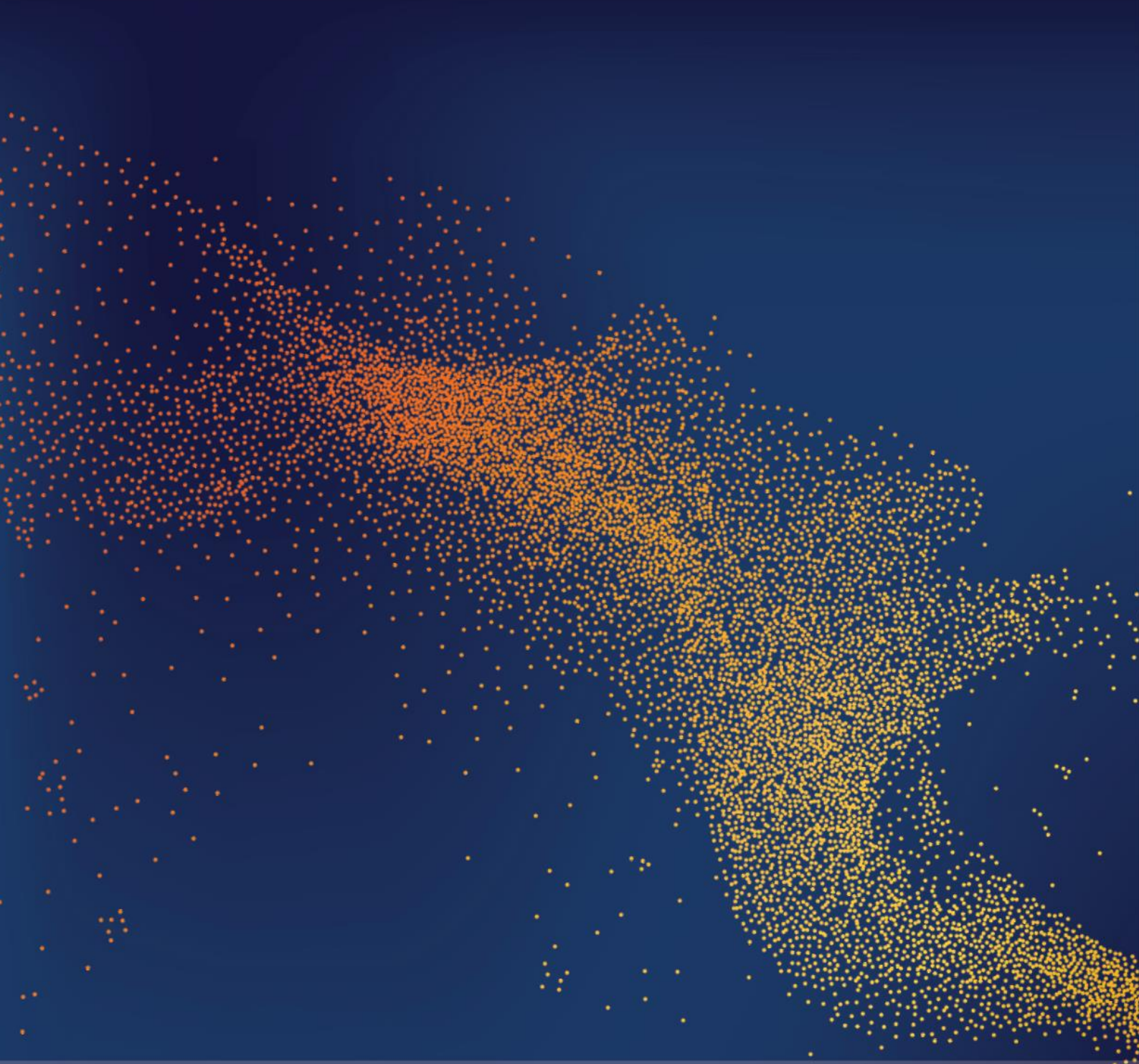

Person-centred services in Western Australia: Directions for health, aged care and disability services in a changing policy environment

A Sustainable Health Review project

Final Report

13 December 2017

Sustainable Health Review

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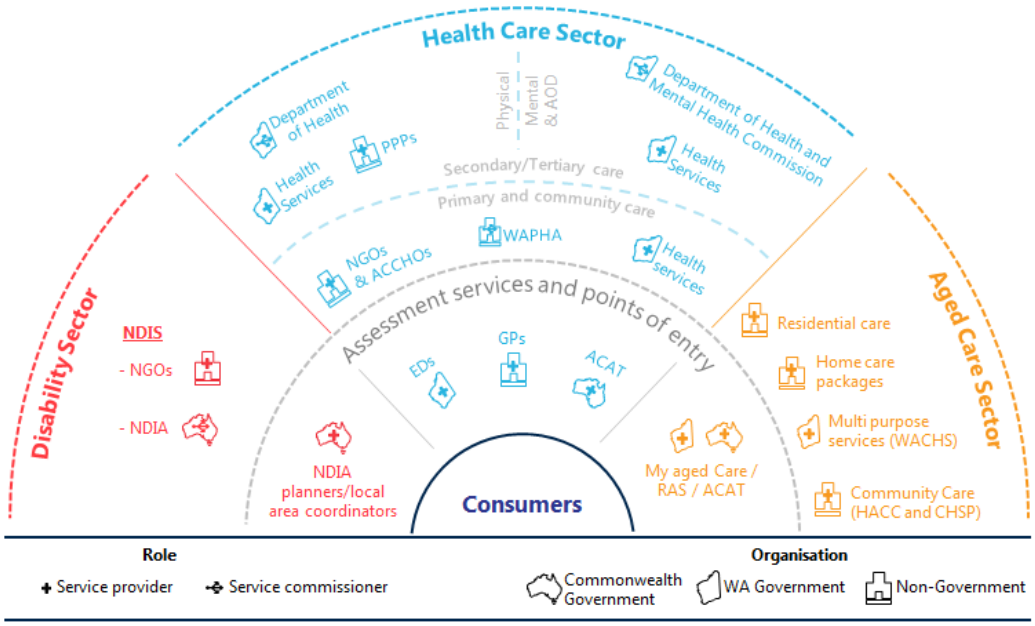
Executive Summary

The health and wellbeing of Western Australians is supported by a complex range of public services. In addition to the public hospitals and community services provided by WA Health, consumers also interact with a range of related government service systems, including primary care, mental health, aged care and disability services. As shown in Figure 1, each of these five service systems operate as a wider health and wellbeing ecosystem (the 'ecosystem'); yet have distinct governance arrangements, funding mechanisms and assessment and eligibility criteria. In 2014/15, approximately $13.4 billion of (State and Commonwealth) funding was spent on the administration and delivery of these five service systems.

Figure 1: The health and wellbeing ecosystem in WA; with the consumer at the centre



The outcomes of the ecosystem are generally good – the health and wellbeing of Western Australians on average exceeds national and international benchmarks. However, there are clear issues with equity, particularly for Aboriginal Western Australians, people living in rural and remote areas and those in lower socio-economic groups.

Despite the generally good outcomes that result from the service systems, consumers can find it hard to navigate the ecosystem and access the appropriate services, particularly in rural and remote areas. Governments face challenges in meeting the growing and changing needs and expectations of consumers and reducing overreliance on acute services (including hospital and residential aged care). Collectively, these issues put pressure on the sustainability of the ecosystem, both from a financial and a workforce perspective. Over time, governments have put in place a number of programs and approaches to mitigate the impact of these issues.

Simultaneous reforms across the ecosystem, in part in response to these issues, will have major repercussions for consumers, providers and governments. In particular, Commonwealth led reforms in disability services (with the roll-out of the National Disability Insurance Scheme – NDIS) and aged care (through the Living Longer Living Better reforms – LLLB), and related changes to the Home and Community Care (HACC) program are already changing consumers' access to services and resulting in a changed operating environment for providers and funders.

While the reforms share some common elements (such as increased consumer choice and control), they are not always consistent and coherent, creating additional complexity for consumers. The reforms do not just

change the internal logic of each service system; they fundamentally change the way the systems interact. Boundaries have changed and will continue to change (as rules around eligibility and concepts such as "reasonable and necessary" are altered), and funding is being redirected away from some existing services. Therefore, these reforms have the potential to exacerbate existing issues and make existing mitigation strategies unviable. Equally, they present an opportunity to shift the paradigm of how these service systems interact to achieve services that are more person-centred and integrated.

Reforming public services to adapt to common challenges such as demographic change, globalisation, digitisation and financial sustainability is not a unique challenge for WA. States across the Australia are grappling with the same reforms in similar health and well-being ecosystems; whilst ensuring services are more integrated is a common theme for many developed health systems around the world.

At the heart of such reforms are many common objectives, including the need for greater collaboration within and outside of government, and the need to ensure services are more consumer-centric. In 2016, the World Health Organisation went one step further and intrinsically linked these two objectives in their global framework for integrated, people-centred services; concluding that all people should have access to services that are provided in a way that is coordinated around their needs and with respect to their preferences.

Research into other jurisdictions has shown that integration of health and wellbeing services is a priority that many governments have been pursuing for over ten years, with varying degrees of success. Amongst the many lessons learned from these efforts are three lessons that are critical in addressing the issues identified in WA:

1. The consumer must be at the centre of integrated services and actively engaged in designing those services (although very few, if any, jurisdictions have genuinely addressed this challenge).
2. Achieving sustainable integration of services requires investment in and alignment between the authorising, commissioning and operational environments of the ecosystem.
3. Integration needs to go beyond the 'health system' to include the wider range of social services that support and enable consumer's holistic needs.

The objectives and lessons have been reflected in the formation of the Sustainable Health Review (SHR), and its intent to guide the strategic direction of the WA health system to deliver patient centred, integrated, high quality and financially sustainable healthcare across the State.

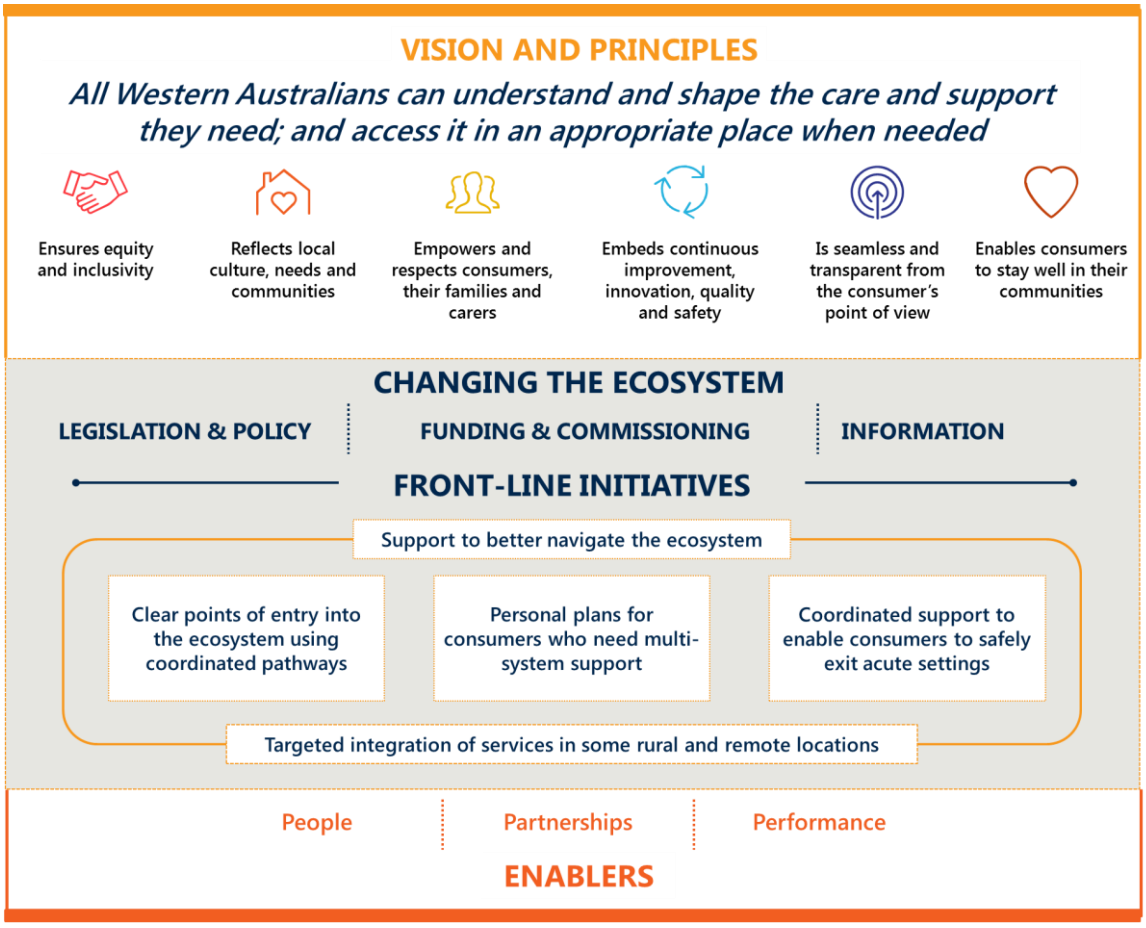
This report contributes to the SHR by rethinking how the health and mental health, disability and aged care service systems could work together to improve consumer outcomes, in the context that there are separate ongoing reforms in all of the service systems.

