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Sustainable Health Review

Interim Report to the Western Australian Government

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Purpose of the interim report

The *Sustainable Health Review* was announced by the State Government in June 2017 to develop a more sustainable health system for Western Australia (WA).

This Interim Report outlines the initial observations and views of the Sustainable Health Review Panel ('we' is used interchangeably with 'the Panel').

We are sincerely thankful for the generous contributions in our consultations to date, which have included over 300 public submissions, 19 forums across the State and many other sessions. Passionate insights have been shared with us by consumers and carers, clinicians and staff in the WA health system, Health Service Providers, non-government organisations, industry and the wider community.

The purpose of this report is to reflect what we've heard so far and to check that the 12 Preliminary Directions we have identified are correct.

Across our Preliminary Directions we have made nine Recommendations for Immediate Action where we believe work can commence immediately to bring potential benefits to the people using the health system and to aid the overall objective of sustainability. We strongly encourage the Minister for Health and Mental Health to request the Director General of the Department of Health to develop an implementation plan and provide oversight for these actions.

We have also identified a range of Areas for Further Work which will inform our next phase of consultation and the development of the Panel's Final Report and recommendations due to State Government in November 2018.

These Areas for Further Work are indicative rather than exhaustive. Additional parts of the Panel's terms of reference warrant further attention including early childhood and youth; dental health; information communications and technology (ICT); alcohol and other drugs; research; teaching and training; and environmental issues and their health impacts.

The Panel acknowledges that some the work outlined in the Interim Report is already underway and supports its progression as a priority.

The Panel once again extends its gratitude and looks forward to further consultation to complete its Final Report.

Robyn Kruk AM
January 2018

Executive summary

The Interim Report has been informed by significant consultation with consumers and carers, the WA community, staff in the WA health system, non-government organisations and other partners. It reflects key themes from consultations to date and aims to test the Panel's Preliminary Directions. The Panel will undertake significant further work and consideration for its Final Report.

Context for change

Challenging conversations are taking place nationally and internationally across sectors about how to make the best use of limited resources. The *Sustainable Health Review* comes at a time of significant reform across the WA health system and the public sector more generally, which must be leveraged.

It is clear that what is required for the sustainability of the WA health system now goes beyond buildings. Transformational change is needed, giving emphasis to reinvestment, people, culture and behaviour.

By focusing on sustainability, it is timely for the WA health system to look towards value – to understand what is being spent and being achieved, and measuring the health benefits to patients and the wider community.

The Panel's lens to sustainability therefore focuses on: patient experience; population health outcomes and safety and quality of services; cost and waste reduction; and staff engagement.

The Panel has detailed some so-called 'inconvenient truths' that need to be acknowledged and addressed in a meaningful way if change is to be more than just incremental. We will explore these issues further and respond to them comprehensively in our Final Report.

The health budget has more than doubled over the past decade – increasing from 24.9 per cent of the State Budget in 2009 to 30 per cent of it now. Should this trajectory continue, the health budget will consume nearly 38 per cent of the WA State Budget by 2026/27.

Unfortunately, while health costs have more than doubled, health outcomes in WA have not improved at the same rate. The system focus remains on treatment rather than keeping people healthy. Improvements have been made to reduce the time people spend in hospital but opportunities for more contemporary reform have not been fully embraced. Health remains more provider than patient focused, with WA losing its State leadership role in approaches that focus on keeping people healthy and supported in the community wherever possible.

The WA health system has made \$7 billion in infrastructure investments and should now ensure it uses its existing infrastructure more wisely. This could include options to look at repurposing existing facilities, using current unused capacity or collaborating with other providers to deliver specific services.

Preliminary updated modelling by the Department of Health indicates that across WA there is predicted to be enough hospital bed capacity to serve the community for the next decade. However there are pressure points requiring attention including Armadale, Midland, Joondalup, Osborne Park, Bunbury, Geraldton, and Rockingham/Peel. Commitment is also required to progress plans for King Edward Memorial Hospital for Women and the co-location of women's health services within the Queen Elizabeth II Medical Centre (QEII Medical Centre). Access to both acute and community mental health services require attention.

The people who rely on health services – consumers and carers – are frustrated and feel their views are not sought or respected and want to be more actively engaged in key decisions about their own health, clinical care and the broader planning and funding of WA health services.

WA needs to be more proactive in partnering to meet consumers and carer calls for greater levels of care in the community, more person-centred care and seamless access to support from across our health, disability, aged care and mental health systems. Consumers and providers must currently navigate a maze of systems and complex rules, leading to people falling through the cracks with the hospital system often being where people end up as a last resort.

There can be no hiding from the fact that the WA health system has a poor history of managing its budget over the last 10–15 years. However, the focus on financial accountability and rigour over the last two to three years has set the foundations towards financial sustainability. Over the past two financial years, health expenditure growth has been contained to less than five per cent per annum compared with average growth of approximately 10 per cent per annum in the past decade. There are signs that indicate the health system is gradually becoming more efficient but the cost of hospital services still remains above national benchmarks.

The implications for the WA State Budget, seen in reduced funding for other key services, such as education, housing and police, caused by 'blowouts' in the WA health system budget are not acceptable to consumers or the community. Priorities for the WA health system need to be agreed and progressed within the budgetary framework on the understanding that there will be no new funding. There needs to be a continuing focus on budget controls and an imperative for health to become financially predictable and 'live within its means'.

The WA health system must continue to become more efficient and effective. It needs to better understand its cost drivers and the levers to improve services within its current budget and identify priorities for reinvestment.

The health system should define targets for sustainable expenditure growth with the Department of Treasury, including incentives to drive necessary change in all aspects of health service delivery. The Final Report will address these issues.

Concerns have been raised by consumers, carers and staff around waste in the system and the need to reduce unnecessary tests, treatments and procedures to assist patients and staff to choose health care that will make a difference to peoples' lives and reduce harm. Further efficiencies and savings in corporate and administrative functions must be identified and supported by appropriate technology.

There is significant opportunity to look at how money is distributed across the WA health system to support innovation and address community need. Activity Based Funding has improved transparency and made it easier to see where money is being spent in the WA health system. Activity Based Funding may reward hospitals for delivering more costly services at the expense of other services; however, it should not be a barrier to innovation. A shift is needed to focus on providing high value rather than high volume care in the right setting and to help people stay well. The Panel supports the move to funding models focused on patient-centred care, incentivising performance and collaboration.

Salaries for staff within the WA health system, particularly doctors and nurses, are among the highest in the country, with workforce costs being 13 per cent more expensive in WA than across Australia. Low wages growth, consistent with expectations across the WA public and private sectors, must become a reality of the WA health system. Conditions for special allowances or 'deals' for particular sectors of the health workforce can no longer be justified in the current employment market and alongside moves to team-based care models.

Significant changes have been made to the governance of the WA health system and further work is needed to bed down these changes ensuring clear and robust accountability to the WA community. Greater transparency is needed. Significant advances have been made in the public reporting of the performance of health systems, including investments in key data and reporting systems on quality and safety. Public reporting of all key data including consumer and carer feedback will be a key driver of innovation and sustainability and requires ongoing focus.

Health care does not equal hospital beds. It is well recognised that the \$7 billion spent on hospital infrastructure was needed (1). In some instances expectations may be beyond what the public sector can deliver and honest discussions need to be had with consumers, carers and staff members to consider the best use of public funding.

The WA health system's track record in the delivery of information and communication technology has led to large amounts of money spent in areas that has not necessarily supported the system or improved health outcomes more generally.

The need to improve ICT systems across the WA health system is clear; the challenge is to mobilise and manage the upfront investment in ICT in such a way that it does not compromise the provision of other initiatives.

Robust planning that supports greater use of technology and more contemporary approaches to health care and patient-staff engagement is required. Progress towards a digital health

system including an electronic health record, is critical, with more effective data sharing helping staff, consumers, carers, researchers and the community to make informed health care decisions.

Agreed outcomes that work for consumers and their carers, health partners and other organisations, and the community, must be a priority. Given the massive current and future costs and impacts of chronic disease, this will involve enhanced health promotion to tackle major health problems such as childhood obesity, smoking, alcohol and drug use.

Consumer and carer expectations are changing – they want their views sought and respected. They want more knowledge about their health and means to improve it, and to have quality in both life and death. A focus on consumers and their carers will drive service improvement, innovation and accountability. Consumer and carers also expect cooperation between various agencies, levels of government and the public and private system. There is still inequity in health outcomes throughout WA, including a significant gap in health outcomes for Aboriginal people, those living in rural and remote areas and people experiencing mental health issues.

WA continues to experience high levels of people entering our hospitals with a 49 per cent increase in presentations to emergency departments and a 39 per cent increase in admissions between 2005 and 2015. This continued focus on hospital care is increasingly out of step with community expectations and improvements nationally and internationally.

Key services in WA have significantly lower capacity than the national average. There are significantly fewer General Practitioners (GPs) and residential aged care beds per capita than the national average. There is a maldistribution of GPs in rural and remote WA.

WA receives a low share of Commonwealth funding and support compared with other states in terms of the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS). This is particularly the case for regional and remote areas of WA, but also in the metropolitan area.

It is critical that the State Government seeks to work more effectively and in collaboration with the Commonwealth Government. This includes exploring opportunities to coordinate services more effectively in the Pilbara and Kimberley regions through improved use of infrastructure, technology and patient transport. This should also extend to other sectors and regions, practitioners and government agencies, including primary care, Aboriginal-controlled health organisations and pharmacists.

The Panel supports exploring a proposal to pilot a joint regional commissioning model (collaboratively with the local community, Aboriginal community-controlled health organisations and the Commonwealth), initially in the Kimberley. The Commonwealth's contribution to pooled funding should be based on its average spend per capita across the State rather than its (typically lower) historical spending at a local level in the Kimberley Region.

Staff and consumers have been clear about the need to improve workforce practice and culture.

The WA health system is often regarded as 'cosy' with a dominance of the medical profession at the expense of other professions, and a reluctance to innovate if it challenges the status quo (2). There is a real opportunity to explore workforce models that better utilise other professions and their full scope of practice, supporting team-based care.

Some staff members have reported feeling not valued or respected and attributed low morale to a lack of meaningful engagement.

Tackling these issues will require an investment in staff and contemporary leadership development to ensure effective clinical and executive leadership through times of change, along with more contemporary approaches to workforce planning.

The WA health system must have the courage to innovate, and be supported to do so. It must challenge the status quo, develop new ways of working and be open and flexible to addressing challenges. It will require difficult conversations and decisions about 'what is needed', 'what is expected', and 'how to make

best use of resources' for a sustainable health system. There has been a reluctance to date to make hard decisions and say 'what stops' or to identify reinvestment priorities. These decisions must be made with consumers and their carers, the community, providers and staff. The health system will need the skills to engage effectively. Sustained change takes time and requires leadership and ongoing political commitment. It must build upon effective community, consumer, carer, staff and service provider input.

There is a real opportunity for everyone to be involved in the change rather than waiting for it to happen. This partnership will be critical to providing the State Government with the social licence to make these changes.

The WA health system has previously struggled with managing longer term change. It is critical that the lessons of implementation from the 2004 report, *A Healthy Future for Western Australians*, by the *Health Reform Committee* are well understood (3). Change will need to be hardwired and monitored at the highest levels to ensure sustainability.

Next steps

The Interim Report has been informed by significant consultation with consumers and carers, the WA community, staff in the WA health system, non-government organisations and other partners. This Interim Report will serve as a starting point for the next phase of consultation and will support the development of the Panel's Final Report and recommendations due to the State Government in November 2018.

Preliminary directions

The Panel has identified 12 Preliminary Directions in this Interim Report. Across these we have made nine Recommendations for Immediate Action where work can commence immediately, and a range of Areas for Further Work which will inform our next phase of consultation and support the development of the Panel's Final Report and Recommendations.

Direction 1: Keep people healthy and get serious about prevention and health promotion

Recommendations for Immediate Action

1. The Department of Health should take an active leadership role across the public sector in developing whole-of-government targets with potential impact for better health outcomes, commencing with childhood obesity.

Areas for Further Work

- Develop and sustain enhanced and new strategies to avoid health impacts associated with smoking and alcohol.

Direction 2: Focus on person-centred services

Areas for Further Work

- The WA health system takes key steps to integrate systems to deliver truly connected care. This includes a pilot of a 'navigator function' to connect people to the right parts of the health system developed collaboratively with key partners, particularly in aged care and disability sectors, to improve person-centred approach to services and ensure our most vulnerable people do not fall between the cracks.
- The WA health system should continue to work with Commonwealth Government agencies and other health and social service agencies to improve interfaces between health, aged care and disability sectors and to progress collaborative service provision to enable a shift to consumer-centric funding.

Direction 3: Better use of resources with more care in the community

Recommendations for Immediate Action

2. Implement a pilot of the Emergency Telehealth Service Model in at least one other specialty in the country and metropolitan area.

Areas for Further Work

- Explore a range of different models (including in the mental health and aged care areas) to enhance emergency department (ED) diversion and avoidable admissions.
- Explore the use of telehealth in the mental health area to increase access to services and support care in the community.
- Undertake a risk/benefit analysis of telehealth and other virtual care opportunities for implementation in metropolitan and country health services, in all care settings. This analysis should include an assessment of the impacts on Patient Assisted Travel Scheme (PATS).
- Formalise more local partnerships with the Western Australia Primary Health Alliance (WAPHA) and develop joint outcomes and associated measures to enhance shared care and improve communication between General Practitioners and hospitals, including outpatient care.

Direction 4: Facilitate effective interaction between acute and community-based mental health services to deliver mental health reforms across the WA health system

Recommendations for Immediate Action

3. In collaboration with the Mental Health Commission (MHC), Department of Health, Health Service Providers, consumers and carers, immediately develop and then implement, an effective, contemporary clinical needs-based model that enhances or replaces the current patient flow model across all health services.
4. Support the immediate review of mental health clinical governance as identified by Professor Hugo Mascie-Taylor in the 2017 *Review of Safety and Quality in the WA health system*.

Areas for Further Work

- Identify current and future mechanisms to ensure appropriate and effective patient care can be delivered for people with mental illness within the community setting.

Direction 5: New ways to support equity in country health

Areas for Further Work

- Develop and expedite options for seamless and safe patient movement around the system through a comprehensive country patient transport strategy, considering cost effective models for emergency and patient transport.
- Investigate formal arrangements for patients and staff in regional hospitals to have a direct association with a metropolitan hospital for access to care for country patients and staff professional development.

Direction 6: Develop partnerships for Aboriginal health outcomes

Areas for Further Work

- Advocate to the Commonwealth Government for a collaborative approach to funding and service delivery to be implemented, for example commencing with a pilot of a joint regional commissioning model, initially in the Kimberley. This should be based on active partnerships with the Commonwealth, State and local government agencies, Aboriginal community-controlled health organisations and non-government organisations.

Direction 7: Create and support the right culture

Recommendations for Immediate Action

5. Identify and report publicly key system quality, safety, financial and performance information at the whole of system, and hospital level as a priority; and further progress public reporting down to department and clinician level.
6. Implement a WA health systemwide employee survey process and benchmark findings to inform and drive systemwide staff engagement programs.

Areas for Further Work

- Launch a one stop portal for consumer information/access on the Healthy WA website. Publish feedback received publicly and at ward level to encourage improvement.
- Develop agreed systemwide core values and metrics regarding workforce health and safety.

Direction 8: Greater use of technology, data and innovation to support consumers, clinicians and drive change

Recommendations for Immediate Action

7. Develop and implement innovative approaches to sharing of patient-level data across public/private providers, including a pilot to demonstrate necessary policy and technology approaches, commencing with pathology results, patient discharge information and medical imaging as an initial priority linked directly to work with the expansion of My Health Record.

Areas for Further Work

- Develop a digital strategy for the WA health system that identifies priorities to support consumers, clinicians and system management.
- Explore options for progression and implementation of a statewide electronic medical record. This should be initially developed in partnership by the Department of Health with one or two Health Service Providers, subject to a robust business case and available funding.
- Support and enact Department of Health-related actions from the Data Linkage Review.
- Partner closely with the Australian Digital Health Agency to support the expansion of the My Health Record program in WA by raising awareness among clinicians and increasing availability of patient information (including pathology, medical imaging results and discharge information) to My Health Record.

Direction 9: Harness and support health and medical research collaboration and innovation

Areas for Further Work

- Continue the increased focus on research and innovation through the State Government's Future Health and Future Health and Research Innovation Fund. Support the enabling of research and innovation translation within everyday clinical practice with the research community, including the Western Australian Health Translation Network. These investments could see WA as a centre of choice for translational and policy relevant research.

Direction 10: Develop a supported and flexible workforce

Recommendations for Immediate Action

8. Cut red tape to hasten the recruitment of staff and reduce unnecessary agency costs. Pilot the broader implementation of a streamlined recruitment process, as tested in the Pilbara region.

Areas for Further Work

- Commence integrated systemwide workforce planning, using a consistent and transparent method for modelling and robust systemwide workforce data.
- Explore options to support and meet regional community needs through programs such as a Rural Generalist program and by increasing both GP proceduralists and Nurse Practitioner training positions and placements.
- Assess and take action as required, where Nurse Practitioners in metropolitan and regional areas are not working to full scope of practice.
- Build a contemporary clinical and corporate leadership program to serve the WA health system and its stakeholders into the future.

Direction 11: Plan and invest more wisely

Areas for Further Work

- Develop options for flexible purchasing and funding mechanisms, pricing and resource allocation which prioritise value, quality, and better population outcomes in consultation with consumers, the Commonwealth, Treasury, non-government organisations and private providers.
- Continue to pursue a fairer allocation of resources and resource allocation with the Commonwealth for rural, remote and regional WA, focusing on balancing the reduced access to GPs, MBS and PBS.

Direction 12: Building financial sustainability, strong governance, systems and statewide support services

Recommendations for Immediate Action

9. Continue implementation of financial sustainability measures ensuring budgetary transparency and enhanced Health Service Provider funding predictability.

Areas for Further Work

- Explore best-practice approaches for meaningful consumer involvement in reforms, including consumer involvement in designing and evaluating services.

About the review

In June 2017, the Government of Western Australia (WA) announced the *Sustainable Health Review* to guide the direction of the WA health system to deliver patient-first, innovative and sustainable health care into the future. The Minister for Health asked that the Review be informed by extensive consultation with patients and community, staff, and a wide range of partners.

The *Sustainable Health Review* comes more than a decade after the 2004 Review, by the Department of Health, *A Healthy Future for Western Australians, Report of the Health Reform Committee* ('the Reid Report') which laid the foundation for a revitalised health system through a wide range of recommendations to improve the quality of health services and manage costs within the system (3).

Since the *Reid Report*, more than \$7 billion has been invested in major infrastructure projects (1) and there have been notable improvements in WA's length of stay in hospital performance and in other areas of health system performance. Implementation of the *Reid Report* recommendations however fell short in bringing about the change needed to ensure the WA health system was able to provide care in the most appropriate setting and address underlying sustainability pressures.

Although WA has seen improvements in its health system, it is experiencing unsustainable budget growth. The WA health system faces major challenges associated with an ageing population, chronic disease and inequity in health outcomes. The challenges may be even greater for WA once the next National Health Agreement is negotiated with the Commonwealth Government in 2018 and demand increases due to changes to private health insurance (4).

In announcing the *Sustainable Health Review*, the Minister for Health emphasised the need for innovative ways of delivering health services, achieved through the 'three person waltz' between consumers and carers, policy makers and staff at the frontline of service delivery (5). We refer to staff rather than clinicians, as this is inclusive of all people employed within the WA health system – clinicians, administration and support staff. It also recognises that the patient experience is everyone's business and is impacted by interactions between all staff and patients, carers and families. The time for change is now.

The *Sustainable Health Review* coincides with wide change across the Western Australian public sector. The State Government's *Service Priority Review* and *Commission of Inquiry into Government Programs and Projects* are focused on reshaping and strengthening public services, and building a high-performing and collaborative sector that delivers better services to the community. Further details on this work are provided in **Appendix D**.

Public sector reform focused on community outcomes provides a tremendous opportunity for the WA health system to partner across sectors to build a more sustainable health system where care is provided in the most appropriate setting – not just hospitals.

The *Sustainable Health Review* is considering:

- ways to improve patient journey and movement through the health system
- the mix of services across the system and ‘doing more with current resources’
- ways to encourage and drive digital innovation, and the most effective use of new technology, research and data
- opportunities to drive partnerships across all sectors and levels of government
- ways to promote safer and more efficient services
- ways to drive predictability into planning, resourcing and funding
- alignment to the State Government’s *Service Priority Review* and *Commission of Inquiry into Government Programs and Projects*
- implementation of recommendations in the short, medium and long-term.

The *Sustainable Health Review’s* full Terms of Reference are provided in **Appendix B**.

Why ‘sustainability’ now?

This question has been raised at every forum to date; however, few have questioned the reality of budget pressures.

Resources are not simply financial – they include people and the environment. We have heard loud and clear from consultations to date that we need to look at the whole of society and the whole person, and all the factors that contribute to a healthier life rather than focus solely on patients and hospitals. The question of how we make best use of resources is not unique to the health industry or WA health system. Challenging and difficult conversations are occurring nationally and internationally about what is needed as our population ages, public expectations rise and the cost of health care increases. These conversations must become more common, louder and involve as many in the community as possible. The *Sustainable Health Review* provides an opportunity to stimulate public discussion and develop solutions with the community.

We have found that many people acknowledge the need for change and recognise that for every decision made about health services or treatments the health system provides, there is a cost impact that cannot be ignored. The reality is that most of the community is locked out of the discussions and decision making about what health services they need and what health investment priorities should be across the health system. There is a need to have open and honest discussions about what is possible and follow these with clear decisions – but experience has shown that decision makers have been either reluctant or not well supported to take steps to change.

