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Dear Sustainable Health Review Secretariat

The Doctors Reform Society (DRS) is an organisation of doctors and medical students promoting measures to improve health for all, in a socially just and equitable way. The Society was formed in 1973 to support a proposal for a publicly-funded universal health insurance system. Medibank (now Medicare) was successfully created despite opposition from the Australian Medical Association.

All members' views are valued, and open debate on all health issues is encouraged both within and outside the organisation. The DRS functions as a medico-political think tank, a lobby group and a public resource centre.

DRS WA is an active branch of the DRS which meets monthly to discuss relevant and pressing issues of public health prominence.

Our President is Dr Alison Creagh.

Public hospital outpatient services – Sustainable Health Review submission

The Doctors' Reform Society of WA (DRS WA) is very concerned about the poor availability of medically necessary outpatient clinic appointments in Western Australia.

We believe that quality health care should be available to all people regardless of their ability to pay. In private specialist practice (other than general practice) bulk-billing occurs at only about a quarter of consultations, and Western Australian patients who are not bulk-billed face average out-of-pocket costs of approximately \$75 per consultation.¹ Such fees are substantial for many of our patients, and are a common barrier to accessing care.²

We are aware of extremely long and sometimes indefinite waits for several specialties in WA public hospitals. For example, when we recently informally surveyed public hospital adult ear nose and throat (ENT) surgical outpatient clinics, we found that all but the most urgent referrals were being put on an indefinite waiting list, with urgent patients waiting longer and longer, and less urgent patients waiting essentially forever.³

We believe there are other specialties with extremely long waiting lists, including in our anecdotal experience neurosurgery, neurology, gastroenterology, orthopaedics and pain management. There are probably others. We would like to cite more complete statistics on clinic waiting times, but we are unaware of these existing in an official published form. Thus, we rely in this submission on vicarious experiences from our patients, and on informal "ringing around".

Timely outpatient care may potentially contribute to cost savings and a more financially sustainable health system by preventing hospital admissions, preventing chronic sequelae of disease, and avoiding unnecessary investigations.

Various initiatives could be undertaken to improve this situation within budgetary constraints. These include:

- Introducing quality/appropriateness criteria for referrals from general practice to specialty clinics, to ensure that specialty clinic appointments are distributed to those patients most likely to benefit from them
- Resources to empower GPs to manage common presentations in more detail prior to referral. Audit of common reasons for referral in each clinic area may be useful in identifying the conditions most amenable to further GP management prior to referral. These resources may include those available to GPs before referral (such as the Health Pathways⁴ resource which is slowly being developed). It also may include feedback from clinics to GPs after review of referral letters.
- Appropriate use of multidisciplinary team members in clinics. Examples include physiotherapy triage of neurosurgery or orthopaedic referrals.

We understand that some of these initiatives are being planned.

However, even with these measures, we anticipate a significant unmet demand from patients who simply cannot afford private specialist fees. Given the inequitable nature of access to private specialist care, we believe further investment by the state government in outpatient clinic appointment capacity is necessary to ensure equitable access to care. Funding from this may need to come from additional revenue raising, from reconsidering low value care elsewhere within the health system, or from reconsidering other priorities outside the health portfolio. The Choosing Wisely Australia campaign offers evidence-based examples of low value care which may offer opportunities for savings.⁵

We also believe that there needs to be more transparency around access to care. We believe that average waiting times, by specialty area and degree of urgency, should be available to referring doctors (to help guide referral decisions) and to the public.

The current state government cites principles of fairness, equity and social justice as being amongst its core enduring values.⁶ Further, it states that it will strive for “a universal public health care system where equity of access to and quality of care is determined by need.”⁶ DRS WA shares these values and goals. We hope that the state government will agree that ensuring access to medically necessary specialist care for all Western Australians is an important step towards realising this government’s vision of universal health care.

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Palliative Care

The Australian population is ageing and the number of people who die annually in Australia will almost double in the next 25 years. Most deaths are due to chronic diseases, and 70 per cent of all deaths can be anticipated. This means that a person with chronic or life-limiting illness should be able to plan their final years, months and weeks of life, allowing them to live, be cared for, and die, in their place of choice. For most Australians, this place is home, rather than a hospital. Yet most people die in hospitals, often preceded by repeated visits to emergency departments and hospital admissions. (Swerissen H, Duckett S. Dying well: Grattan Institute Report No. 2014-10 [cited 2017 Oct 20]. Available from: <http://grattan.edu.au/wp-content/uploads/2014/09/815-dying-well.pdf>)

