United Voice Submission

Sustainable Health Review
October 2017

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“

I enjoy my job.

I’ve been at the hospital for almost 40 years and I love working in health. However, I work at a public hospital and see a lot of wastage.

Sometimes it all gets a bit too much.

Cutting funding for hospitals, cutting staff and increasing our workload; those things affect me, my colleagues and all West Australians.

We have the best care in public hospitals, but still we need a lot to be improved. Improvements not just for us and our jobs, but for the safety and the benefit of everyone.

”

United Voice member
Royal Perth Hospital

About United Voice

United Voice welcomes the opportunity to make a submission on behalf of our members to the West Australian State Government Sustainable Heath Review.

United Voice is a union of workers organising to win better jobs, stronger communities, a fairer society and a sustainable future. In Western Australia, there are over 18,000 United Voice members working in a diverse range of industries including government and private health, disability support, aged care, emergency services, government education, early childhood education and care, cleaning, hospitality, security, and manufacturing.

A large number of United Voice members work in the health sector in public, private and community health and emergency services health care. Many United Voice members are in low-paid and under-valued employment, and all rely on government to provide access to quality public health services to ensure a fair and equitable society.

As the people working in the health sector, and as users of health services, our members welcome the opportunity to be involved in this review to ensure the future of quality sustainable health services for the benefit of all Western Australians. Improving engagement with workers and unions as significant stakeholders in the health sector is beneficial to the development of effective and innovative policy.

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United Voice WA, Assistant Secretary

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Executive Summary

Improving health care systems while containing cost pressures is a key policy challenge for most developed countries. Health care spending per capita has risen by over 70% in real terms across OECD countries since the early 1990s.[1] Health funding has risen faster than economic growth over the past 20 years, and public funds still account for around three-quarters of all health expenditure.[2]

At a time where public budgets are under pressure it is alarming that approximately one-fifth of health expenditure worldwide has proven to result in minimal (or no) contribution to good health outcomes.[3] OECD research has shown that a significant share of health spending is at best ineffective and at worst, wasteful and that one in ten patients is unnecessarily harmed at the point of care.[4] Further, more than 15% of hospital expenditure is spent on correcting preventable medical mistakes or residual medical problems.[5]

The WA health sector delivers essential services to the community. Health services are complex institutions which provide employment to thousands of people, who are entrusted to provide high standards of service delivery to the communities they serve. Given the scale and significance of the health sector, its efficiency and effectiveness has a significant impact on the health and wellbeing of our community.

The delivery of efficient, effective and sustainable health services requires equal access to quality public services. United Voice members know that a sustainable health system is one that provides quality services that achieve patient outcomes, is delivered by a quality workforce of employees, and provides value for money for the state.

The WA health care sector faces a number of challenges that test its ability to deliver effective, efficient, and responsive services. These challenges are well documented and include: an increasing demand for services (particularly emergency care), an ageing population, a growing prevalence of chronic and complex conditions, workforce capacity, escalating service costs, distributional inequity and changing community expectations.[6]

The growth and mismanagement of the state's health budget under the previous Liberal State Government was unsustainable. Annual health care expenditure in WA increased by approximately 83% from $4.8 billion in 2008-09 to $8.8 billion in 2016-17.[7] Spending has grown faster than inflation and the economy as a whole. Health is the single largest contributor to the state's expenditure over the forward estimates. In 2008-09 the health budget accounted for 24.9% of general government

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[1] OECD *Fiscal Sustainability of Health Systems: Bridging Health and Finance Perspectives*, OECD Publishing, (2015).
[2] Ibid.
[3] Ibid.
[4] Slawomirski, L., A. Auraaen and N. Klazinga, *The Economics of Patient Safety: Strengthening a value-based approach to reducing patient harm at national level,* OECD Health Working Papers No. 96, OECD Publishing, (2017).
[5] Ibid.
[6] OECD, *Tackling Wasteful Spending on Health,* OECD Publishing (2017).
[7] Western Australia State Budget 2017-18, Budget Paper No.3: Economic and Fiscal Outlook, p 102; Western Australia State Budget 2017-18, Budget Paper No. 2: Budget Statements Volume 1, p 116.

expenditure. This has now increased to a staggering 29.7%, and is projected to reach 50.4% in the next decade.

There is an urgent need for the State Government to rethink ways in which health care can be delivered more effectively and efficiently without relying on quick fixes such as workforce cuts.[8] Union members know that measures taken in the short term to restrict spending can in fact increase spending over the long term. When permanent employees are replaced with casual or agency staff, this can result in longer hospital stays and increased risk of residual health problems, putting further pressure on the health system. Further, reduced job security can have a negative impact on how people interact with, and contribute to, the wider economy.

Similarly, where health services are privatised in an effort to cut costs, these contracts themselves can contribute to inefficiencies and wasteful spending within the health budget. Market forces do not provide for good decisions in public health care. Cost savings generated by the private provision of essential services are often illusory, and are in fact borne by patients and the workers who are forced to cope with the consequences of low wages, training levels and lack of employee support. Further, private hospitals, and their shareholders, benefit from the public hospital system which takes on the burden of training health professional and treating more complex medical conditions. This creates inequities in our health system that discriminates against people from lower socioeconomic status.

Significant reform in the WA health sector is required to promote and protect the health of the people of Western Australia, maintain a quality workforce, ensure value for money, reduce inequities in health status and ensure the State Government has the capacity to drive efficiencies in the system.

We acknowledge that many of the following recommendations may not initially appear to be cost saving measures. However, government investment in health care should be understood as a social investment. Efforts to improve the efficiency of health spending at the margin are no longer good enough. Incremental reform must not be viewed as the pathway to a sustainable health sector. Reform must be systemic and integrated in order to prove successful. The State Government must make smarter use of the health budget to deliver better value health care.

Summary of Recommendations

Recommendation one: that the State Government reviews the accessibility of workforce data and the capacity of the Department of Health to collect and maintain sufficient and reliable data in order to make informed decisions.

Recommendation two: that the State Government and the Department of Health develop staffing models that maximise opportunities for secure work that will benefit patient outcomes, improve working conditions and enable workers to participate in the WA economy.

[8] Powell G, *WA Health Review to be led by Robyn Kruk As Government tries to Rein in Spending',* ABC News, (20 June 2017): http://www.abc.net.au/news/2017-06-20/wa-health-review-to-be-led-by-former-public-servant-robyn-kruk/8633600.

Recommendation three: that the State Government review current staffing model for nurses to ensure skills and competency for all nurses are being optimised within the workforce.

Recommendation four: that the State Government continues to support the role of enrolled nurses and implement strategies to promote enrolled nursing as a viable long-term career option.

Recommendation five: that the State Government investigate ways to improve equity between public and private health sectors, such as improving the shared delivery of complex care and significantly increasing licensing fees to better reflect the cost borne by the state.