Figure 1: WA public health system has grown between 2005–2015

Source: Department of Health

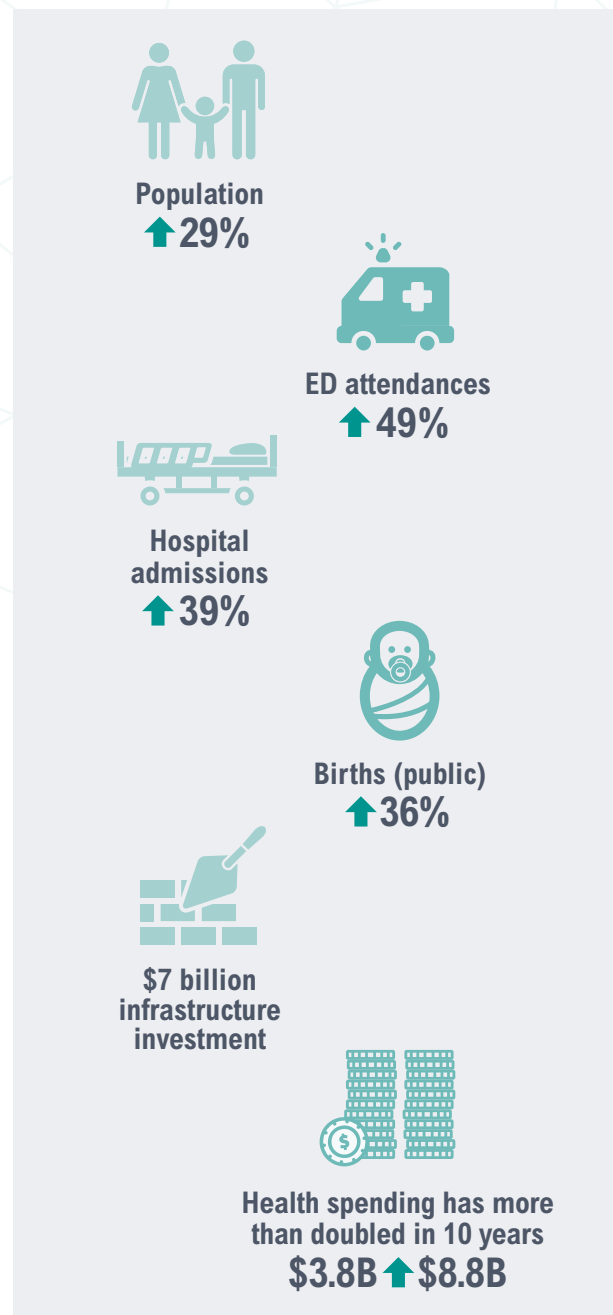
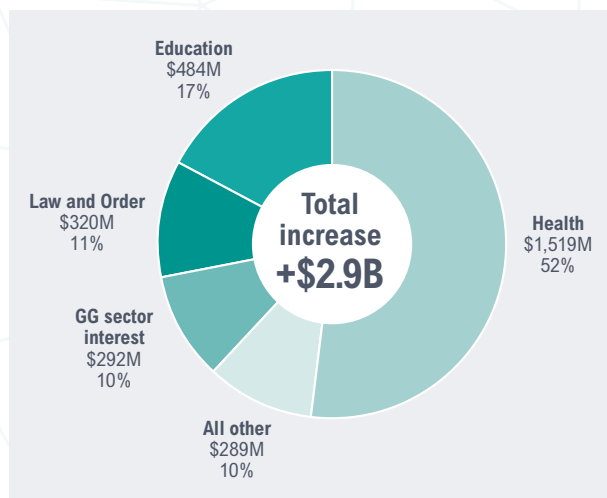


Figure 2: Growth in health expenditure accounts for 52 per cent of WA Government expenditure increase between 2013/14 and 2016/17

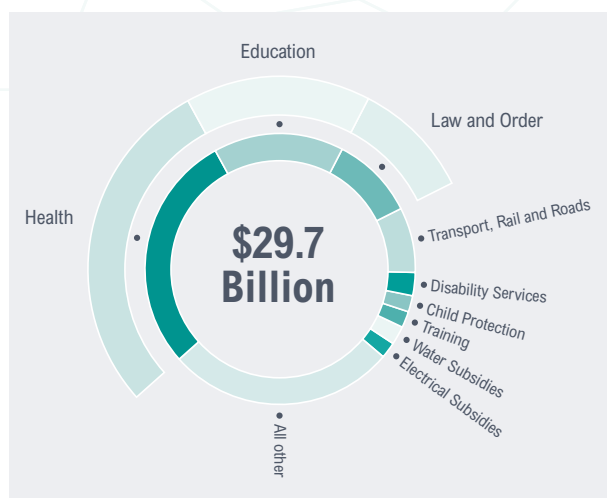
Source: Department of Treasury



The State's health budget has more than doubled to almost \$9 billion over the past decade, accounting for more than half of every new dollar spent between 2013/14 and 2016/17. Although the State's economy has slowed, the WA health system remains the biggest part of the WA State Budget representing 30 per cent of expenditure in 2016/17 compared to 24.9 per cent in 2008/09 (6).

Figure 3: WA budget 2016/17 total expenditure by portfolio

Source: Service Priority Review, Government of Western Australia 2017/18 Budget Paper No.3



While health costs have more than doubled, health outcomes in WA have not improved at the same rate.

There are major issues on the immediate horizon, including obesity (especially in childhood), a growing and ageing population, increasing levels of chronic disease, persistent inequity in health outcomes, wealth disparity, mental health, and drug and alcohol issues, all of which impact upon the sustainability of the WA health system (7).

Commonwealth-led reforms in disability services with the roll-out of the National Disability Insurance Scheme (NDIS) and aged care, through the Living Longer Living Better reforms (LLLBB), and related changes to the Home and Community Care (HACC) program are already changing consumers' access to services, and resulting in a changed operating environment for providers and funders.

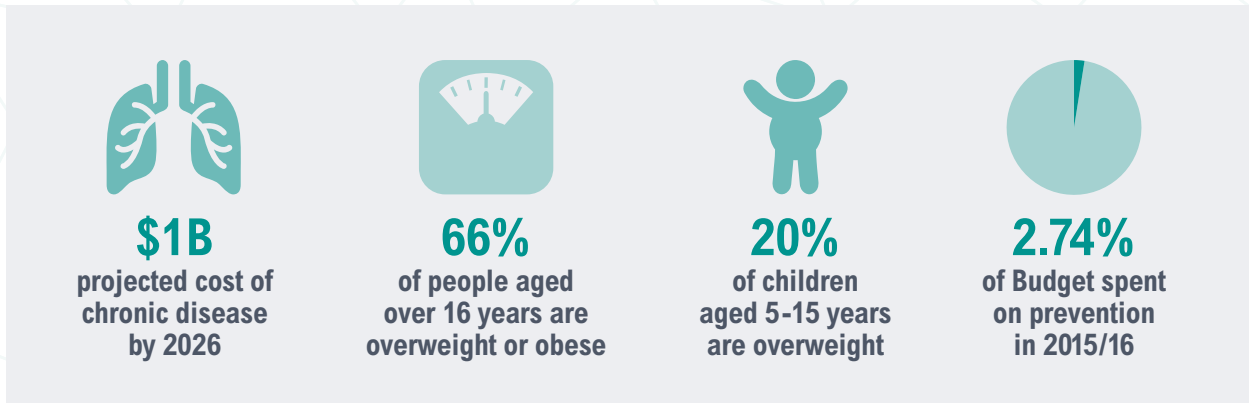
For example, the NDIS is relatively new and has crucial interactions with the health system. Careful planning is required to ensure that people do not 'fall between the cracks'. Agencies with responsibility for health, disability services, mental health and aged care need to work collaboratively to ensure that clients with complex needs can continue to access to full range of services they require.

Further compounding these issues is the reality that WA does not receive a fair share of funding and support from the Commonwealth Government. WA receives less than the national average across the board for the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS). Key services in WA have significantly lower capacity than the national average. There are significantly fewer GPs and residential aged care beds per capita than the national average. There is a maldistribution of GPs and aged care beds in rural and remote WA.

WA's Kimberley region receives a remoteness loading of 1.9 per cent. Tasmania attracts a 2.7 per cent remoteness loading, even though its population is far less geographically dispersed than WA's population (8).

Figure 4: The cost of chronic disease will grow to approximately \$1 billion by 2026

Source: Australian Institute of Health and Welfare



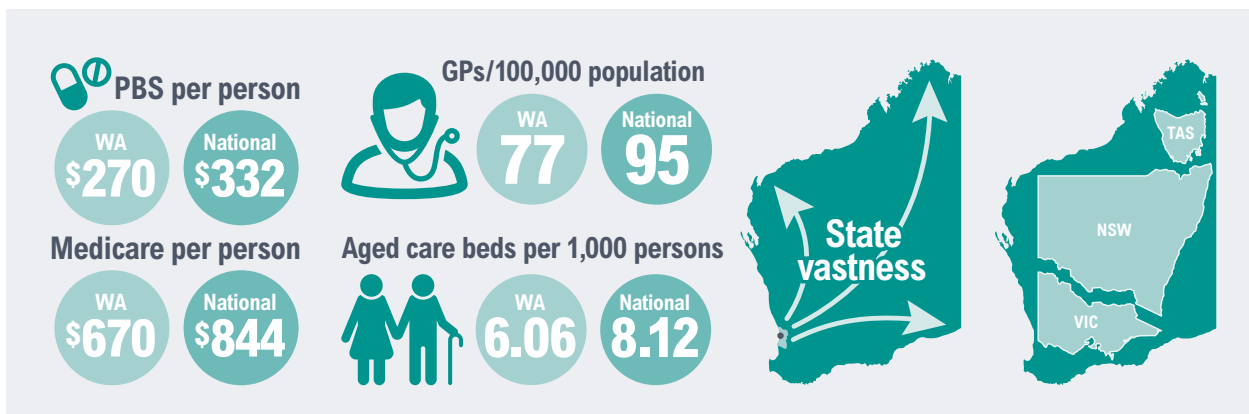
We know that approximately \$100 million of WA's \$430 million Medicare shortfall is lost in country areas due to the community's lack of access to GPs, with public hospitals often being the default provider of last resort (9). Current national funding models have historically not adequately recognised the impact that issues such as location, scale or scope have on how our hospitals operate. The draft national Activity Based Funding (ABF) model for 2018/19 does however include an additional 'hospital location-based' acute patient treatment remoteness adjustment for public hospital services (10). This will significantly improve WA's funding position by better capturing service provision costs in remote and very remote areas within the national ABF funding model. This will benefit facilities in the Pilbara and Kimberley regions but is only a start and it will not assist other regional hospitals.

Concerns about sustainability are not being addressed solely by WA. The recent report of the Productivity Commission highlighted the need to shift the focus of the health system to prevention and promotion through better integration, and noted that 'reform of Australia's health care system will not just be better for patients, but may save up to \$140 billion over the next 20 years' (11).

In order for health care to continue to be high quality and effective, the State Government must plan now and be coordinated and responsive to these challenges. It is critical that the changes towards a more sustainable future are also made with the other government agencies, the community, staff and key partners.

Figure 5: WA does not receive a fair share of health funding from the Commonwealth

Source: Fair Share Report, Government of Western Australia

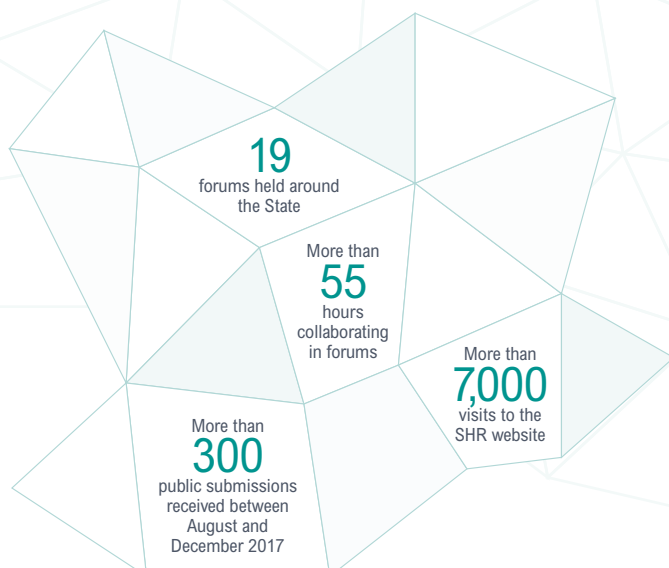


Who we have listened to

The Panel commenced its engagement and consultation program in July 2017 and sought input from all individuals and organisations. We have heard from a wide range of health consumers, carers, advocates, clinicians and health staff. We have engaged with young people, private industry, non-government and community organisations, unions and universities. The response to our request for input from within the health sector in particular has been overwhelming.

Figure 6: The panel heard from people from major centres and remote locations around the State

Source: Sustainable Health Review



The ideas and advice we have received have been of a very high quality. Key themes have informed the observations and Preliminary Directions of this Interim Report. It is clear there is a real opportunity for everyone to be involved in change rather than waiting for it to happen.

Engagement and consultation mechanisms to date have included:

- 19 ‘town hall’ forums across the State in regional and metropolitan locations utilising interactive digital technology, where we asked participants to share their burning issues and ways forward for a sustainable health system
- public submissions opened in August 2017 and closed on 27 October 2017. More than 300 submissions have been received on how to develop a more sustainable health system in WA
- two Reference Groups have been formed to ensure that health consumers, carers and a wide range of clinical areas are actively engaged. The Reference Groups’ membership was gained through expressions of interest, with a summary of progress to date in **Appendix C**
- Working Groups have been formed to provide another avenue for partnering with providers, staff and consumers to seek content expert advice
- targeted sessions with a number of groups within and external to the health sector, such as the Clinical Senate, the Aboriginal community-controlled health sector, and the Ministerial Youth Advisory Council to explore key issues for each group. We also hosted a summit with wider health sector partners to explore new and innovative ways of working together.

Summaries of engagement sessions and submissions have been published on the *Sustainable Health Review* website. The Next Steps section of this report provides an overview of engagement planned for 2018.

The case for change

The Panel has identified a number of ‘inconvenient truths’ which include key challenges and potential barriers that need to be acknowledged and addressed to achieve sustainability. These are outlined below and expanded on in **Appendix A**.

It is clear that what is required for the sustainability of the WA health system now goes beyond buildings. Issues need to be aired and addressed in a meaningful way if change is to be more than just incremental. Transformational change is required, giving emphasis to reinvestment, people, culture and behaviour.

The focus remains on treatment rather than prevention

Health funding currently prioritises and rewards activity in hospitals. However, a high proportion of health costs to the community and health system arise from diseases and conditions that are preventable (including diseases such as diabetes and heart disease) however, currently only 2.74 per cent of health’s budget is allocated to health prevention (12).

Consumers and carers are not central enough

Consumers and carers are frustrated that they are not given sufficient opportunity to contribute to the design of services that are meant to be serving their needs.

There are significant and persistent inequities in health outcomes among some groups of people

Some groups of people, such as Aboriginal people, those who live in remote areas or people experiencing mental health issues, experience far worse health outcomes than the broader population.

The system can be difficult to navigate for health consumers

Health consumers and carers are concerned that the WA health system and its interface with the aged care and disability sector are extremely complex and difficult to navigate. This is increasingly important with an ageing population more likely to rely on numerous services.

Staff do not always feel valued and respected

There are instances where staff morale and engagement are of concern. Staff members have frequently reported that they feel undervalued and frustrated with a system that does not listen.

Health care does not equal hospital beds

While the focus has traditionally been on providing services in hospitals, there is growing evidence and community expectation that many services can better respond to patient values, choices and be provided just as effectively – and often at lower cost in the community. The WA health system has recently made large infrastructure investments. The Panel supports the use of the current infrastructure, noting that there are a few specific places under pressure. Further, we acknowledge that updated preliminary modelling indicates that across WA there is predicted to be enough hospital bed capacity to serve the community for the next decade. This modelling is based on the current utilisation rate and the most recent population forecasts, which suggest the State's population will grow at a somewhat slower rate than has been the case over the last 10 years.

The preliminary modelling has identified Armadale, Midland, Joondalup, Osborne Park, Bunbury, Geraldton, and Rockingham/Peel as pressure points requiring attention. Work is also required to progress plans for King Edward Memorial Hospital for Women and the potential co-location of women's health services within the QEII Medical Centre. Access to mental health services requires attention.

WA is lagging behind in transparency and accountability

WA lags behind other health systems in providing patients, staff and the community with key information regarding safety and quality of services, costs and other measures of performance. Public reporting drives innovation and ongoing improvement.

The system rewards volume rather than value

Activity Based Funding arrangements reward Health Service Providers for delivering a higher volume of hospital-based services rather than focusing on the overall quality and value of services delivering improved health outcomes.

Workforce costs remain well above national benchmarks

Workforce is the largest cost driver within the WA health system representing 53 per cent of total expenditure in 2017. Wages across the WA health system are almost 13 per cent higher than the national average for the majority of occupational groups (i.e. nursing, medical).

Considerable waste and technical inefficiencies across the system

Inefficiencies and waste relate to administrative and clinical matters and include unnecessary tests, treatments and procedures. In addition, funding is currently used to correct preventable medical mistakes or hospital based infections.

The broad skills of the workforce are not fully utilised nor well positioned for technological changes

The system's historical use of the workforce favours a medical model of service delivery not fully utilising the broader skills available within its workforce nor preparing itself for current and future technology changes. Other health professionals such as nurse practitioners, pharmacists and allied health should be enabled to work within their full scope of practice.

Medical dominance and vested interests slow the pace of change

There is strong medical leadership in the WA health system; however, concerns were raised in consultations regarding the dominance of the medical model and the power of the medical profession at the expense of other health care providers.

Too many rules and bureaucracy making it harder for patients and staff

There are too many rules and too much bureaucracy which makes it difficult to achieve even simple change. This includes barriers between Health Service Providers sharing patient details or notes, and mobilising services, money and staff.

Past ICT delivery has been poor

Previous reviews have identified significant shortcomings in the WA health system's past delivery and management of ICT.

The WA health system has fallen short of good change management

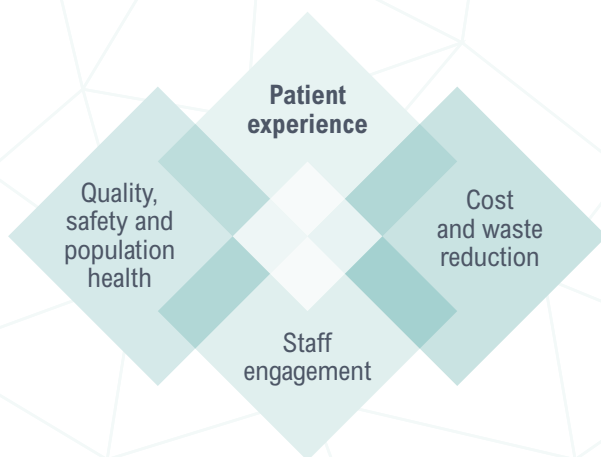
Previous experience and consultation to date has highlighted that many areas of the WA health system have struggled to implement previous recommendations for reform and deliver sustained change.

A future focus on sustainability

The Panel's focus on the future sustainability and direction of the WA health system is informed by a range of approaches.

Four-pillar approach

Figure 7: The Panel's lens to sustainability through a four-pillar approach



Noting the key enablers needed to drive efficiency and change, the Panel has considered sustainability through the lens of four pillars including patient experience; population outcomes, safety and quality; cost and waste reduction; and staff engagement. There is growing evidence nationally and internationally that demonstrates the correlation between high levels of staff engagement and patient experience, with a strong link to high quality care (13).

Prioritise outcomes that matter to people

“Some of the issues that really matter to the community are too expensive and complex to be resolved by individual agencies or within individual ministerial portfolios. Instead, a coordinated, collaborative and aligned approach across several agencies can achieve more effective progress on shared challenges and priorities.”

Service Priority Review

A strong theme of consultation to date is that a targeted focus on health outcomes – not outputs – is needed. Other jurisdictions have made real progress in this area and we can learn from them. An example from the NSW Premier's State Priorities and the State Health Plan is a whole-of-government approach to childhood obesity that includes defining outcome measures with outcomes-related targets (14, 15). We also urge the continuing refinement and implementation of outcomes-based management and evaluation frameworks that are already underway within the WA health system.

Fundamental change in how and where care is delivered

Many people currently receive the majority of their care in hospitals, which can be inappropriate, unduly expensive and not what they wish. Receiving better care in the community would help control rising health costs. We heard from many staff members of the need for better management in the community of groups, such as the elderly, as a means of reducing preventable ED attendances and other hospital admissions. Many staff advocated 'cohort based care' to shift the focus from providers to patients. GPs and geriatricians were also noted as being not adequately linked to aged care services with residential aged care staff usually having little alternative but to refer their patients to EDs for care. It is clear from feedback to date that there are better, smarter ways to use the health system's current services and facilities.

Health must live within its means

Community members have expressed concern that health budget blowouts will lead to less funds for other key services such as schools, roads and police. Recurrent health expenditures have increased by approximately 10 per cent per annum for much of the past 10 years. The Panel notes that over the current Budget forward estimates period it is expected that health expenditure will grow on average by around one per cent, per year.

A strong focus is needed on budget controls and short-term imperatives that will help the WA health system 'live within its means'.

The focus on financial accountability and rigour over the last two to three years has set the foundations towards financial sustainability. Over the past two financial years, health expenditure growth has been contained to less than five per cent per annum compared with average growth of approximately 10 per cent per annum in the past decade. There are signs to indicate that the health system is gradually becoming more efficient but the cost of hospital services still remains above national benchmarks.

Additionally, WA health system leaders and staff emphasised the need for predictability of funding to facilitate change and enable reinvestment of resources across the WA health system and between services. This process must engage and include staff, patients and carers. Transition to this approach will take time, and we acknowledge the importance of the Department of Health as the System Manager working closely with the Department of Treasury.

Honest and open conversations

It is clear that the WA health system must facilitate, encourage and support the challenging and difficult conversations required about 'what's needed', 'what the community expects', and 'how to make best use of resources' for a sustainable health system. This will require strengthening existing measures and new approaches to local engagement which include the wider community in the planning of health services.

At an individual level, a critical component of this is good communication between patients and staff. International experience demonstrates that doctors choose less aggressive procedures for themselves than they provide for their patients (16–18). Similarly patients tend to choose less treatment when they are given greater detail of the impact, potential benefits and harms of a proposed intervention (16–18).

Consumers and staff agree that it is time to have open and honest conversations about goals of care and end-of-life decisions. In Australia it is estimated that while 70 per cent of Australians wish to die at home, only around 14 per cent do so (19). WA is leading work in this area. We also spend more money in the last 1,000 days of peoples' lives and sometimes the quality of that life or death is no better (20).