As defined by the World Health Organisation *“Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering...[it] will enhance quality of life, and may also positively influence the course of illness; and it is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.”* Access to palliative care in Western Australia, like the rest of Australia, is inequitable. Groups who are less likely to receive palliative care include those from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander people, people with disabilities, older people, those with non-malignant disease, and those living in rural and remote areas. In addition, care is “fragmented” across different systems including the public and private, community and hospital, primary care and aged care systems. (<http://ww2.health.wa.gov.au/~media/Files/Corporate/general%20documents/End%20of%20Life/PDF/Th e-End-of-Life-Framework.pdf>)

For example, dementia is the second-leading cause of death in Australia, yet people with dementia are far less likely to receive specialist palliative care at the end of life. Over half of people with living with advanced dementia experience pain, more than half experience agitation, more than a third experience depression, anxiety, and sleep disturbances. (Sampson, E, et al. Living and dying with advanced dementia: A prospective cohort study of symptoms, service use and care at the end of life. *Palliative Medicine*; 1-14, 2017) Many are hospitalised near the end-of-life, even if against their wishes, due to lack of access to palliative care at home (including in residential aged care facilities) and lack of aged care services to support them to live at home.

Many people with chronic diseases will develop disability in their final months or years of life, requiring assistance to perform their daily activities, such as cleaning, cooking and personal care. Lack of access to these services in their home is often a trigger for hospitalisation, or a barrier to discharge from hospital. Following recent changes to the Aged Care system, with the introduction of Consumer Directed Care, mean that thousands of older Western Australians are now on a “National Queue” awaiting an appropriate care package to support them to remain living at home. (<https://gen-agedcaredata.gov.au/Resources/Home-care-packages-program-data-report-2017>)

A recently published study examined the monetary costs of non-beneficial or “futile” treatment received by 907 people who died in 3 Queensland tertiary hospitals. Futile treatment was defined as “treatment that

does not bring benefit to the patient in terms of: improving the patient's quality of life; significantly prolonging the patient's life of acceptable quality; or involving burden that outweighs benefit." Over a 6 month period, futile care cost >\$12 million, with >3000 extra days spent in hospital. It is likely that similar amounts are spent on futile care in Western Australian hospitals. While care should not be rationed for those who would benefit, people with life-limiting illness should be offered the opportunity to make informed choices about what treatment they want at the end-of-life, those that reduce their quality of life or where they perceive that burden outweighs benefit. Any cost savings should be redirected back to health system, such as for palliative care, primary care or preventative care.

In its "Choosing Wisely" recommendations, The Australasian College of Emergency Medicine advocates for a palliative approach for people nearing end-of-life: *"Research indicates that over 50% of Australians who die an 'anticipated' or 'expected' death, will die in acute hospitals, even though the majority approaching end-of-life wish to die at home. In this context, clinicians, patients and their families should work together to ensure they have a common understanding of the goals of care. Values and wishes around medical treatment should be documented. Monitoring and investigations should be appropriate. Clinicians should advocate for the patient by initiating discussion about end-of-life care with inpatient clinicians and community health professionals. When possible, arrange for end-of-life patients to be transferred to a palliative care facility to avoid admission to acute wards."*

(<http://www.choosingwisely.org.au/recommendations/acem>) Unfortunately, many doctors and health professionals lack the requisite palliative care skills to have these discussions with patients and their families at the end-of-life. Improved access to palliative care training and education for doctors and other health care professionals, including those in emergency departments, primary care, aged care, intensive care and other areas would assist in rectifying this.

The Grattan Institutes "Dying Well" report made a number of recommendations about how Australians can have better deaths, including that we:

"be informed about the limits of health care and the importance of discussing our preferences for end-of-life care;

- ensure that greater incentives and encouragement exist for the development and implementation of Advance Care Plans;*

- increase the availability of community- and home-based support for people who are dying, particularly for older people with chronic conditions."*

Their financial modelling showed that improved funding of community palliative care services would be cost-neutral to the health care system, in addition to allowing more people to die at home if that is their choice at end-of-life. (Swerissen H, Duckett S. Dying well: Grattan Institute Report No. 2014-10 [cited 2017 Oct 20]. Available from: <http://grattan.edu.au/wp-content/uploads/2014/09/815-dying-well.pdf>) This places more of a financial burden on family carers, although an evidence-based Compassionate Communities model of public health palliative care, as advocated by Palliative Care Australia, would reduce these costs. (<http://www.compassionatecommunities.net.au/#ccn>)

Improved public discussion about death, dying, advance care planning and chronic disease could also be encouraged, to empower people with life-limiting illnesses to discuss their wishes with their families and health care professionals. This is acknowledged by the WA Health Department's own End-of-Life framework

and could be enhanced by a state-wide media campaign and public workshops with local community groups.

