EDUCATION AND HEALTH STANDING COMMITTEE

SUSTAINABLE HEALTH REVIEW INTERIM REPORT

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 27 JUNE 2018

Members

Ms J.M. Freeman (Chair)
Mr W.R. Marmion (Deputy Chair)
Ms J. Farrer
Mr R.S. Love
Ms S.E. Winton

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Hearing commenced at 10.07 am

Ms ROBYN KRUK
Chair, Sustainable Health Review, examined:

The CHAIR: On behalf of the committee I would like to thank you for agreeing to appear today to provide evidence in relation to the Sustainable Health Review interim report. My name is Janine Freeman and I am the Chair of the Education and Health Standing Committee. I would like to introduce the other members of the committee: Mr Bill Marmion, next to me; Mr Shane Love; Ms Sabine Winton; our clerks are here and Hansard is here. Josie Farrer is not here today; she sends her apologies.

It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this privilege does not apply to anything you might say outside of today's proceedings.

Before we begin, do you have any questions about your attendance here today?

Ms KRUK: No, I do not. I am fine. Thank you for the opportunity to speak.

The CHAIR: Would you like to make a brief opening statement? If you want to give your background at that stage, that is fine, it is probably quite appreciated, and an opening statement about the health review.

Ms KRUK: Just very briefly. I have a background that covers both service industries, having been CEO of New South Wales Health for five years, and regulatory agencies, having worked at both commonwealth and at state level, and also having been a central agency head as head of Premier and Cabinet in New South Wales. I was appointed for the fact of my independence from the WA system to, in effect, chair a panel with a number of people who are very familiar with the Western Australia health system and its key components, staffing and the interfaces.

The committee is also aware of the fact that the panel is supported by a number of reference groups, which I am happy to touch on, but my independence also means—you would not be surprised to know—that I do not have detailed knowledge in each and every issue that you as committee members would have, so please be patient if there are details that I do not have to hand, but certainly I have intersected with the WA health system for many years. Premier Barnett had me chairing as an independent chair the Partnership Forum, which brought together government agencies and key non-government agencies in the human services and health care delivery space.

I am very pleased to take on this role and the challenges that go with that, but also the opportunities involved in it as well.

Happy to answer any questions; I will give it my best for you.

[10.10 am]

The CHAIR: Could you give us a brief run-down of the Sustainable Health Review?

Ms KRUK: Yes. The review, as members know, was part of the government's platform when it came into government to undertake a sustainable health review, to do it in a very inclusive manner, to provide opportunities for the very many stakeholders and partners that intersect with Health, but—I think equally and probably vitally significant—to give a chance for people who rely on the health system to have their input as well.

I think what makes the review powerful is the depth and the level of engagement we have. It was unheard of—from my perspective—that we received over 300 submissions to the review, and they

were not just single pages: they were comprehensive and very detailed submissions where people shared with us both their frustrations and also where they saw there were opportunities to improve the system. A very strong push on a number of issues.

The way the review was set up was in two stages. We were asked to produce an interim report which reflected the feedback that we got in the consultations. We did 19 forums across the state, a huge number of face-to-face meetings as well, and the interim report was intended to give people a chance to say: have we got it right, have you honestly conveyed the issues that were conveyed to you, and also to do a reality check in terms of the series of directions that we were proposing to take in the final report.

We have just finished going through all of the feedback on the interim report. Can I say, it has been a resounding support for the directions being taken. Not surprisingly, people come together on the desire to improve patient outcomes, population health outcomes. There are differing views on how that can be approached, but that is not unusual. A couple of things come through quite clearly. People do not question the need to actually have a reflection point and to look at the issue of sustainability. They do not question the need that things need to be done differently. People have used it as an opportunity to highlight where WA has done some amazing work and to ask why we are not doing these things in other areas. They have identified areas where they think that WA needs to do better, and I think we have picked up those issues in the report. So it has been a reaffirming process.

What we now need to do for the final report is to pick the key elements of ensuring that Health actually progresses on a sustainable path. Members are very familiar with the work that WA Health has already undertaken in the last few years in terms of looking very solidly at its financial impact on government. The rate of growth, very simply—I know you are familiar with the report—is unsustainable. Had the trajectory continued on the path that it was historically going, in the next half a dozen years you were facing a situation where Health would consume 38 per cent of the budget. That is not sustainable. People accept that and come from that point.

The issue is to really look at—in the final report as we did in the interim report—is that sustainability is not simply about money. Sustainability is ensuring that you have good patient outcomes; that actually gives a voice to the people who rely on the health system, and it also recognises that the people who work in the health system are the pivotal agents on that basis.

This area is unique. I know from my own time in Health that often the issues that are the most frustrating and annoying from a patient perspective—and we are all patients at one time or another—also tend to be the areas where there is the most significant potential for waste, and also for injury and avoidable incidents to occur, so there is a nice alignment with where change needs to occur and where people are the most frustrated in relation to the current delivery system. That is a positive.

The challenge is, as in any reform, that Health is an incredibly busy system. The issue is that we are putting in place and working very closely with people working in the sector, partners and the people who rely on Health to realise that there is a system that needs to change consistently over quite a long period of time, but against the backdrop of the fact that they still have to deal with the day-to-day challenges and continue to provide quality services. The final report, due in November, which I think the minister has indicated, will identify what are the key anchors in relation to keeping Health on that path of sustainability.

Does that give you a backdrop? I want to give you the time to ask me questions.