“Each year, tens of thousands of people who are approaching the end-of-life are cared for and die in a place that does not reflect their choice or fully meet their end-of-life care needs. Most people who die do so in two of the least preferred places – hospitals and residential aged care.”

End-of-Life Framework,
Department of Health

Be brave enough to try new ways of working focused around shared outcomes

The WA health system will need to challenge the status quo, develop new ways of working and be more entrepreneurial, open and flexible in how it manages future challenges. This will require effective engagement with the people who deliver the services in addition to those who receive the services. Proven and promising models will need to be scaled appropriately for WA and fresh bold ideas supported by the right data, systems, funding and investment, to shift how the system provides healthcare services and the types of models of care used, over time.

The Panel has been struck by the widespread perception and concern that the WA health system is ‘too big to partner’ and culturally less inclined to cooperate. The recent change in health governance structures, which created Health Service Providers, offers new opportunities to engage effectively at the local community level. The sustainability of the WA health system is dependent on its ability to be outward focused and work more effectively with other sectors in government (state and national) and with key non-government partners, focusing around shared population health outcomes.

Leverage public sector reform already endorsed by State Government

It is critical that the WA health system leverages off, and builds upon, change already underway. Major reform is already happening in the health system, across State Government agencies and in the disability, aged and social care sectors more generally. Collectively, these changes provide an important way toward supporting a sustainable health system for the future.

The *Service Priority Review* released in December 2017 (21) considered the functions, operations and culture of the WA public sector. See **Appendix D** for detail of the State Government’s reviews including the *Service Priority Review* and *Commission of Inquiry into Government Programs and Projects*.

Key links between the *Service Priority Review* and *Sustainable Health Review* include:

- a need to focus on community outcomes, through the introduction of whole-of-government targets and outcomes-based budget management to drive greater transparency, performance and collaboration between Government agencies
- greater community engagement through new approaches to planning, policy development and programs
- the need to improve coordination of services in regional WA
- the need to strengthen data privacy, sharing, linking and analytics
- the need for a more robust and strategic workforce management to better support a fit-for-purpose and contemporary workforce
- governance, financial and assets management, procurement streamlined and strengthened, for a more sustainable and outcomes-focused public sector.

Change must be hardwired and monitored at the highest levels

The Panel acknowledges the commitment of the WA health system to continuous improvement. Identifying what needs to change and what success looks like and planning a clear path to deliver, is essential. We know that ‘what gets measured – gets done’ and having the right metrics and benefits captured will be essential to drive and support sustainable change. This includes being prepared to publicly report on changes achieved, such as incentives and rewards.

It is acknowledged that there are multiple levers for successful change that will need to be applied across the system as a whole, as well as at a local level. Progress needs to be monitored at the highest level of Government and accountability clear at all levels in line with the implementation of the Government’s broader public sector reform agenda.

Direction 1: Keep people healthy and get serious about prevention and health promotion

Prevention, promotion and public health have been raised in every consultation, and was a key focus of the *Reid Report* that was not fully implemented. A sustainable health system is one that keeps people out of hospitals and supports them to maintain good physical and mental health in their community.

“There is strong evidence that investment in prevention and early intervention programs have significant benefits for both the individual participants and the broader health system.”

Council on the Ageing

Preventable chronic diseases, as well as injuries, are taking a toll on individuals, families and the community as well as our health system. We were told the WA health system needs to utilise the various levers available to it, to incentivise a reorientation of services to focus on early intervention, show better use of existing community services and facilities, and invest in primary and community services that focus on self-management and education.

The Panel notes a strong concern regarding the emergence of environmental impacts, such as extreme weather conditions and the growth of infectious and communicable diseases that might expose and put further strain on the WA health system. An adaptive and flexible approach to this area is needed.

Investing in public health and health promotion

In 2013/14, \$2.2 billion was spent on preventative and early intervention strategies within the Australian health sector, mainly on immunisation, health promotion and screening programs amounting to approximately 1.4 per cent of total health expenditure.

The proportion of health expenditure allocated to public health has been declining since 2007/08 (22). Money spent on prevention and early intervention in Australia is among the lowest in the developed world (23), with New Zealand at the top spending seven per cent of its health budget (24). Evidence shows that investment in prevention, rather than treatment of illness or injury, is extremely cost-effective, with public health interventions delivering lower health care costs and better health outcomes (25).

The Productivity Commission recently acknowledged that current funding models do not encourage a ‘whole-of-health’ system perspective and do not acknowledge the challenges in seeing return on investment in public health and prevention (26). The Panel supports this observation and notes that a shift to more mature funding options or incentives to promote efficient prevention and chronic disease management throughout the system would address this imbalance.

The Australian Institute of Health and Welfare calculated that in 2011, Western Australians lost more than 435,000 years of healthy life as a result of premature death or living with disability or illness, due to chronic disease or injury. Cancers, mental health disorders and cardiovascular diseases together accounted for almost half (45 per cent) of the total health loss in WA (27).

Preventable illness and injury is a major issue nationally, with almost one-third of these conditions considered to be potentially avoidable, either through preventing problems before they occur or finding problems early and treating them. Being overweight or obese, tobacco use, and excessive drinking are among the leading causes of preventable illness and preventable hospital admissions (28).

We have heard ongoing concern about the harm alcohol plays in our community. In WA, alcohol use is a contributing factor in road trauma, criminal behaviour, including sexual and domestic violence, foetal alcohol spectrum disorders, and accidental injury or death (29).

We note evidence that shows nearly 28 per cent of people aged 16 years and over are drinking at levels that are considered to put them at high risk of long-term harm (30).

To reduce levels of alcohol use within communities, targeted campaigns for at-risk populations, including Aboriginal communities and pregnant women, have been proven to be effective (31). This should be supported through further community engagement and sustained public education campaigns.

We also heard the need to further address the health impacts associated with tobacco. While smoking rates have declined in WA over the past 10 years, this has not occurred in all population groups (30).

Smoking rates are higher in lower socio-economic areas, among Aboriginal people, and those with a mental illness (30). Continued efforts to lower smoking rates are needed,

“\$176 million invested in tobacco prevention in Australia between 1971 and 2010 averted approximately \$8.6 billion in health costs over that period.”

Department of Health and Ageing,
Australian Government, 2003

with submissions identifying that anti-smoking media campaigns have a strong impact, especially among vulnerable populations.

The Panel has also heard that specific population groups (particularly children and young people) should be targeted and health outcomes supported by investing in prevention opportunities, including physical activity, nutrition, overweight and obesity, at every life stage. The *Health Promotion Strategic Framework 2017–2021* highlights that ‘influencing issues and behaviours such as obesity, poor eating patterns and insufficient physical activity cannot occur through single interventions.

“Analysis suggests that for every dollar invested in services for preschool age children, there will be a \$2 to \$2.60 return to society. Investment before birth and during early childhood achieves the highest lifetime return, with later investments yielding an ever diminishing rate of return.”

Child and Adolescent Community
Health Submission

The cost of obesity

Obesity and unhealthy lifestyles were raised in many public submissions and forums. The Panel recognises that a focus on healthy weight is needed for children and adults throughout WA. Current figures indicate that almost a quarter of children aged 5 to 15 years are overweight or obese in WA (32). These figures increase in adulthood, with almost two thirds of adults classified as overweight or obese (30), highlighting the potential for preventative investment in this area.

Work was commissioned by Obesity Australia in October 2015 to develop a benefits realisation framework to identify the costs of obesity in Australia and the benefits of interventions to reduce obesity.

Figure 8: Without action the estimated costs of obesity will be approximately 10 times higher in 2024/25

Source: Weighing the Cost of Obesity, Pricewaterhouse Coopers



Obesity costs are projected to rise **\$87.7B** by 2025

The Report commissioned by Obesity Australia observed that the total cost of obesity in Australia in 2011/12 was estimated to be \$8.6 billion. These costs include the costs of multiple health problems associated with obesity such as diabetes, heart disease and cancer. The work found that if no further action is taken to slow the growth of obesity, there will be 2.4 million more obese people in Australia in 2025 than in 2011/12 and \$87.7 billion in additional costs to society over the 10 years from 2015/16 to 2024/25. Implementing interventions within primary care, education, environment (food labelling, tax on unhealthy foods) and medical (e.g. bariatric surgery, pharmaceuticals) would cost \$1.3 billion and lead to savings of \$2.1 billion to society (over the 10 years) and a benefit cost ratio of 1.7 (33).

Social determinants of health

Strong evidence and consistent feedback has confirmed the benefits of providing greater focus on the social determinants that affect health to promote sustainability. The social determinants of health are factors that influence how likely we are to stay healthy or to become ill or injured throughout our lives, and include factors such as homelessness, financial hardship, difficulty accessing education or substandard education, and unsafe neighbourhoods (22).

As suggested earlier, we strongly support the need to increase partnerships between service providers, and across sectors, to help address the underlying causes of ill health and create supportive environments which will in turn help address the rising demand for health services. The Panel also supports ongoing dialogue and innovation to support consumers taking greater responsibility in maintaining their own health and wellbeing. Housing, education and violence against women are also health issues. Proposed public sector reforms have the potential to encourage a more holistic approach between government and communities to address these issues.

Recommendations for Immediate Action

1. The Department of Health should take an active leadership role across the public sector in developing whole-of-government targets with potential impact for better health outcomes, commencing with childhood obesity.

Areas for Further Work

Develop and sustain enhanced and new strategies to avoid health impacts associated with smoking and alcohol.

“A social determinants approach would see an opportunity for various Government departments to work together to achieve good outcomes for the WA population.”

Public submission

Direction 2: Focus on person-centred services in WA

Integrating health and social services is a priority for health and social systems around the world (34). Integrated systems aim to ensure equity for the whole community and empower and respect the people accessing services and support.

The Panel has heard that there is a strong appetite for a more integrated system that reflects local culture and community needs. This integrated system would enable seamless transition and be easy to use. The main goal is to support people to stay well in their community, surrounded by family and friends.

We have commenced exploring national and international models, including the Canterbury model (Figure 9). We appreciate that to achieve more integrated care it will be necessary for different health system players to develop partnerships, have a willingness to work together, and for there to be improvements and changes in our collective culture, governance, data capture and funding (35).

Interface between service systems

The Panel has heard from consumers about how hard they find it to navigate our complex system and for patients to transition through and between services.

Many have raised concerns that with an ageing population and more complex conditions, these challenges will only increase. For some groups, such as people in regional or remote areas, these challenges will become even more significant. However, consumers also identified excellent pockets of service and local supports which helped to support good health outcomes.

Figure 9: The Canterbury model of integrated health and social services

Source: A case study in Canterbury New Zealand, The King's Fund



Consumers and staff have told us that existing disability and aged care services often do not have the flexibility to meet their needs. We acknowledge that health, aged care and disability service sectors are all undergoing fundamental reform, and that these reforms will change the way the systems interact. Changes to these systems include giving people greater choice and self-direction, changes to the way governments fund services, and new ways of managing services, that will remove the boundaries between them (36).

Recent changes to the NDIS will see more people with permanent and substantial impairment receiving services, with greater certainty of funding. While many Western Australians will benefit from these changes, there is an urgent need for the Department of Health, Mental Health Commission (MHC) and the NDIS to coordinate their delivery arrangements as access to mainstream health services will continue. Concerns were raised in many forums about the access of people experiencing mental health issues following the reduction of funding and of some services in this area.

Disconnect between different health and social services areas remains an issue. However, the Panel was encouraged by the strong commitment in WA between government and non-government health and social care partners to improve transitions between sectors and progress collaborative service provision. This has the potential to enable joint exploration of consumer-centric funding for person-centred care.

A navigator function works with consumers to work through and connect people to the right parts of the health system.

The Panel is exploring several person-centred initiatives raised in consultation and informed by evidence of successful Australian and international exemplars (37). These include:

- a navigator function that works with consumers to work through and connect people to the right parts of the health system. Similar successful initiatives include the Northern Territory Health and Social Services System Navigator; National Health Service Choices in the United Kingdom and Kaiser Permanente's Patient Care Navigators in the United States
- a place-based coordinated care model that utilises a single point of entry and coordinates care and support for a person across multiple organisations and service systems. The Canadian PRISMA model and Canterbury's CAFLink provide relevant evidence of successful models
- personal health care and support plans for consumers who need multi-system support. The Netherlands and United Kingdom have introduced personal health budgets for people with long-term chronic conditions, aged care needs and disability
- a place-based approach to integrated service commissioning¹ and provision. Some examples come from Catalonia and Canterbury. In western Sydney, place-based integration of services has focused on Aboriginal people with Type 2 Diabetes
- a service for people waiting for an aged care/NDIS package that supports the timely transition from hospital into the community. Canterbury's CREST program and Australia's Transition Care Program are key examples of effective discharge support.

¹ Commissioning is an act of granting authority to a group or person to undertake certain functions

Partnerships to progress integration with primary care

The Panel has heard that the WA health system can improve coordination of consumer care between hospitals and general practice immediately. This would improve consumers' health and allow more conditions to be managed in primary care by GPs and other health professionals working in the community.

Additional possibilities to improve coordination include: promoting Commonwealth and State Government partnerships; working on community needs planning with the Western Australian Primary Health Alliance (WAPHA); and using health professionals in the community closer to people's homes.

WAPHA and the Royal Australian College of GPs (RACGP) are committed to working with hospitals to expand the role of Hospital Liaison GPs². This important link between hospitals and GPs has a vital role to play in improving the communication between them and improving community outcomes.

Opportunities were also identified to use technology and information sharing to encourage the exchange of data between the hospital sector and GPs, enabling better flow of patient information. The Panel is also aware that WAPHA is keen to progress better sharing of information between outpatient services and GPs (see Direction 3 – for more details).

Areas for Further Work

- The WA health system takes key steps to integrate systems to deliver truly connected care. This includes a pilot of a 'navigator function' to connect people to the right parts of the health system developed collaboratively with key partners, particularly in aged care and disability sectors, to improve person-centred approach to services and ensure our most vulnerable people do not fall between the cracks.
- The WA health system should continue to work with Commonwealth Government agencies and other health and social service agencies, to improve the interface between the health, aged care and disability sectors, and to progress collaborative service provision to enable a shift to consumer-centric funding.

² Hospital Liaison GPs work at the interface between hospitals and care in the community and particularly focus on promoting clear and relevant communication between the hospital and primary care providers. The role has been developed through a collaboration between the WA Primary Health Alliance, the Australian College of GPs and the Department of Health.

Direction 3: Better use of resources with more care in the community

The Panel has received consistent feedback about the need to move care closer to home. Many examples were offered to the Panel that ensured that appropriate care was provided at the right time and right place rather than defaulting to the hospital system.

Emergency Department diversion

Emergency Department (ED) attendances continue to grow at an unsustainable rate. Between 2005 and 2015 ED attendances have increased by 49 per cent and hospital admissions by 39 per cent. This can lead to overcrowding in our EDs and hospitals which may ultimately lower the standard of care for patients requiring urgent or acute care. Whilst there have been positive changes to emergency department patient flows through the introduction of the Four Hour Rule in WA, the WA health system needs to re-think its approach to managing ED demand.

Figure 10: Emergency Department attendances have grown by nearly 50 per cent in 10 years

Source: Department of Health



ED attendances
↑ 49%
between 2005–2015

We support the exploration of a number of options within the WA health system to provide alternatives to ED in non-urgent care matters. In combination, these could help reduce ED overcrowding and provide better alternatives for many patients and their families. These include telehealth and virtual care models and diversion of patients to other pathways, mainly in the community. Attendance at ED has become the default in the absence of appropriate community-based care options. Except in critical circumstances, ED is not the most appropriate setting for elderly people or individuals experiencing a mental health crisis.

The State Government has committed to exploring other options to provide 'urgent care' in the community. Urgent care is designed to provide unscheduled care for low complexity injury or illness that is urgent, but not an emergency (10). This could involve urgent care clinics in community and hospital settings, integrated telehealth services, or 'pathways' which redirect patients from EDs to other services.

Establishing urgent care pathways with community services, ambulance and a range of alternative care providers will inform the Urgent Care Strategy for the WA health system. Ambulance and transport services in the community are essential and will play a role in future models to deliver a range of urgent care pathways to better utilise ambulance services in patient diversion.

A further concern to emerge from the public submissions, clinical forums and the Clinical Reference Group were the frequent attendees to ED (consumers who attend ED often, up to 15 times in a year). The most common conditions that bring frequent attendees to ED include mental illness, drug and alcohol-related conditions and elderly people with chronic diseases such as respiratory, digestive and circulatory diseases (38).

Outpatients

The Panel has heard of many inefficiencies in the delivery of outpatient services, including multiple and often unnecessary visits, poor communication with GPs and lengthy waiting times. Most people know that waiting times for outpatient appointments can vary and sometimes be very long.

In recent years, WA has seen rapid growth in the number of outpatient services, with the number of attended outpatient appointments having increased by 6.6 per cent between 2014/15 and 2015/16, with 2.86 million attended appointments in 2015/16. Interestingly, the data shows that a high proportion – as many as 37 per cent – of referrals for outpatient services came from within hospitals.

“Outpatient services are an obvious area where a more mature purchasing model could drive significant cost efficiencies and deliver higher quality outcomes to consumers. Consideration needs to be applied as to the process for tendering for outpatient services, and how we ensure there is not an oversubscription of outpatient services.”

East Metropolitan Health Service

There are opportunities to work with primary care providers and to use technology to deliver more care closer to people’s homes and reduce waiting times.

The Panel considers there is significant opportunity to explore the use of MBS billed non-admitted services for some outpatient clinics. This is well established in other states and an option that we need to consider for the WA health system.

There are a number of different strategies being considered by the WA health system for outpatient services with the aim of reducing waitlists. These include different models of outpatient funding and models of care, and ones that work in a local hospital or Health Service Provider setting, that support the goal of delivering care closer to or at home.

Some of the care currently being provided in outpatients could be provided by GPs with the right information and support. HealthPathways, led by WAPHA³, will support the sharing of information between specialists and GPs to allow GPs to provide more of the care to their patients (39). Partnership opportunities with WAPHA should be explored to identify a range of areas for improved integration and design strategies to reduce hospital presentations, enhance early discharge and reduce potentially preventable admissions.

Care in the community

Care in the community aims to provide different options for patients who require care but their condition does not require them to stay in hospital. Some options help patients avoid hospital entirely, while others allow people to be discharged from hospital to home earlier or to other community-based services. These options provide a more appropriate alternative to manage the care of patients outside of the public hospital system and reduce pressure on hospital bed demand (40).

The Panel supports exploration of further options for enhancing care in the community; this could be through increasing the range of hospital substitution services such as Hospital in the Home (HITH) to allow people to have more care in their homes. Examples of some of the services that can be given at home without someone going to hospital include treatment of Chronic Obstructive Pulmonary Disease (COPD), recovery after stroke through Rehabilitation in the Home (RITH), having a range of infusions for chronic conditions or acute cancer treatment and treatment for cellulitis or any other infection (41).

³ WAPHA HealthPathways is a free to access website for GPs that contains condition specific information to assist in assessing, managing and referring on patients to enable more seamless, effective and complete patient care

Patients who might benefit from home services and an earlier discharge from hospital include those who have undergone orthopaedic surgery, patients recovering from an infection or who require simple services such as wound dressings or intravenous (IV) antibiotics. The WA health system would benefit from further investigating models of care and resourcing for services in the home. This shift in service delivery will need to be developed by working closely with primary care, pharmacists, nursing and other allied health providers.

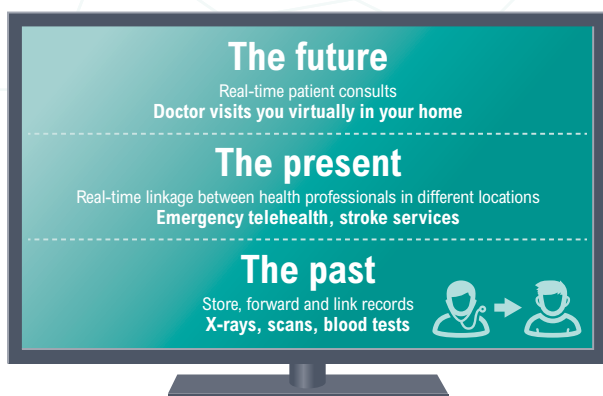
The State Government is currently building a Medihotel⁴ at Fiona Stanley Hospital and exploring options for Joondalup and Royal Perth hospitals. The Panel supports any initiative to move patients into more appropriate community care settings beyond hospitals.

Telehealth and virtual care

The adoption of telehealth and virtual care is seen as one of the enablers to the provision of new models of care in the community. Numerous submissions to the *Sustainable Health Review* advocated for telehealth as a cost effective means of specialist clinicians delivering or supporting care to patients without being physically present. The Panel shares the enthusiasm expressed in these submissions.

Figure 11: Telehealth can support how care is provided in the community

Source: Sustainable Health Review



WA is a world leader in telehealth. We acknowledge the lead role that the Western Australian Country Health Service (WACHS) has taken in this area. Telehealth has most often been seen as a means of delivering and supporting services in country areas. While it is – and will continue to be – particularly relevant as a means of supporting country health service delivery, its application is potentially broader than just in country areas. A doctor in an outer metropolitan hospital, for example, might be able to use telehealth to connect with a leading specialist in a tertiary hospital.

Key opportunities identified include chronic disease management, outpatient service delivery and enhancing access to care for regional and remote areas, as well as addressing professional isolation and professional development in regional and remote areas.

Exemplars of telehealth projects from around the world include:

- Project ECHO, which links specialist teams at an academic hub with primary care clinicians in local communities. Together they participate in weekly teleECHO clinics that enable primary care clinicians to present cases to specialists through telehealth, discuss new developments related to their patients and determine treatments. This creates ongoing opportunities for primary care clinicians to work with specialists as mentors and colleagues, through telehealth (42)
- Mercy Virtual Care Centre in the United States, which provides a wide range of virtual services including case management, monitoring of patients at home and telehospitals. All of these programs use a combination of decision making software and patient monitoring to provide help where gaps in care exist (43).

⁴ A Medihotel is a specialised hotel designed to support patients when they have been discharged from hospital but are still recuperating, being monitored or receiving outpatient tests. Depending on the site and the needs of the population, a Medihotel will be tailored to meet those needs.

