

Public Submission Cover Sheet

Please complete this sheet and submit with any attachments to the Sustainable Health Review Secretariat

Your Personal Details

This information will be used only for contacting you in relation to this submission

Title	Mr <input type="checkbox"/> Miss <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input checked="" type="checkbox"/> Other <input type="checkbox"/>
Organisation	a. Emergency Medicine, University of WA; and b. Fiona Stanley Hospital
First Name(s)	Glenn
Surname	Arendts
Contact Details	[REDACTED]

Publication of Submissions

Please note all Public Submissions will be published unless otherwise selected below

- I do not want my submission published
- I would like my submission to be published but remain anonymous

Submission Guidance

You are encouraged to address the following question:

In the context of the Sustainable Health Review Terms of Reference listed below, what is needed to develop a more sustainable, patient centred health system in WA?

- Leveraging existing investment in Primary, Secondary and Tertiary healthcare, as well as new initiatives to improve patient centred service delivery, pathways and transition;
- The mix of services provided across the system, including gaps in service provision, sub-acute, step-down, community and other out-of-hospital services across WA to deliver care in the most appropriate setting and to maximise health outcomes and value to the public;
- Ways to encourage and drive digital innovation, the use of new technology, research and data to support patient centred care and improved performance;
- Opportunities to drive partnerships across sectors and all levels of government to reduce duplication and to deliver integrated and coordinated care;
- Ways to drive improvements in safety and quality for patients, value and financial sustainability, including cost drivers, allocative and technical efficiencies;
- The key enablers of new efficiencies and change, including, research, productivity, teaching and training, culture, leadership development, procurement and improved performance monitoring;
- Any further opportunities concerning patient centred service delivery and the sustainability of the WA health system.

Submissions Response Field

Please type your response into the field below. Alternatively you may provide your submissions as a separate attachment (Suggested Maximum 5 pages).

Our health system is one of the best in the world by most measures, but I am pessimistic about one component, our acute public hospitals, unless there is major change. I write this submission, concentrating on acute public hospitals, from several perspectives. Firstly as a practising emergency physician at Fiona Stanley Hospital that has worked continuously in Australian EDs for 25 years. Secondly, as chair of the Australasian College for Emergency Medicine Geriatric Special Interest Group, that advises and represents Australia's 2100 emergency physicians on matters pertaining to emergency care of older people. Finally, as an academic with almost 100 peer review publications, most pertaining to systems of care for older people, and who's PhD thesis was titled "Acute medical services for the residential aged care population: measuring preferences for the emergency department and alternatives", important because this work contained the first ever quantitative rather than qualitative study of why people choose to use EDs for care of frail older people when alternatives exist.

In writing this submission, it is central to understand that there are two fundamental and almost certainly insurmountable obstacles to radical reform of the acute public hospital system – the views of the majority of medical specialists working in the system (and the AMA which represents them), and the public resistance to anything that resembles rationing their access to the unfettered care currently available.

Notwithstanding the admirable small steps towards horizontalisation of the hospital system, responsibility for all important decisions regarding patient admission, discharge and the care they receive rightly remain with the medical specialist. As a medical specialist myself, I understand how easy it is to shut down debate about just allocation of resources and reform by stating the thing we are taught from day one as doctors: "I'm only interested in doing the very best for my patient". If one was to take a holistic view of health funding from afar, doctors working in the public health system are in reality nothing more than contracted technocrats, but it is impossible to convince many of my fellow specialists of this. Perhaps the only specialist craft group that is an exception to this is intensive care, which I discuss further below.

The public of WA, in my estimation, have no appetite for restricting their access to what they see as the pinnacle of the health system, and to which they turn when they are most ill, the acute public hospital. Yet it is absolutely central to the sustainability of this system that access is restricted, through evidence based diversion of people away from hospitals to good alternate care and through rationing admission to the finite number of beds that are capped so that public hospital funding does not subsume ever increasing proportions of the state budget. As the group that people most trust, medical specialists, are largely unwilling to have this debate with the public, I don't expect any government to do so either. But without it, truly radical reform is in my view impossible.

Therefore my submission will concentrate on things I believe are achievable and do not rely upon changing these entrenched views, of either doctors or the public. I provide a series of supporting logic based statements, followed by recommendations.