In doing so, it presents a strategic framework that summarises directions for the ecosystem to establish more person-centred and integrated services. The framework comprises four types of reform direction:

- **Vision and reform principles:** A clear, brief and simple intent for the reform directions; which garners consensus and serves as a guide for the shape of the reform directions. The vision is underpinned by a series of six reform principles that collectively set the strategic objectives for the reform directions.
- **Changing the ecosystem requirements:** A series of structural changes that will improve the interfaces between the service systems and create and sustain the conditions for person-centred and integrated services to thrive across the ecosystem.
- **Frontline initiatives:** Five discrete initiatives that will directly impact consumers, the services they access and the support they receive. These five initiatives are not the full range of changes that the system should aspire to achieve in the fullness of time; rather they are intended to be practical, realistic and, importantly, address the immediate need to ensure vulnerable do not fall through the gaps that may open up as the various service systems reform. The initiatives are intended to be targeted at specific cohorts of the population; either those with similar needs/conditions, or local populations in specific places across the state.
- **Key enablers:** The activities that will improve the capability and capacity of the ecosystem into the future to be more person-centred and integrated. Unlike the ecosystem changes, the frontline initiatives

are not dependent on these enablers being in place; however, the sustained performance of the frontline initiatives will require these enablers to be in place in due course.

Figure 2: Strategic framework for a person-centred and integrated ecosystem



It is noted that the emphasis of the framework is predominantly on how government, service commissioners and service providers can better align and collaborate; and that this is a pre-requisite to achieving greater consumer empowerment in the future.

These directions cannot be achieved overnight; they will require a sustained and significant program of reform. Similar reforms in other states and jurisdictions have taken up to ten years to change the capacity and capability of the health and wellbeing ecosystem to be more integrated and person-centric.

The final part of this report sets a series of considerations for how these directions could be implemented. Central to this is that there needs to be a dual focus in the short term: (1) establishing the structural conditions for person-centred and integrated services to thrive within the ecosystem; (2) implementing a range of pragmatic early-adopter initiatives that demonstrate the benefits of greater integration, and enable the ecosystem to test and refine the ecosystem changes.

Introduction

This report is the final report of the '*Person-centred services in Western Australia: Directions for health, aged care and disability services in a changing policy environment*' project. It has been commissioned as part of the WA *Sustainable Health Review*.

The focus of the project is to identify how the interfaces within and between the health (including primary and community care, secondary and tertiary care and mental health), aged care and disability service systems (collectively, the health and wellbeing ecosystem) could be changed in order to achieve more person-centred and integrated services across the ecosystem. This is in the context that all parts of the ecosystem are currently undergoing some level of reform, including fundamental reform of disability services and aged care that results in significant opportunities and risks for consumers and the health system.

The information and strategic directions presented in this report are based upon research, analysis and widespread consultation across the ecosystem in WA; including a series of three workshops with consumers and consumer advocates, state government officials, and leaders of a range of WA's service commissioners and providers.

This report is structured in four parts with supporting appendices:

The case for change 1

A summary of the ecosystem, the outcomes it achieves, the systemic issues that currently exist and the reforms that are being undertaken across the ecosystem.

The experience of other jurisdictions 2

A summary of the types of reforms undertaken in other states and countries to achieve more person-centred and integrated services.

Strategic directions for reform in WA 3

The vision, principles and reforms required to achieve more person-centred and integrated services. This includes five practical initiatives that could be implemented in the short to medium term.

Considerations for implementation 4

A series of considerations for how the strategic directions can be further refined and developed through the next phase of the Sustainable Health Review and ultimately beyond into implementation.

1 Ongoing reforms to adjacent service systems create risks and opportunities for WA Health

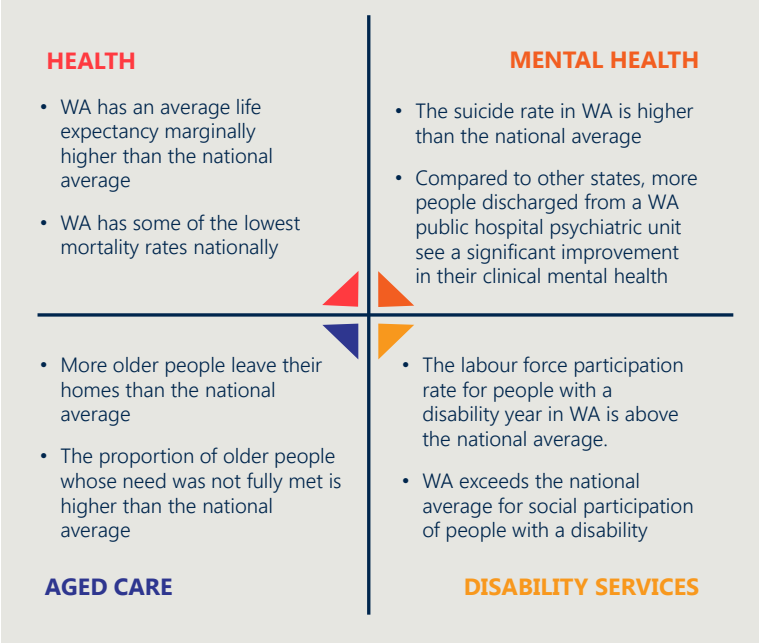
This section summarises the current state of the health and wellbeing ecosystem in WA, the key challenges faced by the ecosystem, the reforms that are being undertaken in the individual service systems, and the risks and opportunities that these reforms present.

1.1 The health and wellbeing ecosystem includes a wide range of services

Australia has one of the best health and social care systems in the world[1], with a life expectancy bettered by only three other countries[2]. Furthermore, as illustrated in Figure 6, on many measures on average Western Australians have better outcomes than other Australians.

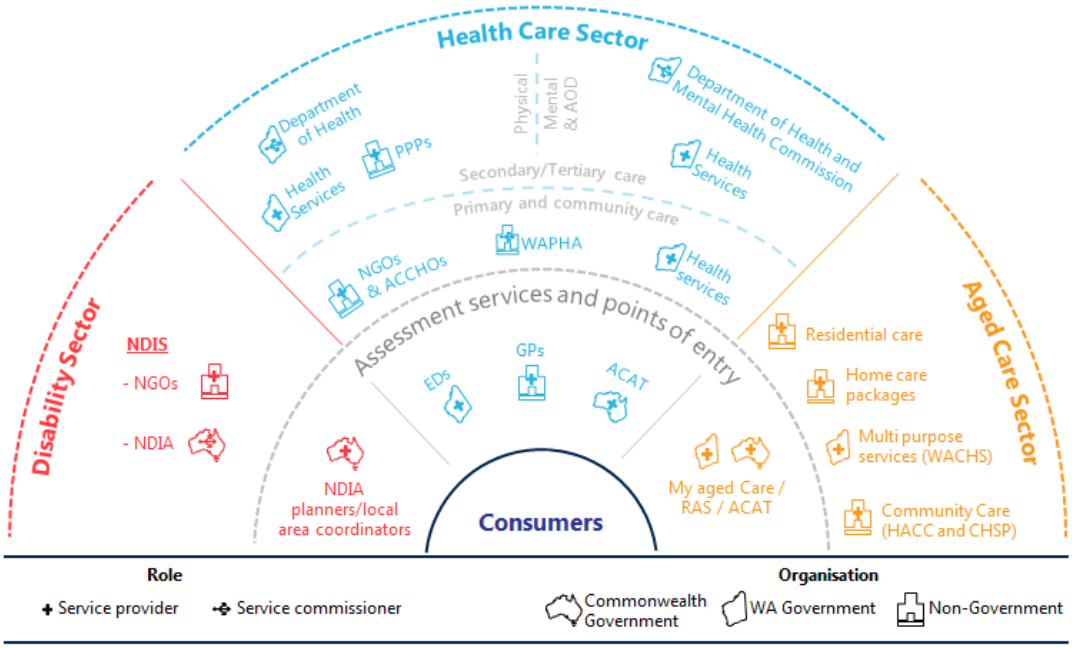
The health and wellbeing of Western Australians is supported by a complex ecosystem of Commonwealth and State Government funded service systems[3] (illustrated in Figure 4 overleaf); including primary care, secondary/tertiary care, mental health, aged care and disability services[4]. Each of these five service systems has distinct governance arrangements, funding mechanisms and assessment and entry processes. Funding in each service system is a combination of Commonwealth funding and State funding, and services are provided by a range of government agencies and non-government organisations (NGOs).

Figure 3: A summary of consumer outcomes for WA



[1] The Commonwealth Fund (2017) *Mirror Mirror 2017: International comparison reflects flaws and opportunities for better US healthcare*
[2] World Health Organization (2016), Life expectancy at birth (years), 2000–2015 – only Japan, Switzerland and Singapore have a higher life expectancy
[3] Note: The scope of this work does not include healthcare services provided by and accessed using Private Health Insurance.
[4] These are the service systems within the scope of the project. It is acknowledged that other social service systems, such as housing, child protection and family services also have a role to play in the health and wellbeing of Western Australians.

Figure 4: The health and wellbeing ecosystem in WA; with the consumer at the centre

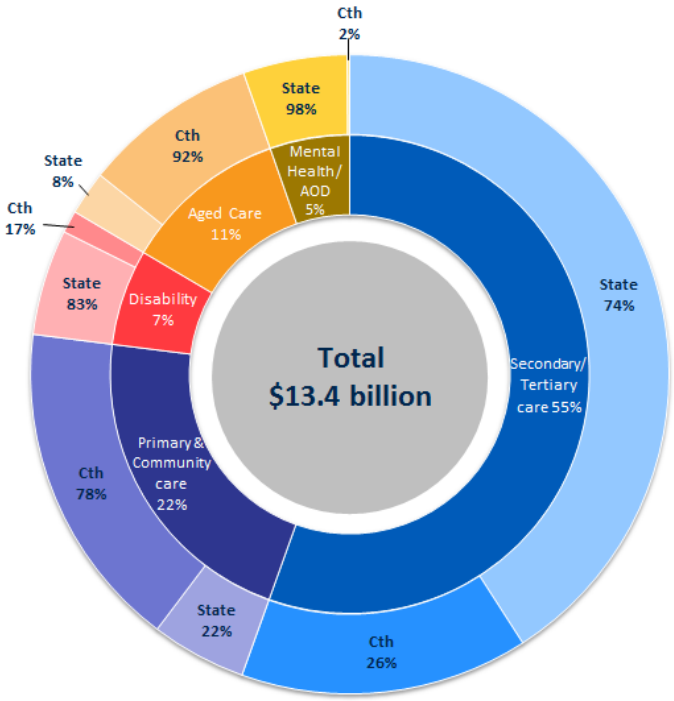


The majority of Western Australians will interact with the ecosystem during the course of the year - whether that be as a consumer, relative, carer or employee – and the ecosystem consumed over $13bn of government expenditure on the administration and delivery of these five service systems[5] in 2014/15, as illustrated in Figure 3.

Collectively, the ecosystem accounts for over 30% of total State Government expenditure; with around 55% of this being within the public hospitals service system.

Although the funding of the disability and aged care sectors is small relative to the funding of healthcare, the national reforms in these two sectors have seen and will continue to see the expenditure in these two sectors grow at a significantly higher rate than the healthcare sector.

Figure 5: The proportion of government expenditure on the service systems in 2014/15[6]



[5] Excludes services funded by non-government sources (e.g. Health Insurance funded services, Individual payments), which themselves exceeded $6bn in 2014/15 (Source: AIHW health statistics)

[6] Sources: AIHW (2015) *Health Expenditure 2014 – 2015;* Productivity Commission (2017) *Report on Government Services*

1.2 Consumers and government outcomes are impacted by the current state of the service systems

Despite the generally good outcomes that were acknowledged in the previous section; consumers and governments experience a range of issues both within and between the service systems. Collectively, these issues put pressure on the sustainability of the systems. Table 1 and Table 2 summarise the issues for consumers and for commissioners and service providers. Further examples are included in Appendix A.

Table 1: Issues with the current state of the ecosystem for consumers

There are significant inequities in health and wellbeing outcomes across the state	
There are notable variations in health and wellbeing outcomes for some cohorts of our population, including Aboriginal Western Australians, residents in rural and remote WA and those in lower socio-economic groups. These disparities are not unique to WA and are an issue across Australia. In The Commonwealth Fund's assessment of the Top 11 health systems in the world (where Australia ranked second overall), Australia only ranked 7th for equity – the single factor that stopped Australia being ranked as the best health system in the world.	*In WA, the life expectancy is 15.1 and 13.5 years lower for Aboriginal men and women (respectively) than for non-Aboriginal people; and the average life expectancy of a Western Australian living in remote WA is more than 20 years lower than for those living in Perth.*
Consumers can find it hard to navigate the ecosystem and access the right services	
Consumers and service providers find the ecosystem hard to navigate and as a result consumers can *'feel ill-informed and uncertain about the services available, their eligibility and the costs involved'*[7]. This is particularly the case where care and support needs to be coordinated across multiple service systems and service systems have different eligibility criteria, different referral and assessment processes and often different technical language. Key services in WA have significantly lower capacity than the national average. There are significantly fewer GPs, residential aged care beds and hospital beds per capita than the national average. There is a maldistribution of GPs and aged care beds in rural and remote WA.	*The number of GPs per capita in WA is 85% of the national average. This drops to 70% in rural and remote WA.*
Consumers have less access to services in rural and remote areas	
Accessing appropriate services in rural and remote WA is challenging, where distance, a dispersed population, high costs and workforce challenges combine to make it often unviable for providers to offer services (so called "thin markets"). As a consequence, the State government (through the WA Country Health Service) has historically provided disability and aged care services as the 'provider of last resort'. This includes the Multi-Purpose Service program that provides integrated health and aged care services in rural and remote areas.	*The number of residential aged care places per capita in rural and remote WA is 62% of the national average.*

[7] Belardi, L., 'Aged care still largely a maze for consumers', *Australian Ageing Agenda,* October 2017.