Recommendation six: that the State Government investigate whether it has the necessary information and expertise within the Department of Health to effectively measure the contribution of the ambulance service as an essential part of the health system in WA.

Recommendation seven: that the State Government consider the benefits of a centralised emergency communications centre that enhances the capacity and coordination of all emergency services.

Recommendation eight: that the State Government review the country model to ensure it best supports paramedics and volunteers in order to achieve appropriate patient outcomes for all people in regional Western Australia.

Recommendation nine: that the State Government investigate innovative models of pre-hospital care that recognises and enhances the role of paramedics in delivering primary health care.

Recommendation ten: that the State Government investigate ways it can take pressure off public hospitals by working with the Federal Government to adequately fund the true cost of care for all elderly Australians.

Recommendation eleven: that the State Government consider increased regulation of GP locations to ensure accessibility of primary care for all West Australians regardless of where they live. State Government should also consider ways to improve the transferability of medical data to improve patient flow through the system.

Recommendation twelve: that the State Government investigate ways to improve awareness of healthcare options, particularly after hours options, to reduce inappropriate hospital attendance and empower people to make informed choices about their own health care.

Quality Workforce

Maintaining a quality workforce is fundamental to delivering high quality and effective health care. The job design of public sector workers impacts on the quality of the work they perform and therefore the quality of the services the public receives. While there is no single measure of quality that can be applied equally, the qualifications, skills and productivity of the workforce are all crucial indicators. Assessments of quality should also take account of qualitative measures of the experience of doing work, job security, pay, and social status. The risk of failing to maintain a quality

workforce is that the State Government will not deliver the level of quality health services that the public needs.

1. Accessibility of Workforce Data

As wages and salaries account for approximately 60% of total health expenditure in Western Australia, workforce planning is vital to ensure funding is appropriately allocated across the health sector.[9] Making informed decisions about workforce planning requires appropriate data being available and easily accessible. Of significant concern is the apparent difficulty that the WA Department of Health (**the Department**) has in ascertaining its own workforce data. This has been made evident through the union's experience requesting workforce data from the Department.

The explanation that has been provided by the Department for why collecting workforce data is often complex and time consuming, or simply impossible to ascertain, has been vague. It appears that Health Service Providers use several different programs to manage the data, some requiring manual data entry, which creates significant delay in providing information to the Department. Further, some managers are reluctant to provide data to the Department and don't respond to requests in a timely manner. The storage of workforce data at a hospital level acts as a barrier to accessing data.

This is simply not good enough. If the Department itself cannot easily confirm who it is employing and how it is engaging them, then it is questionable as to how they are making informed decisions about the workforce.

Recommendation one: **that the State Government reviews the accessibility of workforce data and the capacity of the Department of Health to collect and maintain sufficient and reliable data in order to make informed decisions.**

2. Permanent Employment

> *"I started as a casual worker over seven years ago. I fought hard to become a permanent employee and now I am so grateful because I am the sole breadwinner for my family. You never know what the future holds, so I think it's important to know your rights and that you deserve a secure job. Casual work is tough, they can send you home early even if you need the money and you never know when your next shift is, that really hurts workers. Well trained and permanent staff are vital for public hospitals to function properly."* - United Voice member

The public service is traditionally characterised by secure working conditions with non-ongoing employment being the exception. Under the previous Liberal State Government, job security was depleted under government policy which created an incentive to employ people in insecure forms of work.[10]

Insecure forms of work refer to those arrangements where employment provides little social and economic security and where workers have minimal control over their working lives. The use of fixed

[9] Western Australia State Budget 2017-18, Budget Paper No.2, Budget Statements Volume 1.
[10] Including the Agency Expenditure Reviews, Wages Policy and Workforce Renewal Policy.

term contracts, part-time work, casual work, higher duties, and labour hire have all become part of a growing trend in Australian employment with over 40% of all employees (approximately 4 million people) now in insecure work.[11]

Job security makes a huge difference to the lives of all Western Australians. Evidence shows that the higher the level of job security, the higher the level of productivity. A healthy working environment has been linked to productivity, evidenced by higher output, creativity and lower absenteeism in the workforce.[12] All workers should have jobs that they and their families can rely on with predictable pay and hours of work and access to important conditions such as paid leave, protection from unfair dismissal, quality training and career opportunities.

Insecure jobs invariably mean lower pay and less rights and entitlements. Insecure work not only impacts on an individual's financial security, but can result in an increase of adverse OSH outcomes, decreased job satisfaction, motivation, productivity, and performance, as well as increased turnover, stress, occupational injury and illness levels.[13]

2.1 WA Hospitals

The excessive use of casuals and agency staff in WA public hospitals has led to inferior outcomes for all stakeholders by undermining working conditions, compromising service outcomes for patients and costing taxpayers unnecessary money.

Casual and agency workers do not have the same access to rights and entitlements enjoyed by permanent workers, such as personal and annual leave and training and professional development opportunities. For many of these workers this insecure employment is not a stepping stone to more secure employment, but rather an on-going state of insecurity and hardship.

In March 2017, United Voice was notified by the Department that in the months of October to December 2016, over $2.36 million was paid to recruitment agencies for temporary enrolled nurses and assistants in nursing at Fiona Stanley Hospital. This amount is equivalent to paying for approximately 121 full-time enrolled nurses for the same period of time. This is a clear example of wasteful spending that would be better allocated to providing permanent jobs.

> *"If a hospital needs staff, it should hire them instead of relying on agency staff. It's a waste of money. We need permanency to stabilise the workforce."* – United Voice member

2.2 Economic Impact

The excessive use of insecure work in the WA health sector is unnecessarily increasing the health budget. The use of insecure work is often underpinned by a flawed ideology that these atypical forms of employment will keep workforce costs down. However, a business model that is predicated

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[11] Stanford J, *A Portrait of Employment Insecurity in Australia: Infographic,* The Australia Institute: Centre for Future Work, (2016).

[12] Independent Inquiry into Insecure Work, *Lives on Hold: Unlocking the Potential of Australia's Workforce*, (2012).

[13] Ibid.

on short term profits generated by widespread use of insecure work is unsustainable and will not result in long term benefit for the budget.[14]

Increased costs from insecure work are not limited to the direct cost of engaging agency or casual staff. The drive to engage an insecure workforce ignores the fact that one of the main long-term drivers of productivity is investment in the skill of workers. Insecure work can lead to loss of skills and motivation. There is a growing body of international research linking casual employment to negative effects such as decreased job satisfaction, motivation, productivity, and performance, as well as increased turnover, stress, occupational injury and illness levels. These adverse outcomes are all costly for organisations.[15]

The impact of insecure jobs can go far beyond the workplace itself and have can have damaging impact on the wider economy. The lack of secure work can have severe impact on an individual's living standard, financial independence, and contribution to an engagement with the wider economy. Insecure work will also contribute to a widening of financial inequalities with more people reaching older age with less superannuation, who then find themselves reliant on the aged pension and the welfare safety net.