- i. Health care spending is a concentrated phenomenon. It is estimated that 5% of the population are responsible for 50% of health spending. I assume as a given that the

Submissions Response Field

Please type your response into the field below. Alternatively you may provide your submissions as a separate attachment (Suggested Maximum 5 pages).

panel of experts conducting the SHR is aware of the extensive epidemiological and descriptive research, published in both the grey literature and peer reviewed journals, that identify the disproportionate users of health services including high users of public hospital bed days. If the panel is not aware of this, I am happy to supply numerous references. Of personal interest to me, disproportionate bed day users are mostly older people (particularly the frail and/or disabled community dwelling elderly), and those in their last twelve months of life regardless of age.

- ii. These groups are disproportionate users for good reasons, and not because they want to be in hospital. They are vulnerable, sick and in need of extensive health care.
- iii. Although I am an emergency physician, disproportionate users of emergency departments are not the same as disproportionate users of hospital bed days. The former are not the focus of this submission.
- iv. As the proportion of high bed day users in the community is growing, and the assumption is that the number of bed days is either capped or growing at a much slower rate, high bed day users must logically be the main focus of the SHR.

Recommendation 1. The SHR focus on the two high risk groups where hospital bed day usage is disproportionate on a population basis – the frail and multimorbid elderly, and those with terminal illness in the last 12 months of life

- v. As high bed day users are chronically (often terminally) ill and/or frail, there are substantial challenges in providing appropriate health care to this group. If care is to be provided outside of hospitals, it will require new funding of excellent alternate care models discussed below. This should still be cost beneficial for government.
- vi. To date, most of the focus on reducing bed day usage by any one patient has focussed on improved efficiencies to reduce the duration (length of stay) of a hospitalisation, rather than preventing hospitalisation altogether. This has been spectacularly successful in many circumstances e.g. for elective surgery. This strategy is also applied to some extent for the high bed day user groups when they are transferred from an acute hospital bed to less expensive subacute/transitional beds. These successful strategies are not the focus of my submission, which will concentrate from hereon on strategies to prevent hospital admission occurring in the first place.

Recommendation 2. In these two high risk groups, the SHR examines strategies to prevent some acute hospital admissions altogether, not just strategies to reduce hospital length of stay

- vii. Care of sick people within the geographical setting of an acute hospital offers the immense benefit of access to a highly skilled multidisciplinary workforce and technology on one site.
- viii. The well-cited risks of hospitalisation, however, are also highest in the frail elderly. The common response to reducing this risk to date has been to “make hospitals safer”, which often leads to introduction of resource consuming new work practices with unintended opportunity costs and secondary consequences for those patients that are actually at low

Submissions Response Field

Please type your response into the field below. Alternatively you may provide your submissions as a separate attachment (Suggested Maximum 5 pages).

to negligible risk of being harmed.

- ix. We should instead explicitly view all admissions to an acute hospital bed as a risk versus benefit decision. Where risk exceeds benefit, admission is harmful and so it is good and uncontroversial medical practice to prevent admission. Particularly for the frail elderly, and those nearing end of life regardless of age group, this in reality only occurs where admission can no longer restore quality or duration of life i.e. confers no benefit.

Recommendation 3. The SHR acknowledges that for some patients from high risk groups in some circumstances, hospitalisation is more likely to cause harm than benefit. These admissions should ideally always be prevented.

- x. The obvious barrier to achieving this aim is equipping clinicians with the tools to identify which patient, under which circumstances, will be more likely to be harmed than benefit from admission.
- xi. This barrier can be and have been overcome, For example, in models of care that have been successfully enacted by intensive care specialists to ration access to extremely limited ICU beds. More generally, geriatrician and palliative care researchers have developed robust models to identify, for example, advanced frailty and medical futility in their patients. The future of a sustainable acute hospital system, in my view, is to apply this risk versus benefit model to potential users of all hospital beds, not just ICU beds.
- xii. The ICU model only works because patients deemed unsuited admission to ICU are provided with an alternative hospital bed for care. Therefore, logically, to apply this model to all hospital beds and prevent a harmful admission, more alternatives must be created outside of acute hospitals that are clinically adequate, cost effective and acceptable to the public.

Recommendation 4. The SHR adopt the mantra that all acute hospital beds are a precious resource, and admissions from high risk groups should be subjected to an overt risk:benefit analysis

- xiii. In Australia, between 55-70% of all overnight acute hospital stays occur via the ED.