The CHAIR: You said there was some amazing work and there are places where they could do better. Can you give us a couple of examples of where there is this amazing work that could be translated into other sectors of the health system?

Ms KRUK: It is interesting. I will give you a snapshot. There is no doubt that Western Australia led in a number of areas. You were one of the leaders in population health for many years. The work you did in smoking led to work across every one of the other states. No question about it: you have a strength in relation to the linking of your data; you have an incredibly strong scientific community. One of the clear opportunities is to line those issues up far better and actually to build on areas of strength and to take those to the next step.

It is no surprise that in our interim report one of the issues that we identified as the first direction is to focus on keeping people healthy rather than just focusing on the acute end of the system when they are no longer in a state where they can survive comfortably and ably in the community, so going back to WA's strength in relation to population health and really making that ideally a bipartisan and enduring approach over time. You have some amazing work underway and there are some amazing case studies that were given at the local level as well.

You have led and are leading in a number of areas in relation to shifting the model of care to making it more focused around the patient. At the moment, Health, as you know, under the National Health Agreement, rewards volume. An activity-based system basically ensures that health systems at the end of the day are very focused on activity. The challenge—we have picked up on it in the interim report and in the longer report—is how you start the journey of actually looking at the quality rather than just the volume, so value versus volume. It is looking at those elements.

In the last 48 hours I have met with Aresh from the East Metropolitan Health Service in relation to some of the work that they are doing in relation to the interface between the hospital and the homeless community, looking at how the journey of someone in a troubled state into the acute system is managed effectively back with primary health care. It is quite clear there are opportunities and models that can be rolled out in different areas.

I met this morning with the CEO of the College of GPs to look at opportunities in relation to improving the exchange of information both from a referral from a GP into the hospital system, but equally—if not more importantly—a patient's journey back out into the community, back to their GP, because, having spent three hours yesterday with mental health consumers and carers, that journey is not as good as it could be.

If you look at the statistics, I think up to 60 per cent of GP visits in some way or other have a mental health component. That is worrying. In effect, they can become invisible when they go into the acute system, and lost back to the primary health care system when they are in a state to be able to operate independently back in the community. It is those journeys we need to look at. WA is not unique in that regard. It is a challenge of the way the health system is funded, but it is not a reason to allow the current situation to continue.

I have only touched on those. You will be more familiar with your good experiences in health care and some of your challenges.

There is a consistent message from people who use the health services: Treat us with respect. Look at us as people. Look at it from the perspective of our needs rather than who the funding body is. If I look at it, the simple issue—and I have struck it as well—is the number of times that you are asked in Health to get the same test carried out by different parts in the health system, and the difficulty you have in getting your own health data does not make it easy for people to look after their own health care. The frustration about access to data, the transfer of patient data between one part of the health system to another, is wasteful. It does not respect the fact that you actually own that

data at the end of the day. It makes it hard for you to know how you can manage your own health care better. There are massive opportunities to deal with waste and poor care, potentially.

[10.20 am]

The CHAIR: That sort of model is very much that idea of the NDIS model and the new aged care model, which is much more client-driven. Is there a possibility of making Health client-driven? Is that what you are saying in terms of the Sustainable Health Review? That client-driven aspect of it, which is: I own this, you are not going to over-service me, you are not going to send me for another MRI, you can get that MRI from someone else, you are not going to ask for another blood test, you should go and look at the blood test that I had done at my GP. That is much more that client-driven aspect of things.

Ms KRUK: You have hit on a really good point here. Two things: this is one of the terms of reference for the review; the issue is to make Health more patient-focused, so the ambition is the same. One of the challenges—and they were raised by many of the consultations, both from a provider perspective but also from an individual perspective—is that you have three major systems that are funded on quite a different basis, whether it be aged care, Health, which is universal access or the NDIS; they are all complex systems. It was raised quite consistently—the expectation that you have to make it easier for us to operate across those systems.

You would have noticed in the interim report, only as a very simple step, the concept of actually having far better navigation between those systems. On the whole, most people would be making contact with two of those systems at any one point in time, either in relation to direct family members or yourself. What has struck us—and it is picked up in the interim report—is that within those systems, the rules around both aged care and the NDIS are complex, and even the providers do not necessarily understand the interfaces as well as they should. That is a very simple improvement, but a necessary improvement, because the reality is that one in two of us have a complex problem, a chronic problem, so we are likely to be touching on two of the systems at any point in time. It is a matter of making those things work a lot better. All of them share a focus on the person, because that is obviously the issue that brings everyone together. At the moment they are very big systems that do not intersect as well as they could, but there are opportunities to make that happen.

Mr R.S. LOVE: Something a bit more specific. I represent a regional area, so I will ask questions on that area more than others. In the discussion about regional health there are two key aspects. First of all, there is talk about the expense of operating small hospitals in country areas. I wondered whether the review is looking at some of the work that WACHS did in trying to get away from having the traditional hospital in small country towns, where there are not acute services provided. There might be a bit of A&E and probably aged care, and nothing is actually being done in terms of kids with diseases, who get sent off to other communities.