Table 2: Issues with the current state of the ecosystem for commissioners and service providers

The system is struggling to keep up with the changing needs and expectations of consumers	
Demand for health and wellbeing services is changing. Key drivers include demographic changes, the greater prevalence of mental health, alcohol and other drugs related issues, and more people are living with chronic conditions – a particularly acute issue for Aboriginal people. In addition, society's basic expectations are changing and the increasing adoption of technology is placing pressure on the ecosystem to improve digital capability to support service delivery. The ecosystem is slowly responding, and some service providers are looking at innovative ways to address the changing demands; but these demands will only be met if the ecosystem can be more connected to enable an individual's needs to be addressed holistically.	*Over the last decade there has been a 43% increase in people over the age of 65 in WA.* *As a consequence there has been an increase in age related health issues; for example the number of dementia sufferers is expected to double by 2050.*
There is an overreliance on acute based services	
Where there are deficiencies in service provision, especially in primary care and aged care, then this manifests itself in extra demands being placed upon WA's hospitals, either through delayed discharges or through higher Emergency Department (ED) presentations; whether due to the consumer's condition deteriorating through lack of appropriate support, or because ED presentations are both free to the consumer and simple to access. Although there is a growing awareness, expectation and evidence base that individuals should only be cared for in 'institutions' if there is an absolute need for their continuing health and safety, it will take time to shift the current levels of demand to other types of provision. The availability of appropriate accommodation can also be an important factor. A shortage of specialist accommodation and accommodation support services for people with multiple or complex needs can lead to avoidable admissions and delayed discharge.	*The number of medically fit older persons awaiting discharge from a metropolitan hospital to an aged care service (residential or home based) is increasing, with an average of 110 older persons at any time waiting discharge in 2016, compared to 58 in 2010*[8] *.*
Financial and workforce sustainability are under mounting pressure	
Expenditure in all five service systems has increased rapidly in the period 2008 - 2015. The ecosystem has grown more than the national average, and only Queensland has grown at a higher rate. The rate of expenditure growth in the public hospitals and acute mental health services is unsustainable for the State and a key driver of the SHR. This growth has also placed a significant challenge on the workforce. Workforce shortages are prevalent in all workforce groups with all five service systems competing for similar staff, particularly in nursing and allied health professions.	*Total national health expenditure grew by 27% between 2008 and 2015. In WA expenditure in every one of the five service systems grew by at least 29% (in primary care), with hospital based expenditure increasing by 39% over that period.* *WA has the lowest rate of medical professionals per capita nationally.*

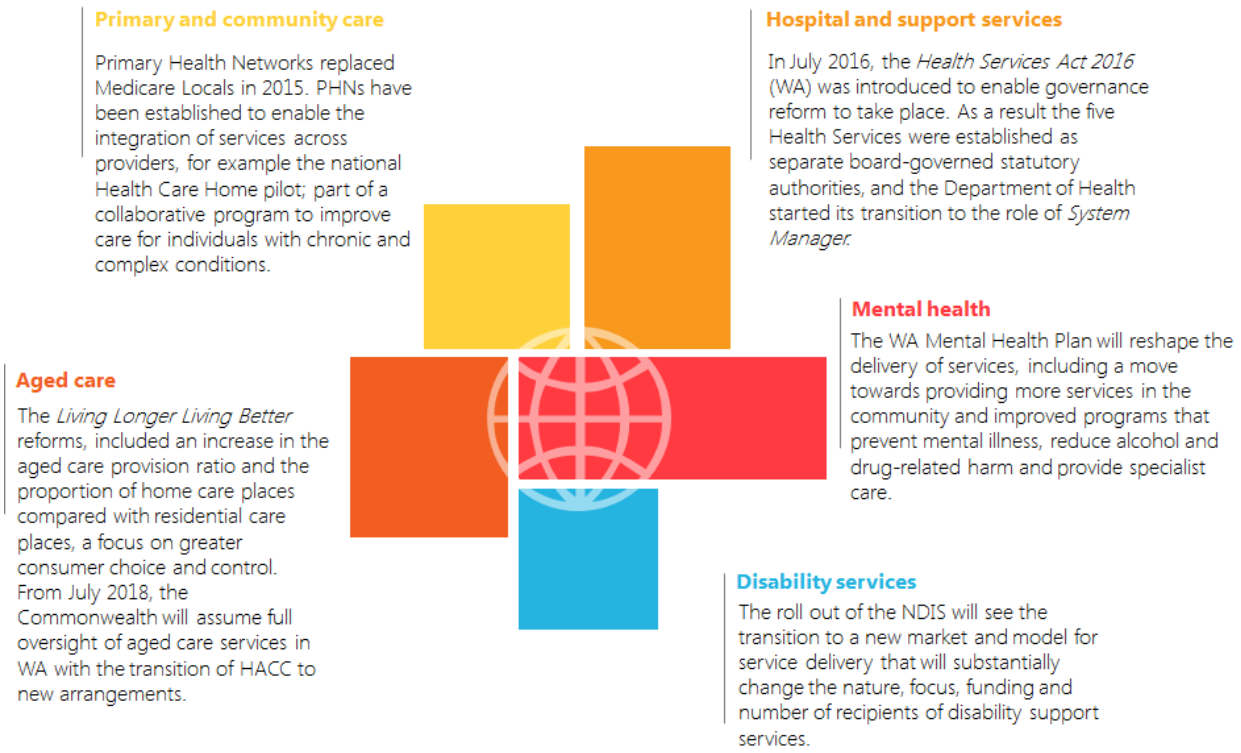
[8] Department of Health (2016) *Preliminary internal advice from System Policy and Planning Division*

As the ecosystem has evolved, the Commonwealth and State Governments have sought to mitigate gaps in service or provide services that are designed to manage the interface between the service systems. These solutions often deliver good outcomes, but in general these services mitigate issues rather address root causes. Solutions such as Home and Community Care (HACC) and the Transition to Care Program are just two examples of these solutions which, collectively have been provided to thousands of Western Australians at a cost in excess of $250 million per annum.

1.3 Significant reforms are taking place across the ecosystem

In part a response to the issues identified above, all parts of the ecosystem are simultaneously undergoing fundamental reform. The reforms do not just change the internal logic of each service system; they fundamentally change the way the systems interact. Boundaries have changed (e.g. as a result of NDIS definitions of reasonable and necessary), assessment and referral processes are being reformed and funding is being redirected away from some existing services (a particularly contentious issue in the mental health sector). Figure 6 summarises the key reforms across the ecosystem.

Figure 6: A high level summary of the reforms taking place in each service system



The reforms are all built around objectives specific to each service system, although there are several common themes across the Commonwealth led reforms in aged care, disability services and to some extent primary care, including:

- **Consumer empowerment** through the introduction of individual choice and control that *puts users at the heart of service delivery and recognises that, in general, the service user is best placed to make decisions about the services that meet their needs and preferences*[9].

[9] Productivity Commission (2016) *Introducing Competition and Informed User Choice into Human Services*

- **Demand driven models** with funds allocated to the individual, rather than the service provider, combined with establishing and sustaining a 'market' for services that meets these demands. Governments have created new institutions with "system stewardship" roles, managing eligibility and access, setting prices to balance provider and system viability, commissioning services and ensuring safety and service quality.
- A **shift from tertiary/ acute/ institutional based care models** to primary/ community/ prevention/ early intervention/ home based models. Many of the prevailing reforms are based upon enhancing community and home based services; shifting services away from resource intensive and expensive acute services where appropriate.

1.4 The reforms create significant risks which could have a detrimental impact on consumer outcomes

While there are common themes to these reforms, the disconnected nature of the various reform agendas creates some risks to consumers and governments; creating complexity and mixed incentives for consumers and service providers. These **risks have the potential to exacerbate the issues explored in Section 1.2**, including:

- The reforms will lead to the **removal of many existing mitigation strategies and provider of last resort arrangements**, either through explicit agreement (for example, the transition from HACC to the NDIS and Commonwealth Home Support Program) or by rendering existing approaches unviable (for example, Multi Purpose Services or the provision of therapy services for people with a disability in rural and remote WA). Without careful management of the transition to new arrangements, there are risks of service discontinuity and of consumers falling between the cracks between service systems.
- Increasing funding complexity, based on individual, activity and program funding, with an evolving blend of Commonwealth and State funding could create **perverse incentives for providers and unintended consequences for the system**. For example, consumer co-contribution requirements in aged care can provide perverse incentives for consumers to avoid the aged care system in favour of the disability service or health sectors. As a consequence, consumers may find themselves accessing inappropriate services or even failing to access the support they require. It also means that government may need to fund more expensive acute based services if the consumer's needs are not met.
- **Changing eligibility requirements and definitions of service levels** (including what is "reasonable and necessary" under the NDIS[10]), combined with funding reallocations may cause some consumers to lose access to services. These risks are particularly high for consumers with a psychosocial disability, for whom eligibility for the NDIS remains uncertain but funding for some programs is being reallocated to fund the NDIS.
- The inclusion of psychosocial disability in the NDIS has created some **tension between the disability services, health and mental health sectors** as distinctions between disability supports, community mental health and clinical mental health services are redrawn and funding is reallocated. This is compounded by the different underlying ethos of the mental health and disability sectors (the former focused on a recovery based model that supports fluctuating demands, whereas the latter is more focused on putting in place longer-term support mechanisms). Ongoing uncertainty of how people with mental health conditions will be supported by NDIS in the future is creating confusion for service providers – which in turn is causing confusion for a vulnerable cohort of consumers.
- The process for assessing and **putting in place new or changed disability or aged care arrangements is time consuming**; and where an individual is in hospital awaiting these new arrangements to be in place

[10] Acknowledging that additional supports will also be available through the Information Linkages and Capacity Building (ILC) stream, for which the reasonable and necessary test does not apply

it is delaying discharges. The hospitals are already experiencing this and it is leading to significant numbers of people staying in hospital for unnecessary periods of time.

- **Market development is an increasing issue** as providers adapt from the security of a block funding model to a consumer choice model; the Productivity Commission recently commented on the roll-out of NDIS, stating it has *'focused too much on meeting participant intake estimates and not enough on planning processes, supporting infrastructure and market development'*[11]. In particular, *w*ithout a wider systemic approach to service sustainability in rural and remote WA, individualised funding approaches **may exacerbate thin market issues and make rural and remote service provision unviable**, worsening the 'equity gap' highlighted in the last section. Indeed the Aged Care Financing Authority noted in 2016 that *'the benefits of the reforms had less impact for rural and remote providers and that some posed greater implementation and administration challenges for rural and remote providers.'*[12]

The State's financial position rules out high cost approaches to dealing with these issues; but many of these risks are likely to place more pressure on hospitals to operate as 'provider of last resort'.

1.5 The reforms also create genuine opportunities

The reforms present major opportunities to create value through integration across service systems and to address the issues previously outlined, including:

- **Increasing the range and volume of services** provided across WA, by more effectively tapping into the potentially significant increases in funding expected through the aged care and disability service reforms.
- Improving the consumer experience within and between service systems; by **re-focusing system interactions on creating a seamless consumer journey.**
- Increasing quality by **reducing variation in practice** for some cohorts with collaboratively designed and agreed pathways across the ecosystem, and introducing place-based and consumer-centred service models that are designed to work at a local level.
- **Managing unnecessary and inappropriate demands** in one service system through targeted interventions in another system.
- Pivoting the service systems towards a greater **focus on preventative programs and services.**
- Driving efficiencies (e.g. integrated service models increasing workforce and infrastructure utilisation) and **reducing duplication** (e.g. replication of diagnostic tests).

Furthermore, the ongoing **negotiations between the State and Commonwealth Governments over the future of health funding** in WA provide an opportunity to influence the design of governance and funding models into the future.

[11] Productivity Commission (2017) *Position paper: NDIS Costs*
[12] Aged Care Financing Authority (2016) *Financial issues affecting rural and remote aged care providers*

2 Services that are more person-centred and integrated will improve outcomes

This section summarises research into integrated and person-centred health and wellbeing services in other states and countries. The majority of examples identified have seen integration within health systems; but in the last five years there has been a greater recognition that integration of health systems with social services achieves even better outcomes for consumers.

2.1 Person-centred and integrated services bring together disparate systems, centred on people's needs

Integration of services is a priority for health and social service systems both within Australia and across the world. Globally, health and social services are shifting their focus to person-centred delivery models that are coordinated across a variety of settings.

In 2016 the World Health Organisation (WHO) recognised that service integration and person-centred services are effectively two-sides of the same coin, as it established a global framework for Integrated People-Centred Health Services (see below). It aims to create an integrated system in which all people have access to services that are provided in a way that is coordinated around their needs, respects their preferences, and are safe, effective, timely, affordable and of acceptable quality.

> *An approach to care that consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organised around the comprehensive needs of people rather than individual diseases, and respects social preferences. People-centred care also requires that patients have the education and support they need to make decisions and participate in their own care and that carers are able to attain maximal function within a supportive working environment.*
> **World Health Organisation Framework on integrated, people-centred health services, 2016**[13]

Many countries, such as Australia, had already begun to develop and implement strategies and initiatives to deliver services that are integrated before the WHO Framework was established. For example, under the National Health Reform Agreement, all state governments have committed to their shared responsibility to integrate systems and services to improve health outcomes for Australians.