> *"Workers continually stuck in these insecure working arrangements lose confidence that things are going to change. Morale in the workplaces is really low when people don't know where their next paycheck is coming from. If workers have permanent jobs and job security they will feel valued by their employer and will be inclined to be productive in the workplace."* – United Voice member

At 5.9%, WA's unemployment rate surpasses the national average and there are thousands of workers who are desperate for a permanent and secure job.[16]Health services is not a boom or bust industry, there is always consistent, if not increasing, level of people who require health treatment. The failure of employers to invest in their workforces by short term cost cutting and cost shifting will increase overall workforce costs. This will have a detrimental impact on workforce productivity and government's ability to meet community needs and expectations on standards of care.

Recommendation two: that the State Government and the Department of Health develop staffing models that maximise opportunities for secure work that will benefit patient outcomes, improve working conditions and enable workers to participate in the WA economy.

3. Nursing Workforce

The nursing profession is the largest single health profession in Australia and has a fundamental role in driving an efficient and sustainable health sector. Maintaining a sustainable nursing workforce is therefore integral to the provision of safe, efficient and high quality primary health care.

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[14] Independent Inquiry into Insecure Work, Lives on Hold: *Unlocking the Potential of Australia's Workforce,* (2012).

[15] Ibid; Arends, I., C. Prinz and F. Abma, *Job quality, health and at-work productivity*, OECD Social, Employment and Migration Working Papers No. 195, OECD Publishing (2017).

[16]ABS 6202.0 - Labour Force, Australia, August 2017.

Enrolled nurses (**EN**) are an underutilised resource in our public hospitals. There is a strong economic and pragmatic case for increasing the numbers of ENs in the workforce. With a health budget under significant pressures, increased EN employment will reallocate funding in a manner that both optimises patient outcomes and is fiscally responsible.

It is equally important that the State Government address structural and cultural issues that devalue the role of ENs in public hospitals to enable all nurses to work to a full capacity. The problem is two-fold; there are not enough ENs employed and where they are employed, ENs are often not being used to their full capacity. Investing in enrolled nursing as a profession and supporting it as a viable long-term career option will contribute significantly to the state's economic growth.

> *"The State could save millions of dollars, and improve patient care, by changing the proportion of ENs. ENs are highly qualified and capable of delivering the majority of care services."* – United Voice member

3.1 Enrolled Nurse Employment

Despite the fact that ENs provide quality, efficient and sustainable health care, their employment in WA public hospitals is minimal when compared with registered nurses (**RNs**). According to data provided by the Department, ENs account for just 9% of all nurses employed in public hospitals.[17] This is compared to a national workforce split (by registration) of approximately 80/20 (RN/EN).[18] Further, there was a 5.3% decline of ENs and a 3.9% increase of RNs employed in WA Government hospitals from 2014 to 2015.This indicates a preference by the Department for employing RNs over ENs.

Scenario modelling

Based on data supplied by the Department it is roughly estimated that the average EN costs approximately $33,000 less per nurse per year than the average RN in a WA public hospital (estimated savings are attributable to income differences and do not take into account the associated costs involved in training and employing different nursing professions).[19]

The cost modelling below at Table 1approximate cost savings derived from changes to the skill mix that increase the number of ENs employed at public hospitals in a substitutive manner.[20] This cost modelling is based on the assumption that the difference between an RN and EN is $33,000. Further, the focus of the cost analysis below is on the potential differences achieved in savings, rather than the absolute costings.

[17] Data provided by the WA Department of Health, 2015: 19,580 total (by headcount) = 1,762 (EN), 17,818 (RN)
[18] Nurse and Midwifery Board of Australia, *Registration Data Table*, (June 2017).
[19] Based on the assumption that for 2015, the weighted average annual income is $78,341.90 (EN) and $111,286.92 (RN).
[20] The following assumptions (based on data provided by the WA Department of Health, 2015) were relied upon in the calculation of these figures: the Department employs 19,580 nurses (by headcount);1,762 (EN) and 17,818 (RN); the average EN costs $33,000 less to employ than the average RN; total employee costs $4,948,051,000 (2016-17 budget); total health budget $ $8,568,073, 000.

Table 1: Estimated Cost Modelling

Estimated Cost Modelling of Skill Mix – WA Government Hospitals					
Workforce Ratio EN/ RN (%)	Worker Numbers (headcount)	Change in Worker Numbers (headcount)	Total Savings ($)	Savings to Workforce Costs (%)	Savings to Health Budget (%)
9/91	EN - 1,762 RN - 17,818	-	-	-	-
30/70	EN – 5,874 RN – 13,706	4,112 more/ less EN/RN	$135,696,000	2.7%	1.6%
50/50	EN – 9,790 RN – 9,790	8,028 more/ less EN/RN	$264,924,000	5.4%	3.1%
70/30	EN – 13,780 RN – 5,874	11,944 more/less EN/RN	$394,152,000	8.6%	4.6%

Impact

As can be seen from the above scenario modelling, there is a clear cost benefit to increasing the number of ENs in public hospitals. ENs are highly trained and skilled nurses who provide quality, efficient and sustainable health care. ENs are generally considered faster to train, cheaper to employ and available in geographical areas where there are shortages of RNs. An appropriate skill mix that optimises EN employment and enables all workers in the health care team to work to their maximum scope of practice will reduce the state's health budget.

Employing the right mix of a qualified and experienced workforce is vital for patient safety and cost savings should never be at the expense of providing quality health care. There is a body of research that indicates scope to change the skill mix in the nursing workforce whilst maintaining safe, quality patient care.[21] Drivers for such change include freeing up of the regulated nursing workforce resources to be employed in more complex practice activities, cost savings delivered by a changed skill mix, as well as increased job satisfaction for highly-trained professionals performing the role they were trained for, with likely consequent effects on workforce retention.[22] These outcomes will have positive flow-on effects for patient care.

3.2 Enrolled Nurse Scope

> *"Enrolled nurses are not being valued. People say that RN stands for 'real nurse'. Being undervalued is why we're underutilised."* – United Voice member

Not only are ENs being underutilised on an FTE basis, ENs skills are also being underutilised due to a myriad of structural and cultural factors that prevent some nurses from working to their full scope. This carries a strain on hospital productivity with workers being tasked at levels below their actual competencies.

[21] *Australia's Future Health Workforce – Nurses Overview*, 2014.
[22] Ibid.

Enrolled nurse role
ENs in Australia must complete a Diploma of Enrolled Nursing and spend 12-18 months studying (full-time) through a state or private training provider. On completion of the course, ENs can practice across a range of clinical settings. An EN works under the direct or indirect supervision of an RN to provide patients with nursing care. ENs are an integral part of the health care team, delivering care that is often described as complimentary to that delivered by an RN. An EN retains responsibility and independence for their actions, and is accountable to the RN for all delegated functions.