There are really three aspects to that. First of all, do you have a view on the definitions of "small hospitals"? With those definitions come some expenses and some funding commitments and also some funding streams. Is it possible to move away from that to a more efficient health site than a small hospital? Secondly, I suppose, the use of telehealth and other technology, whilst that has been very successful in being able to provide care at the remote place, I understand there are some funding problems in terms of getting money through the Medicare system for some of those services. Is the review likely to try to capture some of that, and try to find ways—not just the existing telehealth service but expanded specialist services or other technologies that might come along that we do not have at the moment—to ensure that we are not penalised by having a remote population that is being serviced in a more innovative way than a traditional face-to-face meeting with a medical practitioner?

Ms KRUK: Really good questions. I will try to make sure I cover all of the aspects of it. Yes, we are well and truly familiar with the data and the work that has been undertaken by WACHS looking at some of the challenges and the costs that go with the smaller country hospitals. In New South Wales Health, I think we had something like 120 hospitals of all sizes. Secondly, I think this review and these discussions are underway at the moment with WA Health, and it has been very handy that this review is happening at the same time, with the Independent Hospital Pricing Authority actually ensuring that there is greater recognition in relation to what some of those costs actually are, because they are unavoidable in many respects. That was clear from my experience in New South Wales, and I think there is a growing recognition with the Independent Hospital Pricing Authority about the legitimacy and the extent of those costs. That answers that part of it.

I think you are raising a more complex question about what the role of small hospitals actually is in future health care delivery. Both in New South Wales, and also I am an independent person on a US philanthropic health body, you are seeing significant changes in how the sort of services that are being offered from small country health facilities have actually changed over time. I know that WA is considering that and has already done that in some of the areas that you would come from, where all of a sudden your interface with aged care is significantly changing, and the role delineation of that hospital is also being modified. The clear message is, yes, that needs to be done, but it also needs to be done with the local communities. We had feedback from many fronts: just talk to us about it. Give us a sense of what is actually possible in relation to staffing; what is possible in terms of safe and quality staffing as well. I come from a town of 400 people in New South Wales. It is the desire to actually know what is happening, to know what you can get locally and where in effect you are required to login to the bigger health system as a whole to get those sorts of services. So a strong push from a participant level: talk to us openly. Have those discussions with us, not just around us.

Health is the default provider for aged care services, as you know, probably in your community as well. Yes, that is in our scope of the review. We are hoping to get some time with the federal minister, Ken Wyatt, in terms of looking at that aged care interface too, because WA has some unique challenges—I need not tell you that; you know that as well—in terms of access to GPs in some of those areas, but also access to aged care beds, so we have to look at that intersection between Health and aged care.

In New South Wales the health facilities have changed over time quite significantly in relation to the services that are being offered locally, but our interconnectivity had to change too in relation to access to far more complex procedures and having the networks in place at local levels with metropolitan areas to do that. So, yes, that is in our scope.

If people point to areas that it has worked well—can I say, your Aboriginal-controlled organisations are at that table too. The discussions in the Kimberley—and we have touched on the need to look at a regional commissioning approach in some areas—has to be done with the commonwealth; has to be done with the Aboriginal-controlled health organisations; and I think it has to look at building up capacity at a local community level, not relying on a fly in, fly out model. We have heard a lot of examples on the frustrations and the costs that go with that. I know I am skipping over your questions. Yes, it is in our scope.

Telehealth: you were one of the leaders in this area. The reason we pushed that machinery early on is we heard very clearly from clinicians that a lot more could be done in that space. The evidence is really strong. Certainly, from my own personal experience, we trialled psychiatric telehealth in Broken Hill. I will be frank: I was initially a little bit questioning as to whether it would work. It was incredibly successful and incredibly well received, and it increased people's access to psychosocial health services that they were not getting at all. That has been a model across a whole range of other areas in New South Wales.

Similarly, the feedback we got from clinicians is that there are so many opportunities to build on that telehealth initiative. It is not a replacement for the need to have face-to-face in a whole range of settings, but it has improved access in so many areas. The US has also done it as well. There is a lot of opportunity to build on the virtual health experience as well, where you connect smaller facilities with bigger metropolitan facilities so that you have access to very specialist clinicians when you need it, and I know that that is coming up through WA too. The evidence base is solid on this. Fiona Wood gave a very impassioned statement about the things that she had been able to do using telehealth-related devices. The impact has been that people who would not have been receiving care, or they would have lost two days at work—the young woman we talked to who had quite extensive damage said, "I would have lost my job had I had to consistently go to Perth to get this care." She ran us through how her treatment process was dealt with on those mechanisms. It is unbelievable what it can do.

Mr R.S. LOVE: Did your review highlight any funding difficulties associated with that? Is there a strategy to which you can point to actually change that?

[10.30 am]

Ms KRUK: What we have underway is to look at a lot of the cost benefits of doing that. A number of people have said you need to be able to demonstrate what the impact is in relation to patients, but also at the moment you have significant costs associated with the transportation of people, and the risks and the disruption and the economic impacts of that happening as well, so there is a need to get the business case for that strengthened.

Connectivity is an issue. That arises from a number of capacities. That is a harder, longer-term issue.

I want to go back to your other question. In many respects—and this is one I know the health minister has firmly in his line of sight—Western Australia should not be penalised for the fact that it is employing different types of service delivery through telehealth rather than relying on traditional consultations face-to-face with a doctor. I am never privy to the details, but certainly discussions are underway between WA Health and the federal health department looking at how we can get greater parity in relation to different treatment means. That has to be a consistent argument that recognises WA's current supply issues. Your access to the MBS and the PBS is considerably lower than other states. That issue is something that we have certainly highlighted and will continue to push in this review. Have I answered all your questions?