More broadly, reforms to disability services (under the National Disability Insurance Scheme) and to aged care (under the Living Longer Living Better reforms) are providing opportunities for health and social care systems to put people at the centre of care, providing greater choice and better connecting care within and across the systems

There is a strong body of evidence that integration of care and support can deliver a series of benefits to a wide range of stakeholders; including consumers, providers and government. This evidence demonstrates that integration of care has the potential to achieve the ***quadruple aim***[14] of improved consumer experience, improved provider experience, improved consumer outcomes and reduced costs for the health and social care systems. An overview of the more specific benefits that can be achieved is included in Appendix B

[13] World Health Organization (2016a), *Framework on integrated people-centred health services: report by the Secretariat*
[14] Thomas Bodenheimer, MD and Christine Sinsky, MD (2014), *From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider*

2.2 Many jurisdictions are focusing on more person-centred and integrated services

There has been substantial progress in the integration of health services globally. Several jurisdictions have taken steps to integrate services vertically (that is, integrating primary, secondary and tertiary care within health) and horizontally (that is, between providers or organisations working at the same level). In recent years, there has also been a greater recognition and drive towards integration of social services with health, acknowledging that an individual's health and wellbeing is not wholly defined by the health services they have access to. Some examples of initiatives that have been introduced to improve the interfaces between the health and social service systems include:

- ✓ defining **service coordination practice standards** (Victoria)[15]
- ✓ establishing a **dedicated fund for innovation** in integrated care (Queensland)[16]
- ✓ piloting **integrated care services** in multiple locations and implementing statewide enabling infrastructure (NSW)[17]
- ✓ changing existing fee-for-service payment and **funding models** (Netherlands)[18]
- ✓ establishing **efficient information systems** that flow across the continuum of health and social care (Canada)[19]
- ✓ using **incentives to encourage providers** to integrate personal records (US)[20]
- ✓ developing **regional partnerships** between the NHS and local councils with each partnership developing local sustainability plans (UK)[21].

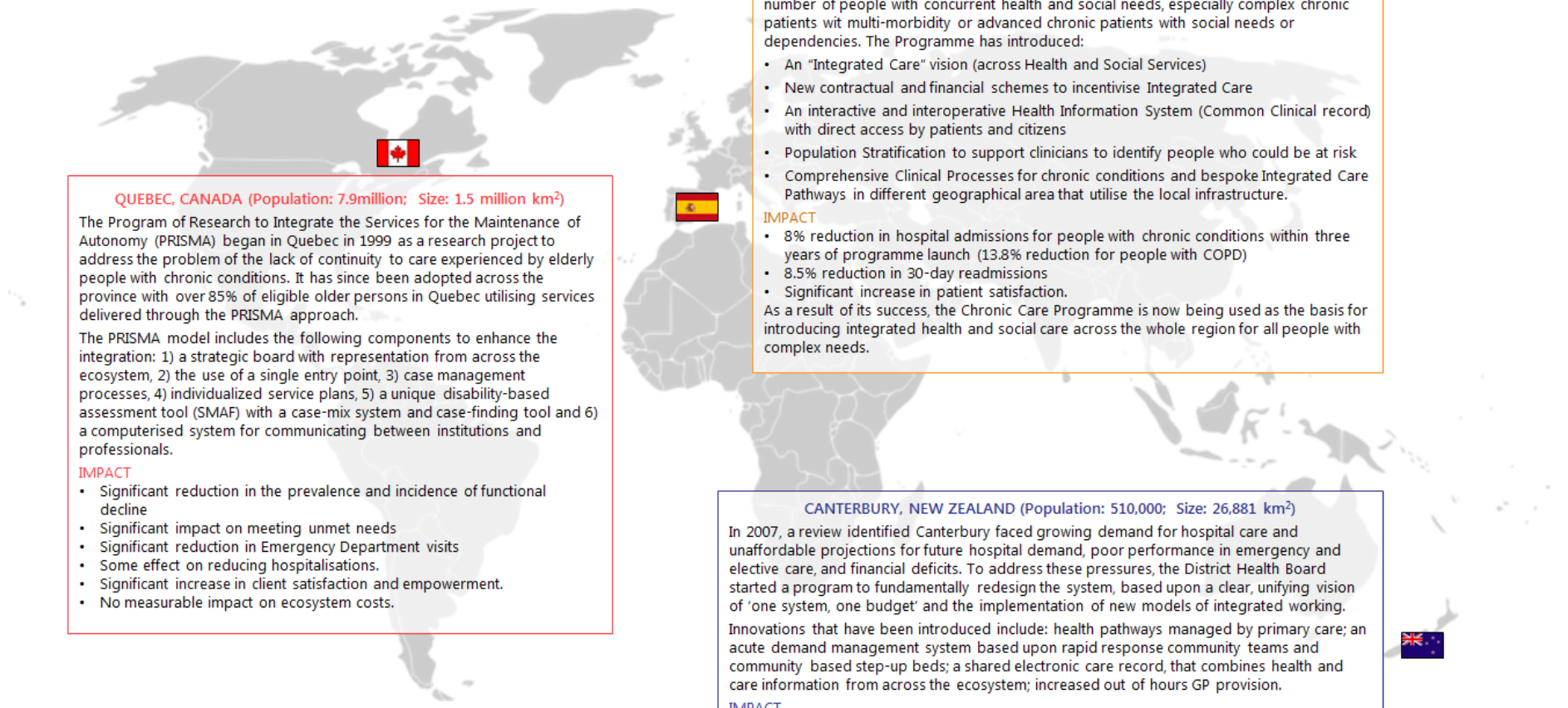
The research has shown there are many different approaches that can be taken to achieve greater integration of services; reflecting the fact that every jurisdiction has a different set of constraints, conditions and consumer requirements. Appendix B provides a summary of the types of initiatives that have been implemented in these other jurisdictions and which have been used to inform the development of the strategic directions for WA (see Section 3).

2.3 Some jurisdictions have integrated the whole ecosystem

Many of the examples of integrated and person centred services across the world have been micro-level changes, where services have been integrated on a targeted basis to address specific consumer requirements. In these examples, services have been focused on small geographic locations or specific consumer cohorts. There are, however, a small number of examples where a whole system has been reformed. These examples include Catalonia in Spain, Canterbury in New Zealand and Quebec province in Canada, which are summarised in Figure 7 overleaf.

[15] Primary Care Partnerships (2012), *Victorian Service Coordination Practice Manual 2012*, Primary Care Partnerships
[16] Queensland Health (2017), *Integrated care innovation fund (ICIF*), Queensland Government
[17] https://www.aci.health.nsw.gov.au/nhn/health-professionals/tools-and-resources/nsw-health-integrated-care
[18] H Drewes W, Strujis, J N, and Baan, C A (2017), *How the Netherlands is Integrating Health and Community Services,* NEJM Catalyst
[19] E Suter, N D Oelke, C E Adiar and GD Armitage, 'Ten Key Principles for Successful Health Systems Integration', 13, *Healthcare Quarterly,* pp 16-23.
[20] Essentials Hospital Institute (2013), *Integrated Health Car: Literature Review,* Essentials Hospitals Institute
[21] NHS England (2016), Sustainability and transformation partnerships, https://www.england.nhs.uk/stps/about-stps/

Figure 7: Three successful examples of whole of system integrated care



QUEBEC, CANADA (Population: 7.9million; Size: 1.5 million km²)

The Program of Research to Integrate the Services for the Maintenance of Autonomy (PRISMA) began in Quebec in 1999 as a research project to address the problem of the lack of continuity to care experienced by elderly people with chronic conditions. It has since been adopted across the province with over 85% of eligible older persons in Quebec utilising services delivered through the PRISMA approach.

The PRISMA model includes the following components to enhance the integration: 1) a strategic board with representation from across the ecosystem, 2) the use of a single entry point, 3) case management processes, 4) individualized service plans, 5) a unique disability-based assessment tool (SMAF) with a case-mix system and case-finding tool and 6) a computerised system for communicating between institutions and professionals.

IMPACT

- Significant reduction in the prevalence and incidence of functional decline
- Significant impact on meeting unmet needs
- Significant reduction in Emergency Department visits
- Some effect on reducing hospitalisations.
- Significant increase in client satisfaction and empowerment.
- No measurable impact on ecosystem costs.

CATALONIA, SPAIN (Population: 7.5million; Size: 32,110 km²)

Catalonia introduced, in 2011, a new Chronic Care Programme to address the increasing number of people with concurrent health and social needs, especially complex chronic patients wit multi-morbidity or advanced chronic patients with social needs or dependencies. The Programme has introduced:

- An "Integrated Care" vision (across Health and Social Services)
- New contractual and financial schemes to incentivise Integrated Care
- An interactive and interoperative Health Information System (Common Clinical record) with direct access by patients and citizens
- Population Stratification to support clinicians to identify people who could be at risk
- Comprehensive Clinical Processes for chronic conditions and bespoke Integrated Care Pathways in different geographical area that utilise the local infrastructure.

IMPACT

- 8% reduction in hospital admissions for people with chronic conditions within three years of programme launch (13.8% reduction for people with COPD)
- 8.5% reduction in 30-day readmissions
- Significant increase in patient satisfaction.

As a result of its success, the Chronic Care Programme is now being used as the basis for introducing integrated health and social care across the whole region for all people with complex needs.

CANTERBURY, NEW ZEALAND (Population: 510,000; Size: 26,881 km²)

In 2007, a review identified Canterbury faced growing demand for hospital care and unaffordable projections for future hospital demand, poor performance in emergency and elective care, and financial deficits. To address these pressures, the District Health Board started a program to fundamentally redesign the system, based upon a clear, unifying vision of 'one system, one budget' and the implementation of new models of integrated working.

Innovations that have been introduced include: health pathways managed by primary care; an acute demand management system based upon rapid response community teams and community based step-up beds; a shared electronic care record, that combines health and care information from across the ecosystem; increased out of hours GP provision.

IMPACT

- A significant increase in the number of people supported at home and in the community.
- Lower admission rates, readmission rates and length of stay compared to the rest of NZ.
- Reduced waiting times and reduced cost of diagnostic testing.
- Reduced expenditure on non-elective hospital based services.
- Demand for residential aged care has fallen by a third.

2.4 Lessons learned from other jurisdictions

The experiences in other jurisdictions have delivered a range of benefits, as mentioned in Section 2.1; but there is little evidence that integrated care has systematically reduced the overall cost of the health and wellbeing ecosystem. What it has achieved in many cases is a significant improvements in both consumer and staff experience, a reduction in the pressure placed upon the acute health and aged care systems; and a reduction to the overall rate of expenditure increases.

If WA seeks to implement greater integration across the health and wellbeing ecosystem it will be able to benefit from these experiences in other jurisdictions. Section 3 focuses on some of the tangible changes that could and should be made to improve integration, but there are a number of overarching lessons learned that WA will need to consider. These four lessons are summarised below.

1. The **introduction of integrated and person-centred services is predominantly service focused**. Much of the focus of the changes seen in other jurisdictions is on how the services can be more person-centred and some of the levers that can be pulled to achieve this (i.e. multi-disciplinary working, integrated care plans). There has been much less emphasis on how to empower consumers and on changing the relationship between consumers and service providers.
2. Sustaining integrated services requires a commitment across government, from system stewards and system leaders to **establish the appropriate authorising environment** for person-centred and integrated services to thrive. Where integration of services has been attempted in a piecemeal manner, it has required the system conditions to be contrived to mitigate systemic barriers to integration, such as funding mechanisms or governance models. However, sustaining these changes into the long term has not been possible because the conditions to make them work in the short-term could not be maintained (e.g. the NHS integrated care pilots from the late-2000s).
3. People centred and integrated services **should not be a 'one-size fits all' approach**. Unless a whole system approach (like Canterbury etc.) is taken, then the approach that has been most successful is to implement integrated services in specific local geographic locations and/or to target specific cohorts of the population with similar conditions. This enables services to be designed to meet the specific needs of the target group and to create a standard interface with the mainstream services that are not being changed.
4. Implementing, refining and sustaining people-centred and integrated services takes time; **it is not and can not be a quick fix solution**. It requires careful planning and preparation before implementation; and then needs time and support to be established as standard practice. This means that there needs to be widespread political support so that the effort and intent can be maintained through the established parliamentary cycles.