These models should be investigated for use in WA. We are aware of local WA progress in home-based health monitoring, fall detection for aged and vulnerable people and the use of assistive technology. The use of telehealth technology to provide greater points of access via GPs, pharmacies, Community Resource Centres (CRCs), health services and ambulances should be further investigated.

Telehealth is successfully utilised in other health services to support mental health services and requires further exploration as part of our Final Report.

WA's Emergency Telehealth Service uses high definition video conferencing equipment installed in participating regional and remote hospital emergency departments (EDs) and nursing posts. It supports clinicians in these rural and remote sites by linking them to an experienced, specialist emergency clinicians to assist with the diagnosis, treatment and transfer of critically ill and injured emergency patients.

Eliminating the duplication of tests to ensure resources are devoted to high-value care

The Panel has heard at forums and through public submissions that patients are frustrated that the same diagnostic tests are often performed repeatedly. We have also heard from clinicians of their frustration that they do not have access to test results from other health care providers including historical results which may be useful in treating the patient. This situation leads to the same diagnostic tests being repeated and, in some instances, treatment delay, which affects patient outcomes. The development and use of electronic health records alongside better sharing of patient information will support clinicians in efficient decision making, as well as reduce unnecessary pain and discomfort to patients.

There is a push internationally and within Australia to ensure that the care the health system provides is evidence-based and effective. At a national level, the Commonwealth is pursuing the *Choosing Wisely Australia* initiative, which is endeavouring to eliminate unnecessary and sometimes harmful tests and procedures (44). Under this initiative, clinicians (via colleges, societies and associations) and consumers are identifying and 'weeding out' practices that are ineffective or even harmful (45).

The Panel notes that the Department of Health has established the WA High Value Health Care Collaborative which is working to improve patient safety and clinical quality identifying areas in the WA health system where high-value health care initiatives can be shared and low-value activities can be identified and improved. The Panel supports the WA health system to continue work to eliminate unnecessary and sometimes harmful tests and procedures.

Recommendations for Immediate Action

2. Implement a pilot of the Emergency Telehealth Service Model in at least one other specialty in the country and metropolitan area.

Areas for Further Work

- Explore a range of different models (including in the mental health and aged care areas) to enhance emergency department diversion and avoidable admissions.
- Explore the use of telehealth in the mental health area to increase access to services and support care in the community.
- Undertake a risk/benefit analysis of telehealth and other virtual care opportunities for implementation in metropolitan and country health services, in all care settings. This analysis should include an assessment of the impacts on Patient Assisted Travel Scheme (PATS).
- Formalise more local partnerships with the Western Australia Primary Health Alliance and develop joint outcomes and associated measures to enhance shared care and improve communication between General Practitioners and hospitals, including outpatient care.

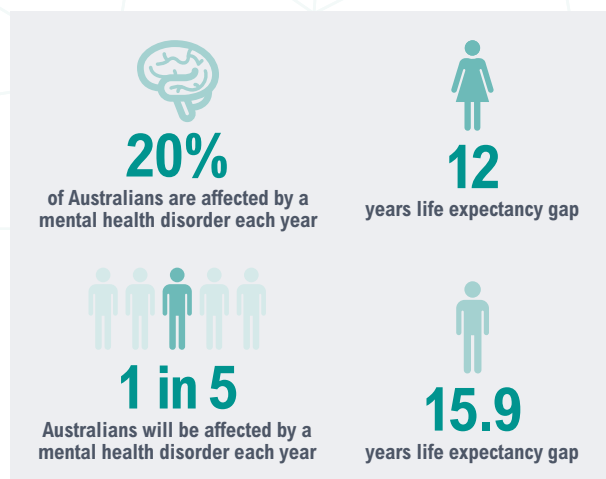
Direction 4: Facilitate effective interaction between acute and community-based mental health services to deliver mental health reforms across the WA health system

Concerns regarding mental health were highlighted throughout the feedback received. Service gaps were identified particularly for rural and regional populations, Aboriginal communities, and young people.

We know that a large proportion of people with mental health concerns also have a chronic or recurrent illness that results in only partial recovery between acute episodes. Deterioration in function can lead to problems in living an independent life. As a result, hospitalisation may be required on more than one occasion with the need for ongoing community-based support.

Figure 12: Mental health affects many people in our community

Source: Mental Health Commission



Community care for mental health

Many consumers and carers have called for a more integrated and coordinated approach to mental health that encompasses all aspects of the person and looks at increasing access to early interventions. The current funding focus remains on acute medical services at the expense of community-based services and the use of multidisciplinary teams working across government and non-government organisations and the routine inclusion of a well-supported peer workforce.

A high quality community-based mental health support system should be able to assist people within the community to access services and supports at any stage, including after an acute episode that may have required hospitalisation.

A community-based system would allow people with a mental illness to manage both their clinical and functional stability, and minimise their need for acute hospitalisation (46).

Patients leaving hospital after a psychiatric admission with a formal discharge plan that includes linkages with community-based services and supports are less likely to require hospital admission.

We know that 69.1 per cent of mental health patients in WA made contact with a community mental health service in 2017 within seven days of discharge from hospital. This is broadly consistent with the national average of 70 per cent (46). Although improvements have been made, engagement with the non-clinical community support services can be driven further to achieve better outcomes for people. The Panel supports further work to improve coordination and collaboration between the acute sector and community-based support services, to achieve better than the national average.

In the past 18 months demand for mental health beds has been high, with occupancy rates consistently over 85 per cent (47). We have heard that demands are not met in a timely manner, and that people have difficulty accessing appropriate services. Mental health services within the WA health system plan and predict patient flow to manage capacity and accommodate peaks in bed demand. We have received submissions arguing that ‘dedicated resources and expertise needs to be developed to support the assertive management of patients out of hospital and into community services’ (North Metropolitan Health Service) and that ‘improved access to services for country mental health patients by ensuring access to acute beds in metropolitan mental health facilities is required’ (WA Country Health Service). The assertive patient flow model currently used aims to maximise the efficient use of mental health beds and to ensure improved and consistent management of admission and discharge across the system.

However, the Panel also sees the need to improve access to mental health beds, improve decision making and the discharge/transfer of mental health patients to maximise best practice patient flow management across mental health services.

Enhancements and improvements to the current model should be developed and implemented to provide patients more contemporary and clinical needs-based services.

There are a number of opportunities for WA to improve the services provided to people with a mental illness in the community setting. These include de-escalation and diversion of people with mental illness from the justice system and providing alternative pathways to EDs by working with police, ambulance and community health providers.

Telehealth services can be expanded to provide more community services and support for GPs to provide more care. GPs report that mental health accounts for up to 60 per cent of their work and would welcome case conferences with acute mental health teams so they can provide more care to their patients in the community.

“We should encourage ‘community admissions’ where the GP retains ownership/responsibility for their patient and they are responsible for having discussions with their patient about post-acute care (e.g. accessing allied health or other community support services).”

North Metropolitan Health Service

The development of a Recovery College⁵ model by the State Government is another opportunity for care in the community. This program aims to help an individual recover through education and by reducing stigma (48).

⁵ The Recovery College model will be designed to address mental health and co-occurring alcohol and other drug (AOD) issues. The Recovery College model of service will consider the provision of learning opportunities about recovery and wellbeing designed for people with mental health, and co-occurring AOD issues, their families and carers, staff of mental health service providers, and staff and volunteers of non-government service providers. The State Government has identified Wanneroo and near Royal Perth Hospital as preferred locations for recovery colleges in WA and has provided the Mental Health Commission with funding to develop a comprehensive model of service for Western Australia. This will build upon the work undertaken to date.

There is also a significant opportunity for the health sector to partner with other providers, such as the human services sector, in relation to housing, education, vocational training and primary care to address some of the many issues faced by people with mental illness. Addressing the patient as a whole in relation to mental health is a key part of helping them stay well and managing their illness within the community.

Governance of mental health

Western Australia led mental health service reform in Australia through the establishment of a Mental Health Commission (MHC) with dedicated resources to commission government and non-government community-based mental health services. Many consumers, carers and families are highly supportive of the MHC and believe there have been significant gains over the past seven years, especially in recovery-based approaches to treatment. They have also noted stronger intersections with housing, employment and other key health determinants through the development of a long-term plan to guide investment and service delivery at the community level.

Views on the area of mental health, however, are highly polarised with some advocating that mental health be reintegrated or returned to the governance of the Department of Health. The recent review of Quality and Safety in the WA health system by Professor Mascie-Taylor identified various communication and governance-related challenges between the MHC, the Department of Health, Health Service Providers and the Office of the Chief Psychiatrist, relating to the clarity of roles and accountabilities that need to be addressed in the immediate future (2).

The Panel supports a review of mental health clinical governance, to simplify and clarify the organisational arrangements supporting mental health services in order to provide direction, consistency and facilitation across service providers in WA. We also note that the resolution of these issues will be further assisted by the dual portfolio responsibilities of the Minister for Health and Mental Health.

As reported by the National Mental Health Commission, mental health has traditionally not fared well as part of broader health administrations despite injections of significant additional resources. Various audits confirmed the tendency for health funds to be redirected to more acute health services in response to funding pressures and a greater focus on activity targets (49). A key benefit of the MHC being a separate entity is its ability to hold Health Service Providers accountable for ensuring that all funding provided by the MHC is spent on mental health services.

The Panel also believes that a shift in all the responsibilities of the MHC back into the Department of Health is likely to be seen in the mental health sector as contrary to the Government's commitment to driving community-based services and a reassertion of the medical model in favour of recovery-based approaches. Concerns were also raised regarding the efficacy and focus of existing consumer and carer advisory and engagement mechanisms, and the potential benefits of consolidating these to drive ongoing reform in this area.

We support resolution of outstanding governance issues, acknowledging the strengths of the current governance model which allows for dedicated resources to be invested into mental health, and aligns with the intention to move appropriate services into the community, and away from traditional hospital-based services.

We have heard of the need to review WA's current licensing and regulations for mental health services as this is out of date and no longer fit-for-purpose. This has led to frustrations by organisations which are seeking to commission contemporary community accommodation services, but are being held back by current arrangements. There is an urgent need for a modernised licensing framework that will appropriately license and regulate a range of community accommodation services capable of delivering contemporary, evidence-based models of care. The Panel supports work in this area by the Department of Health in conjunction with the Mental Health Commission and other relevant stakeholders.

Recommendation for Immediate Action

3. In collaboration with the Mental Health Commission (MHC), Department of Health, Health Service Providers, consumers and carers, immediately develop and then implement, an effective, contemporary clinical needs-based model that enhances or replaces the current patient flow model across all health services.
4. Support the immediate review of mental health clinical governance as identified by Professor Mascie-Taylor in the 2017 Review of Safety and Quality in the WA health system.

Areas for Further Work

- Identify current and future mechanisms to ensure appropriate and effective patient care can be delivered for people with mental illness within the community setting.

Direction 5: New ways to support equity in country health

About 548,000 people, or 20 per cent of Western Australia's population, live in the State's vast rural and remote areas spread over 2.6 million square kilometres. The Panel heard about the particular difficulties country-based Western Australians faced in gaining equitable access to services. This is reflected in key health data, with people living in the country tending to have lower life expectancies, higher rates of disease and injury, and limited access to the use of health services than people living in major cities (22).

“The vast spread of the population and the corresponding small population numbers mean that WACHS cannot sustain complete services to all population groups across regional WA. Significant factors driving service demand include changes in population and population demographics, increased availability in the scope of local services and a higher than average burden of disease in Aboriginal and rural populations.”

The WA Country Health Service

While Western Australians generally have a good health status, those living in rural and remote areas tend to experience poorer general health than those in the metropolitan area. The average life expectancy for people living in remote areas is five years less than that of a person living in the metropolitan area (37).

For Aboriginal people, while there is only a two-year age difference for those living in remote areas compared to metropolitan areas, overall there is a significant difference in life expectancy for Aboriginal people compared to the rest of the community.

In Western Australia, the life expectancy of Aboriginal people is 15.1 and 13.5 years lower for Aboriginal men and women respectively (50). WA has the largest gap in life expectancy between Aboriginal and non-Aboriginal males compared to New South Wales, Queensland and Northern Territory (50).

Many of the medical services delivered at country hospitals in WA are provided by visiting specialists and practitioners who may also be country GPs or registrars on training rotations.

Coordination with metropolitan hospitals and patient travel

The Panel has heard concerns about the quality, consistency and cost of patient transport services in country areas. We have also heard that many trips to Perth by rural and remote patients to access services funded through the Patient Assisted Travel Scheme could be avoided through an increased utilisation of telehealth services.

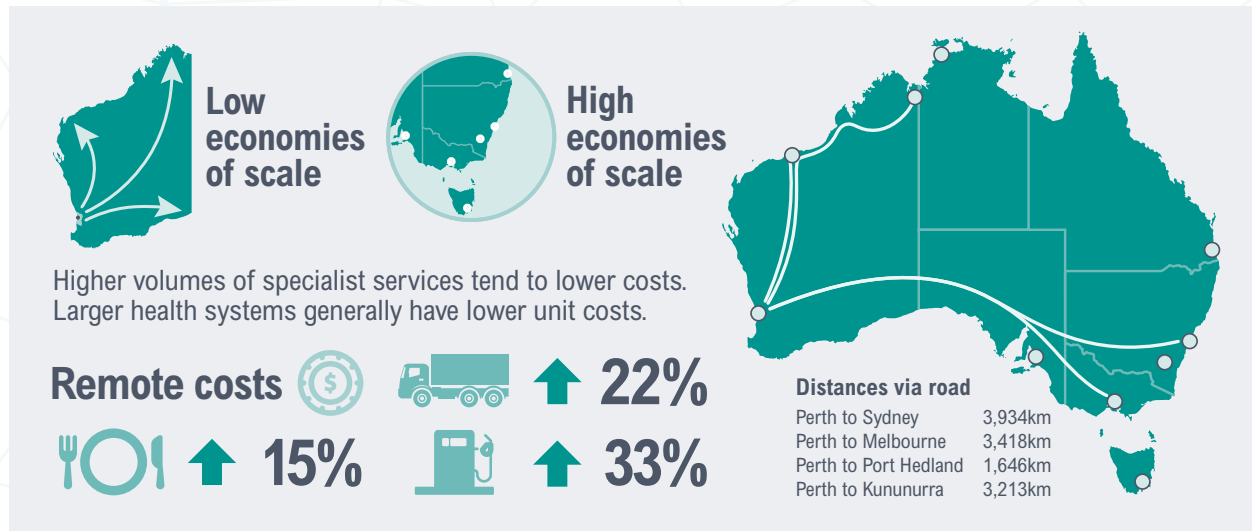
More formalised links between metropolitan and country hospitals to better support patient care and professional development for staff should be explored.

A comprehensive country patient transport strategy that considers cost effective models for emergency and patient transport (incorporating Ambulance, Fire and Emergency Services and the Royal Flying Doctor Service) should also be explored.

The strategy will review established arrangements for emergency and planned patient transfers to metropolitan areas for improved access and better coordinated care with metropolitan providers, and reference contemporary national and international models.

Figure 13: Country health remote costs – Unique factors that impact the cost of health care in WA

Source: Fair Share Report – Government of Western Australia



Service delivery costs

An issue that has been repeatedly raised is the need to adequately recognise the higher costs of providing care in regional WA, including staff accommodation, allowances and travel.

Small hospitals in country areas are required to provide patient services on a 24-hour basis but are unable to achieve economies of scale compared to larger metropolitan hospitals. In allocating funds to country health services, consideration must be given to the funding adjustments required to account for the higher cost of service delivery. The Panel heard that commissioning and funding of services should involve the community as a whole, as well as key community agencies, WAPHA and local governments to develop creative, localised solutions for regional health.

We understand that the Independent Hospital Pricing Authority (IHPA) proposes to include additional acute patient treatment remoteness adjustments in the draft National Efficient Price for 2018/19 and shadow pricing for multidisciplinary case conferences where the patient is not present. In addition, the draft National Efficient Cost Determination will provide the average cost for block-funded small rural hospitals (10).

A consistent concern raised with the Panel was the need for funding to country hospitals, in relation to the WA and national IHPA arrangements, to adequately recognise the additional costs of service delivery in rural and remote areas. The Panel considers that the WA health system should review the level of funding it provides for regional hospital service delivery to ensure it sufficiently takes into account these additional costs and makes representations to the IHPA regarding higher regional costs.

Partnerships, joint planning and commissioning

A number of parties are involved in designing, commissioning and delivering services in country communities, including both the State and Commonwealth Government, Aboriginal-controlled health organisations and other non-government organisations.

There is significant opportunity for joint planning and commissioning of health services, with funds to be pooled on a regional basis and with the State and Commonwealth Government working together in the planning and funding of services tailored to respond to the health needs of communities. The WA community as a whole deserves a meaningful say in what health services are invested in and that can be achieved through sharing clear and transparent costings for the provision of health care. Building community understanding of appropriate levels of service in small or remote sites is an important investment in continuing to contain our costs and improve health outcomes.

The Panel supports a proposal to pilot a joint regional commissioning model (collaboratively with the local community, Aboriginal community-controlled health organisations and the Commonwealth) initially in the Kimberley. The Commonwealth's contribution to pooled funding should be based on its average spend per capita across the State rather than its (typically lower) historical spending at a local level in the Kimberley Region.

In addition to State and Commonwealth Government partnerships, we believe there is also the potential for more on-the-ground localised cooperation between different State Government agencies. This could involve partnerships in planning and delivering services to individuals and communities. There is also the potential to pursue initiatives such as agencies co-locating offices and sharing administration support. This would align with a direction of the *Service Priority Review*.

Areas for Further Work

- Develop and expedite options for seamless and safe patient movement around the system through a comprehensive country patient transport strategy considering cost effective models for emergency and patient transport.
- Investigate formal arrangements for patients and staff in regional hospitals to have a direct association with a metropolitan hospital for access to care for country patients and professional development.

Direction 6: Develop partnerships for Aboriginal health outcomes

“The philosophy of empowering people in ‘owning’ and ‘driving’ the health and other community services that they receive in their communities is applicable to all Western Australians.”

Aboriginal Health Council of WA

In 2015 there were more than 94,000 Aboriginal people in WA, with 60 per cent living outside the Perth metropolitan area. Aboriginal people have a much lower life expectancy compared to non-Aboriginal Western Australians, and are three times more likely to be hospitalised, compared to non-Aboriginal people (51).

The Panel heard of the need to develop the cultural competency of the health workforce, the importance of Aboriginal people having ownership and driving decisions regarding health and other services in their communities, and the need to focus on the social determinants of health.

At public forums the Panel heard about the difficulties associated with the patient journey and the lack of culturally appropriate support for Aboriginal patients while receiving care in the Perth metropolitan area.

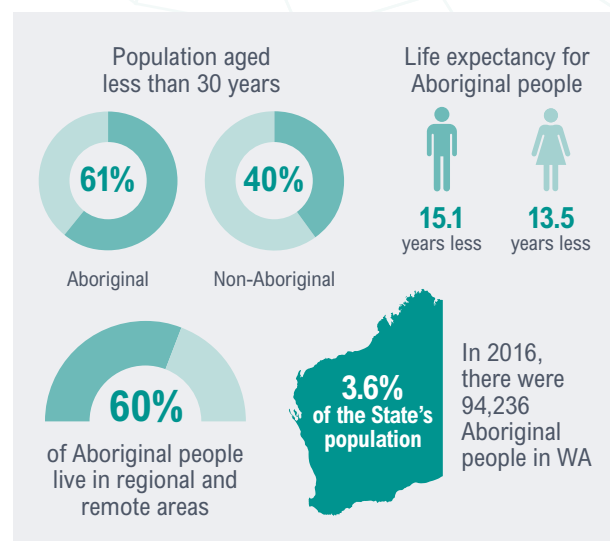
Through face-to-face conversations with Aboriginal stakeholders we heard about the dilemma of remoteness in providing care in WA, patients discharging from hospital early to return to country and the need for better coordination and partnerships with Aboriginal people.

Culture is central to Aboriginal people and a key determinant to health and wellbeing. The need to develop and improve access to culturally appropriate and secure health services was highlighted in public submissions. Past experiences including racism and discrimination can influence Aboriginal people’s decisions about when and why they seek services, their acceptance or rejection of treatment, the likelihood of adherence to treatment and follow up, and their views about the facility and its staff (52). Aboriginal patients in hospital, for example, are more than 10 times more likely to discharge against medical advice as non-Aboriginal patients. People who leave hospital against medical advice are more likely to need to return to the Emergency Department (53).

The Panel has heard that providing culturally competent care to Aboriginal people is vital. Building cultural responsiveness into health services is essential to strengthening Aboriginal health outcomes.

Figure 14: A snapshot of Aboriginal Health in WA

Source: Department of Health



Continuing to build the Aboriginal health workforce will help the health system deliver culturally safe and responsive health services. Aboriginal employees bring a diverse range of skills to the health sector including a cultural perspective, the ability to break down barriers and provide culturally appropriate care. A mandatory cultural eLearning training package has been in place in the WA health system since 2015, with ongoing development of a cultural competency continuum to ensure a consistent approach to building a culturally competent WA health system.

Another important aspect of Aboriginal health that came through in submissions was empowerment of families and communities, which involves increasing Aboriginal ownership and giving Aboriginal people a greater say in decisions that affect them individually (54). There is considerable international and national evidence that interventions which empower socially excluded groups can be linked to better health outcomes and quality of life (55).

Aboriginal people experience particularly high rates of chronic diseases, kidney diseases, injury, and disability (53). A number of submissions pointed to the need for greater effort to be put into wellness and prevention including a suggestion for longer-term funding for targeted interventions. The Panel has heard from submissions that Aboriginal people also want to have care closer to their community and out of hospital. The submission from the Aboriginal Health Council of WA urged the redirection of resources from hospitals to integrated primary care services. It advocated for services that looked more comprehensively at the situations of individuals (the social determinants of health) as well responding to their immediate health needs.

The health outcomes of Aboriginal people, more than almost any other population, have been disproportionately impacted by the social determinants of health. A number of submissions to the Review focused on addressing the social determinants of health through partnerships. Partnerships between State and Commonwealth health agencies, non-government organisations and Aboriginal organisations will be vital in addressing these social determinants and achieving shared goals.