Mr R.S. LOVE: You have. I might have some more.

Mr W.R. MARMION: I will try and bring it to the higher level. I worked for the Minister for Health in 1993, Peter Foss, as chief of staff, as an engineer who knew nothing about health and after two years I did not know anything more about it either! We met the commissioner of Health every single day, because our office was in the Health Department. He always had four people behind him as well, because it is just too big for one person to be across the detail.

I was the shadow minister last year for Health—I tried to avoid that area but I got it!—and I drove to Kalgoorlie and saw the new hospital there and I was actually blown away by the systems in place: IT, telehealth, the wards, what they do for people with blood transfusions. I am just giving the background because I can see lots of improvement in IT. However, if we move to the big picture, you have other inputs such as doctors' fees, and they are part of the system, and they have their fees, and you have the AMA as another input. The strongest union probably in the world is the Western Australian AMA. That is a high part of your cost. If you get more efficiency through the system, which I am sure we can do, it is like a bed—let us use the medihotels as an example; I can see we can do this—you free up the bed, but if your input, in terms of dollars—this is your budget—and now there are free beds because you are more efficient because you got the patient through in

one day instead of three, and then you fill the bed, you need more money for that. So it is the inputs and the outputs in terms of the dollars. I am interested in how you solve that?

Ms KRUK: If you look at it traditionally, health systems have been judged on the number of beds in terms of whether they were successful health systems, and it was considered to be a measure of success. When gaining an understanding, actually, of both quality care—what a patient wants, and, in effect, efficiency—the ducks line up in this case. No-one starts their day with a hope of ending up in the hospital at the end of the day. The issue then is also the costing factors, as such: so much care can appropriately be provided in the home or in the community, hence the importance of the GP. But if the assumption is that success is actually having a hospital bed, then that skews the equation, hence in our report we are saying that health is more than hospital beds. The issue is then to have an understanding of what services make a difference.

My father-in-law passed away in the last 12 months. He was 91 and he did not want to be in hospital. The default setting is, of course, for an elderly person to go to hospital when there is an emergency incident. The coordination and certainly the assistance was there to provide wraparound services for him in his own home. They were largely social care services; they were not health care services, but he had nursing services. That was his desire. We had to be clear on what his intentions were, so those discussions from a personal perspective are really very important, and then, in effect, to be quite clear with the health system that his desire was to be in his own home. I feel for emergency clinicians, having done a number of sessions with our clinical reference group here. They say that at the emergency department is the wrong time to have some of those really personal discussions about what level of care you actually want to receive. My father-in-law did not want further surgery, but that was a lot of discussions at the family level and him making it quite clear. That was not something that needed to be made and should be made in an emergency situation. The complexity of what you raised is really important. It is actually having an understanding of what the person seeks—having a better understanding—and allowing the services to grow at a community level at the right time, but with the confidence of knowing that when you actually need emergency care and that the sort of care—WA has amazing hospitals. You are blessed. You have had considerable investment in this area. The issue is that the solution is not more and more hospitals. It is not sustainable; it is not what your community is asking for. The issue is to actually make that system glue together better between the community level—the acute system—and also what people are asking for.

Mr W.R. MARMION: I agree 100 per cent: that is the solution. When I worked for Peter Foss, about four expert researchers from a London university came over, and they said, "You build a hospital and they will come." Therein lies the problem. To unpick what we have, I agree, you have to get more services in the home, but you have hospitals and they have beds. The person running the hospital wants somebody in the bed because they have to run the hospital. So if you want some runs on the board early you will have to have some hospital beds free, because you do not want to use those beds, because the person will be at home. Therein lies the challenge.

Ms KRUK: The challenge is a real one, and that is why we have been clear that it is not as simple as more beds. If you look at it, Health provides a whole range of other step down, step up–type facilities that do not rely on the complexity and the cost of an ICU bed—which you will know from your time is an incredibly expensive facility—and Health does provide a range of other services which are less acute, less intense and which, in effect, seek to avoid the need to be in a hospital environment.

If you look at the statistics in WA, what is scary, is your ED attendances are increasing by 49 per cent. That is unbelievable. That is incredibly scary. If I look at your admission rate, that is increasing by 39 per cent. But when you start to break the numbers down, actually what is the reason that people

are turning up at those hospitals, so many of them are avoidable because they have to do with weight-related issues and alcohol-related issues. There are a whole range of interventions that need to be undertaken now, because otherwise you will have a tsunami which is of such a scale it is—both from a personal, human perspective and from a cost perspective—not sustainable.

The other issue comes back to why so much of what we are looking at is the interface between different systems. I saw some amazing stuff in New South Wales on what you can do to avoid the need for hospitalisation. Dieticians were actively working with people on the waiting list for knee surgery or for hip surgery, and the number of people that did not require surgery because of the active work being done on their diet was amazing. It had good health outcomes anyway: a number did not need surgery, but it also meant that there were better surgical outcomes as a result of them being of a lower weight. So it is not one thing. You are right: if you build a hospital, you are saying they will fill up. That is why the solution is not as simple as building more hospitals.

I look at it historically: you have had a lot of money put into building hospitals. The issue is now building capacity in the right place. We have also been quite frank. You have some hot spots in the system, some pressure points, and we need to move capacity around the system, but WA is not unusual in that regard.

The CHAIR: Can you go through the weight and alcohol-related issue, and that New South Wales has a different approach from Western Australia to obesity in the hospital system?