Within their scope of practice, an EN is accomplished in the practical skills of nursing, with advanced ENs being able to undertake more complex procedures. Despite the fact that the role of the EN in Australia has been greatly expanded in recent years, opportunities for graduate positions and career progression remain somewhat limited, and for this reason, many ENs undertake further study to progress to an Advanced Skill Enrolled Nurse, or to convert to an RN or midwife.

RNs & ENs
While both roles fulfil a distinct function in the delivery of nursing care and are an essential part of an appropriate skill mix, the role boundaries between RNs and ENs are unquestionably becoming less delineated. RNs and ENs work together in complementary roles within the nursing team, but maintain a different scope of practice. Over the past decade, significant changes have occurred in the educational preparation of ENs. This has increased their shared scope of practice, meaning ENs are undertaking many roles and responsibilities previously undertaken only by an RN such as in emergency departments, operating theatres, and acute medical and surgical wards and administering medications (including dispensed schedule 8 medications).[23]

Scope of practice
The extent of an individual's scope of practice in a particular clinical setting is dictated by the organisational policies and requirements of the employing entity. In practice, this means that despite the expanded scope of the EN, if an employer dictates a scope of practice that limits their ability to work to this scope, they will be restricted from working to their full competence in that setting. By dictating a scope of practice that unnecessarily limits the EN scope of practice below actual competence, employers are contributing to productivity issues that puts the sustainability of the health sector at risk.

> *"As an EN in a private hospital I could do everything I was educated to do. When I went to work in a public hospital I got to do very little."*- United Voice Member

Where ENs are supported to work to their full scope of practice, RNs will be supported to work to theirs. The *Australia's Future Health Workforce – Nurse Overview Report 2014* modelled skill mix scenarios to illustrate the budget impact of different ratios of nurses, whilst maintaining safe and high quality patient care. This included reducing the proportion of RNs and increasing EN and AIN resources. Changing the skill mix was said to have consequent effects on workforce retention by increasing job satisfaction of RNs and ENs, who would be better able to work to their scope and perform the roles they were trained for.

[23] Jacob E, McKenna L and D'Amore A, *Educators' expectations of roles, employability and career pathways of registered and enrolled nurses in Australia*, Nurse Education in Practice 16 (2016).

Various research studies in Canada in the early 2000s highlighted the productivity issues with minimising the scope of practice for LPNs (Canadian equivalent to an EN).[24] Minimising scope of practice was said to reduce productivity, job security and retention rates at a time when the health budget was already under pressure.[25] It was widely recognized that all nurses should be utilized to the fullest extent of their competencies to meet the health needs of the public and that there is a need to determine optimal nurse mix and use of non-nursing personnel. Further, overall costs are reduced when experienced nurses are retained. Retention is more likely when there is job security and when nurses can work to their full scope of practice.

3.4 Supporting the EN Role

As noted above, despite the fact that the EN role has been greatly expanded in recent years, opportunities for career progression and earning capacity remain somewhat limited, and for this reason, many ENs undertake further study to progress to an Advanced Skill Enrolled Nurse, or to convert to an RN or midwife.

While there will always be a cohort of workers who see the RN conversion course as natural career progression, there are those who are motivated by negative or 'push' factors. Literature reviews regarding EN conversions found that ENs view the RN conversion program as the primary means for achieving their goals of working with higher and increased responsibility, developing their career, and experiencing more job satisfaction.[26] Others were driven by negative factors, such as limited opportunities for career advancement; a lack of professional development; confusion about their scope of practice; lack of encouragement; role erosion; perceived prejudice and the increasing role of nursing support staff. These factors can further entrench the perceived devaluing of the EN role.

Anecdotally, United Voice members report:

- *"We do pretty much the same thing as an RN, but we don't get paid for it and we don't get recognised for it, we don't have the same opportunities."*
- *"I have been an EN for almost 10 years now. The EN role is really limited, I can't move into non-clinical roles. I can't progress any further unless I chose to do a conversion course to become an RN."*

The reduced gap between the cost of a Diploma of Enrolled Nursing and a Bachelor of Nursing may also result in an increased number of potential students choosing to find an alternative pathway into university to enter the RN course as a viable alternative to the EN course. While a Diploma of Enrolled Nursing at TAFE can cost anywhere between $8,675 to $22,500, a Bachelor of Nursing from university will cost anywhere between $19,500 to $32,844. This is compounded by the fall in the minimum entry scoring for the RN course which is now between 55-75 ATAR.

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[24] Walker A et al, *Collaborative Nursing Practice: RNs and LPNs Working Together*, Canadian Nurse, (2015); *Nursing Education and Regulation: international profiles and perspectives*, Kings College London (2007); Parker, O.R, *2012 Nurse Staffing Literature Review*, RPNAO (2012); Little, *Nurse Migration: A Canadian Case Study*, Health Services Research (2007); *Toward Increased Integration of LPNs into Health Authority Employment Settings*, Health Authorities Health Professions Act Regulations Review Committee (2002).
[25] Ibid.
[26] Ralph et al, *From EN to BN to RN: An exploration and analysis of the literature,* Contemporary Nurse (2013) 43(2): 225–236.

Supporting the EN role as a viable long-term career option will be essential to ensure the ongoing sustainability of the EN workforce. The EN role must be amended to attract people and retain them in the workforce.

Potential strategies include:

- Maximising scope of practice so that ENs are completing the tasks that they have been trained to do.
- Greater definition between EN and RN roles to ensure each is working to their full competence.
- Greater career progression opportunities, including progression into non-clinical roles such as ward management without having to complete an RN conversion course.
- Reduced TAFE fees to pre-2014 levels to ensure the EN role is not priced out of the market.
- Greater access to EN graduate positions to ensure retention of new graduates. For 2015, the shortfall was estimated at 78.5% for ENs and 55% for RNs.
- Greater access to training and professional development over and above the standard annual requirements.

Recommendation three: that the State Government review current staffing model for nurses to ensure skills and competency for all nurses are being optimised within the workforce.

Recommendation four: that the State Government continues to support the role of enrolled nurses and implement strategies to promote enrolled nursing as a viable long-term career option.

Measuring Value

As health care costs continue to climb, the State Government must ensure that health expenditure is delivering value for money and achieving positive health outcomes for all West Australians. Where the structure and governance of the health sector compromises value for money, this will put further pressure on the sectors ability to deliver sustainable health care. Health care funding must be effective or it will ultimately undermine public finances.

As health expenditure now accounts for almost 30% of our state budget, an essential component of a sustainable health sector is that it provides value for money. In 2015-16 the estimated cost for delivering health care in WA was $6,907 per person. This is 3.5% above the national average, and the second highest after South Australia at 3.6% above the national average. This is compared with Victoria at 4.5% less and NSW at 2.2% less than the national average.[27] These numbers are not an indication of value as value must be understood in the context of patient outcomes and not just a dollar figure.