WA Health Aboriginal Health Framework

Although there have been improvements in Aboriginal health outcomes over the last two decades, significant disparities remain. The WA health system introduced the *WA Aboriginal Health and Wellbeing Framework 2015–2030* ('the Framework') to provide a vision for taking meaningful and measurable actions towards improvements in Aboriginal health and wellbeing outcomes (56). While recognising the gains made to date, a number of major challenges remain, including a key challenge raised during consultation around the uncertainty regarding longer-term funding and therefore the inability to commit to long-term sustainable programs.

The development of the Framework was informed by an extensive statewide consultation program with input from key stakeholders such as the Aboriginal Expert Reference Group, WA Health Senior Aboriginal Leadership Group, Regional Aboriginal Health Planning Forums and Aboriginal young people. In addition, the Aboriginal Health Policy Directorate within the WA health system held a consultation forum to seek further input and guidance from senior Aboriginal professionals, Aboriginal community members and people who provided health services to Aboriginal people.

The Framework recognises the need to respond in a coordinated, flexible and practical way to improve health outcomes for Aboriginal people. It includes six strategic directions (Figure 15).

Figure 15: Strategic Directions, WA Aboriginal Health and Wellbeing Framework 2015–2030

Source: Department of Health



This is accompanied by the *WA Health Aboriginal Workforce Strategy 2014–2024* (57), which highlights a vision to develop a strong, skilled and growing Aboriginal health workforce across the WA health system. This theme was supported by a number of public submissions.

We strongly support the implementation of these two key strategies to improve the health and wellbeing of Aboriginal people.

Exploring new partnerships and funding arrangements

There is an opportunity to better align State and Commonwealth Government commitments for purchasing and ensuring predictable funding. It has been highlighted in submissions and forums that short-term, program-based funding in the past has led to unsustainable models of care and health services. Building sustainable strategic funding, working towards funding on the basis of evidence, and moving to longer-term funding models are steps towards achieving more equitable health outcomes.

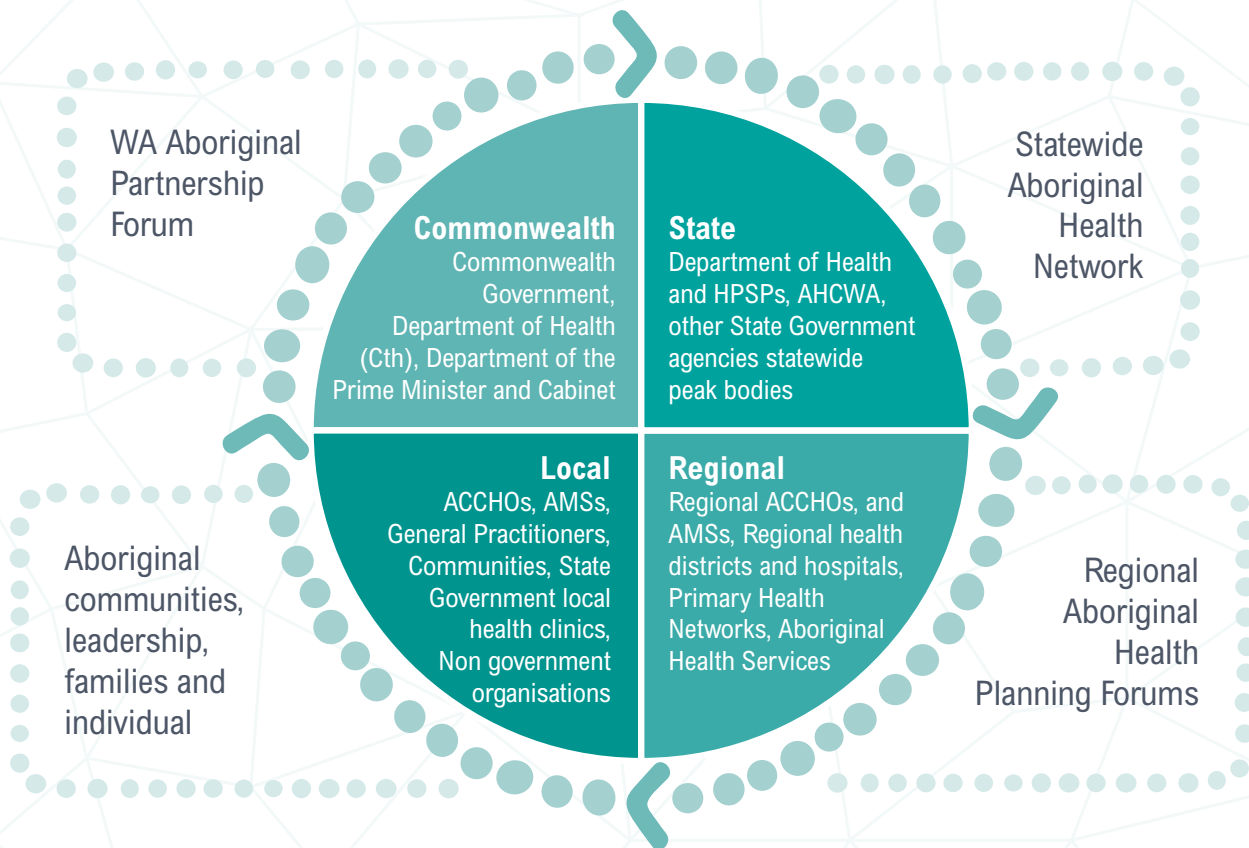
Traditional commissioning in WA has historically focused on independent funding of individual organisations by various levels of Government with an emphasis on processes and activity. The Panel notes this has inadvertently contributed to the fragmentation of care and services delivered.

Joint regional commissioning aims to deliver improved community health and wellbeing supported through an integrated model where all service providers regardless of location pool funding, ‘talk’ to each other, and focus on delivering better population health outcomes. This whole of region population focus prevents fragmentation and works to deliver targeted activities, with both new and existing models of care.

The Panel acknowledges joint regional commissioning takes a long-term focus, encourages innovation and collaboration across providers by connecting systems of care in a person-centred approach. An audit of existing services and infrastructure within the region will be a prerequisite to establishing joint regional commissioning arrangements. The Panel recommends identifying opportunities for co-location of services using existing facilities that are under-utilised to provide both cost savings and more seamless services to the local population. Joint regional commissioning also provides opportunities to expand services in the local area which in turn reduces the requirement for patient transport to metropolitan facilities for the service.

Figure 16: Aboriginal partnerships, WA Aboriginal Health and Wellbeing Framework 2015–2030

Source: Department of Health



The Department of Communities is working to address the significant and historic gap between the life expectancy of Aboriginal and non-Aboriginal people in regional and remote areas, with a particular focus on the Kimberley, Pilbara and more recently in the Goldfields. Strong collaboration between the State, Commonwealth and local governments; service providers and Aboriginal people underpins this work and is essential for significant, long-term change. The Panel supports the Supporting Communities Program being developed by the Department of Communities. The new program seeks to create connected, inclusive and healthy communities and respond to local priorities, by focusing on community resources, strengths and aspirations.

Establishing partnerships at all levels of government, with non-government, Aboriginal community-controlled providers, and communities is required to develop better coordination and communication pathways to improve the health of Aboriginal people. The Panel acknowledges the need to undertake further consultation with Aboriginal people and existing service providers. Potential health benefits will only be achieved based upon strong collaboration and partnership with Aboriginal communities.

Areas for Further Work

- Advocate to the Commonwealth Government for a collaborative approach to funding and service delivery to be implemented, for example commencing with a pilot of a joint regional commissioning model, initially in the Kimberley. This should be based on active partnerships with the Commonwealth, State and local government agencies, Aboriginal community-controlled health organisations and non-government organisations.

Direction 7: Create and support the right culture

When asked about what would make a truly sustainable health system, many people we consulted pointed to the importance of culture in driving change and innovation. Globally in health care it is recognised that culture drives the key elements of sustainability including improved patient safety and outcomes, organisational performance and waste minimisation. The Panel acknowledges that system change takes time, requires strong and authentic leadership, true staff engagement and an investment in people.

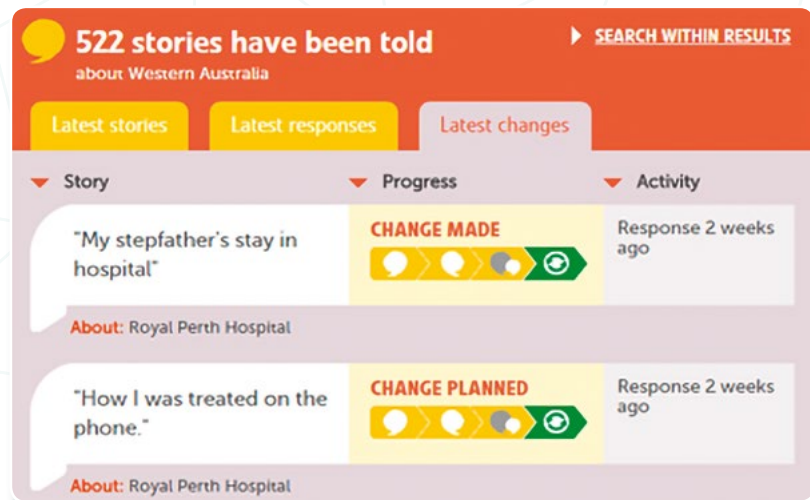
Patient and carer voice and engagement

Embedding the patient voice into health service planning will be an ongoing driver for improved performance. The Panel has heard forcefully of the need to orientate the system around what matters to patients, families and carers and a desire for community members to be more involved in the decision-making processes and design of the WA health system. This has been echoed by the *Service Priority Review* which suggested that ‘funders, policy design specialists, service providers, communities and citizens work together in an equal partnership throughout the policy design process’ (21).

The Minister for Health’s commitment to roll out a Patient Opinion System to all publicly run hospitals was completed in 2017. The Patient Opinion System helps to modernise the way feedback from patients and carers is received and leads to real changes in service delivery. A similar system exists for experiences of care and support services, called ‘Care Opinion’, which could be explored across government and non-government health and human services providers.

Figure 17: Patient Opinion is being used by Health Service Providers to receive and respond to consumer feedback

Source: www.patientopinion.org.au



The Panel also notes that the Department of Health has a Patient Opinion Hub which is about to go live on the *Healthy WA* website as a one stop portal for consumer information/ access, and the Department of Health is exploring further opportunities with the Health Consumers Council for promotion and use of the Patient Opinion System to help improve services and the patient experience.

Other measures already in place include feedback surveys, consumer compliment and complaint processes, and advisory structures. A range of options to support or improve these warrant consideration over time, including new ways of engaging consumers and the public in decision-making and policy development, platforms for live and real-time patient feedback mechanisms, and further development of Patient Reported Experience Measures and Patient Reported Outcome Measures. Some of these are being utilised now or being explored in other States.

Staff voice and engagement

The need for a louder staff voice and greater engagement has been a major theme of feedback we have received. We know engaged and motivated staff drive safety and performance, and the alignment of staff collective values is a critical success factor for workplace culture.

While there is a range of staff engagement practices underway across the WA health system, the significance of staff engagement to drive systemwide change warrants immediate attention.

The Minister for Health has announced that a regular systemwide staff survey will be introduced. The Panel believes that this as an important first step towards the WA health system adopting a systemwide commitment to regularly benchmarking staff feedback in relation to values and other areas – a practice undertaken by other jurisdictions.

Workplace and organisational health are important underpinnings of a high-quality health system. Problems such as bullying, fatigue and burnout can drive down staff morale and ultimately impact negatively on the quality of patient care. As noted in the *Case for Change* (see **Appendix A** for details), there are some recent instances where problems with leadership and staff morale in WA have been highlighted (58, 59). The Panel has heard that staff engagement across the system and between professional groups varies.

A key to improving the quality and effectiveness of services is to have a workplace that values and rewards innovation, where all staff are confident in raising concerns and can put forward new ideas. Unfortunately, the Panel has heard in submissions that there are ‘plenty of people who are very happy to knock down anyone who shows innovation and prepared to do things differently’. We expect variation across different workplaces in approaches to staff innovation and feedback but wish to see staff always encouraged to put forward ideas about how services can be improved.

The Panel has seen limited evidence of an agreed systemwide approach to measuring key workforce health and safety metrics, something monitored in other health organisations and industries. Submissions have also highlighted excessive middle management barriers to innovation and performance noting, ‘there is an increasing divide between clinical staff and executive and middle management and loss of engagement on both sides.’

“The larger institutions can, at times, seem like no one is able to affect change. You ask people around you ‘who can fix this issue, make this better?’ and the answer is ‘I don’t know, maybe the CEO?’ Contacting a busy senior executive to tell them a bit of kit is too expensive or wasteful is a bar too high, so people just continue the wasteful practice”

Public submission

Effective leadership is crucial to creating the ‘right culture’. The Panel acknowledges the need for contemporary health leadership competencies and practices, including a shift towards collective leadership and empowering all staff to become leaders and influencers. Strengthening of performance assessment processes of senior executive officers is also consistent with the recently released *Service Priority Review*.

Public reporting and benchmarking

Enhanced transparency was a strong theme emerging from our consultations. This was viewed both as a means of helping patients make informed health care choices and driving a culture of accountability for clinicians and health service executives.

Public reporting and benchmarking will allow for oversight of system performance and resources, with a focus on patient safety, outcomes and costs. This is a direction strongly emphasised in the *Service Priority Review* and the 2017 *Review of Safety and Quality in the WA Health System* and has been supported by recent announcements by the Minister for Health.

The Panel recognises the work the Department of Health has commenced on transparent performance reporting. This includes a project to improve public reporting and access with a centralised location for consumers to access information and compare performance across the system.

The Panel is also aware that Health Service Providers are progressing initiatives to publish more information about their performance supported by a systemwide approach.

Recommendations for Immediate Action

5. Identify and report publicly, key system quality, safety, financial and performance information at the whole of system, and hospital level as a priority; and further progress public reporting down to department and clinician level.
6. Implement a WA health systemwide employee survey process and benchmark findings to inform and drive systemwide staff engagement programs.

Opportunity for Further Work

- Launch a one stop portal for consumer information/access on the Healthy WA website. Publish feedback received through public release and at ward level to encourage improvement.
- Develop agreed systemwide core values and metrics regarding workforce health and safety.

Direction 8: Greater use of technology, data and innovation to support consumers, and clinicians, and drive change

Both locally and globally, technology has been a driving force in health care delivery and reforms, and new horizons in digital technology are becoming the reality (60).

Across all sectors the Panel engaged with, it was agreed that enhancing the access to data and use of ICT was a major area for further improvement.

“Reduce wastage by increasing access to data around the patient so that health care professionals can treat the patient in their totality, not just the acute presentation in front of them at that moment.”

From a public forum

Digital strategy

Consumers want to use technology to help navigate the complexity of the system and manage their care better themselves. This involves advances in biomedical devices, with virtual care options, such as telehealth, that could provide ‘truly patient-centred care by bringing the care to the patient, including at home and to their mobile device, at more accessible times and locations.’

There are further opportunities enabled by data and digitalisation that have been put to us, such as Enhanced Medical Mixed Reality Technology (which combines real-life, projected holograms and video conferencing) which Silver Chain reports it is exploring (61). Other opportunities include spatially enabled health, predictive algorithms for early prediction of disease, detection and monitoring of illness, robotics, collaboration of real time data and enhancing individual data analytics with systemwide data (60).

Figure 18: A digital strategy supports consumers and the health system



The Panel has heard that past investments in ICT have not delivered the benefits expected and the money spent has not been allocated under an integrated statewide plan. Further work is needed to develop a well-considered and orderly transition to a digital future in the WA health system. This work will involve exploring how digitisation can empower consumers, support clinicians and integrate services (with particular focus on regional and remote areas), with a focus on prioritising and optimising investment for digitisation.

Electronic health records

The Panel has heard overwhelmingly of a need for access to patient medical records (including diagnostic test results) to patients and across all services and sectors via digital platforms.

The Australian Digital Health Agency is responsible for implementing the My Health Record system across the nation. My Health Record is a secure online summary of a patient's health information that enables patients to control what goes into it and which health care providers have access to the information. The Commonwealth Government announced in the 2017 Budget a commitment of \$374.2 million over two years to the My Health Record to continue to expand the system (62).

The WA health system will be progressing connection to the My Health Record system through its various ICT applications. My Health Record is now accessible at all hospital sites across metropolitan and country regions. Collectively, this represents 113 sites across metropolitan and country hospitals and a number of remote communities (63).

From the perspective of staff and the wider health sector, the use of electronic health records, accessible to health professionals in both the public and private sector, has been identified by many submissions as a logical step to reducing costs and improving efficiency by reducing duplication and unnecessary investigations (particularly pathology and radiological investigations). The WA health system is well advanced compared to other jurisdictions with a unique patient identifier system in place. This should facilitate the implementation of a statewide electronic health record system. The Panel supports the progression and implementation of a statewide electronic medical record. This may initially be developed in partnership by the Department of Health with one or two Health Service Providers, subject to robust business cases and available funding. Two-way data sharing between the WA health system and private providers should consider pathology results, patient discharge information and medical imaging as initial priorities and link directly to work with the

expansion of My Health Record. This will assist with maximising clinician engagement, and would put the health system in good stead for the full roll out of electronic health records across WA. This area will be explored further in our Final Report including timelines.

The Panel has heard that when staff have difficulty accessing data, their ability to plan and improve services is limited, including the development of data analytics, and their ability to communicate with consumers.

'There are various systems currently used to manage individual health records. These systems typically have limited interaction with each other. This results in various components of patient health records being held and stored in multiple, stand-alone systems with no single system, nor the patient having holistic access to their health information.'

Health Support Services

The Panel supports data being 'linked by default' internally and externally within the wider health care landscape. WA is a pioneer in data linkage, with 'one of the most comprehensive data linkage systems in the world' (64).

It will be critical that data protection is well managed to ensure these systems consider privacy and confidentiality. The *Service Priority Review* also recommends the strengthening of data sharing. The development of legislation and processes to facilitate data sharing while protecting sensitive personal information is a key precursor to open data sharing.

The Panel also notes the Bureau of Health Information in NSW as an exemplar in the space of independent data analytics and performance reporting of the public health care system.

Recommendations for Immediate Action

7. Develop and implement innovative approaches to sharing of patient-level data across public/private providers, including a pilot to demonstrate necessary policy and technology approaches, commencing with pathology results, patient discharge information and medical imaging as an initial priority linked directly to work with the expansion of My Health Record.

Areas for Further Work

- Develop a Digital Strategy for the WA health system that identifies priorities to support consumers, clinicians and the system management.
- Explore options for progression and implementation of a statewide electronic medical record. This should be initially developed in partnership by the Department of Health with one or two Health Service Providers, subject to a robust business case and available funding.
- Support and enact the Department of Health-related actions from the Data Linkage Review.
- Partner closely with the Australian Digital Health Agency to support the expansion of the My Health Record program in WA by raising awareness among clinicians and increasing availability of patient information (including pathology, medical imaging results and discharge information) to My Health Record.

Direction 9: Harness and support health and medical research, collaboration and innovation

WA has an impressive track record in the area of health and medical research which has had lasting impacts on both the WA health system and community more broadly.

Despite such progress, the Panel has heard that the health and medical research community in WA is being held back by a lack of progress in introducing electronic records, a commitment to data sharing, an historic lack of National Health and Medical Research Council (NHMRC) funding and the lack of uptake by new graduates in research careers.

The Panel supports giving greater prominence to research and moves to better enable the research environment, generating policy-relevant research and driving research translation into health.

There are four main categories of research:

1. *public health research* – develops and improves disease prevention programs
2. *basic research* – improves understanding of the causes and mechanisms of disease
3. *clinical research* – improves the treatment and management of diseases
4. *health services (systems) research* – enhances the quality and effectiveness of health care delivery.

WA has a number of international and national leaders in research, with clinicians in the system being responsible for innovations that are significantly benefitting patients worldwide. Most notably, the implementation of:

- new treatments for stomach ulcers through the ground-breaking research of Professor Barry Marshall and Dr Robin Warren
- new public health programs to prevent neural tube defects in children through the research of Professor Fiona Stanley and her team
- new treatments for burns victims through the pioneering research of Dr Fiona Wood.

The WA health system is a founding member of the International Rare Diseases research Consortium, Global Alliance for Genomics and Health and the Undiagnosed Diseases Network International. The *WA Rare Diseases Strategic Framework 2015–2018* has been acknowledged nationally and internationally and the WA Rare Disease Service is an exemplar of a person-centred, innovative clinical service.

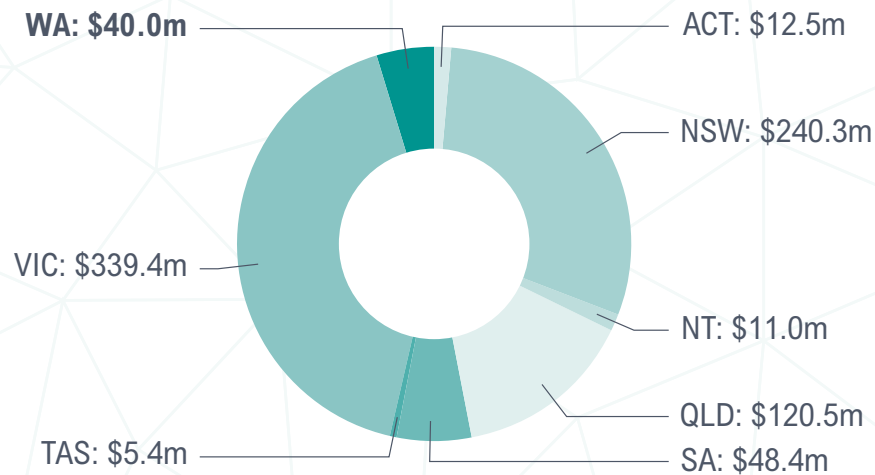
The WA Data Linkage System (WADLS) is also recognised as one of the most comprehensive and high-quality linkage systems worldwide. The WADLS enables secure linking of health data from a wide range of sources to support a range of activities including research.

Figure 19: Four main categories of research



Figure 20: National Health and Medical Research Funding share by State and Territory in 2016

Source: Grants Funding 2000–2016, National Health and Medical Research Council



Improving WA's share of national research funding

WA has high calibre health and medical researchers, however a continuing concern is the State's inability to attract funding support for research. In this regard, the major source of health and medical research funding is from the Commonwealth Government through the NHMRC. According to figures provided by the NHMRC for 2016, WA researchers received around \$40 million, which represented about five per cent of competitive NHMRC funding distributed across Australia (64). This is a poor outcome given WA accounts for about 10 per cent of the national population.