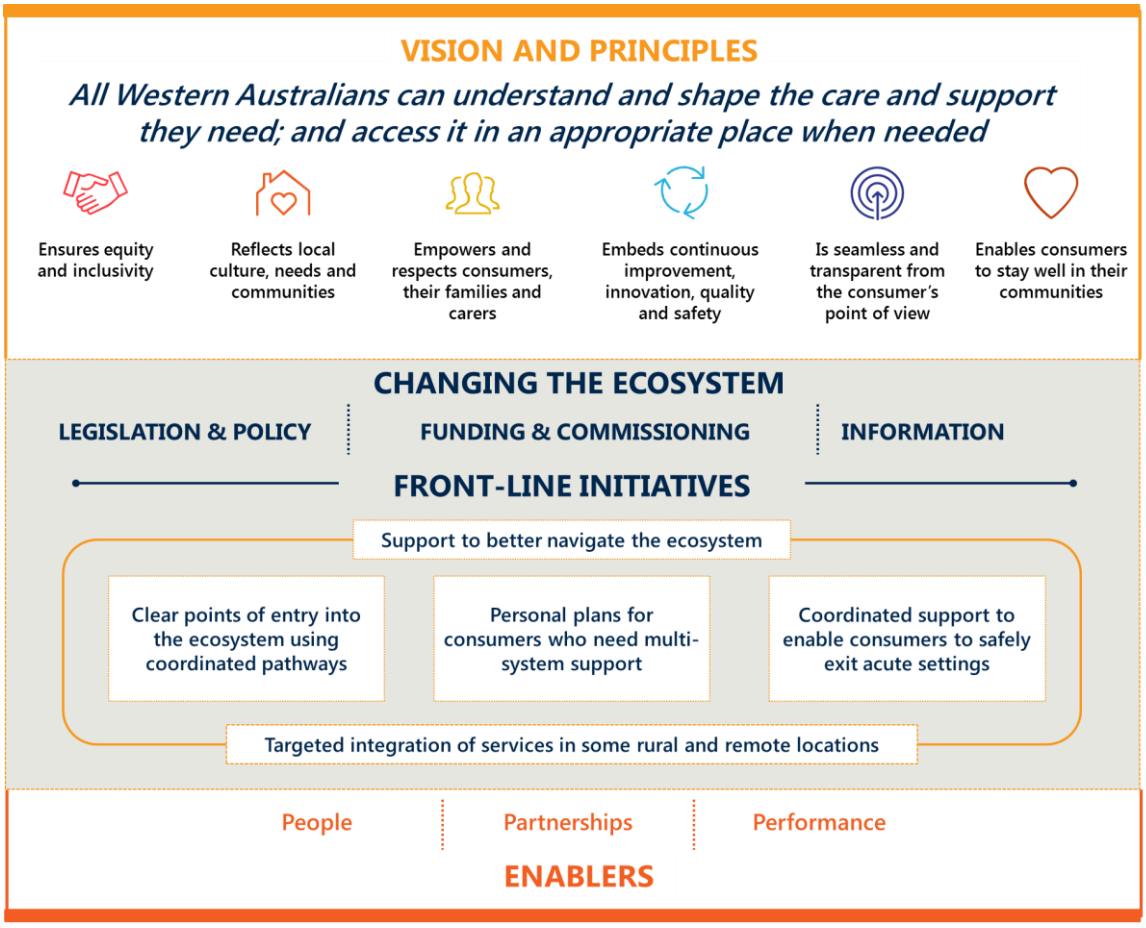
3 Sustainable change will require reform at all levels of the system

This section presents a series of strategic directions that would see the targeted implementation of person centred and integrated services within WA. These strategic directions were developed through the consultation process outlined in Appendix C, building upon evidence from other jurisdictions. The reform directions proposed in this section are intended to improve how consumers, their families and carers experience the ecosystem and promote person-centred and integrated approaches.

3.1 The reform directions balance systemic changes with a series of practical reform initiatives

The strategic directions are presented in a framework shown in Figure 8 below that summarises an aspirational but pragmatic agenda for change across the health and wellbeing ecosystem in WA.

Figure 8: Strategic framework for a person-centred and integrated ecosystem



The research shows that to achieve sustainable change at a service delivery level, the right systemic conditions need to be in place to introduce person-centred and integrated services. As such, the strategic directions presented in this report include systemic changes that will create the conditions for sustainable integration as well as a series of practical frontline initiatives that can be used as a vanguard for the wider introduction of person centred and integrated services.

The Framework collectively sets the direction for better care and support for Western Australians, particularly vulnerable and at-risk populations, including older people, those with disability or mental health issues, complex health and social needs, and those from culturally and linguistically diverse or Aboriginal backgrounds.

The Framework is built around four distinct types of reform directions; which are intended to complement each other and begin to address the key issues associated with the ecosystem interfaces. The four types of reform direction are:

- **Vision and reform principles:** The vision is a clear, brief and simple intent for the reform directions; which garners consensus and serves as a guide for the shape of the reform directions. The vision is underpinned by a series of six reform principles that collectively set the strategic objectives for the reform directions.
- **Changing the ecosystem requirements:** A series of structural changes that will improve the interfaces between the service systems and create and sustain the conditions for person-centred and integrated services to thrive across the ecosystem. These changes will be critical in the long-term as they address the key systemic barriers to collaboration, cooperation and partnerships across the ecosystem.
- **Frontline initiatives:** Five discrete initiatives that will directly impact consumers, the services they access and the support they receive. These five initiatives are not the full range of changes that the system should aspire to achieve in the fullness of time; rather they are intended to be practical, realistic and, importantly, address the immediate need to ensure vulnerable do not fall through the gaps that may open up as the various service systems reform. The initiatives are intended to be targeted at specific cohorts of the population; either those with similar needs/conditions, or local populations in specific places across the state. The frontline initiatives have been identified because they address the immediate risks presented by the current state of the ecosystem and the potential impact of the reforms across the service system. As these initiatives are established, as some of the ecosystem issues are addressed, and as benefits are demonstrated, it would be expected that further frontline initiatives are identified, planned and implemented.
- **Key enablers:** The activities that will improve the capability and capacity of the ecosystem into the future to be more person-centred and integrated. Unlike the ecosystem changes, the frontline initiatives are not dependent on these enablers being in place; however, the sustained performance of the frontline initiatives will require these enablers to be in place in due course.

3.2 A clear vision and principles set the intent for the reforms

Evidence from other jurisdictions indicates that to fully establish and embed person-centred and integrated services across a whole jurisdiction is a long term reform commitment of at least 8-10 years. It is therefore essential that this reform commitment has a clear intent, objectives and a vision to make a substantial difference. This intent has been distilled into a draft vision and underpinning principles that have been developed in consultation with stakeholders. They articulate 'heart' of the reform objectives, in a way that is consumer focused, and cognisant of the WA context. Together, the vision and principles establish the strategic objectives for a long term program of reform and set the aspirational but realistic directions for change. In that context, the draft vision is that:

"All Western Australians can understand and shape the care and support they need; and access it in an appropriate place when needed."

A set of principles have been developed to underpin this vision and outline the expectations and behaviours required from the ecosystem. The principles deliberately emphasise the consumer perspective rather than that of the ecosystem or government; this encourages a deeper consideration that reforms must be focussed on making a tangible difference for consumers, and that in doing to this will achieve tangible benefits for the ecosystem and for Governments. These principles are summarised in Table 3.

Table 3: Principles to establish the shape and practical expectations for the ecosystem

Principle		Intent
	Ensures equity and inclusivity	Services are connected across the ecosystem to ensure all Western Australians can access the appropriate level of service to best meet their needs; regardless of their location, culture or capacity.
	Reflects local culture, needs and communities	Consumers can access care and support services that understand, align with and actively promote the local nuances of the person's community and are designed to address the prevailing needs of that community.
	Empowers and respects consumers, their families and carers	The planning and delivery of services place the person at the centre, empowering consumers to direct their services and support according to their needs and aspirations and where appropriate actively involving their families and carers in shared decision making .
	Embeds continuous improvement, innovation, quality and safety	People centred and integrated services operate in an authorising environment where innovation is supported, quality and safety is measured and reported, and there is a focus on learning from and sharing experiences across the ecosystem.
	Is seamless and transparent from the consumer's point of view	The services across the ecosystem are connected in such a way that consumers do not notice or experience the interfaces or handovers between and within the service systems.
	Supports consumers to stay well in their community	The focus of the ecosystem is to actively keep people out of institutions, through a greater focus on preventative care and support, education of consumers and primary care based pathways.

Achievement of this vision and principles will require a long term reform commitment (comparable to the *Living Longer Living Better* Commonwealth reforms). It will require a multi-agency reform program across both State and Commonwealth governments to address some of the key challenges (such as funding mechanisms, service system silos; inequity in outcomes; and access to services). The reform program will be complex, but the vision and principles are a benchmark for success. Future reform activities should be tested to ensure that they are contributing to the vision and aligning to the principles.

3.3 Practical front-line initiatives will provide momentum

This section outlines a set of practical, front-line initiatives to provide the reform process with momentum. Five initiatives have been developed with input of consumers, service providers and government representatives. These initiatives are underpinned by an analysis of successful reform approaches in other jurisdictions and have been tailored to the Western Australian context. The initiatives are:

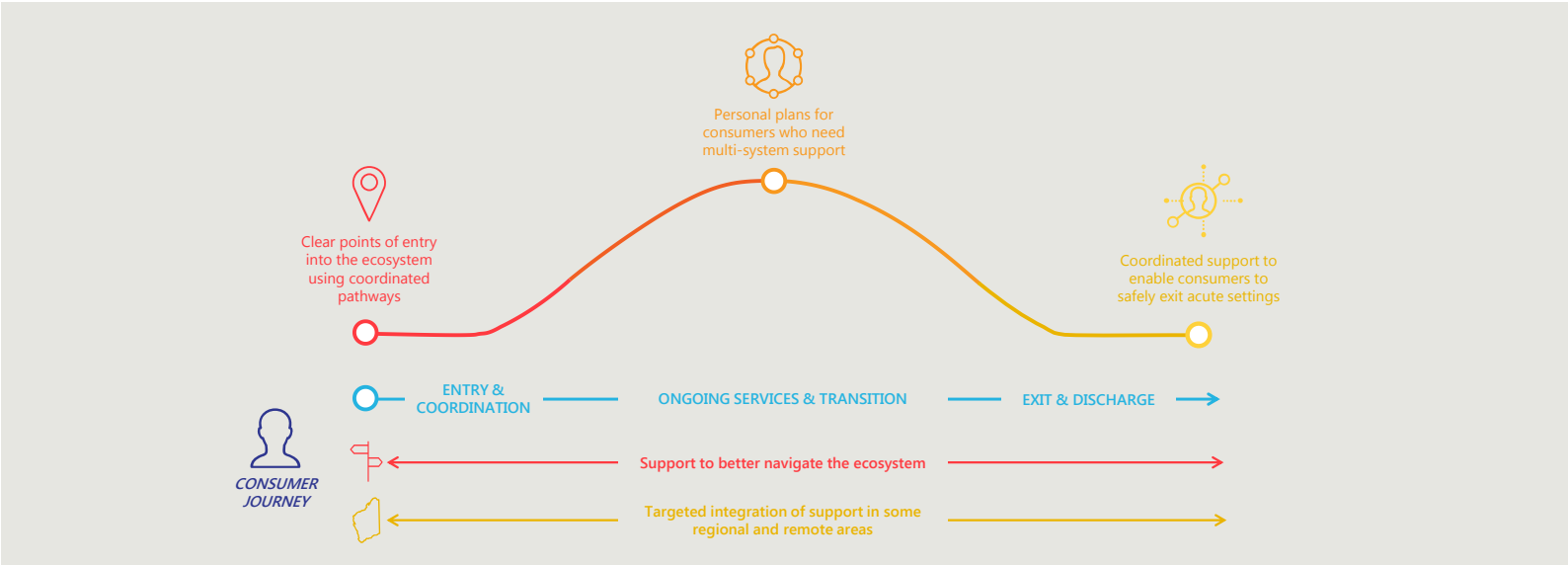
1. Support to better navigate the ecosystem.
2. Clear points of entry into the ecosystem using coordinated pathways.

3. Personal plans for consumers who need multi-system support.
4. Coordinated support to enable consumers to safely exit acute settings.
5. Targeted integration of support in some rural and remote areas.

These initiatives follow the general continuum of the consumer journey through service interfaces; including entry points, on-going service and transitions between systems and exit/discharge support.

To some extent, practical initiatives around navigation and coordination provide a 'band-aid' solution to current systemic issues without addressing the root causes of these problems. For example, the consumer navigation initiative is more of a mitigation strategy to help consumers deal with the siloed and often confusing nature and of the current ecosystem, rather than a solution that will make the ecosystem itself more integrated and person centred. However, to complement system-wide reforms required to address these root causes, navigation and coordination support is needed to manage these challenges and support consumers, their families and their carers within the existing system as it undergoes reform.

Figure 9: Initiative sequencing along the consumer journey



The front-line initiatives will provide practical, achievable approaches to addressing system interface challenges for priority cohorts and consumers. While the overall system adequately manages the experiences of the majority of consumers, cohorts targeted by these initiatives represent the minority of consumers that risk falling through the cracks between key interfaces across primary health, tertiary health, disability services, aged care and mental health. These specific cohorts of consumers place intensive demands on the ecosystem and their health services experiences are not equitable. Targeted initiatives for these cohorts or populations are likely to have significant social and economic benefits. Stakeholder feedback emphasises that it is important that they are not seen as 'pilots'; as this carries the connotation that they may not be sustained.

SUPPORT TO BETTER NAVIGATE THE ECOSYSTEM

REFORM IMPERATIVE

The five service systems (primary health, tertiary health, mental health, aged care and disability services) within the health and wellbeing ecosystem are individually complex and collectively challenging to navigate. Few, if any, consumers, staff or administrators understand the full intricacies of the ecosystem. The majority of consumers accessing the ecosystem have predictable needs, or do so as a one off, and therefore do not require broader knowledge of the ecosystem. The vulnerable minority of consumers need support to navigate a range of services and supports across different systems. To ensure that consumers, their families and carers, can access the optimal care and support from the ecosystem, they require support to navigate the parts of the ecosystem relevant to their needs. A system navigator assists by putting information in the hands of consumers so that they can make informed choices about the support they need.

