration when discharging a patient back to their home environment.

End-of-life care

Palliation is a process and takes place over a period of time. Some timeframes are shorter than others and many occur at the end of a full life. But many also don't. Viewing palliative care as end-of-life care and seeing it as a process rather than an expectation at a point in time, allows for better coordination of resources, better planning, and better reconciliation by the person palliating and those people close to them.

The current *End of Life Framework* could be revised to place increased focus on decision-making. Associated legal frameworks (power of attorney, guardianship etc) should be aligned with these broad principles so that health practitioners are not expected to prolong life or make decisions on end-of-life where ambiguous circumstances may exist. Ultimately legislation could be considered, as in Victoria, for euthanasia to be legalised.

Frameworks developed through end-of-life care provisions may be applied to futility care, where decisions need to be made for end-of-life due to sudden trauma or disease onset for example. A clear logic in decision-making

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and a strong framework of emotional supports may mean decisions can be made that promote dignity *and* allow resources to be applied to care circumstances that are less futile.

Recommendation 4

Life-cycle planning implemented which includes provision for end-of-life planning with a framework developed for end-of-life decision making, with legislation synchronised.

Workforce planning

The Health Department needs to acknowledge that it is headed for a clusterfug. A clusterfug is a business construct championed out of Stanford University (Scaling Up Excellence) to describe the perfect storm when scaling up. The broader scaling principles explore concepts like "What got you here, won't get you there" and "When scaling up, less is more". The clusterfug concept is introduced to avoid things going wrong and conducting a pre-mortem to analyse mitigating factors. This would be valuable to apply when looking at workforce. The challenge with workforce is definitely one of scaling-up, especially as the population continues to grow, continues to age, continues to live well, and continues to consume more resources.

The WA Government is well aware of the pressures on the health system. It now needs to consider the interplay with other sectors. The disability sector is seeing a doubling of resources in just five years with the introduction of the National Disability Insurance Scheme (NDIS). For an organisation like Therapy Focus, one of Australia's leading providers of professional therapy services, this means a workforce growing from 220 clinicians in 2017 to at least 400-500 by 2022. We know this. The forward estimates are already in place in both Commonwealth and State budgets (at least for three years). So with the clusterfug being clear, we should be conducting a pre-mortem to navigate a path to avoid it. We should be putting in place strategies now manage resources across sectors; to re-engage with therapists who have left the profession; recruit, retain and develop the existing professional cohorts; and we should be investing forward with research, academic and training institutions to create the coming generations of therapists. Consumer choice and control depends on it, but so too ultimately does quality of care.

In a Federation over a century old, the health system can still resemble the train tracks that were subject of gauge disputes at the turn of last century. Whilst inroads have been made to standardise competencies nationally for doctors and nurses, there remains inconsistency across much of the allied health disciplines, especially those not within the Australian Health Practitioners Regulation Authority (AHPRA) scope. Not only should work be undertaken to further the standardisation of competencies and national regulation, but the industrial framework should also be harmonised where possible. With a population of only 24 million people occupying a landmass on par with the US (340m) and China (1.4b), Australia needs to do all it can to enhance portability of its specialised medical and health workforces.

When planning for future workforce needs we should consider not only quantity, but also quality. Much of the allied health workforce is trained in a general medical model. There should be an ability for students to gain specialist skills in areas like disabilities and paediatrics. Currently these skills are only developed on practical placements or in the first few years of employment.

Recommendation 5

Acknowledge workforce challenges going forward as real and confirmed and apply leading business management strategies to scale-up supply of workforce to meet future demand.

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Health financing

The Sustainable Health Review panel has presented information to the public that states health costs 20% more in Western Australia than in other states. In looking at any service being delivered one must consider both expenditure and revenue. This paper (and probably most submissions) will be concentrated on expense minimisation. This note is to remind the review panel that revenue should also be taken into account.

In formulating the Health Service Agreements with the Commonwealth, the WA Government should ensure all weightings for remoteness, Culturally and Linguistically Diverse service users, Indigenous service users and other higher needs cohorts are taken into account properly. Rather than bleat an emotional "we are special" rhetoric, can a more sophisticated science be applied that properly maps the true cost of service provision to the population living in, and visiting, Western Australia? This is especially important when considering how much of the frontline health servicing is now financed on an activity based funding paradigm. Activities vary from hospital to hospital, region to region, and state to state.