The Panel acknowledges that the WA health system has undertaken a range of initiatives designed to increase WA's share of the research funding pool.

These include:

- a substantial capital investment in new research facilities, co-located with major hospitals including the Harry Perkins Institute of Medical Research (inclusive of the Lions Eye Institute and the Institute for Respiratory Health at QEII Medical Centre); the Telethon Kids Institute to be co-located with the new Perth Children's Hospital; and the Ralph and Patricia Sarich Neuroscience Research Institute in the QEII Medical Centre precinct

- funding programs that facilitate high-quality research, assist WA researchers in preparing competitive funding applications that achieve translation of research into medical practice and programs and that attract, develop and retain quality clinical researchers.

Recognising the importance of collaborative networks for effective health and medical research and translation, the Western Australian Health Translation Network (WAHTN) was formed. The WAHTN provides a forum for Western Australia's major hospitals, medical research institutes, and universities to make use of State investment in facilities for research, patient care and population wellbeing. The WAHTN builds on the strength of WA medical research to maximise collaboration and the rapid translation of medical discoveries to patient care and community health. In 2017 the WAHTN achieved Advanced Health Research Translation Centre status, which facilitates our State attaining a greater share of NHMRC funding into the future.

The Panel is encouraged by these initiatives but considers there is scope and opportunity for WA to significantly increase its share of medical research funding, and increase its focus on health-related policy challenges and collaboration.

Systematic approach to innovation and research translation

The Panel has observed that in WA, local innovation, research and technology uptake occurs well, but new ideas and changes in practice do not seem to spread effectively across the system. We have heard many examples of local-level innovation, ideas and research from the health sector. There are many unsung heroes at the local level who demonstrate exceptional commitment and dedication to ensuring systems are operational while promoting continuous improvement.

The Panel has heard that opportunities exist to work with Health Service Providers (locally, nationally and internationally) to explore centres of excellence, further attracting talent to WA. New approaches to ideas generation, such as 'hackathons', that engage frontline staff in developing innovative solutions also warrant further exploration.

Approaches taken in other jurisdictions such as the NSW Agency for Clinical Innovation and Better Care Victoria (65, 66), could inform future directions for clinical innovation, research and translation into practice in WA.

The State's investment in the WAHTN supports the development of a systematic approach to innovation and research translation and enhances WA's opportunities for increasing research funding, including the Future Health and Research Innovation Fund, that provides a significant opportunity to invest in and develop research, technology and innovation capability in WA. We also recognise the State Government's commitment to the development of the WA Health Innovation Hub located at Royal Perth Hospital to support industry partnerships, innovation and research translation.

Areas for Further Work

- Continue the increased focus on research and innovation through the State Government's Future Health and Research Innovation Fund and also support the enabling of research and innovation translation within everyday clinical practice with the research community including the Western Australian Health Translation Network. These investments could see WA as a centre of choice for translational and policy relevant research.

Direction 10: Develop a supported and flexible workforce

Preparing for a more diverse, agile and fit-for-purpose workforce of the future is a key theme from consultation. This will require building on the capability of the current workforce to support a multidisciplinary approach that is flexible enough to meet the requirements of new models of care, use of technology and the provision of more complex care in the community setting. Building capability is dependent on having the right people with the right skills, in the right roles and with the right behaviours and values.

The *Service Priority Review* also highlighted the need to strengthen employee capability and for contemporary, more efficient human and industrial resource management in the WA public sector.

Workforce planning and training

The Panel is aware that previous approaches to workforce modelling and planning in the WA health system have focused exclusively on considering profession-to-population ratios. This approach is overly simplistic and does not forecast and manage shifting service delivery needs, expanding scope or changes in roles.

Current workforce requirement and supply models do not identify or quantify all the pathways for staff joining the system, consider progression pathways or future possibilities of different workforce categories. Scenario modelling and other sophisticated approaches may position the health system better for a flexible workforce in the future.

The Panel also acknowledges the need to plan better for a broad future health workforce. Work across government, non-government and social care agencies is required to develop strategies in workforce planning methodologies.

We have heard that many professions do not consider they are being used to their full potential. The WA health system should look

for opportunities for more efficient service delivery and to fully utilise the scope of practice for all health professionals. We have heard strong calls for change, particularly from nursing, allied health and health science professionals, recommending the exploration of more contemporary, multidisciplinary models that would make better use of the broad skills and experience of the professions employed within the health system. Submissions have highlighted to the Panel that such changes would 'facilitate better outcomes for patients, enhanced productivity and value for money for health services'. This is supported by experience in other jurisdictions.

The WA health system workforce comprises a large proportion of professional and para-professional skilled occupations, with people in many cases requiring a degree and also often a post-graduate qualification in order to practice in their profession.

The Panel has heard that there is a need for improved collaboration between health services, academic providers (including universities, TAFE and medical colleges) and accreditation agencies to ensure that training needs for the health care worker of the future are met; that sufficient numbers are being trained to meet operational demands and ensure that persons being trained are equipped with the skills required in future workplaces within the WA health system, including working in an inter-disciplinary team.

As professional boundaries and roles evolve, new knowledge and skills are acquired, maintained and expanded, there will be continuing need to review the length and currency of vocational education and training programs. New models of workforce mobility should be considered if they enhance the health needs of the population through better quality and innovation and should not be thwarted by historical precedents and vested interests.

Suggestions have also been made to formalise a collaboration with the academic sector and create a 'health university' to facilitate education and training of health staff. We are supportive of the concept of a training collaboration, noting that with the length of the training trajectory, work is required now.

The Panel has also consistently heard concerns regarding the maldistribution of specialist doctors and GPs across the State. Current projections indicate an estimated shortfall of 974 GPs in WA by 2025 (8). Combined with this there will be a significant increase in intern numbers coming through by 2025, up from 330 to 430. This provides the WA health system with significant opportunity to recruit to areas of medical need – rural and outer metropolitan areas for GPs, and specific areas of specialist shortage.

Figure 21: WA's projected GP shortfall

Source: Department of Health



To address the GP shortage, WA has already worked cooperatively with the Commonwealth Government to increase the number of places in medical schools. A key focus has been on creating places for students who will, once trained as doctors, practice in rural and remote areas.

The Commonwealth Government's Australian General Practice Training Program (AGPT) is the vehicle for GP training. We have heard that unfortunately the number of training places available through this program in WA is fewer than is needed to train aspiring GPs in WA, particularly for the rural training pathway.

Furthermore, rural and remote locations and regional centres that cannot support resident specialists will continue to rely on diversely skilled procedural GPs to deliver anaesthetic, obstetric and surgical services. It is not only increasingly challenging to find GPs and GP trainees who seek to fulfil these roles, but also to secure essential training positions in the metropolitan region. However these positions are essential to providing appropriate safe care in rural and regional areas where people live and the community requires such services.

Recruitment and retention

Submissions to the Panel have highlighted that recruitment processes in the WA health system are complex and cumbersome, resulting in lengthy and costly delays in filling positions. Concern has also been raised that positions are often filled on a contract basis, with contracts then repeatedly extended on a short-term basis.

The lengthy process to fill positions means that positions can remain vacant for long periods, potentially impacting workflows and contributing to issues such as patient access. It can also result in the loss of good candidates for positions.

The Panel has further heard that difficulties in attracting and retaining staff have underpinned the development of wide and varied 'attraction and retention allowances'. Although it had been necessary to provide attraction and retention allowances at one point in time, this does not mean that such allowances should continue to be paid in the long term. Future use of allowances may need to be brought into alignment with current and predicted areas of skill shortage and assist staff to transition with the increasing use of artificial intelligence and other technology in the delivery of health care.

It has been encouraging to learn of an initiative in the Pilbara region of WACHS to streamline recruitment and appointment processes. This initiative aims to reduce the administrative barriers in the hiring process and direct appoint, and will identify opportunities for expansion to additional occupational groups and elsewhere in the WA health system.

Submissions have also highlighted the need to develop a WA health system workforce strategy, and WACHS has highlighted the particular needs of country health for inclusion. We support the development of a WA health system workforce strategy.

Aboriginal people are significantly under-represented in the health workforce. This potentially contributes to the reduced access to health services for the Aboriginal population. Aboriginal people currently represent 1.4 per cent of the health workforce (as at September 2017), well short of the Public Sector Commission's Aboriginal employment target of 3.2 per cent (53). The Panel supports growing the Aboriginal health workforce as it is essential for the health system to deliver culturally-safe and responsive health services.

Inspirational leadership

The importance of good leaders, and the impact that an inspirational leader can have, is widely recognised. In health the failure of leadership and disengagement of staff from management has been widely publicised. The power of leaders who inspire at every level of an organisation is hard to overstate (67).

Leadership capability across all levels of the WA health system is a key component to ensure optimal patient outcomes and embed system change. Contemporary leadership is more collaborative than historical health service management with broader clinical representation in clinical leadership roles. Leadership now emphasises open communication and problem-solving to maximise staff engagement, empowerment and influence.

Strong and confident leaders are essential for the WA health system to motivate and build capacity in our workforce, provide workforce development opportunities and empower staff to be high performers. This aligns with a workforce having a consistent culture of performance and continuous improvement through safe and compassionate care. The Panel needs people leaders who can listen and integrate feedback from all levels of the workforce. The WA health system leaders need the capability and capacity to lead and sustain change.

In Victoria a new program to develop leadership capability across all levels of the health system is a key to high-quality health care and continuous quality improvement (68).

The WA health system's ongoing commitment to leadership and leadership development was marked in 2007 with the launch of the Institute for Health Leadership (IHL) supporting leadership development, focusing on continuous improvement, innovation and patient safety. The Panel further supports a commitment for ongoing leadership capacity and capability development to ensure staff are better equipped to drive and ensure momentum for change and shape a positive workplace culture. This will involve a review of the now 10-year-old IHL program and build on the IHL with a more contemporary leadership program to serve the WA health system and its stakeholders into the future.

Recommendations for Immediate Action

8. Cut red tape to hasten the recruitment of staff and reduce unnecessary agency costs. Pilot the broader implementation of a streamlined recruitment process; as tested in the Pilbara region.

Areas for Further Work

- Commence integrated workforce planning, using a consistent and transparent method for modelling and robust systemwide workforce data.
- Explore options to support and meet regional community needs through programs such as a Rural Generalist program and by increasing both GP proceduralists and Nurse Practitioner training positions and placements.
- Assess and take action as required, where Nurse Practitioners in metropolitan and regional areas are not working to full scope of practice.
- Build a contemporary clinical and corporate leadership program to serve the WA health system and its stakeholders into the future.

Direction 11: Plan and invest more wisely

How well the WA health system plans and invests is key to achieving equity, quality and value, and meeting community needs and priorities. Sound investment decisions require robust information, the right expertise and engagement, and flexibility in funding mechanisms.

The WA health system is one of a number of funders and providers of health services, and where these different services are inter-related, there needs to be coordination. This requires cooperation and coordination with the Commonwealth Government and other health and social care providers.

Contemporary and robust service and investment planning

A key role of the Department of Health is to provide a robust and evidence-based systemwide service planning and investment strategy, based on robust modelling oriented around key priorities and outcomes. We are aware that to date such planning has not always been well integrated or updated, with disconnects arising between service planning, investment and desired outcomes. It has also never involved consumers of health services. A 10-year WA Health State Plan is required to focus the system on a common purpose and provide a clear investment and reinvestment strategy aligning to the WA health system's goals and priorities and the State's economic parameters. Importantly, the Panel wishes to explore further purchasing and funding models for better value for inclusion in the Final Report.

The Panel is also aware of pipeline and pathway planning and analytical models to better inform decision-making across different sectors of Government. These models map and simulate the downstream impacts of policy changes or decisions within the system. Central to the development of a focused and relevant systemwide plan is strong consumer and clinical engagement. This will involve the use of multiple mechanisms including WA Health Networks, existing health consumer groups, local clinicians and other partner agencies, enabling initiatives to be developed and prioritised.

During consultations we have heard about the need to place much more emphasis on a person's first 1,000 days and in their last 1,000 days as crucial parts of a healthy life. Another example where a focus or emphasis can make a difference is in the rare diseases population. The Panel has been told that rare diseases affect two per cent of the WA population but account for 10.5 per cent of all hospitalisation costs in WA. This is an example of a group that would greatly benefit from more considered planning pathways.

“Funding models that work on the right care being delivered in the right place at the right time are imperative to facilitate practice change. There is an opportunity to embed such models across the health business and to develop mutually beneficial partnerships to improve health outcomes.”

South Metropolitan Health Service

Funding and commissioning approach

The *Service Priority Review* has proposed setting some whole-of-Government targets supported through an overhaul of the budgeting process (21). This simply means holding government agencies accountable for the delivery of key outcomes that currently require effective multi-agency engagement and a reorganising of budgetary processes to prioritise these outcomes. The Commonwealth Government is also shifting to a funding model which purchases not only for activity, but also for value and outcomes.

The Productivity Commission's *Five Year Productivity Review* also suggests greater commissioning flexibility at the local level and reducing low-value health interventions (26). Greater commissioning flexibility would assist in aligning service funding to community needs. Reducing low-value interventions would help in making the system more efficient by having funding directed to services that are backed by evidence that they are effective.

Health Service Providers have strongly advocated to us that there needs to be greater accountability and financial responsibility given to each Health Service Provider for servicing the population within their catchments. Additionally, they have also recommended greater flexibility in what services are purchased and for health funding models to be reviewed and funding predictably enhanced using a three to seven-year timeframe to enable medium and long-term planning at the local level. Subject to an agreement about the appropriate outcomes, we consider there is merit in providing this flexibility to encourage innovation and assist in resources being allocated to align with the needs of the local community.

Flexible, patient-focused, funding and commissioning models, along with incentives that support a shift in focus on quality and value (not activity), need to be more widely explored. This includes ensuring flexibility of funding across service settings (hospital and community).

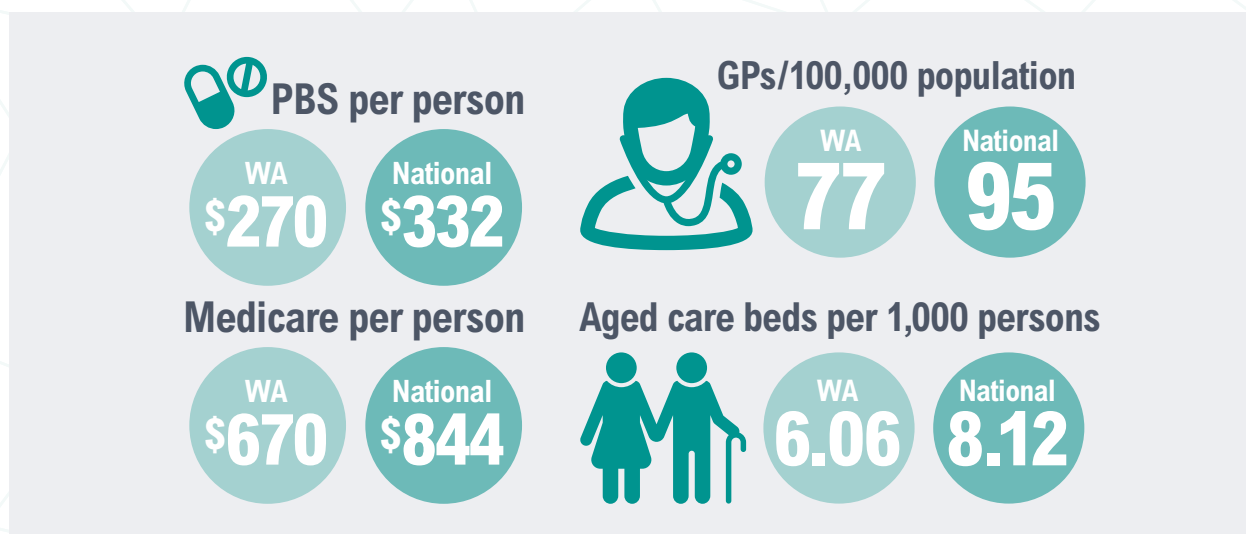
Partnership with the Commonwealth Government

WA does not have a strong history of successful engagement with the Commonwealth Government and driving reform. The community is not tolerant or accepting of the existing arrangements and has told us strongly of 'gaps' in services due to funding barriers between the State and Commonwealth governments. Better working relationships are needed to support alignment of funding and services, alongside an overall focus on consumer outcomes over provider-focused decisions.

The Panel has heard that the gaps in funding coverage and cost shifting between Commonwealth and State government agencies prevents collaboration across service providers. The Panel supports the move to funding models focused on patient-centred care, incentivising performance and collaboration.

Figure 22: Comparison of WA and national averages in Commonwealth-funded services

Source: Fair Share Report, Government of Western Australia



Negotiation of the next national health agreement between the State and Commonwealth Governments commencing in 2018 provides a critical opportunity for the State to improve outcomes for Western Australians. It is imperative that the State develops its position to maximise opportunities for State and Commonwealth Government partnerships to better align planning and delivery mechanisms to ensure funding for resources that provide better health outcomes.

Exploring shared commitment by both tiers of Government to pooled funding and joint commissioning for outcomes-based integrated care should be a priority. For meaningful change, this must be backed by a willingness to share accountability for performance, based upon agreed and measured outcomes.

Areas for Further Work

- Develop options for flexible purchasing and funding mechanisms, pricing and resource allocation which prioritise value, quality, and better population outcomes in consultation with consumers, the Commonwealth, Treasury, non-government organisations and private providers.
- Continue to pursue a fairer allocation of resources and resource allocation with the Commonwealth for rural, remote and regional WA, focusing on balancing WA's reduced access to GPs, MBS and PBS.

Direction 12: Building financial sustainability, strong governance, systems and statewide support services

The *Health Services Act 2016* ('the Act'), passed by the WA Parliament in May 2016, established a framework for the governance of the WA health system, clarifying roles and responsibilities at each level of the system.

The Act creates a clear separation of roles, responsibilities and accountabilities between a policy arm (the Department of Health) and a service delivery arm (the Health Service Providers).

Through the Director General, the Department is established as the System Manager and responsible for the strategic direction (aligned to Government objectives), oversight and management of the WA health system. The Department also functions as a Department of State to advise and support the Minister for Health in carrying out his or her portfolio responsibilities.

Health Service Providers are established as statutory authorities, responsible and accountable for the provision of health services to their area or support services to the WA health system.

Financial sustainability

The WA health system faces a number of challenges. An ageing population, increasing consumer expectations, more expensive technologies, a growing burden of chronic conditions, and the current economic downturn are among factors driving increased demand for public hospital services and rising health expenditure in WA.

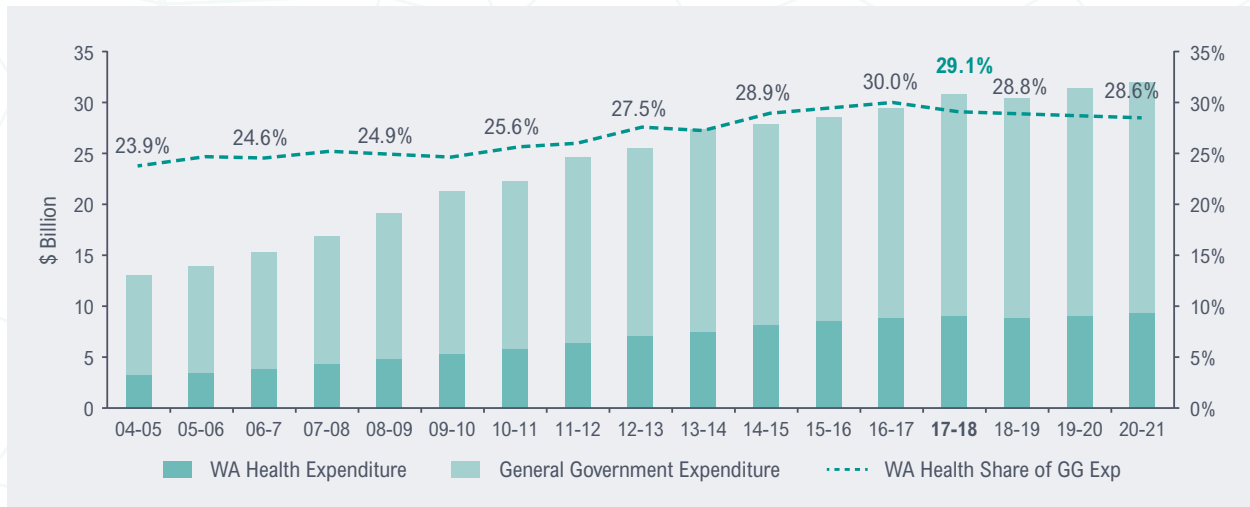
Recurrent health expenditures have increased by approximately 10 per cent per annum for much of the past 10 years. These unsustainable rates of growth have largely been made possible by historically high rates of growth in State revenues, with health expenditures remaining at around 25 per cent of total State recurrent expenditures for much of the period. However, in recent years and through a period of significant decline in the State's revenue, health expenditure as a proportion of General Government expenditure has grown to 29.7 per cent in 2016 (69).

The Panel has heard consistently from submissions and forums that the community expects the WA health system to become more efficient and work within its budget. There is a real concern that failure to address financial sustainability across the WA health system will seriously impact funding for other important services delivered by the State Government.

In 2015 the Department of Health initiated a Financial Sustainability Strategy (FSS), focused on tightening performance management aligned to hospital operations, streamlining budget and resource allocation processes, providing accurate and timely information for managing hospital operations under an ABF framework, strengthening procurement and contract management processes and offering a voluntary severance scheme for staff, to support transition across the system. The FSS, combined with greater authority and accountability by Health Service Providers, has seen annual growth in expenditure decrease from 8.4 per cent in 2014/15 to below five per cent in both 2015/16 (4.6 per cent) and 2016/17 (4.9 per cent) which is the lowest growth in more than a decade.

Figure 23: WA health system expenditure as a proportion of general Government expenditure

Source: Department of Health and Department of Treasury



Furthermore, the actual unit cost of delivering Activity Based Funding (ABF) hospital services in 2016/17 declined relative to the original forecast, while delivering higher activity than expected. This is the first time that this has occurred since the introduction of ABF in 2013/14 and the trend is expected to continue in 2017/18. This indicates that the WA health system is gradually becoming more efficient in the delivery of ABF hospital services.