[27] Australian Institute of Health and Welfare, *Health Expenditure Australia 2015–16* (2017).

4. Privatisation

United Voice supports the State Governments commitment to stop the privatisation of public health and hospital services and where possible bring services back into the public sector.[28]

Privatisation of public health services does not represent value for public money. Privatisation, at its core, pushes organisations to other goals away from the key goals of patient outcomes. The private sector is motivated by bottom line profit, which incentivises continually reducing costs and improving delivery mechanisms, often to the detriment of service delivery. Cost savings generated by the private provision of essential services are illusory, and are in fact borne by the workers and patients who are forced to cope with the consequences of low wages, training levels and lack of employee support.

The Union's position against privatisation has been well documented in previous submissions.[29] United Voice members have directly experienced the privatisation of essential health services and the detrimental impact this had had on patients, the workforce and the wider community. In a recent survey of union members, 89% of members in the health sector believe that further privatisation of public hospitals will erode the quality of health care in WA.

5. Private Hospitals

As users of the public health system, United Voice members know the importance of equitable health service delivery. In WA, health services are delivered in the public and private sectors. The state, the public hospital system and the tax payer are unfairly taking on the burden of training health professionals and treating higher levels of complex care patients. Private hospitals and their shareholders unfairly benefit at the publics expense. There is a growing need to address the inequalities and costs associated with a two-tiered system of health care.

5.1 Equity of Service Delivery

In Australia, approximately 40% of the population has private health insurance. Private insurance buys access to privately provided hospital care and choice of doctor in public hospitals. Private hospitals do not have the same degree of service obligations as public hospitals, and have more scope to raise revenue from fees. On average, private hospitals treat more patients living in areas classified as being the highest socioeconomic status.[30] The incentive for private (particularly for-profit) hospitals is to generate returns on their capital investment and labour force, for the benefit of owners and shareholders.

Public hospitals are required to provide free treatment to all public patients, and are also assigned specific functions including the provision of emergency services, clinical teaching and research, and

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[28] Putting Patients First, WA Labor Policy (2016).

[29] Public Accounts Committee, *Inquiry into the decision to award Serco Australia the contract for the provision of non-clinical services at Fiona Stanley Hospital*, Western Australia Legislative Assembly, October 2011; Education and Health Standing Committee, I*nquiry into the transition and operation of services at Fiona Stanley Hospital*, August 2015; Commission of Inquiry, *Inquiry into Government Programs and Projects,* June 2017; Service Priority Review, June 2017.

[30] *Admitted Patient Care 2015-16: Australian Hospital Statistics*, AIHW: https://www.aihw.gov.au/getmedia/3e1d7d7e-26d9-44fb-8549-aa30ccff100a/20742.pdf.aspx?inline=true

equity of access. Patients treated in public hospitals are, on average, from lower socioeconomic groups, and have more complex medical conditions.[31]

Acuity of services

Typically, public hospitals take on the burden of complex high acuity cases. For 2015-16, public hospitals accounted for approximately 61% of all acute care patients nationally. In 2015–16, public hospitals accounted for the majority of childbirth separations (75%), medical separations (73%) and emergency admissions (92%). In private hospitals separations were more likely to be elective (94%) or other planned care (95%). Private hospitals also performed the majority of elective surgery procedure (67%).

Under the current funding model, there is no financial benefit to taking on a higher number of complex cases. Higher complexity cases tend to increase financial pressure on hospitals as they are more likely to result in longer hospital stays and higher chances of residual health problems, such as infection.[32]

One example of the public sector taking the burden of complex and costly services is evidenced through obstetrics services. On average, pregnant patients who use private hospitals tend to be low risk, meaning that they are generally in good health and not likely to experience complications during pregnancy or birth. Public hospitals on the other hand are more likely to provide care for women with a higher likelihood of experiencing complications.

In WA tertiary care is provided at King Edward Memorial Hospital (**KEMH**). Women assessed as having a 'high-risk' of pregnancy complications and who require on-going specialised obstetric care will be referred by their GP or obstetrician for tertiary care. Women who receive care initially through other WA maternity services, including private hospitals, who experience unexpected and complex complications during pregnancy or in labour may be transferred to KEMH for specialist care.[33]

Private patients in public hospitals

Private hospitals should be tasked to genuinely reduce the pressure on the public health system. Since 2010 there has been a rapid growth in privately insured patients using public hospitals. Across Australia the number of private patients in public hospitals with an urgency of admission status of 'Emergency' increased by 37.9%, compared with the number of public patients which increased by 17.3%.

Further, the number of private patients in public hospitals with an urgency of admission status of 'Elective' increased by 17.1%, compared with the number of public patients which increased by 7.6%. Overall the number of private patients in public hospitals increased by 28.6%, compared with the number of public patients which increased by 13.7%.[34]

This increase of admissions increases the demand on public hospitals and can lead to discrimination of public patients in public hospitals. In 2015-16, public patients had a median waiting time of 42

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[31] Ibid.
[32] https://theconversation.com/which-are-better-public-or-private-hospitals-54338
[33] http://www.kemh.health.wa.gov.au/having_a_baby_in_WA/tertiary_care.htm
[34] *Admitted Patient Care 2015-16: Australian Hospital Statistics*, AIHW: https://www.aihw.gov.au/getmedia/3e1d7d7e-26d9-44fb-8549-aa30ccff100a/20742.pdf.aspx?inline=true

days for elective surgery in a public hospital, while patients who used private health insurance to fund all or part of their admission had a waiting time of just 20 days.[35]

5.2 Private Hospital Licensing

Private hospitals in Western Australia are licensed and monitored by the Department of Health Licensing and Accreditation Regulatory Unit and governed under legislation.[36] Private hospitals must pay a licensing fee once a licence has been granted. This fee consists of a fixed component for the granting of licence and an Approval of Premises component that depends upon the maximum number of patients to be treated. Licenses must be renewed annually at a fee also based upon the capacity of a facility.[37]

As can be seen below at Table 2, a large private hospital, such as St John of God Midland, will pay a maximum of less than $2,000 a year in licencing fees. This is a remarkably low cost considering Government significantly contributes to the cost of hospital infrastructure and would represent a nominal proportion of overall hospital revenue. Further, as public hospitals often take a burden of the health system, private hospitals and their shareholders are unduly benefiting from these low costs.

Table 2: Licensing Fee 2017-18

Maximum # patients to be treated	Grant and approval of premises	Renewal fee
Fewer than 25	$8,085	$1,200
25-100	$9,160	$1,250
101-200	$12,295	$1,450
201+	$15,395	$1,990

Recommendation five: that the State Government should investigate ways to improve equity between public and private health sectors, such as improving the shared delivery of complex care and significantly increasing licensing fees to better reflect the cost borne by the state.