[10.40 am]

Ms KRUK: A couple of things. I know the current government is looking at what will be the outcome targets to guiding the sector. Over successive Premiers—I have worked I think for seven Premiers in New South Wales—we have had the commitment developed to have outcome targets which are the Premier's priorities. I think this has actually bridged both Labor and Liberal governments. One of those is actually the reduction of obesity. I remember every one of the health bureaucrats had that afeard look. They said, "It's too hard; why are you asking us to do this; this is one of the toughest ones to actually tackle." But successive governments had recognised that this is one of the ones that really are one of the most significant issues to address in the longer term. This is not just about Health. That means that Health had to partner with Education; Health partners very strongly at the local level with local government as well. What it has basically meant, each of the different health entities—local health districts for us in New South Wales—actually has a population target; they know what the demographics are in their population so that they are working on solutions that work in the local area. There is no order from Sydney about, "You shall do it like this." There is, "This is what we want you to change." This is hard. They have been able to successfully slow the rate of growth, which is actually already a significant change in its own right, but there is no one agency that can do it on its own.

Very strong interaction at schools; very strong focus on people getting a better understanding; also in their pregnancy phases of their life about the impacts of mothers carrying too much weight; so really dealing with it at all aspects. It is a responsibility and it is a priority for the state.

I think we looked initially at the New Zealanders in terms of how they had done, we learnt some of their lessons, and certainly in the interim report we said: this is really important. That is probably what has changed the approach. If I look at—the one I always smile at—in New South Wales, Wellington, a small township, the way they approached it, they said, "Our aim is to lose one tonne of weight." That was driven by local government and it became such a strong focus, all of a sudden their planning at a local level was changed in relation to more opportunities for people to exercise. It changed and it is changing behaviour at all different levels of government and of that community. It also showed that the government cared.

The CHAIR: In terms of acute care and going into hospitals, is it the practice now in New South Wales that any acute care has that aspect of a dietician being attached to acute care?

Ms KRUK: It is not mandated. In New South Wales—a bit like in WA—a lot of things are tested in one particular hospital or health entity. We then do an assessment in relation to whether it is scalable; whether it can be rolled out more broadly across the system.

Health is very competitive. People work in Health because they care; they are after different, better ways of doing things, the same as in WA. What we will be proposing in the final report is we will identify some really exemplary models and ask the question: what is stopping us rolling this out more broadly?

What we have learnt in New South Wales has been the same experience in Victoria: set the right ambition, the right outcome; let people be creative, give them a licence to try different things and to test it. It has been that sort of model over time.

The CHAIR: What is the penalty if they do not make it? It is great to set ambition, but if it stays the same, where is the penalty? Is the incentive only in setting it?

Ms KRUK: In terms of having been both the head of Health, and having also been a board chair at various points in my life, these are commitments in your performance agreement. We had to front up on a very regular basis to a meeting of the senior ministers: What is the progress? Why have you not done this? Why have you not done that? You are judged on your performance as a board on the basis of whether you have actually achieved that difference. We know what the ultimate sanctions are in that regard—your responsibilities in the health system.

The issue is there was a clear message from government that this mattered. If I go back to where I started, you have a health system where the commonwealth state payment rewards activity, so all of the health systems are looking at different ways to actually move to value of care, and many health systems—New South Wales is one of them, where we have population health targets and particular population health challenges, actually, as a target right across the health system, but it is actually across government.

Another simple example is the police chief and I were jointly accountable for the reduction of alcohol-related violence. That was something we were judged on, and if we did not make progress, that was a reflection on our managerial ability. We made progress, I can assure you.

The CHAIR: That was mostly to do with lockdowns, is it not?

Ms KRUK: No, to the contrary. Again, it was done in different ways in different parts of Sydney and different parts of the country. It led to a whole range of different practices at a local level between the police, between Health and between local government, and quite different policies grew up. I think the one that attracts all the media is the lockdowns around the CBD. The irony is that I live between two 24-hour trading pubs. It is a significant impact in relation to how they operate. At a local level it has made a really significant difference, but again it came back to the identification of an outcome target about things needing to change. Big issue for me in Health: I had staff that were being physically attacked in emergency departments. We could see the trauma data; we could see the cost for the individual and from the police perspective similarly. No, we do not prescribe how it is done, but we prescribe the areas where we want the change made.

I think this is my understanding from having read some of the policy documents: that is not an inconsistent direction being followed at the moment here.

The CHAIR: Apart from that, apart from some of the things you have talked about around the waiting list for knee surgery and people getting dietician treatment, that is a difference you have identified.

Ms KRUK: I just gave that as an example where the acute system is putting its hand out there and saying, actually, yes.

The CHAIR: Where else does the WA health system differ greatly from New South Wales? In terms of health system costs, the New South Wales system runs at less than the Western Australian system.

Ms KRUK: We have identified in the report that your wages are higher; I just make that as a statement of fact. I think it is not as simple as making a comparison between any health systems. It is looking at the evidence of what works in different health systems and actually looking at what is translatable; at the same time, it is looking at what works in WA already. What specifically do you want me to focus on? Just go back to it, sorry.

The CHAIR: Specifically in terms of cost.