Financial sustainability scenario modelling undertaken by the Department of Treasury indicates that continued expenditure along historical trends (2011/12 to 2016/17) is unsustainable and would result in health consuming more than 38 per cent of total general Government spending by 2026/27. Growth in WA health system expenditure would need to be constrained to 2.6 per cent to maintain parity of growth with general Government expenditure.

The Panel notes that, consistent with this economic imperative, over the current Budget forward estimates period it is expected that health expenditure will grow on average by around one per cent per year, stabilising and even resulting in a small decline in health expenditures as a proportion of State recurrent health expenditures.

The health system should define targets for sustainable expenditure growth with the Department of Treasury, including incentives to drive necessary change in all aspects of health service delivery. The Final Report will address these issues. The challenge for the WA health system will be to increase efficiency in service delivery to increase services and maintain system performance with no real growth in health costs. There is opportunity to engage and involve the community meaningfully in new investments and associated redirection of funds to these new initiatives.

“Collaboration is important to avoid duplication and link resourcing and expertise to ‘solve’ problems.”

From a public submission

Focus of the System Manager

The Department of Health is continuing to transition to the role of System Manager.

The System Manager is responsible for the overall management of the WA health system and the Health Service Providers as separate statutory authorities. This governance model has clear separation of roles, responsibilities and accountabilities between the policy arm (Department of Health) and the service delivery arm (Health Service Providers) to achieve a more efficient and effective balance between systemwide governance and policy, and local service delivery and decision making.

The System Manager buys health services from Health Service Providers through the annual budget cycle by way of service agreements, where services are delivered to agreed outcomes or standards (not in competition) with patients' interests at the core. The service agreements include using flexibility and incentives to achieve the best outcomes and ensure equity for the community in resource distribution.

The relationship between the Department of Health as System Manager and the Health Service Providers is critical to ensuring the best outcomes for the WA community. Consumer involvement is central to this success to ensure a patient-centred approach to care. The community is interested in how to obtain the care they need, regardless of which hospital or health service provides it. The Panel acknowledges the work underway to transform the Department of Health including:

- considering the methodology for distributing funding to health service providers, and determining the most appropriate option for distribution of funds and how the community can be involved
- managing how Health Service Provider performance will be monitored and reported; identifying what measures will be used to assess whether value-based outcomes are being achieved and progressed

- monitoring performance and supporting any actions to be taken by a Health Service Provider to achieve desired improvements
- setting standards and benchmarking for safety and quality
- developing a comprehensive and integrated workforce strategy
- the development of systemwide digital and data strategies
- improving strategic procurement processes and governance
- developing performance outcomes and measures aligned with whole-of-Government goals, including prevention and promotion measures.

The Panel recognises the importance of these changes to strengthening coordination and collaboration across all areas of the WA health system, while supporting flexibility and innovation at the local and hospital level. It is critical that this work continues and that appropriate capability and leadership is in place to build and support these changes into the future. Consumer involvement must be prioritised as central to a patient-centred approach to care and ensuring the best outcomes for the community. To achieve this, the health system must measure and reward collaboration across Health Service Providers.

Best practice statewide support services

The WA health system is supported and underpinned by critical clinical and non-clinical services. Health Support Services was created as a separate statutory authority from 1 July 2016 and provides critical ICT, procurement and supply, human resources, payroll and financial services to the WA health system and a number of external clients. Health Support Services oversees a procurement spend of approximately \$3.5 billion.

While a number of recent changes have been made to improve the delivery of support services, we have heard consistently that there is significant scope to transform the delivery of these services and support more innovative and cost-effective approaches across the WA health system.

Critical to the success of the changes will be continuing to benchmark the performance and value of services, combined with a focus on supporting and understanding the link to clinical care. In addition there must be consideration of certain functions supporting services to be conducted in more innovative and less centrally controlled models. The *Service Priority Review* also identified strategic procurement as a focus area for State Government (21).

Further changes recently announced to the delivery of pathology services will further support the value and performance of these services to the WA health system. The creation of PathWest as a statutory authority from 1 July 2018 will enable further transformation of this important service and deliver value and financial benefits to the system more generally.

Recommendations for Immediate Action

9. Continued implementation of financial sustainability measures ensuring budgetary transparency and enhanced Health Service Provider funding predictability.

Areas for Further Work

- Explore best-practice approaches for meaningful consumer involvement in reforms, including consumer involvement in designing and evaluating services.

Next steps

The Panel's focus in 2018 will be on gathering targeted feedback on the overall themes and Preliminary Directions outlined in this Interim Report. This is anticipated to include:

- public consultation on the Interim Report
- targeted engagement with stakeholders
- a staff survey
- an expanded program of inclusive consumer engagement
- further targeted exploration of areas for further work.

Insights from the second round of consultation and engagement will be used to inform and support the development of the Panel's Final Report, and detailed recommendations, due to Government in November 2018.

The Panel acknowledges learnings from implementation of the *Reid Report* and the importance that will come from a transparent and accountable approach to implementation. The Panel notes that strong oversight and leadership will be vital to supporting the next phase of reform of the WA health system. The Panel will further address in the Final Report the necessary and key implementation actions that will be critical to supporting the transparency and accountability required to realise benefits, track initiatives, and drive and sustain the change required across the WA health system.

However, the Panel recommends that following public release of the Interim Report, the Minister for Health and Mental Health requests that the Director General, Department of Health develop an implementation plan for the Recommendations for Immediate Action. The plan should present key deliverables, milestones and responsibility. It is critical that the implementation plan include consumer involvement, benefits realisation and lessons learned to inform future initiatives. The implementation plan should be publicly available and there should be regular public reporting on progress.

Where pilots are to be conducted, the implementation plan will identify the nature of the pilot, the approach (e.g. identification of a local area or specific cohort), and articulate how the pilot will be evaluated. In order to ensure openness and transparency, it is envisaged that expressions of interest may be issued for some of the opportunities to lead and/or participate.

In parallel, further consideration will be given to implementation of Government-endorsed recommendations arising from the *Service Priority Review and Commission of Inquiry into Government Programs and Projects*. This includes the scope and sequencing of recommendations in the short, medium and long term, and future development of a 10-year State Health Plan.

Appendices

Appendix A – The case for change

The following expands on the ‘Inconvenient Truths’ the Panel consider critical to acknowledge and address for sustained change in the WA health system.

The focus is on treatment rather than prevention

In 2011, Western Australians lost more than 435,000 years of healthy life as a result of premature death or living with disability or illness due to chronic disease or injury (27). Despite the demands on the health system arising from health conditions that are preventable, only a small proportion of health expenditure is devoted to prevention.

In this regard, the Australian Institute of Health and Welfare (AIHW) has estimated that in Western Australia, in 2015/16 State and local governments spent \$160 million on public health services, accounting for only about 2.7 per cent of their total recurrent health expenditures. The AIHW also estimated the Commonwealth Government spent only \$140 million on public health, or 2.1 per cent of its recurrent health expenditure in this State (12).

Priority also needs to be given to improving the management of people with existing health conditions, reducing their attendance at EDs and admission to hospitals. People with chronic health conditions account for a disproportionately high proportion of inpatient occasions of care, representing around 28 per cent of all hospitalisations in WA in 2014. Improved self-management, care by GPs as opposed to hospital care, and care through outpatient services can improve health outcomes and result in people with chronic conditions needing fewer inpatient episodes of care. Around 22 per cent of all ED attendances resulted from chronic conditions (including cardiovascular, respiratory, endocrine and musculoskeletal (70).

Consumers and carers are not central enough

We have received strong feedback that consumers and carers are frustrated, with few opportunities to authentically contribute to key discussions on health care, with tokenistic advisory structures and little access to data about their own health or how well the health system is performing

“The most important consideration is the patient/consumer. They should be first, second and third.”

Public submission

Through their stories, consumers have highlighted how onerous processes, lengthy waiting times and repeated testing and inefficiency are common. We have also heard overwhelming feedback of poor or inadequate communication, and the views of consumers not being respected. Consumers have made it clear they wish to be actively engaged in managing their own health and involved in individual care decision making. We know this is critical for improved outcomes (71).

“Consumer and carer representation and consultation should occur at every level in safety and quality processes, and inform service evaluation.”

Public submission

Beyond individual health care experience, it is essential for the WA health system that consumers are central to health service design, development and evaluation (72). Putting consumers at the centre at all levels of the system is good practice.

There are significant and persistent inequities in health outcomes among some groups of people

There are significant inequalities in the health and wellbeing of some Western Australians particularly for Aboriginal people and people living in regional and remote areas. In WA, the life expectancy is 15.1 and 13.5 years lower for Aboriginal men and women (respectively) than for non-Aboriginal people (50). WA has the largest gap in life expectancy between Aboriginal and non-Aboriginal men compared to New South Wales, Queensland and the Northern Territory (50).

The average life expectancy of a Western Australian living in remote WA is more than five years lower than for those living in Perth (37). The confusing maze of systems and money is not an excuse for governments or public servants to fail in addressing these issues and requires changes in behaviour, services and funding models.

We recognise the ongoing investment in Aboriginal health programs including \$88.7 million over three years to improve Aboriginal health outcomes. While this has yielded some benefit, clearly continuing effort will be required to close the gap between Aboriginal health outcomes and those being achieved for the broader community. This effort must focus on meaningful co-design with Aboriginal communities to create the services that improve outcomes.

The system can be difficult to navigate for health consumers

We have heard the strong concerns from consumers and service providers about fragmented and over complicated systems that do not connect, are difficult to navigate and access, or are not understood by the WA community and staff. These and other factors are leading to people falling through the cracks, inadequate referral processes with the hospital system often being where people end up as a last resort.

WA's health system is supported by a complex range of services that are not well integrated. In addition to public hospitals and community services provided by the State Government, consumers access a range of related service systems including primary care GPs, mental health, aged care and disability services (Figure 24). The majority of Western Australians will interact with one or more of these systems, whether as a patient, consumer/carers, relative or employee.

Figure 24: High level mapping of the health, aged care and disability sectors in WA

Source: Nous Group

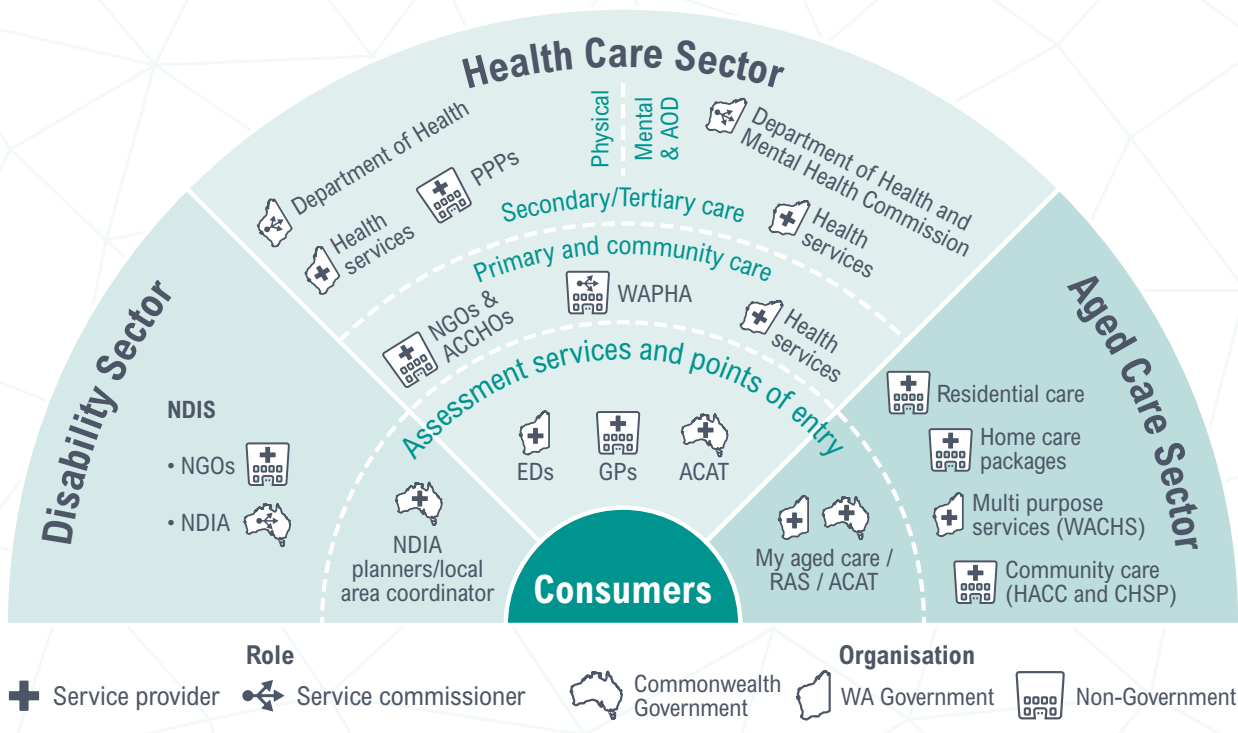
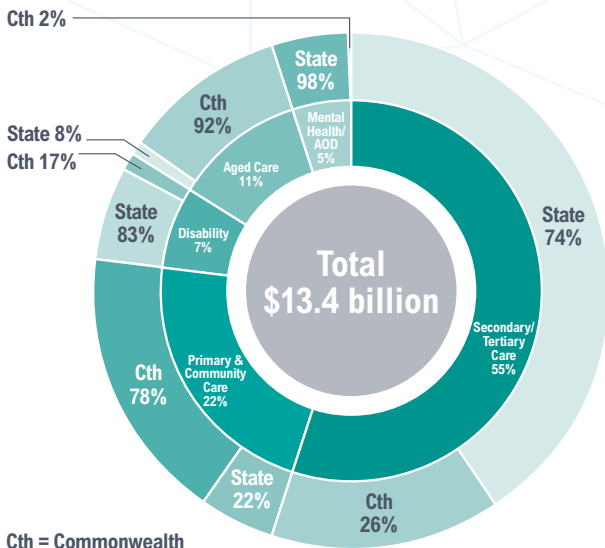


Figure 25: The proportion of government expenditure on the service systems in 2015/16

Source: Nous Group



In 2015/16 approximately \$13.4 billion was spent by State and Commonwealth governments on administration and delivery of health and social services. (37).

Many of these services are provided by the Commonwealth Government, such as the NDIS and aged care, and are undergoing significant reform. In Western Australia the NDIS reforms have been particularly complex and confusing, with both Commonwealth and State NDIS trial sites and only a very recent decision that WA will adopt the Commonwealth NDIS scheme. Both the NDIS and aged care reforms are fundamental and will inevitably take some years for the early implementation issues to resolve.

Staff do not always feel valued and respected

Recent reviews have highlighted significant areas of the system where staff morale and engagement are a major concern. The reviews have highlighted a ‘broken’ system with reports that staff describe feelings of not being valued and not being heard or listened to. We have heard similar views and feedback through public consultation and submissions.

Engagement is two way, and staff need to be able to confidently speak to their leaders to enable changes to improve quality and sustainability of health care. The absence of this confidence is evidenced by many of the submissions made to the Panel by WA health system staff who requested anonymity. The WA health system needs to find the balance between a more accountable performance-focused system and sound strong staff engagement during fiscally challenging times. These two parameters have to co-exist. There is strong evidence that shows that an open and responsive culture that values the voice of staff is essential to support value based care (73).

Health care does not equal hospital beds

Evidence suggests that people in WA spend too much time in hospital settings as they do not have the necessary access to the right services, in the right place, at the right time. One in five of all ED attendances could have been avoided and the consumer better managed in general practice.⁶ WA is well behind the expectations of consumers, and with contemporary practice elsewhere in Australia or internationally. However, according to the Organisation for Economic Co-operation and Development (OECD), Australia has better than average life expectancy for a lower than average cost/share of gross domestic product (GDP) (74).

Compounding this is that current activity based funding arrangements at both State and Commonwealth government levels do not incentivise the delivery of appropriate care outside of a hospital setting.

The large infrastructure investment that was made in the WA health system was needed but it is emerging through preliminary updated modelling that across WA there is predicted to be enough hospital bed capacity to serve the community for the next decade, noting there are a few specific places which will require further beds. This modelling is based on the current utilisation rate and the most recent population forecasts, which suggest the State's population will grow at a somewhat slower rather than has been the case over the last 10 years.

Preliminary modelling has identified Armadale, Midland, Joondalup, Osborne Park, Bunbury, Geraldton, and Rockingham/Peel as pressure points requiring attention. Work is also required to progress plans for King Edward Memorial Hospital for Women and the co-location of women's health services within the QEII Medical Centre. Access to both acute and community mental health services requires attention.

Any planning of future requirements should also require the WA health system to work smarter and use its existing infrastructure more wisely. This includes looking at the types of services provided across sites in the WA health system with consideration given to cost effectiveness and opportunities for other service delivery providers. The WA health system needs to better understand current needs, future requirements and gaps in existing facilities such as long term maintenance, underpinned by robust cost benefit analysis and support innovations in the delivery of services. This could also include options to look at repurposing existing facilities, using current unused capacity at existing facilities or collaborating with other providers to deliver specific services.

⁶ "The WA rate for all potentially preventable hospitalisations was 25.1 per 1,000 population in 2011/12 and this was lower than the national average of 26.4 per 1,000 population. In 2015, there were more than 64,000 potentially preventable hospitalisations in WA that could have been provided in an appropriate non-hospital setting such as at home or in a GP surgery. The following year, one in five of all ED attendances could have been avoided and the patient better managed in general practice."

WA is lagging behind in transparency and accountability

A recent review of safety and quality in the WA health system by international expert, Professor Mascie-Taylor, made a number of recommendations that are strongly supported by the Panel (2). In particular, the Mascie-Taylor Review found that WA lags behind other national and international health systems in providing patients, staff and community with key information regarding safety and quality of services, costs and other measures of performance.

Professor Mascie-Taylor noted that greater transparency was needed, alongside benchmarking, as a ‘hugely important, collaborative quality improvement tool’ in order to drive improvement activities within the health system. The Mascie-Taylor Review also cautioned that WA’s health system is a relatively small and close community. As Professor Mascie-Taylor noted, while this brings strong working relationships that support how the system operates, the closeness of the system also brings a strong resistance to transparency, change and challenging the status quo (Table 1).

“The WA health system should move towards greater transparency and publish, at a minimum, hospital-level safety and quality performance data. There should be a presumption in favour of publication at all times...”

Review of Safety and Quality in the WA health system, Recommendation 11

Table 1: Summary table of cultural context and impact on Governance

Source: Review of Safety and Quality in the WA health system

Observation of culture	Pros	Cons
There are established relationships between groups and individuals across the system	We make everything work irrespective of system configuration at a macro level	We create workarounds that might indirectly undermine S&Q or any new governance structure
The legislation may have changed but the people haven’t	A detailed ‘corporate memory’ exists – the workforce operates in the knowledge of what has gone before	We unconsciously block change and continue to do the job we previously did/ tacitly ignoring the changed model
We have all worked here for a long term in many roles and know one another professionally and socially	We have relationships built on trust/ deep personal relationships	There is a lack of appropriate tension/inability to challenge others

The system rewards volume rather than value

We have heard from many in the system that the current national model of ABF undermines sustainability. We have been told that ‘hospitals do what they are paid to do – see more patients’ in hospitals rather than in the community. Staff have often referred to ‘perverse incentives’ related to these arrangements. However, the Panel recognises that ABF offers opportunities as well as perverse incentives, and the maturing of the WA health system in its use of the ABF system offers opportunities to improve financial sustainability.

The National Health Reform Agreement (NHRA) sets out the shared intention of the Commonwealth, State and Territory governments to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system. However, the Panel noted that under the Addendum to the NHRA, safety and quality dimensions have now been introduced to pricing and funding of public hospital services, shifting the focus to value-based care and not just volume, specifically not funding sentinel events and reducing funding for hospital-acquired complications. While the Commonwealth Government has just introduced these reforms, other Australian jurisdictions such as Victoria and Queensland for instance, have had value-based purchasing mechanisms in place for a few years in the form of incentives/disincentives for safety and quality performance.

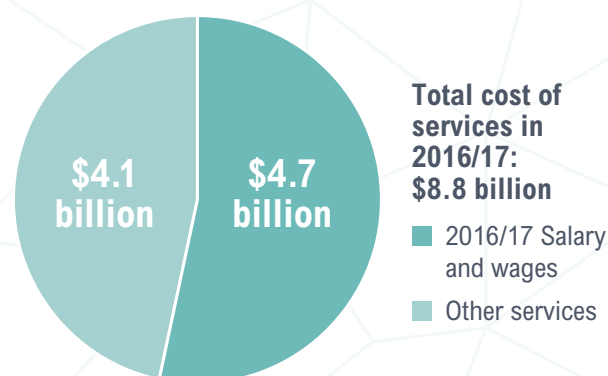
By focusing on sustainability, it is timely for the WA health system to look towards value – to understand what is being spent and being achieved, and measuring the health benefits to patients and the wider community.

Workforce costs remain well above national benchmarks

Workforce is the largest cost driver within the public health sector representing 50 per cent of total health costs. Wages for all professions in the WA public health system are almost 13 per cent higher than the national average (75).

Figure 26: The proportion of health expenditure in 2016/17 spent on wages

Source: Department of Health and Government of Western Australia 2017/18 Budget Paper No. 2.



In the 2016/17 financial year, expenditure on workforce wages totalled \$4.7 billion – which comprised more than half of the WA health system’s total expenditure of \$8.8 billion. Between 2010/11 to 2016/17, wage costs grew an average of six per cent while growth in FTE averaged two per cent. Wages and allowances for medical practitioners and nurses in WA are higher compared to the national average (69).

In particular, medical and nursing wages make up a significant proportion of total workforce expenditure. As the largest occupational group within the WA health system (just under 40 per cent), nurses and nurse support staff account for almost 34 per cent of workforce costs in 2016/17. The medical workforce, which makes up just over 12 per cent of the workforce, accounts for nearly 30 per cent of workforce costs in 2016/17.

Labour costs are the greatest contributing factor (44%) to the overall cost variance between the WA State price and the National Efficient Price (NEP) as highlighted in Table 2.