6. Ambulance Services

Ambulance officers, including paramedics, communications and transport officers all play a critical role in protecting the health and welfare of the Western Australian community. Emergency services providers are often the gateway to the primary health care system. The efficient delivery of pre-hospital health care, emergency response and patient transport services are critical components of our health care system. The provision of quality ambulance services goes to the core of government

[35] Ibid.

[36] Private Hospitals and Health Services Act 1927, Hospitals (Licensing and Conduct of Private Hospitals Regulations 1987 and Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997

[37] Department of Health, *How to Obtain a Licence for a Private Health care Facility,* (2017), http://ww2.health.wa.gov.au/Articles/F_I/How-to-obtain-a-licence-for-a-private-health care-facility.

responsibilities toward its citizens. Any inefficiency will have an impact on patient care and will result in substantial flow on costs to the entire health system.

In the alternative, an effective ambulance service which meets the health needs of its constituent community, can provide quality health care, is associated with a decreased number of medical interventions, shorter hospital stays, and lower levels of patient morbidity.[38] An ambulance service that can provide genuine out of hospital and pre-hospital clinical care services will substantially add value to the functionality and sustainability of the health sector.

The contract with St John Ambulance Western Australia Ltd (**St John**) to deliver emergency services for WA represents a significant proportion of the health budget, at approximately $100 million per year. St John have been providing ambulance services in WA since 1922 and have an effective monopoly on the provision of ambulance services in WA. As a consequence of successive governments, the role of government appears to have been diminished to merely a narrow contract management role. This has an impact on the government's ability to make informed decisions to best utilise the ambulance service within the wider health system.

6.1 St John Ambulance WA

WA and the Northern Territory are unlike other Australian jurisdictions where ambulance services are provided by government agencies and regulated by legislation. St John is currently contracted by the Department to provide ambulance services throughout the state, excluding Derby, Fitzroy Crossing and Halls Creek. Covering 2.5 million square kilometres, the contract covers the largest area of any single ambulance service in the world.

St John operates 144 regional locations as well as 29 metropolitan depots across Perth. Metropolitan depots are staffed by paid paramedic and transport officer crews. A mix of paramedics and volunteer crews staff the 15 larger country sub-centres (career sub-centres), while the remaining country sub-centres are staffed almost entirely by volunteer ambulance crews (volunteer sub-centres).

6.2 True Cost of Ambulance Service

WA's expenditure per person for ambulance services is 27% lower than the national average (see below). The difference in expenditure nationally can be largely explained by the comparatively high number of volunteers engaged by St John in WA that offsets the overall expenditure. Through its reliance on volunteers, this service model is not comparable to services in the rest of Australia that are provided predominately by paid ambulance officers. As per Table 3, although the economics of this model may appear to be attractive, the measurement doesn't indicate the capacity of the service model to deliver the same standards of patient care.

[38] Centre for Policy Development (CPD) (2017) How an Ambulance Service can contribute to the health care continuum https://cpd.org.au/2007/07/how-an-ambulance-service-can-contribute-to-the-health-care-continuum/

Table 3: Ambulance Service Organisations Expenditure, 2015-16[39]

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Aust.
Total $m	888.3	809.4	671.1	241.4	271.3	69.2	47.3	28.1	3026.1
Per person $	115.80	134.99	139.56	92.72	159.30	133.83	120.30	114.95	126.40

Measuring outcomes

The Department lacks ability to measure patient outcomes and standards of practice for ambulance services, particularly in the country. While the contract provides for some measureable KPIs these are limited and therefore the governments capacity to make informed decisions is also limited.

Measureable indicators under the contract are limited to response time targets and arrival time targets. Anecdotally our members report that these targets are wholly inadequate, do not provide for good patient outcomes and are measured in such a way that it is impossible for the government to be satisfied that community expectations are being met.

Anecdotally our members report:

- *"Everyone regardless of where they live should receive the same chance of survival post cardiac arrest. Currently the response times are recorded for the whole metro area so quick response times in the CBD off set the slow response times in the outer suburbs. This means you are more likely to survive cardiac arrest in the city than in the outer suburbs."*
- *"Currently our response times blow out in winter due to the effect of the flu on the elderly but these slower times are offset by better summer response times meaning your chance of survival in an emergency is better in summer compared to winter."*

Not only is reporting limited, funding is not linked to service outcomes. There is no compensation to the state if the obligations under the contract are not met. As such, there is no financial risk under the contract in relation to the levels and quality of service delivered.

Further, the contract does not require reports to government on patient outcomes, other than a broad "patient satisfaction" rating. Whilst important, this is not an indication that a patient has received the most efficient or appropriate level of care that is in the best interests of the state's health system.

Inefficient service delivery

There are a number of inefficient work practices at St John that compromise patient outcomes and do not represent value for money. As noted above, due to the constraints of the contract, the Government has little ability to intervene and address these issues.

There are a range of important measurements that the government needs to ensure the best outcome for the health system. These include:

- Number of ambulance crews on the road.
- Number of ambulance crews on stand-by.

[39] *Report on Government Services 2017*, Chapter 11, (2017).

- Number patient transport crews on road.
- Number of paramedic crews being required to perform low acuity patient transport.
- Allocated priority codes appropriately match acuity of job given higher priority jobs attract a higher fee for service.
- OSH outcomes including health and wellbeing of the workforce.

State operations centre

St John also operates the State Operations Centre (**SOC**) located at Belmont. The SOC are responsible for call taking and ambulance dispatch and work separately from other emergency services. In 2015-16, the SOC responded to a total of 552,275 calls, 219,288 of which were emergency triple zero calls. This is an increase of 8% for total calls and an increase of 13% for emergency calls on the previous year.[40]

The separation of ambulance communication from other emergency communications centres inevitably creates issues in the coordinated delivery of services. For example, police may be limited in their capacity to provide information to ambulance communications which can have an impact on ambulance crews attending scenes which require a police presence. Integrating communications would enable services to directly communicate with each other avoiding duplication and improving patient outcomes.

Country model

As noted above, WA's compatibly cheaper expenditure per person for ambulance services can be explained by the country services model that puts volunteer (not paid paramedic) at the centre of its service delivery model for country WA. In the 2015-16 annual report, St John confirmed it has a total of 7,998 volunteers in WA, a 65% increase on the prior year. 3,178 of these volunteers staff the country sub-centres.[41]

Table 4: Ambulance Service Personnel, 2015-16[42]

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Aust.
Number of Paramedics (FTE)	2,904	2,704	3,006	602	738	249	144	88	10,434
Paramedics (FTE) per 100,000 people	37.9	45.1	62.5	23.1	43.4	48.2	36.7	35.9	43.6
Number of Volunteers (FTE)	150	723	139	3,178	1,441	513	-	38	6,182

St John volunteers should be commended for the role they play in delivering emergency health care in country WA. Volunteers formed the backbone of the historic ambulance services of the 19th and 20th centuries, however modern norms of professionalization in paramedicine mean that they should now be viewed as a valuable supplement to, rather than substitute for qualified paramedics.