[10.50 am]

Ms KRUK: Cost: so in terms of where WA is different? There are a number of areas where I would say it is different. You have a focus on outpatient service which no other state is doing any more. A lot of the care that is currently provided in the outpatient setting in WA is provided in primary health care in every other jurisdiction. It is getting a better understanding of how that change can occur over time. There is obviously a long history here, which you would know—more so than me—but it is actually looking at how we can look at some of that care being provided in a better setting. There is a lot of data about some of the challenges that are being provided in the outpatient setting in addition to cost, because someone may be seen only for one part of their problems, whether it is a hip problem, and their other health challenges are not being considered at the same time.

The CHAIR: Apart from anything else, they have to pay for the parking.

Ms KRUK: The parking is the most frustrating. The issue is to look at what can be done in that space.

The second issue, your workforce. I am meeting with the universities, I am meeting the AMA, all parties on this sort of basis. The models of care have changed quite significantly in other jurisdictions and internationally.

The CHAIR: Many more nurse practitioners?

Ms KRUK: Nurse practitioners, but also recognising that, at the moment, health care workers are actually asked to do a range of work, which is often social care, and that is frustrating for them. It is not a good use of their skills; it is also the most costly approach. It is ensuring that the right care is being provided by the right person, so health and social care need to be looked at, at the same time.

The other issue, I have seen some of the most amazing models of service delivery in an Aboriginal-based organisation where they had dental assistants very actively involved in communities; where they have grown new professional groupings that are actually able to provide care, most often under a physician-led model, but in effect have changed the scope of work. There is a lot of opportunity for WA to do that. I know it is politically sensitive, but no change —

The CHAIR: Is it politically sensitive because the medical profession in Western Australia dominates the way our health system operates and they push against the change in status quo? For example, they push against midwives and home births and things like that. Is that an issue?

Ms KRUK: WA is not unique in that regard. I can remember having very similar discussions with the AMA when we rolled out nurse practitioners. We agreed to differ. We were very strong in our commitment to providing quality care; we were strong in our commitment to providing increased access in communities that were not getting any care. Basically, that is background now; it is a proven model of care. There are a range of things. In Queensland as well, they have taken some

real leaps and bounds in relation to providing care in more remote communities because they do not accept the status quo. They are changing.

Mr R.S. LOVE: Can you point to examples in Western Australia where nurse practitioners are being used efficiently? I have seen attempts by WACHS and others to use it in the regional areas, but invariably they come up against some institutional barriers and it falls away.

Ms KRUK: It is those institutional barriers, but it is also using nurse practitioners in the right locations. That is the feedback we have had. The other issue: nurse practitioners are not a panacea. The issue is to look at the right person to provide that care. I look at changes in relation to remote workers actually in the allied health space, looking at giving someone who may be a physiotherapist some additional training to expand their scope of practice so that you do not have three health workers and associated infrastructure turning up to provide care, even if it is units in relation to dieticians or a speech component. That is fundamentally changing the role of workers. It is interesting: we have a round table in July bringing all the parties together. There are a range of things that need to be done within universities. Health needs to be more strategic in saying, "These are the workforce models we need." It is the major purchaser, and Health is the biggest growth area in terms of jobs. Health needs to be quite clear where it needs a different type of employee to provide the right care.

The CHAIR: That is great, so you are suggesting that Health actually say to the universities, "This is the outcome we want." We tried that in the educational space. We tried to say to the universities, "Actually, when you are producing your teachers, you should get them so that they have qualifications to teach trades, to teach vocational education training in schools", and the universities told us, "Don't tell us what we should be teaching our students."

Ms KRUK: I have had some very encouraging discussions with the three universities. The issue is as much from their viewpoint to be confident that they are actually producing the workforce that is needed for the future. There have been a lot of studies in the last six to 12 months looking at the extent to which students coming out of university are fit for purpose for the workforce. That worries the universities—let us be honest—and so it should, but at the same time Health needs to actually have the necessary discussions in relation to what it needs going forward.

My niece is a radiation therapist. She knows her job will probably have about two more years of life left because AI will come out and do most of the analytics. I said to her, "Has Health spoken to you about that?" She said, "No, I am actually voting with my feet." She has changed her profession in anticipation of that change.

It is not a criticism, but WA Health, because of some of the isolation, is in a very powerful position to be able to say: this is the sort of workforce we need in going forward. The universities are asking for that. There is not a university that is not concerned about the loss of WA graduates to the state, and also the frustration into providing a workforce that becomes readily employable within WA Health. Health is a powerful employer, and it needs to ensure that it is clear in relation to the sort of workforce it needs going forward.

The CHAIR: Shane asked a question about the nurse practitioners, and you were just talking about some examples in Queensland where they do some innovative stuff in remotes in Queensland. Can you expand on that?

Ms KRUK: Yes, the Queensland government moved very quickly to actually look at what needed to be done in relation to both the GP space, and I cannot remember the title that they gave it, but a fast, stronger GP procedure role—members will be familiar with that—but recognising the sort of skills that are needed in country areas and putting a lot of emphasis on that. They moved very quickly, also recognising the fact that you need far more multi-skilled workers, and to look at that

intersection between the health and social care workforce, because you only have a certain number of people in those areas that you can recruit anyway, so you want to make sure that they have the right skill set.