Table 2: The labour costs contributing to the cost variance between WA State price to the NEP 2015–16

Source: The Challenge of Funding Healthcare’ keynote address by Director General, Department of Health to the Committee for Economic Development of Australia

Cost difference attributable to:	% of total difference
Area A – Under Management Control <ul style="list-style-type: none"> • Differing models of care • Differing length of stay • Higher levels of staff, staff mix and resource utilisation 	12%
Area B – Wages Policy <ul style="list-style-type: none"> • Higher wages outcomes in WA • Additional remuneration/allowances for staff in WA 	48%
Area C – WA Unique Factors <ul style="list-style-type: none"> • Disparate adjustments for the large FIFO workforce in rural WA i.e. the remoteness adjustment is dependent on a patient’s postcode and not the locality of the hospital where health services are provided. • Inadequate recognition of remoteness costs within the national ABF model • Higher need in WA to cater for high-cost, high complexity but low volume services 	15%
Others (some Area A) Coding variances; primary and aged care shortages; fewer co-located public and private hospitals causing reduced synergy to be leveraged to reduce public health costs; lower rates of private patients in public hospitals.	25%
Total	100%

Focus also needs to turn to improvements in productivity and the more efficient use of our workforce, including effective rostering, less use of more expensive agency staff, optimising scope of practice across all professions and ensuring optimal workforce mix (in terms of full time and part time staff), to meet fluctuating service needs and assist in future proofing health.

Considerable waste and technical inefficiencies across the system

Research by the OECD indicated that 10 per cent of hospital funding is spent on correcting preventable medical mistakes or infections that people catch in hospitals. Further evidence (76) from Canada suggests up to 30 per cent of tests, treatments and procedures are potentially unnecessary (77).

The Panel has received consistent feedback that this situation is mirrored in the WA health system. In this regard, we are aware that the Health Services Providers are reviewing procedures and practices to ensure that services are backed by evidence as providing genuine benefits to patients.

There is an international and national shift to eliminate unnecessary tests, treatments and procedures using simple tools to assist patients and clinicians choose more wisely, reduce low-value health care and reduce harm (43, 77, 78) which is a focus of attention by the Commonwealth and State Governments (79).

The broad skills of the workforce are not fully utilised nor well positioned for technology changes

The WA health system needs a more strategic and focused approach to workforce that leads to decisions that are based on the needs of the community. The WA health system employs approximately 44,000 staff and the broader health sector has continued to be the largest employing industry in WA, growing 19 per cent since 2011. The Australian Bureau of Statistics reported that the health sector is already one of the country's largest providers of employment, and the fifth largest contributor to Australia's Gross Domestic Product (80). Across the developed world, health workforces are being reviewed to make sure they are agile and sustainable.

Health care is a growth industry, where our workforce needs to be fit-for-purpose to support new ways of working, including the use of technology and new or changing roles (including scope of practice changes), and these must be supported within affordable wage structures.

We have heard through submissions from a number of professional organisations that they believe the skills of people from the profession they represent are not being fully utilised in their work in the health system. They believe that care could be provided at lesser cost and just as effectively if their members were allowed to work using their full skill set (for example, nurse practitioners, pharmacists and allied health).

We understand and appreciate the lead role that the medical profession plays in the delivery of health services. However, as suggested in some submissions, opportunities exist for some services now led by doctors to be managed by other professions without compromising patient safety or quality.

Medical dominance and vested interests slow the pace of change

There is strong medical leadership within WA's health system. However, concerns were raised in consultations regarding the 'dominance of a medical model' and the power of the medical professions at the expense of other health care providers. Current workforce models favour medical models of care, rather than multidisciplinary teams. This imbalance requires addressing. We have heard the calls to allow other health professionals such as nurse practitioners and allied health to work their full scope of practice to improve access to and coordination of health services. Encouraging diversity and broadening the scope of all health professions by building capability, capacity and leadership is vital, but will only be achieved through a genuine focus on removing barriers to professional practice.

“Doctors pay and incentives... huge burden for health... have the guts to tackle this very powerful group.”

Public submission

Too many rules and bureaucracy is making it harder for patients and staff

Patients and staff have told their personal stories about how too many rules and the bureaucracy made it more difficult to achieve even simple changes. This includes barriers between Health Services Providers, sharing patient details or notes, and mobilising services, money and staff.

The Panel also heard about the bureaucratic processes to employ staff and the request to simplify human resource (HR) processes for staff working in multiple positions.

A strong theme from patients and staff is the desire to reduce the amount of paperwork, with patients repeating themselves in hospitals and health services, and junior doctors saying they do little other than paperwork in their jobs.

The effective use of personal devices and software is also being held back by onerous rules. Junior doctors are telling us that the use of smart phones to share patient information is the quickest way to make sure the information gets to the right people. We need to adapt the rules to make it easier to work, rather than relying on staff to develop 'workarounds' to benefit patients.

Patients have told the Panel that they want to use video software at home to get advice from health staff. However, current technology doesn't allow for this.

Past ICT delivery has been poor

ICT investments across the WA health system have been beset with challenges and issues that have had a significant impact on delivery and created a culture of distrust in the management of ICT. Some of the challenges are inherent in all health systems, including the complexity of the business, the depth and breadth of services provided, the geographic spread of the population to be served, and the need to deliver projects within a realistic timeframe.

Issues with the delivery of ICT across the WA health system have been well documented and explored including by the Office of the Auditor General, Public Accounts Committee and Education and Health Parliamentary Standing Committee.⁷

While technology is often seen as a way to save money, it is currently one of the largest drivers of cost and hence investments in this area require careful consideration. The Panel notes ICT investments have positively contributed to achieving safer patient outcomes. Evidence outlines that technological advancements are seen as means to improve efficiency both in terms of expenditure and effective service delivery. The need to improve ICT systems across the WA health system is clear; the challenge is to mobilise and manage the upfront investment in ICT in such a way that it does not compromise the provision of other initiatives.

⁷ There have been several review reports in the last 10 years that point to the inability of ICT investment in the WA health system to deliver what has been required. In February 2016 the Office of the Auditor General (OAG) released a report into the "*Health Department's Procurement and Management of its Centralised Computing Services Contract*". The audit was initiated by the Acting Director General of the Department of Health. The OAG found that the governance and leadership over the contract was poor. This led to procurement of additional and unnecessary IT services worth millions of dollars. In addition, inadequate planning and implementation of critical data centre facilities cost millions of dollars and ultimately failed to meet service expectations.

The September 2016 "*Doing ICT Better: Improving outcomes from the Western Australian Government's Investment in ICT*" report by the Public Accounts Committee found many examples of ICT projects or programs that have run over time, over budget and failed to deliver the intended benefits. Although these problems are common amongst government there was also a perception that Western Australia has been the worst state in Australia for public sector ICT performance for at least the past decade.

The April 2016 "*More than Bricks and Mortar*" report of the challenges associated with commissioning Fiona Stanley Hospital by the Education and Health Parliamentary Standing Committee found that the commissioning ran significantly over budget (>\$300 million) and over schedule, especially in relation to the ICT elements and clinical readiness. Fiona Stanley Hospital was intended to be a fully digital hospital but the ability to deliver on this vision was hampered by poor governance and project management. This included unrealistic opening dates (compromising patient safety), unclear and unintegrated project reporting arrangements, and a Taskforce and Minister for Health without a clear understanding of the project status.

“Vested interests, difficult political decisions, personalities, lack of commitment to follow through on decisions made.”

Comment from a Clinical Senate participant on the lessons learned from the *Reid Report*

The WA health system has fallen short of good change management

Achieving beneficial change in a large and complex area of service delivery like health takes time, effort and long term commitment. Health service consumers must be key players in shaping change, partnering with front-line health staff in ongoing active involvement in health care design, delivery and evaluation. Community support offers huge, as yet largely untapped, potential to give government social licence for necessary changes for a safer, more effective health system.

Feedback to the Panel on the implementation of the *Reid Report* was one of disappointment due to a lack of genuine engagement, limited focus on enforcing and measuring implementation and achieving benefits, and the lack of sufficient ownership, political will and investment by the WA health system and to support the changes required.

In our consultations to date, staff and the community acknowledged the link between the decision on the kinds of health services or treatments provided and the impact on the bottom line. Others noted an unwillingness, reluctance or lack of support to consider trade-offs or change.

Appendix B – Sustainable Health Review Panel and Terms of Reference

The Sustainable Health Review is being conducted by an experienced panel of experts that have been appointed by the Government of Western Australia and chaired by Ms Robyn Kruk AM.

Sustainable Health Review Panel Members

Ms Robyn Kruk AM (Independent Chair)

Ms Kruk has more than 30 years' experience in public sector service reform at State and Commonwealth level, including as Director General of NSW Health and NSW Premier and Cabinet and inaugural CEO of the National Mental Health Commission.

Dr D J Russell-Weisz, Director General, Department of Health

Dr Russell-Weisz is the Director General of the WA Department of Health. Prior to his appointment as DG, Dr Russell-Weisz directed the commissioning of Fiona Stanley Hospital and was Chief Executive of the North Metropolitan Health Service through the redevelopment of the QEII Medical Centre.

Mr Michael Barnes, Under Treasurer, Department of Treasury

Mr Barnes was appointed as Under Treasurer in 2015 having started his career in the Commonwealth Treasury before joining WA Treasury. He has worked primarily in the areas of revenue policy, economic and revenue forecasting, fiscal strategy, and whole-of-government financial management and reporting.

Mr Warren Harding, Minister for Health Nominee

Adjunct Professor Harding has more than 25 years' government, senior corporate management, consulting and board experience in the energy, sports, utilities, resources and government sectors and brings a unique knowledge of public and private sector, information technology, culture and leadership.

Ms Pip Brennan, Consumer and Carer Nominee

Ms Brennan is the Executive Director of the Health Consumers' Council and brings extensive knowledge of the community sector and health advocacy, including experience in community midwifery and the not-for-profit sector.

Dr Hannah Seymour, Clinical Nominee

Dr Seymour is a Consultant Geriatrician, Medical Director and Clinical Lead for Information Technology at the Fiona Stanley Fremantle Hospitals Group. She is the Co-director of the Surgical and Women's, Children and Newborn Services, and works clinically in orthogeriatrics where she has a passion for falls prevention and improved outcomes in aged care.

Ms Meredith Hammat, Employee Nominee

Ms Hammat is Secretary of Unions WA, representing more than 150,000 employees in industries across WA. She has more than 20 years of broad experience representing working people, in the government, utilities, community services and private sectors.

Sustainable Health Review Terms of Reference

Background

In March 2004, the Health Reform Committee report (the *Reid Report*) set strategic directions for the WA health system, including a range of recommendations to reprioritise and reconfigure the WA health system, which were endorsed by the State Government.

While a number of major infrastructure projects and other changes have been initiated since 2004, WA's health system continues to experience unsustainable budget growth and faces challenges associated with an ageing population, chronic disease and health inequity.

Health expenditure has grown faster than inflation and the economy as a whole, accounting for 52 per cent of overall Government expenditure growth between 2013/14 and 2016/17. The WA health system is the largest single expenditure in the WA State Budget representing 30 per cent of expenditure in 2016/17 compared to 24.9 per cent in 2008/09.

The growth in the cost of health care has not been accompanied by an equivalent increase in services to the community. This growth is unsustainable, especially in a constrained budgetary environment.

There is significant disruption to health services, including through advances in technology and research. There are increased opportunities to partner across sectors to deliver integrated care.

With the background of these ongoing challenges, the WA State Government has committed to a Sustainable Health Review to put the WA health system on a sustainable footing. This review will do that through putting patients first, while driving efficiencies and change through enhancing quality, clinical and financial performance, using innovation and new technologies.

Sustainable Health Review Panel Membership

- Independent Reviewer (Chair)
- Minister for Health Nominee
- Director General, Department of Health
- Under Treasurer, Department of Treasury
- Consumer Nominee
- Clinical Nominee
- Employee Nominee.

Purpose

Provide advice to Cabinet through the Minister for Health to guide the strategic direction of the WA health system to deliver patient centred, integrated, high quality, and financially sustainable health care across the State.

Role and functions

The role and functions of the Panel are to make recommendations regarding:

1. the leveraging of existing investment in primary, secondary and tertiary health care, as well as new initiatives to improve patient centred service delivery, pathways and transition
2. the mix of services provided across the system, including gaps in service provision, sub-acute, step-down, community and other out-of-hospital services across WA to deliver care in the most appropriate setting and to maximise health outcomes and value to the public
3. finding ways to encourage and drive digital innovation, the use of new technology, research and data to support patient centred care and improved performance
4. seeking opportunities to drive partnerships across sectors and all levels of Government to reduce duplication and to deliver integrated and coordinated care
5. finding ways to drive improvements in safety and quality for patients, value and financial sustainability, including cost drivers, allocative and technical efficiencies

6. the key enablers of new efficiencies and change, including, research, productivity, teaching and training, culture, leadership development, procurement and improved performance monitoring
7. how to best implement any Government-endorsed recommendations arising from the *Service Priority Review* and the *Commission of Inquiry into Government Programs and Projects* that are relevant to the *Sustainable Health Review*
8. the scope and sequencing of implementation of its recommendations in the short, medium and long term, including development of a new 10-year State Health Plan
9. any further opportunities concerning patient-centred service delivery and the sustainability of the WA health system.

The Panel is to consider the following areas in its Review:

- population health and socio-demographics, including chronic disease, mental health, Aboriginal health, and rural and remote health outcomes and access
- patient experience, pathways and continuum of care
- value, safety and quality of services innovation and technological advances in health care
- opportunities to reduce environmental impacts.

The above issues are to be considered in the context of relevant previous reviews and experiences, particularly within Western Australia but also in other States and Territories, nationally and internationally where appropriate. Wherever possible, the recommendations should be clear and specific.

The Panel is to engage with the panel undertaking the *Service Priority Review* and the Special Inquirer undertaking the *Commission of Inquiry into Government Programs and Projects* to ensure that these parallel reviews and inquiries are informed by each other.

Engagement

The Panel will be supported through use of two reference groups:

- a Clinical Reference Group, and
- a Consumer and Carer Reference Group.

The Panel will undertake consultation and dialogue with Health Service Provider Boards, the Mental Health Commissioner, consumer advocates, front-line staff and health leaders, including through Patient First Dialogues.

The Panel will invite submissions from the wider community through a public advertisement. The Panel will also engage with key agencies across Government to promote a whole of government approach in the articulation of recommendations.

Term

Unless otherwise agreed in writing by Cabinet, the Panel is required to submit an Interim Report to Cabinet, through the Minister for Health, by December 2017 and a Final Report and recommendations by March 2018.

Secretariat

The Department of Health will provide secretariat support for the Panel including project management, data collection and analysis, the development of working documents, records keeping, facilitation of stakeholder engagement and other functions as required. The secretariat will work under the direction of the Panel.

Appendix C – Reference Groups

Two Reference Groups have been established to provide expert advice and experience to the Sustainable Health Review Panel – the Consumer and Carer Reference Group and the Clinical Reference Group. Reference Groups will ensure that health consumers, carers and staff are represented and actively engaged when shaping the future directions of the WA health system.

Consumer and Carer Reference Group

The Consumer and Carer Reference Group is Chaired by Pip Brennan and comprises members with diverse personal and professional experience of the health system as consumers, carers and advocates.

Ms Pip Brennan
(Chair)

Mr Tony Addiscott

Ms Vicki Barry

Dr Richard Brightwell

Mr Nigel D'Cruz

Ms Jaime Farrant

Mr Paresh Gandhi

Ms Tania Harris

Ms Rebecca Johnson

Ms Manjit Kaur

Ms Lorrae Loud

Ms Amanda Lovitt

Ms Margie Lundy

Ms Rhonda Parker

Ms Angela Ryder

Ms Rebecca Tomkinson

Clinical Reference Group

The Clinical Reference Group is Chaired by Dr Hannah Seymour and comprises staff with experience across the areas of primary, secondary and tertiary care, community care, public health and mental health and across a variety of specialties and settings, including metropolitan, regional, rural and remote WA.

Dr Hannah Seymour
(Chair)

Dr Alan Altham

Dr Matthew Anstey

Dr Lesley Bennett

Ms Sharon Bushby

Dr Martin Chapman

Dr Michael Civil

Mr Mark Cockayne

Ms Sue-Anne
Davidson

Mr Jason Ellis

Mr Clinton Fonceca

Dr Sallie Forrest

Ms Lesley Forrester

Ms Nicole Harwood

Dr Simon Hazeldine

Dr Rupert Hodder

Dr Paul McGurgan

Ms Emma Jarvis

Dr Linda Irvine

Dr Claire Langdon

Dr Peter Maguire

Ms Zoe Mullen

Dr Victoria Pasco

Ms Donna Rogers

Ms Linda Sinclair

Dr Amanda Stafford

Dr Stephen Stick

Dr Faraz Syed

Ms Monica Taylor

Dr Simon Towler

Dr Fiona Wood

Dr Marianne Wood

Dr Justin Yeung

Dr Jilen Patel

Dr Patty Edge

Reference Groups

Progress to date can be summarised as:

- Each Sustainable Health Review Reference Group convened meetings of its full membership in August and October 2017, with one joint meeting of both Sustainable Health Review Reference Groups held in November 2017.
- Each Reference Group provided initial comments and key areas for change against each of the Sustainable Health Review themes which were used to develop a strategy for six Sustainable Health Review Working Groups.
- The Reference Groups identified groups of staff and consumers that were not being fully represented by the Review. This has led to an ongoing targeted engagement program and additional Reference Group members.
- Clinical Reference Group members worked individually, engaging with specific clinical groups, in order to encourage participation and contribution to the Review.
- Consumer Reference Group members also worked with specific consumer groups, gathering feedback into the Review and ensuring the consumer voice was heard.
- Several Reference Group members attended public forums and made public submissions to the Review. Many are also active members of Working Groups, ensuring their skills and experience can further be used to inform working group discussion papers.
- The Consumer Reference Group has led an ongoing discussion on defining 'sustainability' which has been used to inform public and targeted engagement activities of the Review to date.
- The Reference Groups have engaged in in-depth discussions of several challenging issues faced by the WA health system. Key points were then used to focus and inform the Interim Report and these conversations will continue in 2018 to inform the Final Report.

Appendix D – State Government reviews: *Service Priority Review* and *Commission of Inquiry into Government Programs and Projects*

Public sector reform

Since March 2017 the State Government has commenced several activities to drive significant reform and cultural change across the public sector. The wide-ranging [public sector reform](#) aims to create a high-performing and collaborative sector that delivers better services to the Western Australian community.

Reforms measures include:

- Machinery of Government changes
- CEO Working Groups
- the Commission of Inquiry into Government Programs and Projects
- the Service Priority Review
- the Sustainable Health Review.

A number of these initiatives are occurring at the same time.

Service Priority Review

In May 2017, the Government announced the *Service Priority Review*, an independent review aimed at driving lasting reform of service delivery, accountability and efficiency. The State Government recognised that while Machinery of Government changes can deliver efficiencies through a reduction in duplication and overlap, more substantive cultural change is necessary to build a sustainable, responsive and high performing public sector. Accordingly, the Government sought independent advice on how to deliver different, better and lower cost services to regional and metropolitan populations into the future.

Mr Iain Rennie CNZM, former New Zealand State Services Commissioner was appointed to chair the Review. He was supported by former Indigenous Land Corporation Chief Executive Officer Michael Dillon and former University of Western Australia Senior Deputy Vice Chancellor, Professor Margaret Seares AO.

The Terms of Reference of the *Service Priority Review* tasked the panel with reviewing, reporting on, and make recommendations regarding, achieving cultural change within the public sector, promoting a culture of collaboration in the achievement of outcomes for the community, promoting public service innovation and identifying opportunities to further consolidate public sector entities into departments or other entities aligned with Government's strategic imperatives.

Further, the panel was tasked with identifying opportunities to deliver Government services, programs, projects and other initiatives more efficiently or effectively, developing and implementing whole of sector key performance indicators to ensure more effective delivery of services to the community, support for economic activity and job creation, attracting and retaining a skilled public sector workforce, and achieving greater economies and efficiencies in Western Australia's public sector administration.

The [final report](#) on the *Service Priority Review* was delivered to the WA Government in October 2017. The report sets out a [Blueprint for Reform](#) comprising 17 recommendations and 37 actions grouped under four directions for reform:

1. building a public sector focused on community needs – putting issues of community priority at the forefront of everything the public sector does
2. enabling the public sector to do its job better – overhauling internal systems to allow the sector to carry out work more efficiently and in the public interest
3. reshaping and strengthening the public sector workforce – embedding better workforce practices to support a more agile and innovative sector
4. strengthening leadership across government – applying stewardship and continuous improvement to get the best performance out of agency heads and central agencies.

The WA Government has endorsed the final report, broadly supporting the recommendations, and will move to begin implementing them in 2018.

Commission of Inquiry into Government Programs and Projects

Also May 2017, the Premier Mark McGowan and Treasurer Ben Wyatt announced the *Commission of Inquiry into Government Programs and Projects*. Former Under Treasurer John Langoulant AO, was appointed as the Special Inquirer.

The *Commission of Inquiry* examined 26 State Government programs and projects, focusing on the associated governance arrangements, decision-making processes and financial consequences. Eight health projects were part of the review including:

- Fiona Stanley Hospital
- Perth Children's Hospital
- QEII Hospital parking
- Karratha Hospital relocation
- St John of God Midland Public Hospital
- Department of Health – major IT procurement
- outsourcing of non-clinical services
- NurseWest arrangement.

Though not specifically under the Health portfolio, the *Commission of Inquiry* also examined (and may make findings relevant to Health) with regards to:

- Common Use Arrangement for Temporary Personnel Services
- GovNext ICT Project.

The Terms of Reference empowered the *Commission of Inquiry* to examine and report on the 26 identified programs and projects including analysis of contracts as necessary, entered into by the State Government between 2008 and 11 March 2017 and focusing on the governance arrangements and decision-making processes associated with these. Key aspects of the programs and projects that were examined include their financial consequence, the adequacy of the decision making processes leading to the awarding of the projects, the adequacy of their procurement processes and whether reasonable value for money outcomes were achieved.

The investigation and examination phase of the *Commission of Inquiry* has now concluded with the final report now scheduled for release in early 2018.

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