Improved access to palliative care, advance care planning and aged care services, would help more Western Australians achieve their wishes at the end of life.

Mental Health Care

The DRS WA believes that mental health care in WA can only be described as dire at all levels of illness and care. It is highly fragmented and in need of integration, collaboration and communication. The necessary changes can only be achieved with a large injection of resources.

The cost to society of poorly resourced mental health care is enormous, including premature death. There is huge loss of productivity in the workplace – “for Australian business this results in around 12 million days of reduced productivity a year” (1). We are seeing an increase in homelessness, and nearly 50% of prison inmates have a mental health disorder (2). Mental illness may cause a drift to welfare dependency and occasionally it can increase the risk of crime.

The importance of the Social Determinants of Health cannot be ignored and all Mental Health Strategies should link closely with housing, welfare, cost of living, urban design and childcare, to name only some of the important issues.

The Public Mental Health Services are currently not able to manage their patients according to their needs, nor even to communicate with GPs routinely. To provide the necessary coordinated care, they must be resourced sufficiently to do shared care with GPs, and as a minimum, always write prompt letters. Patients should all receive psychological treatments, and routinely have a Case Manager who should also be able to integrate physical health, and collaborate with all health professionals involved with the patient. Currently this type of care is unusual, and the consequences can be either duplication, or omission of necessary health care, which is ultimately more expensive.

For patients who are accepted into the Public system, Mental Health formularies restrict medication possibilities available, tying the hands of the doctors beyond the usual bounds of the PBS. Doctors should have all available PBS options available to them.

Many patients have dual diagnoses and their care is split between services. We believe that Drug and Alcohol Services should be provided within the Public system, and integrated with patients' Mental Health Care.

For Post Partum Depression and Psychosis I would like to acknowledge the importance of the Mother and Baby Units in KEMH and FSH for those with severe illness. It would be much better if they were resourced sufficiently to provide same day admission for crises, given the immense importance of keeping babies with their mother. This is often not possible in crisis beds. The mothercraft courses are very important – these should be free and widely available for those who are sick but do not need admission. There is ample evidence early childhood support and education for parents and for infants / toddlers significantly reduces intergenerational trauma and therefore saves money in the long run. We would like to see more resources in this direction.

Patients with Complex Trauma Disorder, otherwise known as Borderline Personality Disorder, are frequently refused care. When they are accepted into the Public system they are usually discharged quickly before receiving any useful therapy. Missing appointments and using alcohol and drugs exclude them from being treated, when these two issues are a usual expression of their illness. We need a more creative approach to engage these people – withdrawal of services does not work. There is an enormous waiting list (eg 2 years) for treatment groups, for example Dialectical Behavioural Therapy, which is proven to help (4). These people have a treatable condition which, while disastrous for the individual concerned, can also be an enormous financial burden on the state. They should be treated properly in our Public Mental Health system with an understanding that it will take time.

Child Mental Health care is in dire straits. Accessible, timely, appropriate care for mentally ill adolescents and children is often simply not available. There is well documented poor morale in the Public services, which impacts on patient care in and out of hospital. Riots and the constant need for crisis management at the adolescent inpatient unit, due to it being poorly resourced and badly managed, affects all the patients. Poor care has severe long-term ramifications for young people, who experience delays in obtaining qualifications and participating in the workforce. Inadequate treatment at such a crucial stage affects children and young people for their whole lives. (5)

Headspace has been a good addition to services in the community, however psychological services are capped under Better Access (see below) and frequently insufficient. It is good that treatment for Drugs and Alcohol is often available in the service, but, like all services, it is limited by its resourcing and lack of connectivity.

Older Adult Mental Health services also have their difficulties mainly due to poor integration of services. It is a sad reflection of society's values that the rate of suicide in institutional care is increasing (6). As doctors, we frequently see inadequate support for carers in the community.

In the community, Mental Health Care is fragmented and inconsistent, and inequity abounds. Poor mental health is often the consequence of layers of trauma, and the most crucial part of healing is an enduring relationship with a skilled therapist who can provide continuity of care.

ATAPs has been prematurely disbanded and WAPHA are in the process of setting up alternative pathways. The most common model will be short term courses of superficial treatment - many people will not engage if they have to tell their story to multiple different people with no enduring therapeutic relationship. It is desperately sad that there will be no option for ongoing psychotherapy. The communication with GPs during the transition has been very poor and there has been a substantial gap in service provision which continues. We also have concerns that patients have to have a Pension or Health Care Card to access most WAPHA services - this will exclude a number of patients in financial need eg those who do not engage with Centrelink, and victims of Domestic Violence who do not have access to their own money. The Care Management being made available for severe and complex cases will not provide any psychological therapy at all, which is a very serious deficiency, and may result in extremely poor long term outcomes for these patients. We hope that the evolving care WAPHA can provide will prove to be affordable and accessible, and provide long term continuity of care where it is needed. At current resource levels, this is not possible.