They have done a number—and we can give you a bit more detail as we go along, no doubt we will be talking again. They have been very good at developing a systems position, making greater use of current scope of practice, but actually questioning: are people in their current roles actually performing at the top of their scope as opposed to being required to fill a lot of positions? There is not one easy role on it. I know from my experience in New South Wales, Aboriginal midwives—and that grew in my time as director general—had one of the most profound impacts in relation to outcomes with Indigenous children, and we underestimated the impact of those, because actually the mother's health improved; we were able to impact positively in relation to smoking. The impacts were at all levels, in relation to a child meeting milestones, but also every possible indicator. There was the resistance to that particular role being developed as well, but it is again looking back at evidence continually and looking at whether you have the right skilled employees. We had to very actively recruit as well. We had to create quite different pathways from local communities into training. Broken Hill kids did not want to come to Sydney for training as an EN, so that was working very closely with the universities and totally changing how we pull people into the system. So there is not one strategy.

We understand your concept of distance here too: the traditional model of come to Sydney to go to university or VET colleges was not working. We were not getting the right staff. We tried having bachelor and spinster balls in terms of trying to get people to stay in local communities, but ultimately we had to change roles and responsibilities in relation to the health workforce.

Ms S.E. WINTON: We were talking about the workforce. I note in the report that a lot of submissions were made around the culture in the workforce, particularly nurses, and there are some recommendations around that. Can you elaborate a little more on that aspect of your work?

[11.00 am]

Ms KRUK: It was one of these ones, I struck it, and it is still an issue in the New South Wales health system. Speaking in relation to my role as board chair of Ambulance, culture is so significant. We had very frank and open discussions with staff at the various forums, it came through in my survey feedback as well, the need for a couple of things—leadership, and also the need to give staff the opportunity to engage. I mean, that came through in various forums. I know you have had surveys from various sources as well that have highlighted it. It is important. We have signalled in the interim report. I look at it in New South Wales. We report regularly and openly on culture and an engagement survey right across the Health workforce. As a board chair, that is one of your most pivotal indicators in relation to where your focus needs to be in an organisation. If you do not have engaged staff, they are a direct relationship in relation to patient outcomes; this is an area where those issues are very closely aligned, and we think there is a place in WA to have a stronger series of measures to ensure there is that sort of engagement. Culture is challenging in health systems. It is not unique to WA, but it is an important part of the sustainability journey.

It is no coincidence that one of the four pillars that we have picked is staff. That is evidence-based. That is critical in terms of driving innovation. They need to feel that they are part of the process; they need to feel that they can lead it. At the end of the day, I very rarely had a situation where I struck someone who does not desperately want to work in Health to do the right thing and to make sure that that line of sight is maintained with staff. It is critical.

Ms S.E. WINTON: In terms of retaining the staff too, because there is a cost to constant—

Ms KRUK: Absolutely. I have seen the numbers in relation to costs to train our clinical staff, particularly in WA, where it is more important in terms of attracting staff as well.

Ms S.E. WINTON: So you see that as an issue that desperately needs—

Ms KRUK: It is one of the four that we have picked on, but it is an ongoing journey. It is not unique to Health. The issue is to show that this is a really important part of the sustainability journey. Health is about people; it is about the delivery of services often to the most vulnerable members of the community. If you do not have an engaged staff or you do not have a means of picking where you have some issues, you have potential challenges from a quality and a safety perspective. No, critical.

The CHAIR: On staff, critically for me, part of the issue—and I am wondering whether you are looking at sustainability—is the ongoing use of contractual staff in the public sector and so the uncertainty for staff in terms of that. Is that within your scope?

Ms KRUK: Clearly, the unions are one of our stakeholders as well. The issue that comes up in many instances, the current recruitment processes are incredibly slow. There are significant opportunities to look at the red tape, without in effect affecting the integrity and the merit-based process. Some of that is IT; some of that is rules within Health. That is why we have picked that particular issue. There is some good work underway to look at condensing that. There is no doubt that you could make a lot of improvements to ensure that you have appropriately skilled permanent staff as well.

The contract situation often arises because of the delays associated with those recruitments. There is not a staff member that would say to me anything but that job security is important to everyone, you know what I mean? So it comes up in many fronts. There is no doubt that contract labour has additional costs associated with it as well.

The CHAIR: I am not talking contract labour. There are incidents of people being on rolling contracts for 10 to 15 years—not just in the public health system, in the education system as well—and asking someone to be on a contractual rolling relationship when clearly there is a position that they are filling on an ongoing basis. I wondered whether that is in your remit, because again it is bound by that idea of—I think you said it at one stage—activity-based, or it is bound by: this is the activity ceiling even though this is the outcome we require; we will just have a contract worker for 10-odd years.

Ms KRUK: Yes. I come back to this: Health is in a journey of change. There is no doubt that the positions that it will need in five years' time and in 10 years' time will actually have quite a different skill set than is currently available in many areas. So you actually want the flexibility to be able to change the skill set of your workforce. I gave the example of my niece. It is necessary to reskill her in terms of another set of skills rather than to keep her on a contractual basis, so you would not want to do that, you know what I am saying? But you need that sense of what it is you need in the future. There is no doubt that Health needs a staffing set with the appropriate capability. I will be frank: a focus on FTE is a crude focus in relation to looking at getting the right mix of your workforce. I will say it here; I would say it in any other inquiry as well. As a health administrator, you need to be able to have the levers to be able to get your most productive high-quality workforce with the right skills. It has come up I think in nearly all of the submissions from the Health entities; it is an issue where everyone accepts that the current situation is not ideal and we need to put some solutions in going forward. That is having more flexibility.