There are lessons in health financing from other jurisdictions. The famed National Health Service (NHS) of the United Kingdom has changed its mantra from "free health for all at point of need" to "free health for all at point of access". This semantic change recognises that there are still costs associated with meeting basic human rights. This is especially important for Western Australia with its huge geography and cost of services to the further corners of the State. Possibly more innovative solutions for outreach could be found, by supporting the Royal Flying Doctor Service to maintain a network of first responder boxes and conduct scheduled primary health care visits for example.

Like any sector, there is an industry that underlies the service delivery. To manage health financing into the future, especially given the expectations for population growth and changed demographics (proportionately older people), the government should be investing in innovation and should be nurturing healthy collaboration as well as competition amongst providers. This includes fostering relationships between large providers in the community like Silverchain and Brightwater, with more specialised services like Therapy Focus and Ability Centre, with research institutes like Telethon Institute for Kids and Harry Perkins Institute of Medical Research, with private insurers like HBF and Bupa, with private providers like St John of God and Ramsay Health, with both the public health and hospital systems as well as the labyrinth of private general practice and other health professionals operating in suburban Western Australia. Fostering innovation in initiatives like *My Health Record* or more recently Health Engine, or even in shared innovation infrastructure hubs like Spacecubed, may incubate tomorrow's solutions for health financing in Western Australia. It is noteworthy that "working across boundaries" is one of the guiding principles of the NHS in the UK.

> ***Recommendation 6***
>
> ***Investigate anomalies in health service costs that are specific to Western Australia and identify the cause where possible and design solutions. Once outliers are normalised, develop the evidence for ongoing health service costs associated with the people and the geography, as unique to Western Australia, and build a case for recognition of need and commensurate revenue to meet need.***

Preventative

As a continuation of the primary health care theme raised in health financing, a focus on incentivising wellness could be implemented. Taxing tobacco and alcohol only tackle one side of the economic equation (supply). Incentivising wellness through subsidised wellness programs will tackle the other (demand). There will be natural

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partners in this, including private health insurers. An emphasis on preventative health and wellness programs may make private health insurance relevant in remote areas like the Kimberley, where otherwise there is a reliance on a public health system which for many then negates the relevance of private health insurance.

The health sector should watch the development of the National Disability Insurance Scheme (NDIS) with interest as it is a revolutionary approach to invest in early interventions to offset future lifetime costs. With actuarial modelling already being proofed in early trending, the implications for health financing could be huge. In a health context, this may finally prove that a dollar spent in prevention will save five dollars spent on treatment.

A continued emphasis on population health campaigns is necessary for long term benefits. The Quit campaign has been shown to deliver long term results. Other campaigns like "Life be in it" and "Slip, slop, slap" are now part of the Aussie folklore. Effort should be made to translate these very effective campaigns, and their preventative health messages, into contemporary media formats that are appropriate for today's discerning consumer. Social media is an obvious start with the popular "Act, Belong, Commit" campaign providing a shining light.

In all public health campaigns, the *You Matter* guidelines should be considered, especially in relation to people with disabilities. Access to campaigns needs to be measured not just in coverage, but also impact.

Recommendation 7

Resources and effort should be invested into prevention via population health campaigns and through preventative health measures incorporated into broader primary health care services. Funds should be allocated for evaluation of initiatives to build the body of evidence for efficacy and value.

People with disabilities as consumers

Many assumptions that underpin the features of consumer directed care, like the new NDIS system for example, are largely untested. The competitive market is yet to mature in many areas and without a deregulated price, is no more than a projected concept. Consumers having choice and control is an aim, but there remain many impediments to achieving this (see previous submission from this author to the Productivity Commission, available http://www.pc.gov.au/__data/assets/pdf_file/0005/204908/sub206-human-services-identifying-reform.pdf). These impediments, in short, can range from information overload, market shortfalls, institutional disempowerment, latent loyalties, fear of change, and in some instances even too *much* choice. To suggest there is adequate depth and resilience in the market to underpin financial sustainability is more wishful thinking than statement of fact. The recent focus on private health insurers and the AMA campaign to end the superficial health insurance policies, is an example.

Recommendation 8

Develop rigorous engagement strategies to ensure people with disabilities have effective input to decision-making on matters that impact their lives.