There are some good community based services, for example the Centre for Clinical Interventions. However, its waiting list is too long to be useful. For example, a patient with a recurrent depressive illness may be in remission by the time they reach the service, so care is rejected, even though they have high motivation to try to prevent and manage future recurrences themselves. The assessment interview is then a waste of everyone's time. Poor resourcing has meant that the service is not able to continue the effective and timely care that it could originally provide..

The community services, especially WAPHA, and the Public Mental Health system ought to liaise very closely together. Unfortunately, that is not the case at present. In the past public psychiatric registrars have recommended ATAPs for patients who do not fit the ATAPs criteria, and have excluded them from

public psychotherapy in the expectation ATAPs would provide it. This poor coordination of care has to change.

Better Access Mental Health services are limited by the large gaps routinely charged by private providers and the capped nature of the system. For those who can afford the system it can work well, providing much needed continuity and longevity of care with highly skilled psychologists and psychotherapists eg for patients who remain in the workforce. The system is not adaptable to evolving needs, being capped, and therefore frequently can only provide maintenance treatment rather than real useful therapy. There is no integration with other services, and communication is very dependent on individual providers. Adequacy of therapy depends on the time of year patients present, and the postcode lottery is very evident: there is a dangerous paucity of mental health providers in some regions. Under-treatment risks a drift to welfare dependency, which is ultimately more expensive than timely therapy. It would be good to see the State Government liaise with these providers for a more collaborative integrated approach that could enhance Better Access for those in need.

The final point we would like to make is that organisations and the people they treat need certainty and longevity. The current situation where many organisations are only given short term funding means that they waste large amounts of time and money re-applying to continue. Their service provision does need to be audited and assessed, however there should be an expectation of funding for 5 year periods to allow them to make real change, and for patients to know they will receive ongoing care and not have to keep re-telling their stories to new mental health providers.

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Glossary

ATAPs = Access to Allied Psychological Services

WAPHA = WA Primary Health Alliance

Contraception And Abortion

The DRS WA is very concerned about both a widespread lack of access to contraception and abortion services for women, and a lack of clinical training opportunities for medical students and junior doctors in this field.

The importance of access to these services, particularly within general obstetric and gynaecology services, cannot be underestimated. In Australia, the rate of unintended pregnancy is much higher than many European countries. Long Acting Reversible Contraceptive (LARC) methods are approximately 20 times as effective as the most commonly used methods, such as the combined contraceptive pill^{1 2}, yet LARCs are used relatively uncommonly. Adequate contraceptive knowledge by health care professionals, and training in the insertion of IUDs and implants (the highly effective LARCs) are essential to the prevention of unintended pregnancies.

Studies in various settings have demonstrated that for each dollar spent on contraceptive services, approximately three to four dollars are saved on the costs of caring for unintended pregnancies. For example, the Guttmacher Institute regularly publishes such figures: <https://www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-2017>

For some time now, in metropolitan public hospitals, access to contraception and abortion has been diminishing significantly. In rural and remote areas, access to these services is highly dependent on the attitudes of local health providers. For example, in Geraldton, Kalgoorlie and Port Hedland, excellent services exist; in Broome there is limited access to surgical abortion only, and in Karratha there is no access to abortion services.

In metropolitan Perth, the very limited (1/2 day per week) KEMH Family Planning Clinic was closed in July 2017. Women no longer have access to this free service, and the many junior doctors training at KEMH and other public hospitals have close to no opportunities to train in general contraception provision, and very limited opportunities to train in the insertion of the most effective methods, the Long Acting Reversible Contraception methods (IUDs and implants).

One of the most severe gaps in services is access to abortion. Women accessing the privately run clinics pay close to \$600 for an early medical or surgical abortion, and this fee is extremely difficult to manage for many of the women we see. It is essential that increased access through the public system is provided so that all women wanting to end a pregnancy are able to do so. It is also essential that public hospitals who have the responsibility to train junior medical officers in gynaecology incorporate this care into their usual services. Keeping it separate has the effect of increasing the stigma associated with accessing and providing abortion services. Some US studies have demonstrated that being exposed to abortion care results in a more careful consideration of attitudes to abortion by medical students and junior doctors, and a greater understanding of the need for these services.

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