[40] St John Ambulance, Annual Report 2015-16.
[41] St John Ambulance, Annual Report 2015-16.
[42] *Report on Government Services 2017*, Chapter 11, (2017).

The government must satisfy itself that the volunteer model provides an appropriate level of service for country WA when compared to metropolitan WA. When people in the country call for an ambulance, the chances are they will be attended to by at least one volunteer who cannot be expected to provide the same level of service as a qualified paramedic.

Recommendation six: that the State Government investigate whether it has the necessary information and expertise within the Department of Health to effectively measure the contribution of the ambulance service as an essential part of the health system in WA.

Recommendation seven: that the State Government consider the benefits of a centralised emergency communications centre that enhances the capacity and coordination of all emergency services.

Recommendation eight: that the State Government review the country model to ensure it best supports paramedics and volunteers in order to achieve appropriate patient outcomes for all people in regional Western Australia.

6.3 Contemporary Best Practice Ambulance Services

The growing demand for emergency health care requires an efficient use of existing emergency resources. Overall demand for ambulances has increased by 68% since 2006-07.[43] An ambulance service that can provide genuine out of hospital clinical care services outside of emergency departments would have substantial benefits for the sustainability of the WA health sector.

There is a body of evidence that considers the needs for the development of innovative models of care that recognise the important role paramedics can play in primary health care and service delivery, particularly in rural communities and for elderly patients.[44] Integrating ambulance services into the primary health care system has been shown to increase efficiency and provides an opportunity for an ambulance service, with its relevant expertise, to positively influence the outcome of health objectives.

In response to the increase in ED demand a small number of 'extended care paramedics' (**ECPs**) have been introduced in New South Wales and South Australia. The premise is that for certain non-critically ill patients, the ECP can either 'see and treat' or see and refer' to another primary or community care practitioner. ECPs provide an alternative model of care to the current 'see and transport to ED'.

Similarly, in the ACT the Intensive Care Paramedic pilot program examined the benefits associated with expanding the clinical role of paramedics into primary health care. Preliminary results from the program indicated that approximately 65% of extended care paramedic cases result in the patient being safely managed in their home residence and referred to other primary health care providers.

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[43] *Report on Government Services 2017*, Chapter 11, (2017).

[44] Berchet C and Nader C, *The organisation of out-of-hours primary care in OECD countries*, OECD Working Papers, No. 89, OECD Publishing, (2016) ; Smith M & Smith L, Paramedics As Primary Care Providers?, PHC Research Conference (2014); O'Meara, P. F et al, *Extending the paramedic role in rural Australia : a story of flexibility and innovation*, Rural and remote health, vol. 12, no. 2, (2012); *How an Ambulance Service can contribute to the health care continuum*, CPD (2007): https://cpd.org.au/2007/07/how-an-ambulance-service-can-contribute-to-the-health-care-continuum

This resulted in improved patient satisfaction and reduced the number of patients transported to emergency departments.[45]

In England, Emergency Care Practitioners (**ECPs**) are paramedics who have undertaken additional training to assess, treat and refer patients to the most appropriate medical services. A randomised controlled trial found paramedics with extended skills can provide effective response compared to standard ambulance transfer and treatment in an ED for elderly patients with acute minor conditions.[46] Overall, patients attended by a paramedic practitioner were less likely to visit hospital EDs and to undergo some form of investigation. Care provided by paramedic practitioners reduced the need for subsequent referral to unscheduled care services in a large proportion of cases, and lead to greater patient satisfaction.

Recommendation nine: that the State Government investigate innovative models of pre-hospital care that recognise and enhances the role of paramedics in delivering primary health care.

Demand for Services

As both workers in, and users of, the WA health care sector, United Voice members know that that health care should be universally available on the basis of patient need and not on socioeconomic or demographic status. Inequities in access are a major driver of the increased demand for emergency services. Improving access to after-hours health care and increasing sector awareness can reduce demand for hospital care.

Australia is a geographically large country with an extremely skewed population distribution, with high urbanization combined with very low population density in rural areas. An ageing population coupled with increase in non-traditional forms of employment brings a renewed focus on the need to improve equitable access to health care, including how to target cultural and informative barriers and how to better coordinate out of hospital care.

7. Accessible Health Care

Emergency Department (**ED**) activity in WA has been steadily increasing over a number of years. More people are waiting for health services and they are waiting longer. In 2015-16 there were over one million emergency department attendances in WA hospitals. This is an increase of 20,000 people presenting for admission on the previous year.[47] On any given day approximately 1,740 people will attend a metropolitan ED in WA.[48]

Of great concern is the number of admissions to an ED for conditions more appropriately treated through alternative primary care options such as local general practitioners. Inappropriate visits to

[45] Smith M & Smith L, *Paramedics As Primary Care Providers?,* PHC Research Conference (2014).
[46] Mason et al, *Effectiveness of paramedic practitioners in attending 999 calls from elderly people in the community: cluster randomised controlled trial,* BMJ (2007); Berchet C and Nader C, *The organisation of out-of-hours primary care in OECD countries*, OECD Working Papers, No. 89, OECD Publishing, (2016)
[47] Department of Health WA Annual Report 2015-16.
[48] Government of Western Australia Department of Health, Metropolitan Health Service Annual Report 2015-16.

ED account for nearly 32% of ED visits in Australia.[49] In 2015-16 more than 60% of people discharged from the ED were discharged without hospital admission.[50]

Inappropriate ED visits are a source of concern for several reasons; they consume ED inputs and jeopardise the prompt treatment of more seriously ill patients; they reduce the quality of care through prolonged waiting times and delay diagnosis and treatment; they lead to overcrowding and disrupt patient flow within hospitals, which might adversely affect quality and outcomes of care. Non-urgent ED visits contribute to the strain on public hospitals and are a significant inefficiency in the health system.

7.1 Elderly Patients

Australia's ageing population has been well documented as a significant and increasing challenge to the health system.[51] Australia's older generation continues to grow and is projected to more than double by 2057. [52] The ageing population and increases in chronic conditions is a major contributor to increased hospital admissions and increased health expenditure.

Older Australians disproportionately represent hospital attendance, admission, and extended stays. Australians aged 65 or older are 13% of the population, but make up 35% of hospital admissions and are 11.1 times more likely to be admitted for a multiday inpatient stay.[53] This demographic constitutes 47% of hospital bed-days. By 2050 this bed utilisation is projected to rise to two thirds of all hospital bed-days.[54]

An ageing population not only increases demand for services, but it changes both the mix and volume of medical procedures and services required. An increase in the proportion of people who are ageing is combined with increased levels of chronic disease and co-morbidities. The 2012 *ABS Survey of Disability, Ageing and Career* reported that 51% of men and 54% of women aged 65 and over had some form of disability. This proportion was higher for those aged 85 and over, with four out of five people experiencing disability. There has also been an increase in the expected years of life with a severe or profound core activity limitation, for both men and women. People are living longer, but with a higher number of years spent in ill health as a share of life expectancy.