Social determinants

Human beings are social animals and as such have complex social habits and interactions. The provision of health services for human beings needs to take account of this complexity and manage from a holistic stance, rather than from a sterile standalone siloed approach resembling chapters from *Gray's Anatomy*. A holistic stance can be achieved by adopting a co-production approach like that developed by Governance International http://www.govint.org/our-services/co-production/. This model encompasses all aspects of planning,

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implementing and evaluating (co-production) via its co-commission, co-design, co-delivery and co-assessment framework.

Putting real effort into tackling the social determinants of health will lead to higher impact and lower cost. Whether or not someone is gainfully employed, or has a house over their head, or access to the community for sport and recreation are considerations that may have as much impact (or more) on a person's health than whether or not they can access health care.

Indeed many health professionals are aware that their health care intervention is only a temporary Band-Aid and when the individual returns to their home in the community, the same social determinants will quickly undo the good intervention. Examples of this include:

> *The dialysis patient who receives expensive dialysis treatment due to end stage renal failure following a lifetime of diabetes type 2 from foods not suited to everyday consumption. The call to St John that night sees an ambulance dispatched and a despondent volunteer seeing the same patient they were treating that day as a health professional, now unconscious with near empty bottles of Jim Beam and Coca Cola next to them.*
>
> *The prisoner in gaol who undertakes a comprehensive health care assessment and receives good timely health care, nutritional food, appropriate shelter and sanitation whilst incarcerated. Only to be released into a community without any continuation of the good supports, and without any guidance on where to access those supports from. A prisoner who serves their penalty in a system more concerned with incarceration than rehabilitation and reintegration.*

Maslow's hierarchy of needs was conceived in the 1940's but remains relevant today. If people's basic human needs for survival are not met, than any subsequent investment (like dialysis) will not be effective. Investing in therapy for a child with a disability is important. But if that child is living in a dysfunctional home environment where domestic violence is rife, meals are ad hoc and never nutritional, and their main concern is for their personal safety, then any higher level investment like therapy is only superficial. The importance of good social workers is coming to the fore as we realise evidence based practice is only such if tested and practiced in the real world where people live.

> ***Recommendation 9***
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> ***Ensure health services are connected vertically, horizontally and diagonally, with all other portfolios that are interacting with people's lives.***
>
> ***Treat people holistically and co-design services with consumer input where possible.***

Indigenous Health

All aspects of this submission are especially relevant to Aboriginal and Torres Strait Islander citizens of Western Australia. The need for a holistic approach that takes into account social determinants of health. The need to consider preventative health measures, and complement with self-management measures. And especially the integration of acute acre with community care systems.

Indigenous people live in their communities. More so than mainstream populations, these communities are spread not only through metropolitan Perth and major regional towns, but also throughout the length and breadth of this State. Any health care that is delivered to Aboriginal and Torres Strait Islander people needs to be

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culturally appropriate and take account of the living environment of the people. Design thinking needs to be incorporated to best match services to people's needs, and in doing so should build on the body of work already undertaken by the Aboriginal Community Controlled Health Sector.

Recommendation 10

Understand and acknowledge the burden of disease afflicting Indigenous peoples and the evidence of disparity in key life metrics.

Commit to the Closing the Gap campaign with sincerity.

Work in partnership with Aboriginal people and their community controlled health services to plan, develop, implement and deliver health services that meet their needs, both individually and collectively.

Evaluation

Contemporary social policy has elevated a mantra of outcomes measurement. Much of this measurement actually relies on what can be measured in quantifiable terms leaving the qualitative measurements appear poor cousins to the easily identified and measured data. However this data is often actually a measure of outputs, and not outcomes. Effort (and resources) should therefore be applied to undertaking qualitative evaluations of health service delivery and public health initiatives.

In delivering health services and in commissioning for health services, the WA Government should specify quality requirements and should consider the range of total quality management (TQM) schemes available. Whether externally sourced, like the ISO 9001 standards that Therapy Focus are certified under by SAI Global, or internally managed like the contracted Quality System used by the Department of Communities: Disabilities, the government should ensure providers are embracing continuous improvement in their health service delivery and are evaluating their services for outcomes.

Recommendation 11

Invest in both qualitative and quantitative evaluations of health services and embrace quality evaluations and their focus on continuous improvement.

END OF SUBMISSION