Interim Report: Feedback Survey

The Sustainable Health Review Interim Report feedback survey consisted of 14 questions. The responses to the open feedback questions are detailed below. Responses to questions 9-12 have been published in a summarised report on the SHR website.

Your Personal Details	
1. **Title**	Mr ☐ Miss ☐ Mrs ☐ Ms ☐ Dr ☒ Other ☐
2. First Name(s)	David
3. Surname	Mountain
4. Contact Details	
5. Organisation	
6. Location	☒ Metropolitan ☐ Regional WA ☐ Outside WA
7. Are you providing a response on behalf of your group/organisation or as an individual? **(Required)**	☐ Group/organisation ☒ Individual ☐ Other, please specify_____
Q8. Do you consent to your feedback being published, in summaries or in the Final Report? (Required)	
☒ I consent to my feedback being published ☐ I consent to my feedback being published anonymously ☐ I do not consent to my feedback being published	

The next two questions will allow you to provide more detailed feedback on how to maximise improvements in each of the Directions or suggest other areas or actions for the Sustainable Health Review Panel to consider to develop a more sustainable health system.

13. In regards to the 12 Directions, please provide detailed comments on how to maximise improvements in each of the Directions. Where possible, please indicate which Direction your comments relate to.

Keep people healthy and get serious about prevention and health promotion:
Prevention is good, but requires Govts to spend first for later rewards; need to spend wisely (not more leaflets to the worried well). Money spent early in life, targetted for the vulnerable / poor/ disadvantaged is money well spent BUT rewards will be for another govt. Poorly spent money in poorly regulated/ non evidence based NGO sectors is not helpful.

Exploring person-centred initiatives including:
these are laudible BUT needs state/fed agreements and stop cost shifting- deliberate blocks;
navigators sound great BUT are expensive partic if don't deliver results
not all patients wants are needed/ useful- many want MRI of their low back pain (and many get it) but v little good/ benefit comes from it when it happens
engaging consumers should mean not just consumer groups/ that become part of the bureaucracy-peoples forums/senates are more preferable - better range of views/ less history/ previous biases

• Better use of resources with more care in the community;
Again this sounds great BUT as exampled in mental health poorly co-ordinated ideological driven closure of formal services to fund disregulated NGOs (which mainly run 9-5 M-Friday) and don't manage complex/ high acuity patients, issues well is disastrous. WE need to concentrate on programmes that can deliver proven results, in sub-acute environments that facilitate exit from acute care, re-entry to community services, stop the gaps and are cost effective and reduce re-attendance. Funding models should require ongoing proof of effectiveness, service delivery and improved patient outcomes AND that can deal with high level care/ complexity cases.
Another issue with increasing community services (good for patients/ bad for govts wanting to save money) is that they tend to pick up unmet need, increase demand and find cases.

Facilitate effective interaction between acute and community-based mental health services to deliver mental health reforms across the system;
There can be no disagreement here about the worthiness of the title. However given the tragedy of mental health provision in WA over the last 10-15 years, the failure of the MHC to deliver, the poor current governance structures and delivery at all levels in Mental health with siloed management divorced from mainstream health, and the proliferation of low level NGOs without good delivery/ co-ordination it is hard to see progress with current governance arrangements. The MHC model is a failed policy, . Mental health and physical health are not separate and running them so induces even more poor outcomes for a population who die of physical illnesses 15-20 years before the rest of the population.
Mental health is underfunded by all govts- but not even mentioned in the report. previous reports have reccoomended increased funding required to deliver reforms-again ignored by multiple govts and this report.

13. In regards to the 12 Directions, please provide detailed comments on how to maximise improvements in each of the Directions. Where possible, please indicate which Direction your comments relate to.

• New ways to support equity in country health;
The Interim report seems to think almost all of that will be via Telehealth models- telehealth is a poor substitute for Face 2 face medicine; when F2F can't happen the it is useful BUT we should find ways in delivering F2F care/ services in regional hubs and supporting regular FIFO with supports for local teaching/ governance/ supports for local clinicians.

• Develop partnerships for Aboriginal Health Outcomes
Yes we need pooled funding, less paperwork, better focus on outcomes- with better support (stop interfering so much and support for paperwork/ admin) and joined up programmes where health is part of total infrastructure packages in more remote areas.