A key reason older patients are staying in hospital is delay in transitioning into alternative care.[55] Hospital beds are being utilised by elderly patients who have been cleared for discharge or no longer

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[49] Berchet C and Nader C, *The organisation of out-of-hours primary care in OECD countries*, OECD Working Papers, No. 89, OECD Publishing, (2016).

[50] https://www.mediastatements.wa.gov.au/Pages/Barnett/2016/06/New-campaign-aims-to-reduce-non-urgent-ED-visits.aspx

[51] Arendts G, and Lowthian J, *Demography is Destiny: An Agenda for Geriatric Emergency Medicine in Australia*, Emergency Medicine Australasia 25 (2013); Nichol B, Longeran J and Mould M, *The Use of Hospitals by Older People: A Casemix Analysis*, Occasional Papers: New Series No.11 Commonwealth Department of Health and Ageing, Canberra.

[52] Australian Institute of Health and Welfare, *Older Australians at a Glance* (2017).

[53] Arendts G, and Lowthian J, *Demography is Destiny: An Agenda for Geriatric Emergency Medicine in Australia*, Emergency Medicine Australasia 25 (2013).

[54] Ibid.

[55] Ou L et al, *Discharge Delay in Acute Care: Reasons and Determinants of Delay in General Ward Patients,* Australian Health Review, (2009); M. Crotty et al, *Transitional Care Facility for Elderly People in Hospital Awaiting a Long Term Care Bed: Randomised Controlled Trial*, BMJ; R. Karmel et al, *Transitions from Hospital to Residential Aged Care in Australia,* Australian Journal of Ageing, (2009).

require acute hospital care. This inefficient allocation of resources limits capacity of public hospitals to provide care to all Western Australians who require it. Further, the Federal Government has cut more than a billion from aged care which is putting further pressure on the residential aged care sector with flow-on impacts for the hospital system.

> *"I work in a palliative care ward and we always have a waiting list for beds. Yet at the moment six of our twenty eight beds are being take up by elderly patients who have been medically cleared for discharge because they do not need acute care. Families are choosing to have their loved ones stay in hospital, taking up much needed beds, instead of being transferred to a different facility or taking up a place in an aged care facility. As a nurse this is incredibly frustrating as I'm not able to provide services to those most in need."* – United Voice member

Recommendation ten: that the State Government investigate ways it can take pressure off public hospitals by working with the Federal Government to adequately fund the true cost of care for all elderly Australians.

7.2 General Practitioners

Equitable access to GPs is a crucial element of a sustainable health system. GPs are the key primary health care providers for the majority of Australians. GPs also act as the gateway to specialist medical care. However, most often GPs are closed between 5pm and 8am and it can be difficult for patients to book appointments in the short term. The over presentation at EDs for non-urgent health care concerns is a clear indicator GPs are not sufficiently accessible for many West Australians.

The geographical distribution of GP practices can also drive equitable or inequitable access to primary health care. Presently, the location of GPs is entirely outside of State Government responsibility, meaning there is no centralised planning of this major facet of primary care. This is in sharp contrast with the government regulation of pharmacy locations under section 90 of the *National Health Act 1953*.[56]

It is becoming less common for people to access the same GP over their lifetimes. As medical data and patient records are not easily transferable between GPs, this can also result in inefficiencies within the health sector with inconsistent or inappropriate service delivery.

Recommendation eleven: that the State Government consider increased regulation of GP locations to ensure accessibility of primary care for all West Australians regardless of where they live. State Government should also consider ways to improve the transferability of medical data to improve patient flow through the system.

7.3 After-Hours Health Care Options

Primary health care services should strive to be patient-centred, and respond to the needs of patients 24 hours a day, seven days a week. A large proportion of United Voice members are in insecure forms of employment and do not work a traditional 9-5 work day. As such they are reliant

[56] Australian Government Department of Health, *Pharmacy Location Rules (the Rules) and the Australian Community Pharmacy Authority (ACPA):* http://www.health.gov.au/acpa.

on the provision of adequate after-hours health care. The organisation and delivery of out of hours primary care is fundamental for a well-functioning health system. Lack of access to after-hours primary care results in an increase in the use of more expensive resources such as hospital care.[57]

In Australia after hours provision of care by providers is voluntary. Research shows that the proportion of health care practitioners in Australia reporting they worked in practices providing their own after-hours services declined from 36% in 2004-05 to 31% in 2013-2014. These factors are heightened in remote areas.[58]

Internationally, a range of policies have been implemented aimed at improving access to and quality of after-hours primary care that are applicable to a WA context, particularly in rural WA. These include increasing organisational and financial support (i.e. free space in facilities or additional resources); making better use of or changing scope of practice for health care professionals (such as nurses and paramedics), making out of hours care participation compulsory for health practitioners, setting up a telephone triage system, using new technologies, and developing better information systems.[59]

There is no one policy innovation that will solve this issue. For example, the Australian Practice Incentives Programme (PIP) after hours incentive programme in Australia has been shown to increase the probability of GPs providing after hours care, but the magnitude was small and financial compensation needed to be balanced with other policy levers.[60] The State Government should take an innovative approach and trial different options for afterhours care that are most appropriate to the individual environment.

Increased awareness

The Australian health care system is a complex mix of federal and state government funding and responsibility with services delivered through public and private sectors. Compounding this complexity is the lack of accessible information for people trying to navigate their way through the health sector, particularly for after-hours care. This complexity bars people from seeking timely and appropriate health care, resulting in strained points in the system such as increased pressure on EDs as people present with non-urgent care needs simply because they are not aware of alternatives.

Health education needs to be strengthened so that patients are able to understand the range of health care services available. Empowering Western Australians to make informed choices about their own health care will precipitate an efficient system in which services are appropriately utilised. Further, while 81% of primary care providers reported having after-hours services, 56% of patients reported having difficulty accessing after hour care. This indicates that for after-hours care the greatest hurdle is access.

Healthdirect Australia is tasked with providing education and access, with the GP helpline, triage service and information about general practices, hospitals, EDs and pharmacies. The number of inappropriate attendances at ED are a potential indicator that it is currently underutilised. The State

[57] Berchet C and Nader C, *The organisation of out-of-hours primary care in OECD countries*, *OECD Working Papers*, No. 89, OECD Publishing (2016).
[58] Ibid.
[59] Ibid.
[60] Ibid.

Government should investigate ways to improve and educate people on Healthdirect. For example, ED waiting times could be included to assist people make a decision about which hospital to attend. Information about accepting walk-ins, appointment lengths and standard costs, and payment options could be added to the GP section of the app.

Recommendation twelve: that the State Government investigate ways to improve awareness of healthcare options, particularly after hours options, to reduce inappropriate hospital attendance and empower people to make informed choices about their own health care.