EVIDENCE BASE FOR INITIATIVE

System navigator roles have been used in other health and human service systems. System navigators use a combination of human and digital resources to assist consumers to identify and access pathways through service systems. The following examples provide the evidence base for this initiative:

- **A Health and Social Services System Navigator (NT, AUS)** – introduced to 'help consumers with questions and concerns about how to access services provided by the NT health and social services system'. The System Navigator provides information about health and social services available in the Northwest Territories, connects consumers with service providers and assists consumers to find commonly used forms.
- **NHS Choices (UK)** – provides a comprehensive health information service with thousands of articles, videos and tools, helping consumers to make informed choices with service directories that let consumers find, choose and compare health, support and social care services.
- **Kaiser Permanente 'Patient Care Navigators' (USA)** – one of the largest clinical networks in the United States has full-time roles for 'Patient Care Navigators' who work alongside multidisciplinary teams to support the non-clinical needs of their most complex members. Their focus is continuity of care, identifying the right care packages and minimising the cost to Kaiser in the support provided to the member.

TARGET COHORT

- People with chronic conditions in and a range of health, mental health, disability services and aged care needs in rural and outer metropolitan areas with low socio-economic status, with a particular focus on Aboriginal and CALD people who for cultural and linguistic reasons find the current ecosystem hard to navigate.

INITIATIVE OUTLINE

An Ecosystem Navigator function works with consumers to resolve concerns, provide information, and connect the consumer to the right parts of the ecosystem. Key elements of the function include:

- The need to possess knowledge of the ecosystem as a whole and the ability to connect the consumer to the appropriate services required to best meet the consumer's needs.
- It works on behalf of the consumer, but is not a decision making authority, rather its focus is advocacy, support, brokerage and guidance
- Individual and system level data is made accessible by Government; focused on available services and

facilitation of third party access to myHealthRecord where the consumer has given consent.

The initiative should also include:

- An online navigation tool for open access (with an initial roll-out targeted at information for specific cohorts).
- A human interface element targeted to particular cohort(s) and locations and using peer support where possible.

This service should be delivered by non-government organisation(s). Sufficient information should be provided by government (including individual and system level data) but the design of the Navigator should be developed by the market through a commissioning process. The design could include considerations such as:

- A navigator 'wiki' with appropriate incentives across services and providers to encourage regular updates of their service offer.
- The Navigator function to be integrated with other digital functions such as myHealthRecord, remote monitoring and telehealth.
- Location of a Navigator in a hub location and aligned with a peer support workers.
- The Navigator role should complement existing functions in disability services (Local Area Coordinators) and aged care (MyAgedCare).

IMPLEMENTATION

Design of the Navigator initiative should be developed by the market through an EOI process. This would encourage providers to develop innovative approaches to system navigation for the target cohort, potentially including business models that do not rely on State government funding.

There are key risks to be managed during the commissioning and implementation process. These include:

- Ensuring that there is no conflict of interest between providing the function and the provision of other services;
- Management of individual service demand (due to improved navigation and knowledge of available service options)
- Sustainability of the navigation approach such as clear processes and capability training to ensure that the service does not rely on individual knowledge of the ecosystem.

Negotiation with the Commonwealth government will be required to ensure that information regarding Commonwealth funded services is available through the Ecosystem Navigator and there is appropriate inter-operability with the Aged Care Gateway and the NDIS portal.

Implementation of this initiative can draw on existing efforts in WA, including:

- The "Green Book" directory of mental health and drug and alcohol services
- The "Think Mental Health" portal
- Local Area Coordinators for disability services

CLEAR POINTS OF ENTRY INTO THE ECOSYSTEM USING COORDINATED PATHWAYS

REFORM IMPERATIVE

Keeping people well in the community requires easy to access points of entry into home and community based services and supports. If people cannot find or access home and community based services, they may resort to an ED presentation or their condition may deteriorate to the extent that they suffer an acute episode that requires an ED presentation. This is particularly a problem for vulnerable cohorts who find it hard to find and access points of access into home and community based services and supports and in specific locations where there is limited access to such services.

EVIDENCE BASE

Support for this initiative is drawn from two key interjurisdictional examples:

- **The PRISMA model (Quebec, Canada)** – an integrated care and support model that assists vulnerable cohorts to stay at home and in the community. Frail older persons are eligible for PRISMA based on the need for the individual to access services across the health and wellbeing ecosystem. Case Managers works with assigned GPs to plan a holistic range of services including mental health, home support, access to day centres, communities services and specialised care; and in some cases temporary institutionalisation in residential aged care facilities.
- **CAFLink (Canterbury, New Zealand)** – Child, Adolescent and Family Mental Health Service 'single point of entry function' which streamlines access to mental health services for children, adolescents and their families. All referrals to the mental health service are centrally received at CAFLink. As well as providing an easily identifiable point of entry to services, CAFLink ensures better quality and more consistent information to referrers, young people and their families. Referrals are centrally processed and this includes screening, triage into the service, and referral to the appropriate service or services (inpatient, day unit, community outreach teams).

TARGET COHORT AND LOCATION

Finalisation of the target cohort(s) and/or location(s) will require further analysis and consultation, but could include:

- Children and adolescents with mental health conditions.
- Frail older people living at home, particularly in outer metropolitan and rural areas.
- People with disability and/or mental health conditions experiencing homelessness.

INITIATIVE OUTLINE

A place-based coordinated care model that utilises a single point of entry and coordinates care and support for the individual across multiple organisations and service systems. This coordination model is more resource intensive than system navigation. Elements within the model include:

- A single point of entry that consumers are referred to where the individual is assessed for eligibility and assigned to a case manager.
- A case manager responsible for planning the required services, arranging access to the appropriate services and coordinating ongoing support. The case manager would also be responsible for the ongoing reassessment of the individual's needs and adjusting their plan accordingly.
- Defined pathways based upon a case-mix classification that uses cluster analysis techniques to define target groups and the range of care and support that achieves the best outcomes for the case-mix.
- A multi-functional single assessment instrument to ensure all individuals are consistently evaluated and

can be referred onto the appropriate pathway

- Linking a range of data from across the ecosystem will be necessary to ensure the coordination and case management can be most effective

The experience for the consumer should be simple with clear ways of accessing the service and knowledge of where to ask for help.

IMPLEMENTATION REQUIREMENTS

It is likely that access to appropriate forms of accommodation and accommodation support will be required for many individuals in the target cohort(s). The early involvement of the Commonwealth government (regarding Commonwealth Rental Assistance and other forms of welfare payments) and WA Department of Communities (regarding access to public, community or specialist housing) will therefore be necessary.

Funding mechanisms for this model must incentivise joined-up care around the consumer. At a minimum, case managers (or consumers, supported by case managers) will require a small discretionary budget to support service integration and to respond to emergencies. Ideally, more integrated funding (through joint commissioning, pooled funding etc.) would be available.

Implementation of this initiative can draw on the lessons of existing efforts in WA, such as:

- Young People with Exceptionally Complex Needs (YPECN)
- Complex Needs Coordination Team (CoNeCT) managed by the South Metropolitan Health Service

Negotiations with the Commonwealth will be required to identify Commonwealth funded services that will be in scope and agree secure a contribution for the costs of coordination, given the benefits that would accrue for both tiers of Government. .

PERSONAL PLANS FOR CONSUMERS WHO NEED MULTI-SYSTEM SUPPORT

REFORM IMPERATIVE

Individuals who are living with long-term conditions are some of the largest consumers of health based services and this is expected to increase. Much work has been undertaken in WA over the last ten years to develop condition specific models of care, but this imposes a standard health-based model on the individual, rather than empowering the individual to choose a range of services that meet their personal requirements and circumstances. Many individuals with long-term conditions are also be eligible for funding through disability and/or aged care services; and as the reforms in these sectors are rolled out, these individuals will have greater control over the support they receive. At the moment these services would be planned in isolation from any health care plan.

EVIDENCE BASE

Personal health budgets for individuals with long-term chronic conditions have been introduced in both the Netherlands (1995) and England (2005). In both instances the introduction of personal health budgets has also covered individuals with aged care needs and individuals living with a disability. The evidence in both countries has shown a significant increase in consumer satisfaction and increased choice.

A 2012 evaluation in England concluded that the introduction of personal health budgets had reduced the use of hospital based services, with a significant shift to well-being services and specialised community health services; without a detrimental impact on the health outcomes of the individual. It also noted that personal health budgets had had a positive influence on the ability to introduce further system integrations into the future.

The initiative must be well targeted to focus on high consumers of services. In the Netherlands the initial eligibility criteria was too broad leading to an 'exponential' increase in costs over the first ten years.

TARGET COHORTS

Finalisation of the target cohort(s) will require further analysis and consultation, but could include:

- Children (0-15) and young people (15-25) with NDIS packages who also have health needs.
- Older people with Home Care Packages with chronic health needs.

INITIATIVE OUTLINE

On an opt-in basis, eligible individuals would receive support to develop and implement a personal health care and support plan funded by a personal budget to complement their disability or aged care support plans and funding packages, with flexibility to manage funding within and between packages. This will enable them to access funding and select from a broader range of services across the ecosystem than they can currently utilise. The personal plan may be used for a range of things to meet agreed health and wellbeing outcomes. This could include therapies, personal care and equipment.

A Personalised Health Care and Support Plan will help consumers to identify their health and wellbeing goals and sets out how the budget will be spent to enable them to reach these goals. Goals are set by the consumer within defined parameters (including quality safeguards) and with guidance from a planning support officer.

As has been seen with the NDIS roll out, a move to personal plans and budgets has required significant investment to implement; including the training of planners and coordinators, and building the capability

of consumers to develop and implement plans. It will be important that this initiative is additive to the investment that has been made in NDIS implementation and capability development; rather than duplicating/contradicting/undermining the NDIS and similar aged care reforms. Capability training should be provided for different services to proactively identify when a consumer may require a Personalised Care and Support Plan, rather than waiting for a request from the consumer.

IMPLEMENTATION REQUIREMENTS

There is a risk that this initiative creates 'two classes' of consumer; those with personal budgets and those that navigate the traditional model. In the short term, this initiative should focus on specific cohorts, to manage the transition. Data from these specific cohorts should be used to identify and measure benefits and outcomes of personal budgets to later extend the scale of the initiative to a wider set of consumers.

Negotiations with the Commonwealth must ensure that funding for health based personal plans is not deducted from other personal budgets that the consumer receives from the Commonwealth. There must also be clear protections in place so that funding follows consumers not providers.

COORDINATED SUPPORT TO ENABLE CONSUMERS TO SAFELY EXIT ACUTE SETTINGS

REFORM IMPERATIVE

Supporting specific cohorts of consumers to safely and quickly exit acute settings is usually in the best interests of the consumer, and can relieve pressure on hospitals. Whilst hospitals seek to safely discharge patients as soon as they are clinically fit, there are acknowledged issues (including inadequate availability of accommodation and accommodation support options) that mean some consumers end up staying in hospital beyond the point where they are fit for discharge. This would include older persons awaiting a residential care place; and individuals who have experienced a trauma that means they will be eligible for a new NDIS package.

EVIDENCE BASE

Any initiative would need to consider that the provision of any early supported discharge service must avoid conflicts of interest from service providers that could benefit from onward referrals. Key examples include:

- **Community Rehabilitation Enablement and Support Team (CREST), (Canterbury, New Zealand)** – established in 2011, CREST is a community based early supported discharge and admission avoidance service for older people that has reduced length of stay, reduced residential care placement and the need for long term home based care. It is based around an interdisciplinary team including a liaison team based in hospitals who identify eligible persons for the service. This identification triggers a range of activities designed to ensure the safe and supported discharge of the individual and a series of supports to avoid the readmission of the individual.
- **Transition Care Program (Australia)** – provides packages of services to older people after a hospital stay that may include low intensive therapy (such as physiotherapy and occupational therapy), social work, nursing support or personal care. This package allows older people to return home after a hospital stay rather than prematurely enter residential care.

TARGET COHORT

Finalisation of the target cohort(s) and/or location(s) will require further analysis and consultation, but could include individuals in hospital whose home support arrangements need to change, including:

- Adults with a life changing injury, including those likely to be eligible for NDIS funding.
- Older people transitioning to a new aged care service.

INITIATIVE OUTLINE

An early supported discharge service for individuals that are awaiting a new or changed aged care/NDIS package to be in place could support the timely transition from hospital into an intermediate ('step down') care setting. This service effectively 'pulls' individuals from the hospital at the point they are clinically fit for discharge into an intermediate services; replacing the need for the hospital to wait for the appropriate service to be in place before the individual can be discharged.

From the moment the individual is identified, the service would work with them to coordinate the appropriate NDIS/Aged Care package and any additional intermediate care services required. An early supported discharge service would need:

- To have a presence in participating hospitals and collaborate with the clinical teams to identify the appropriate individuals who would benefit from this service.

- The use of intermediate services to support the safe transition of individuals including handover with clinicians, transport of consumers (if required), provide a first review, and subsequent update of consumer needs within defined timeframes.
- Individual case management and advocacy to put in place the appropriate program of support with all relevant agencies; including the intermediate support packages whilst the individual is in hospital.
- Data linkages to ensure that coordination and case management can be effective. All data and plans would be owned by consumers with consent required for sharing.
- Access to accommodation infrastructure that is appropriate for the individual's needs.

IMPLEMENTATION REQUIREMENTS

There is a risk that the current system that is already overly complex, and involves multiple decision makers. There need to be clearly articulated roles and decision making responsibilities at each point of the discharge and follow up process.