Mr W.R. MARMION: What you are doing is really important, because you have to do it, and we need to change the system, we need to try and get things working better, people talking to each other, all the different silos. One of the areas which unfortunately for me I see as a growth area, and it is going to be difficult, is mental health. I think we have only dipped a toe in the water there, and I can see if you have success in what you are doing in mainstream health, you will find that the space

will be filled by servicing mental health. My question is about sustainability and how the system can work on that.

Ms KRUK: Yes, it is firmly in our line of sight. As I said, I had three hours with stakeholders in mental health, and also with the Mental Health Commissioner Tim Marney yesterday. The reality is that people do not just touch the system in relation to mental health; they have a whole range of other issues, so you really do need to look at that from a personal perspective. WA statistics in mental health are no different from any others in relation to its incidence. The issue is that because of the vulnerability of that population, you need far better structured processes between the community and the acute system, and you really need to be confident in relation to the level of support early in the system.

What gives me comfort, I set up the National Mental Health Commission in Australia. Mental health enjoys a bipartisan support in most governments, and the fact that you need an enduring approach to mental health to actually build that capacity up in the community level. Every jurisdiction is in the same basis. WA led by setting up a Mental Health Commission and in effect recognising that and being quite assertive in doing that, but your challenges are still ahead, in many respects, to be able to continue that journey and to understand that that intersection is even harder. People on the whole normally do not just have mental health issues, they also have physical health issues, and you do not want to lose sight of that. Yes, it is.

Mr W.R. MARMION: The management of that is complex and requires hands-on, and if you do not have people in your family that can do it, it is a lot of work for the Health Department.

Ms KRUK: Yes. It is interesting, in New South Wales, under Premier Iemma, the reality is we had a whole-of-government approach to Mental Health, very clearly, because housing was as critical as the quality of care. There is no benefit in having someone receive appropriate medication if they are sleeping rough. We dealt with it on a whole-of-government basis.

Mr R.S. LOVE: You have identified in the interim report areas for further work. How will you address those areas for further work generally? For instance, in the rural health area you have identified safe systems of transport; you have identified arrangements for people in regional areas; association with metro hospitals et cetera as an example. How do you see that progressing? Will it be finalised in the final report?

[11.10 am]

Ms KRUK: Yes.

Mr R.S. LOVE: Are there recommendations to these areas?

Ms KRUK: The final report will actually pick some of the key areas in relation to sustainability. We signal a lot of that work because it is work that is underway or is pivotal in going forward. You touched on telehealth. You cannot really look at telehealth without looking at the associated transportation issues as well, because that is a question that is most often asked at the same time. If we increase telehealth, can we be confident that people will no longer have to travel backward and forward? That is actually requiring a current behaviour change. In some instances, clearly the transportation issue is the only option, because you have your specialists, your top people in Perth, to actually make that transportation work better. They were issues that we picked up in the submissions and in the approaches from various parties, that that is stuff that really cannot be forgotten in going forward, but the transportation issue is part of it.

This report will not replace the need for detailed planning in a number of those areas—that is quite clear, but some of those issues we will say are important to be done immediately. As I said to you,

we are doing some business case planning at the moment for this review in relation to telehealth versus other means as well, just to strengthen that case.

Patient transport is not unique to WA. The issue is to look at where the opportunities are to make it work better; perhaps have different relationships with either the Royal Flying Doctor Service or between the metro hospitals and some of the country hospitals. The other issue is again to grow capacity at the local level. Health is a major purchaser. I come back to the fact it is one of the biggest agencies in government; it is your biggest spend in the budget, to actually look at how you strategically use that spend in terms of trying to get some stuff at the local level, and that means working very closely—I am now talking remote Kimberley-type stuff too—in relation to how you build that capacity up at local level.

I am very familiar with the work of Grahame Searle in the Communities role and what they are doing. That is doing a lot with what is on the ground, but also looking at the sustainability and building up that capacity of what is on the ground.

Mr R.S. LOVE: In remote areas, there may be nothing; in other areas, St John does a lot of that work. In locking in that one provider, which is a particular model of transport, it seems to me to be an excessively expensive way of doing things. You were talking about opportunities at a local level; I wonder if there is not an opportunity for other providers to be involved, but that is not going to happen when the government sets out years ahead that it is going to exclusively use one provider.

Ms KRUK: I am not familiar with the background of the contracting. My commentary would be, again, because Health is purchasing or commissioning that sort of work, it is Health having a better sense of what it actually seeks to purchase in those contracts. Clearly, transport in New South Wales is provided by New South Wales Ambulance, but it does not do the non-urgent transport. Health needed to be clear on what it was actually purchasing and what the expectations were. The first step is being clear on what you value in that relationship as opposed to just getting someone to the hospital, you know what I am saying? You well and truly understand.

Mr R.S. LOVE: I know that that model relies upon volunteer effort, and it has now got to the point where the volunteers are few and far between.

Ms KRUK: That was raised with me through the WACHS consultations as well.

The CHAIR: Thank you very much. We scheduled an hour, we have gone about 10 minutes over it, so thank you very much for your time.

Ms KRUK: Thank you for the opportunity to speak to you all; I really do welcome it. I hope I have touched on the issues that are important to you. I appreciate your interest.

The CHAIR: It was more that we, as the Education and Health Committee, felt that we should equip ourselves with more knowledge about what was going on.

Ms KRUK: If it is desirable in the future, I am really happy to spend more time with you on specific areas, whatever I can do, because the health–education link is pivotal.

The CHAIR: Thank you very much.

Hearing concluded at 11.12 am

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