• Create and support the right culture
The interim report is nakedly anti-doctor, divisive and almost deliberately tries to alienate a key group in delivering change, and fostering a culture of disharmony, jealousy and fragmentation. This is no way to foster change. Doctors are already the most demoralised, disengaged and burnt out group in health. The report is the antithesis of the right culture and cannot possibly foster teams with it's divide and conquer attitude. Indeed do check what the problems are in health and survey attitudes/ engagement etc. but we already know how problematic the systems attitude to one of it's key workforces is and the SHR will be the unsustainable ill health review if these attitudes continue.

• Greater use of technology, data and innovation to support consumers, clinicians and drive change;
Easy to say- v hard to deliver, health is crippled by poorly designed IT fixes, poor long term planning for IT and terrible implementation. WE are a decade+ behind in IT and it is not possible for this to get sorted out on the pittance spent currently on IT. There is no cheap fix here BUT what does get implemented and designed must be designed with clinicians, properly beta tested and have properly resourced implementations and modifications when introduced. Currently most new IT systems seem to reduce work efficiency, reduce patient contact time and increase FTE requirements. EHR and data collected should be used, valued and readily available for QAI and research- the attitude should be to have data readily usable to improve care - consumers and clinicians agree , only bureaucracy doesn't

• Harness and support health and medical research collaboration and innovation

Again a v worthy statement, and there is some promise BUT WA need to continue to increase support for access to support funds, make us nationally competitive again (for NHMRC/ similar grants), update our data restriction units in the bureaucracy to data facilitation units, fund our centre of excellence and reduce the governance burden on researchers.

• Develop a supported and flexible workforce :

13. In regards to the 12 Directions, please provide detailed comments on how to maximise improvements in each of the Directions. Where possible, please indicate which Direction your comments relate to.

Currently this seems to be code for take potshots at doctors, role substitution and a poorly paid workforce- not sure where the support is. I suspect saying all WA health professionals are overpaid and should have a pay cut doesn't make them feel v supported. neither does suggesting that WA staff have delivered nothing for the 120% funding increases over the last decade. This is palpably untrue- WA national KPIs and specialty KPIs constantly rank highly across states- including of course always having best NEAT targets, good NEST etc against a rising population/demand > inflationary costs in WA- particularly in the boom and increased delivery of services, both acute and elective. IN fact almost all the increases in budget are explained by inflation -CPI- wages index(3-3.5% p.a- health inflation prob >); population growth(2-2.5% p.a), and complexity-age- new techniques/drugs. WA health wages are in line with the rest of WA wages in terms of how we compare with Eastern states- e.g. throughout the WA economy the 10-25% boom driven increase in wages have stayed in the WA economy after the boom finished, along with all the costs that these wages drive in the local economy. Anyway the superficial analysis of health performance vs the rise in health costs is galling in it's poorness and assumption that there was minimal gains during the last decade.

• Plan and invest more wisely ;
One can only hope government, treasury and senior admin do manage to do better in this next decade. The billions wasted in public -private tenders, poorly written contracts, mismanaged moves and constant name changes and administrative reshuffles hardly bare thinking about. How you rein in such rank incompetence at such senior levels is probably beyond the remit of simple clinicians

• Building financial sustainability, strong governance, systems and state-wide support services ;
within health no one really understands how budgets are put together- they are opaque to almost all; there is poor literacy throughout health (inclding financial areas). Budgets that arrive late, don't have a logical basis and where there is no long term strategy do not engender respect or buy in. The rampant waste, dysfunction and mismanagement evident in government make it hard for clinicians to be lectured to by whichever accounting firm has just been hired by admin/ DoH/ treasury to justify further cuts.

14. Is there anything else that the Panel has missed so far that is important in developing a more sustainable health system for Western Australia?
yes clearly- the SHR interim report is in a parallel universe to the one clinicians inhabit; Capacity is a major issue in all parts of the health system with many avoidable deaths, harms and complication caused by constantly overloading the hospital system. It is laughable to believe that a system which routinely runs at over 90% and often a 100% occupancy will manage for a decade without further bed capacity. Only planners who don't have to deal with consequences can convince themselves of this sort of nonsense. WA currently has 11% less beds than the next lowest state (2.15/1000 vs 2.4 /1000) Victoria and 14% less than the national average (2.5/1000). This for a state with the largest remote area in Australia, the worst access to primary care and least use of medicare rebates. The overall performance against national KPIs is pretty miraculous when considered with how far up our back WA's arm is when trying to compete. Capacity can be provided in many ways BUT in the end change is slow, populations and demand still increase and capacity is required and some of that will have to be beds.