Negotiation with the Commonwealth should:

- seek to align supports provided by this initiative with management and applications for income support and disability support pensions for eligible consumers through Centrelink.
- identify and resolve any barriers to timely discharge created by NDIS and aged care planning and funding mechanisms.
- identify innovative means of financing an increased stock of appropriate accommodation (including Specialist Disability Accommodation and high-needs residential aged care), in partnership with the WA Department of Communities.

Implementation of this initiative can draw on existing efforts in WA, including:

- Hospital in the home services
- Post-Acquired Brain Injury rehabilitation services
- Palliative Care services
- The roll-out of the Medihotels election commitment

TARGETED INTEGRATION OF SUPPORT IN SOME RURAL AND REMOTE AREAS

REFORM IMPERATIVE

Health outcomes for Western Australians in rural and remote WA are significantly worse than those residing within metropolitan Perth. Access to services is a significant issue, with "thin markets" leading to low rates of service availability. Reforms to disability services and aged care, and the transition away from the Home and Community Care (HACC) program mean that the WA Country Health Service (WACHS) will no longer be in a position to be the provider of last resort for aged care and disability services. Targeted effort will be required to attract and retain NGO service providers to operate disability and aged care services within remote and rural areas; and to manage a transition from WACHS provided services. Commissioning services separately is unlikely to generate sufficient demand for those individual services to be financially or operationally sustainable.

This initiative is consistent with WACHS' submission to the Sustainable Health Review, which recommended a regional commissioning pilot based on a single independent commissioning body that will plan in collaboration with local communities, the services they need and commission providers to deliver these services.

EVIDENCE BASE

Integration of place based services has been implemented in Catalonia (Spain) and Canterbury (NZ) on a large scale. These examples demonstrate that integration of health and wellbeing services across whole populations can provide solutions that move away from a 'national model' to focus on a more tailored local solution. On a far smaller scale, the demonstrator sites in Western NSW have introduced place-based integration of services focused on small condition cohorts (e.g., Aboriginal individuals with Type II Diabetes in Dubbo).

Accountable care models have been in place in the US for over 10 years, are being adopted in the UK and form part of the Canterbury model. The models vary in form but are built around three core elements: (1) Commissioners define the health and wellbeing outcomes and objectives for a defined population; (2) A provider or alliance of providers will be commissioned and held to account to deliver these outcomes and objectives; (3) This commissioner gives the provider or alliance a fixed budget to design and deliver the range of services that best meet these outcomes and objectives.

TARGET PLACE

Further analysis and consultation will be required to identify which rural or remote area of WA would be the most effective starting point, with initial potential identified for:

- The Kimberley region, consistent with the WA Country Health Service submission and the Regional Services Reform agenda.
- The Wheatbelt or Great Southern regions, building on the investment made through the Southern Inland Health Initiative

INITIATIVE OUTLINE

A place based approach to integrated service commissioning and provision across the ecosystem in the region. Services will be designed to meet the specific needs of that population, and operate within the local constraints. At a minimum, this would involve:

- A clear statement from government on the desired outcomes, timings and support for the initiative.
- Agreement between the State and Commonwealth governments on a joint funding and commissioning approach with appropriate mechanisms and incentives to encourage collaboration between providers.
- A single local service commissioning and development plan.
- A local sector development and transition plan, that sets out the timetable for the services to be in place and that ensures WACHS can step away from non-health services.
- 'Seed' funding to support the implementation and transition period.

This would create opportunities for alternate and/or complementary approaches, including:

- A single point of accountability/authority for the performance of the local services; effectively an accountable care model extended to cover NDIS and aged care services.
- An aligned approach to targeted Population Health funding for the locality that addresses specific Social Determinants of Health for the catchment population, as well as cultural determinants for Aboriginal people.
- Combining services within single facilities ('hubs') to gain scale that makes services sustainable.
- The use of technology, such as telehealth, to connect community services to specialist services.

Consideration would need to be given to the role of Aboriginal Medical Services and other Aboriginal community controlled organisations, and the potential to expand beyond the ecosystem to include and partner with other human services such as education, child protection and housing.

IMPLEMENTATION REQUIREMENTS

Implementation for this approach should support the development of local workforce capability, to offer flexible, culturally secure support for consumers. This support may extend to local training for existing or new professions (such as 'medical assistants') or consideration of innovative workforce and employment models (such as shared employment across providers).

Negotiation with the Commonwealth should consider how existing Commonwealth health funding, including through the Medical Benefits Schedule (MBS), Pharmaceutical Benefits Schedule (PBS) and Aboriginal health funding can be "cashed out" and reallocated to the single commissioning body.

Comprehensive evaluation of the approach, commencing before roll-out to provide a baseline, will be required to assess the financial and health and wellbeing status outcomes of the approach.

3.4 Changing the ecosystem ground rules will be necessary to ensure the initiatives can be sustained

There are a series of structural levers within the health and wellbeing ecosystem that will be needed to create and sustain the conditions for person-centred and integrated initiatives to thrive. These levers will effectively 'change the rules' of the health and wellbeing ecosystem in WA, establishing appropriate incentives to achieve the vision and removing some of the barriers that at present would hinder the ability to implement sustainable reforms. Many of the potential changes may not be directly experienced by consumers, but they will help the discrete front-line initiatives to be successful, and systemically sustainable. Three key structural levers are:

- **Legislation and policy:** Establishing alignment of legislative and policy settings at both a State and Commonwealth level to enable effective interfaces between the service systems; and/or remove the barriers to the service systems being more integrated.
- **Funding and commissioning mechanisms:** Putting in place funding and commissioning mechanisms that incentivise and/or support greater integration between the service systems and enable more person-centred services.
- **Information management:** Establishing mechanisms that enable data and information to flow through and within across the ecosystem; and increasing the levels of transparency of system performance at a local and state-wide level between government, providers and consumers - enabling consumers to make informed choices to best meet their needs.

These levers align with the findings of a recent report by the World Economic Forum[22] which identified five key areas of focus for public policy. Four of these areas are directly relevant to the WA health and wellbeing ecosystem and the introduction of person-centred and integrated services, namely:

1. Enabling cooperation, coordination and partnerships; whilst protecting against conflicts of interest [Legislation and Policy];
2. Encouraging and establishing payment models based upon outcomes [Funding and Commissioning];
3. Tracking outcomes, with set standards for data collection and transparency [Information management]; and
4. Striking an appropriate balance between privacy and data sharing [Information management].

Each lever is summarised below, with brief examples of the types of directions that could be implemented to enable the desired outcomes.

[22] World Economic Forum (2017) *Value in Healthcare*

LEGISLATION AND POLICY

SUMMARY

The health and wellbeing ecosystem is large, complex and heavily regulated. As such, it is essential to have a legislative and policy environment that enables the move to person-centred and integrated services. Even where key stakeholders may collectively aspire to deliver better outcomes, often a range of disincentives and risks built in to the current system make it difficult for individual stakeholders to achieve that goal on their own; not least the tangled web of accountability and funding across the ecosystem.

The WA Government has a key role to play in enabling and providing the incentives for greater integration across the ecosystem. If the aim is to create an ecosystem where providers can both cooperate and compete, then government must set the rules and define an appropriate legal and regulatory framework to allow such cooperation and competition to emerge. This may require changes in legislation, and while this may be necessary it can take time. Therefore, ensuring that policy is aligned and consistent across state-based agencies will be necessary in the short to medium-term.

KEY CONSIDERATIONS

- **Alignment of relevant cross-agency legislation and/or policy.** The reforms in aged care, disability services and health have been developed in isolation and with little consideration of the interfaces between the individual systems. Alignment of the policy landscape will help to remove inconsistencies and perverse incentives.
- **A ten year strategy and staged reform program.** The strategy will need to articulate how the vision can be achieved, define the key steps in the journey, and set expectations that this reform is a long term commitment for government. It will need to be underpinned by a staged reform roadmap and implemented through a cross-agency program (more detail on how this might be approached is summarised in Section 4).

WHAT IS NEEDED FOR THE FRONT LINE INITIATIVES

- All of the front-line initiatives will need to be delivered within the context of the ten year strategy and reform program.
- The integration of services in specific rural and remote locations will need to be driven by specific cross-agency policy and cross-agency oversight.
- The introduction of holistic personal health and care plans for specific cohorts may require some legislative amendments.

WHAT BARRIERS NEED TO BE OVERCOME

- The primary health care and aged care (and in the future, disability services) sectors are administered by the Commonwealth, so the relevant legislative and policy landscape is not all within the purview of the State.
- This will require multiple government agencies to develop and sign-up to a significant reform program. It will also require political support that can transcend the election cycles at a Commonwealth and State level.

FUNDING AND COMMISSIONING MECHANISMS

SUMMARY

How health and wellbeing service providers are funded can be a major obstacle to reform and collaboration. The funding mechanisms in the ecosystem can create many (real or perceived) disincentives to change service models. For example, Activity Based Funding compensates hospitals for the number of patients treated in hospitals; MBS and PBS incentives primary care providers to treat volume; and the early roll-out of NDIS has seen a focus on the volume of people to be signed up, rather than an emphasis on quality.

Public health and wellbeing systems around the world do not typically focus on a holistic approach to funding across the care and support continuum. This is often due to the siloed nature of the service systems, but also because the financial benefits are often not accrued in the service system delivering the service (for example, the cost of significant investment in health prevention in Western Australia would be borne by the Health system, whilst the primary financial benefits would be received by Treasury (with more people able to work) and the welfare system (fewer people claiming financial support).

With the added complication of a mixed state and funding model laid over this context, it is inevitable that commissioning and appropriately incentivising integrated of services across the ecosystem will be complex.

KEY CONSIDERATIONS

- **Outcomes based commissioning.** A shift from funding and measuring activity as a key system performance measure to an environment where consumer outcomes are defined, measured and incentivised. Outcomes based commissioning is a key focus for the emerging Primary Health Networks. This strategic approach to commissioning places the emphasis on outcomes of services and systems, rather than on outputs.
- **Individualised and portable funding.** Reforms within the aged care and disability services systems are being built around the introduction of individualised funding packages. There is the potential to extend align this approach for consumers who also have complex health needs; in a way that is familiar to consumers and with the potential for the individual to pool funding from across the ecosystem.

Note: Outcomes based commissioning and individualised funding are two mechanisms seeking to achieve the same objective – services that are better designed to meet individual outcomes and circumstances. There is a fundamental difference in how this objective is achieved. Individualised funding gives control of the budget to the consumer and lets them decide the services they want to purchase to meet their individual outcomes; whereas outcomes based commissioning is a data driven approach that seeks to identify local population needs and provides funding to organisations to deliver services designed to meet desired population outcomes.

- **Joint commissioning and bundled funding.** This would see two or more government agencies/ service commissioners commission and fund a single health and wellbeing service for a specific population/cohort, utilising a pooled budget approach and including shared incentives for achieving described outcomes. This has the potential to connect hospitals, community services, voluntary organisations and social services into a single service framework.

Other funding consideration that could be explored include: Consumer influenced funding (for example, in some jurisdictions 'citizen's juries' have established to inform and influence policy making); and the need for sustainable funding commitments (i.e. at least three years) for critical services targeting cohorts - such as mental health and Aboriginal health service provision - that are at risk of falling between the cracks in the interfaces of the ecosystem.

WHAT IS NEEDED FOR THE FRONT LINE INITIATIVES

- The integration of services in specific rural and remote locations will require joint commissioning and pooled funding. A focus on outcomes based commissioning will provide a clear framework to assess the impact of these changes at an individual and community level.
- Personal plans for individuals with complex needs will require individualised and portable funding.
- The two care and support coordination initiatives (Single point of entry and Supporting safe discharges) will need to consider the financial implications across the ecosystem and may require the introduction of specific incentives (in the short-term) to compensate for the impact of these initiatives.

WHAT BARRIERS NEED TO BE OVERCOME

- Outcomes based commissioning requires significant stakeholder consultation and buy-in to design and develop outcomes, measures and indicators that are consumer focused, and achievable.
- Personal health budgets and pooled funding need to overcome the challenge of aligning funding from multiple sources and the need to acquit these funds back to their source.
- As above, there may be a short term impact on some providers (notably the public hospital system) which are currently funded based upon the volume of patients they treat. This is at a time when all parts of the public hospital system are under significant financial pressure. This impact needs to be evaluated and mitigated.

INFORMATION MANAGEMENT

SUMMARY

Better management of information has the potential to significantly change the way the health and wellbeing ecosystem interacts within itself and how consumers interact with it. This potential includes empowering consumers to make their own choices; improving data connection and health literacy; enabling remote health monitoring and management; the secure sharing of individual information to better connect the ecosystem; and enhanced analytics, including the utilisation of 'big data' and the use of artificial intelligence techniques.

The improved use of information and analytics across the State Government is a key recommendation from the WA Service Priority Review (published in December 2017) and opportunity to better connect data across the ecosystem is a key part of the Data Linkage Expert Advisory Group's report into Western Australia's data linkage capabilities released in October 2017; which concluded that *'broadening data linkage beyond health is an important opportunity for WA to make the best data-driven policy decisions for the community, through a whole of government approach'*.