Recommendation 5. The SHR focus on the ED as the key locale for clinicians to enact this risk:benefit analysis and prevent hospital admissions

- xiv. I have previously written that reducing hospital admission via ED should be considered under three headings: primary, secondary and tertiary prevention.
- xv. By primary prevention I refer to the establishment of alternative acute care services to which unwell patients may self-present, or to which ambulance services may refer patients, bypassing ED altogether. Conceptually primary prevention may be the most important strategy to pursue in the long term, because the one way to 100% guarantee that an ED does not admit a patient to hospital is to not have the patient attend ED in the first place. However, there is massive complexity in developing systems for primary prevention for all but very low acuity/urgency patients, and the funding of these systems may be best pursued through federally funded Medicare. I will not discuss these further in this submission, except to say I see St John Ambulance in WA as key to development of

Submissions Response Field

Please type your response into the field below. Alternatively you may provide your submissions as a separate attachment (Suggested Maximum 5 pages).

any future primary prevention funded by the state government.

- xvi. Secondary prevention refers to enhanced and modified care within the ED for patients that have presented there, so that discharge rates from ED are maximised. Key to this is to reverse the incentivisation of admission of the high bed day users that currently exists under the WEAT ('4 hour rule"). The WEAT is a sensible idea when applied to many patient groups – those with simple single system problems should be quickly admitted to hospital (e.g. acute appendicitis), or discharged (e.g. sprained ankle). WEAT makes absolutely no sense, and indeed is counterproductive, when applied to multimorbid, frail and disabled older people. WEAT targets create perverse incentives to admit this group, even when the risk:benefit ratio for admission is high and a better patient and system centred strategy would be to spend more time and effort in ED to prevent admission..

Recommendation 6. The SHR advocates for the abolition of WEAT targets for high risk groups of patients being considered for secondary prevention strategies.

- xvii. As an illustration, I have successfully developed and enacted one type of secondary prevention strategy at Fiona Stanley ED that serves as a template for the type of work the SHR should support. The FSH ED falls pathway applies to all patients over 65 presenting to ED with a fall. The model works on several key principles: the target population is cohorted within one area of the ED, identified as a high priority from the point of triage, and receives standardised best practice assessment by ED staff augmented with rapid access to a geriatrician in the ED. Under this model, discharge rates from ED for this often physically and cognitively frail group has increased from 46% to over 70%, and we have achieved a 2750 reduction in acute bed days used by falls patients over 12 months.
- xviii. As an emergency physician myself, I acknowledge that one considerable barrier to any successful secondary prevention program will be the attitude and skill set of emergency medicine specialists. FACEM's may be disengaged from the process altogether as they consider it outside their clinical role, or if engaged may lack the skills to either identify patients unlikely to benefit from restorative admission, or prevent that admission through work up in the ED and linkage with the community sector.

Recommendation 7. The SHR advocates for either the upskilling of emergency physicians/clinicians to adequately conduct secondary prevention, or the embedding of other trained professionals in the ED to work with high risk groups e.g. geriatricians

- xix. Tertiary prevention refers to programs enacted for those where secondary prevention failed or was not indicated because of a condition that would benefit from hospital admission. Tertiary prevention refers to the identification of those patients, typically with terminal illness in the last year of life, that would benefit from strategies and referrals enacted on this admission to prevent subsequent ED attendances and admissions, In other words, benefit from access to palliative care and/o advance care planning.

Recommendation 8. The SHR prioritise and give equal weight to secondary and tertiary prevention strategies for high risk groups in acute hospitals.

I have not attempted to address many of the things which I predict are likely to come before the SHR in submissions but which in my estimation distract from what should be the key focus of

Submissions Response Field

Please type your response into the field below. Alternatively you may provide your submissions as a separate attachment (Suggested Maximum 5 pages).

the review. Whilst topical and no doubt of some importance to the health of the population globally, they should be of less importance to a state government review than addressing the primary problem of the sustainability of the acute hospital sector in WA. Many of these would be more appropriately considered by a federal government review

In no particular order these include:

- Mass information media campaigns to “keep people healthy and out of hospital”
- Increased funding of chronic disease management in general practice
- Low acuity GP type presentations to ED, which do not contribute to hospital occupancy
- Undue focus on hospital attendance by older people living in residential aged care, when a numerically far larger issue are the community dwelling elderly
- The choosing wisely campaign

Thank you for the opportunity and please feel free to contact me if you require further details or references for my submission.