KEY CONSIDERATIONS

- **The appropriate use of My Health Record across the health and wellbeing ecosystem.** The accelerated adoption of My Health Record across the primary, secondary and tertiary health system; and facilitating access to the system by aged care and disability service providers - where there is consumer consent; and supporting the population at large to effectively utilise it.
- **Cross-government data linkages with enhanced analytics and artificial intelligence.** Data analysis in the ecosystem is predominantly focussed on performance reporting and performance management. The potential of enhanced analytics, the utilisation of 'big data' and the use of artificial intelligence techniques is still untapped. An immediate need will be the cohort analysis required to appropriately target the frontline initiatives outlined in the previous section.
- **A standard metadata structure across the ecosystem.** Analysing data even within one service system is complicated by the different data that is collected and stored. Whilst data linkages can address fact data is not well connected, it does not address the issue that different data (formats, data definitions etc.) is typically collected within and across the ecosystem. A common metadata structure across the ecosystem will enable each part of the system to more readily share and effectively utilise data.

WHAT IS NEEDED FOR THE FRONT LINE INITIATIVES

- All five of the front line initiatives will be reliant on good data and the ability to analyse data in order to identify the appropriate cohorts and to ensure good information is used to manage and assess the performance of each initiative.

WHAT BARRIERS NEED TO BE OVERCOME

- The implementation of My Health Record has been characterised by low take-up, system security issues and privacy concerns. A national digital health strategy 2018-2022 was approved in August 2017 and it will be important for WA to be clear how it aligns with this strategy.
- The lack of privacy legislation in WA needs to be addressed – a recommendation from both the Service Priority Review and Data Linkage review noted above.

3.5 Reform will be underpinned by people, partnerships and performance

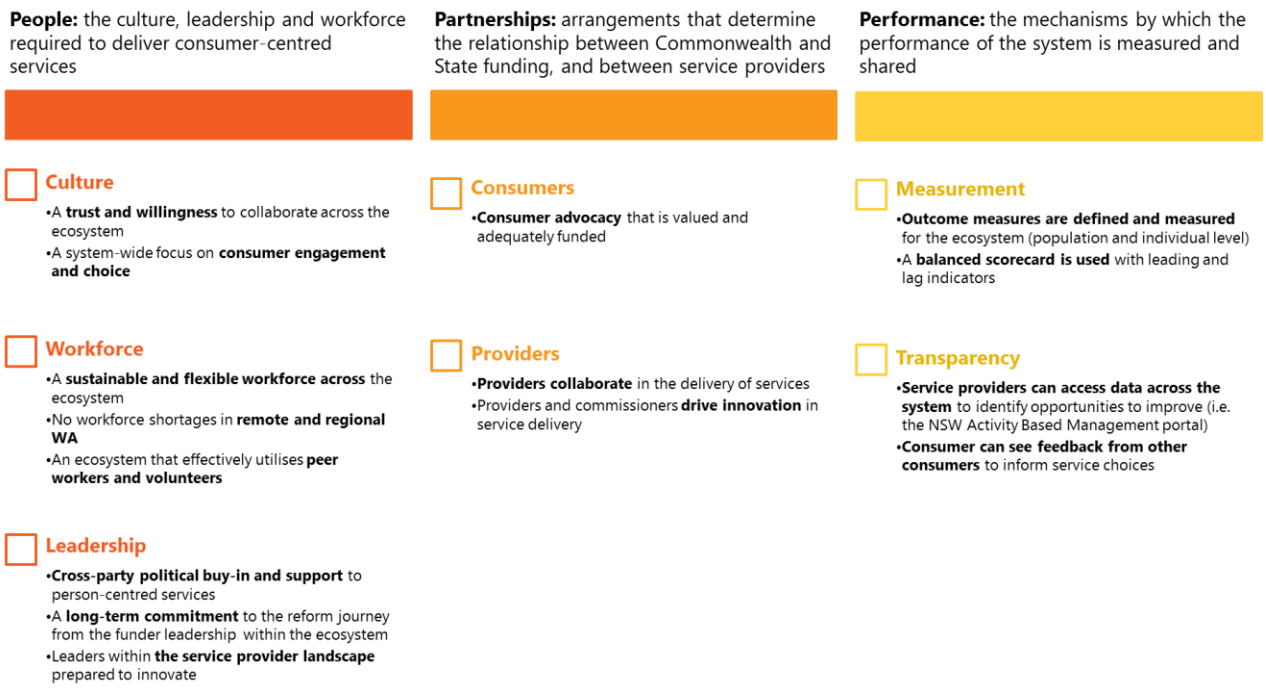
Key enablers underpin success of the reform process. The enablers are a range of elements that need to be improved to support the initiatives and delivery of services across the ecosystem. They include:

- **People** – the culture, workforce and leadership required to deliver consumer centred services.
- **Partnerships** – arrangements that determine the relationship between funders, commissioners and service providers
- **Performance** – the mechanisms by which the performance of the system is measured and shared.

Focus on these activities will improve the capability and capacity of the ecosystem to be more person-centred and integrated. The frontline initiatives are not dependent on these enablers being in place; however, the sustained performance of the frontline initiatives will require these enablers to be in place.

A detailed description of each key enabler is provided in turn:

Figure 10: Key enablers of the ecosystem



People

Good culture, workforce capability and strong leadership provide the underpinnings of consumer-centred services.

Culture

Across the ecosystem, developing a culture of trust and willingness to collaborate across sectors is crucial to be able to support integrated, consumer-focused support. There are a number of cultural behaviours that should be reinforced to achieve the desired culture. These include:

- **A system wide focus on consumer engagement and choice** – putting in place mechanisms that actively bring the system focus at all levels towards consumers.
- **Building trust across sectors** – including a greater role for all parts of the WA Health system to look beyond the health system and to develop strong working relationships with other sectors.

The desired culture will be reinforced when valued behaviours are frequently recognised at an individual, system and ecosystem level and poor behaviours are actively addressed.

Workforce

Initiatives will be further supported with considerations of key workforce requirements:

- **A sustainable and flexible workforce across the ecosystem** – planning and development for a sustainable and capable workforce equipped with the skills and qualities required to deliver integrated, person centred services. This includes specific planning for rural and remote workforce planning across the system.
- **Utilisation of peer workers and volunteers** – effective inclusion of peer workers and volunteers across the ecosystem to provide support and experience to ensure that services are consumer focused.
- **Clarity of purpose** – the workforce across the ecosystem is clear about what is expected of them and hold themselves and others to account. This clarity enables the required cultural change for the broader workforce and will help to articulate the expected behaviours of staff across the ecosystem.

Leadership

There are three dimensions of leadership required to support the front-line initiatives:

- **Political leadership** - cross-party political buy-in and support of person-centred services. This leadership sets the mandate for a long-term commitment to the reform journey.
- **Commissioning leadership** – commitment from funders and commissions to set the conditions that enable providers to trial and deliver integrated and consumer-centred service delivery approaches.
- **Provider leadership** – leadership across the ecosystem at an individual, sector and system level to change behaviour across the ecosystem in a way that encourages innovation. This change requires leaders' to align their decisions and behaviours in a way that sets the standard for their staff, and delivers a positive experience for consumers.

Partnerships

There are opportunities for the Department to improve its existing and future relationships with consumers and providers to deliver better outcomes for all stakeholders.

Consumers

There should be an increased emphasis across the ecosystem on actively valuing and including a range of consumer advocacy mechanisms into system design, support and policy. This includes:

- **Increased value of consumer advocates** – creating a culture and a relationship where consumer advocates are a central component of system design, support and policy in a way that ensures that advocates are valued by the ecosystem.
- **Funding consumer advocacy** – adequate levels of funding for engagement must be in place to ensure that advocacy forums are accessible to a wide range of consumers, and to ensure consumers are consulted with on all parts of the system that impact the consumer experience, for continuous improvement.

Providers

Developing strong partnerships and relationships between providers and with the Department will enable the delivery of better integrated, joined-up service approaches that improve experiences for consumers. Partnerships should focus on:

- **Improving departmental relationships with service providers** – a healthy ecosystem will rely on the health system to develop and maintain better relationships with providers. There are two components to this relationship; greater focus on collaborative procurement and service delivery approaches, as well as a broader consultation and engagement role.
- **Greater inter-provider collaboration** – there need to be proactive partnerships between providers to enable the delivery of a coherent and effective health and wellbeing ecosystem for consumers. Strong provider partnerships will deliver improved experiences for consumers during their interactions with or journey through the ecosystem through increased collaboration in the delivery of services, for a seamless consumer experience.
- **Linking up commissioners and providers** – greater collaboration between commissioners and providers to drive innovation in service delivery through provision of services that are flexible, consumer focussed and outcomes driven.

Performance

Performance of the ecosystem requires clear monitoring of defined service outcomes in order to identify opportunities to improve delivery and to enable consumers to make informed choices about the services they receive.

Measurement

Measurement of performance should focus on outcomes rather than activity or output based measures. Benefits to this approach include:

- **Accountable service monitoring** – outcomes based commissioning enables the measurement of the impact of services. This will enable the ecosystem to hold everyone to account through service monitoring, including the extent to which services are delivering integrated, consumer-centred support.
- **Defined outcomes and measures for the ecosystem** - outcome measures are defined and measured for the ecosystem and can be aggregated a population and individual level (with consumer consent).

Transparency

Transparency of service performance is critical for consumers and providers:

- **Consumers can make informed choices** - consumers can see feedback from other consumers about service options to inform the choices they make about the providers they choose and the services they receive. Consumers can also access provider reporting on service outcomes to provide clarity on the services funded, the deliverables expected, and the outcomes achieved. This provides consumers and their communities with additional visibility of the services they should be receiving.
- **Providers can improve services** – provision of feedback to service providers by consumers can assist provider to gain insights and make iterative adjustments to their delivery approach that supports integrated, consumer-centred delivery approaches.

4 Achieving more person-centred and integrated services will require a significant program of change over many years

4.1 The strategic directions establish the basis for a strategic reform program

The reform directions set out in this paper and the evidence presented in support of these directions demonstrate that there is the opportunity for the health and wellbeing ecosystem to pursue a targeted approach to person-centred and integrated services. This approach should: reduce pressure on WA's hospitals; provide more holistic and joined-up care and support for some of Western Australia's most vulnerable people; mitigate some of the issues currently experienced in the ecosystem; and help the ecosystem adapt so that the reforms across the individual service systems do not have a negative impact on consumers, taxpayers, service providers or government.

The framework provides the basis for a strategic reform program that could enable targeted person-centred and integrated initiatives to be implemented across the ecosystem:

- The **draft vision and principles** will help establish a mandate for change
- The conditions for sustaining person-centred and integrated services will be created through the **changing the ecosystem** elements
- The **front-line initiatives** provide five examples of practical changes that can be the early focus of the reform program
- The **key enablers** are a range of elements that need to be improved by the ecosystem; these improvements will support both the front-line initiatives presented in the framework and the wider delivery of services across the ecosystem.

Although the framework provides the strategic directions for reform, it is only an outline of the potential for change. The next step is to translate these directions into practice, utilising the Sustainable Health Review as the key mechanism for progress, but recognising that the scope and objectives of these directions cover a far broader range of consumers, services, funds, government agencies and ministerial portfolios than the Sustainable Health Review.

At a high-level, the key steps for moving forward with these directions are illustrated in Figure 11, with detail on the implementation approach in Section 4.3.

Figure 11: Implementation steps

4.2 Sustained success will depend upon how the reforms are executed

As the ecosystem embarks on a program of significant reform, there are a series of critical success factors that should be factored in, to ensure the program is given the greatest opportunity of success, buy-in and sustainability:

- **The reforms will take time to plan, implement and establish.** Where similar programs have been introduced, they are often implemented as part of 5-10 year strategic plans. For example, the integration of health and social services in Catalonia targeted at individuals with chronic conditions was implemented as part of five year strategic plan (2011-16). A second four year strategic plan (2016-2020) has since been established to roll-out the lessons learned from this program for other vulnerable cohorts of people; for example, children with complex health needs.
- **The detail of the reforms will require co-design with consumers, families and carers.** The detailed design of the reforms and resulting service models will require genuine co-design with consumers, families and carers to ensure that they primarily meet consumer rather than system needs.
- **The reforms will need cross-party political support.** The reforms can be expected to traverse multiple parliamentary cycles. It is critical that any potential change in government does not interrupt or disrupt the reform program.
- **The reforms will need to be led and driven by the whole ecosystem.** The scope of the reforms cover multiple service systems, which in turn are funded and managed by multiple government agencies from both the State and Commonwealth. A single, cross-representative body will need to be established to oversee the planning and implementation of any reform program.
- **The reforms will require a dedicated program with dedicated resources.** The nature of the reforms means that they cannot be achieved by resources with competing demands for their time. Dedicated resources with a range of expertise will be required to manage, plan and support the delivery of the reforms.
- **The reforms need to balance evidence with innovation.** As previously described in this report, many of the changes proposed have been implemented in other states in Australia or in other countries. There is a growing bank of evidence that such reforms will deliver positive outcomes, but in some examples it is too soon to evaluate the overall impact. On an initiative by initiative basis, WA will need to strike the right balance between the need to progress and innovate and the need for multiple points of evidence that such changes will achieve the desired outcomes.
- **The reforms will need to identify establish and maintain momentum.** There is a danger in any program of reform that momentum stalls through over-analysis or overly detailed planning. The importance of the early-adopter initiatives will be to generate momentum and early successes for the reforms, whilst some of the wider systemic enablers and changes to the ecosystem are being developed; for example, the widespread adoption and effective use of electronic personal health and care records will take some time and should not hold up the progress of the early-adopter initiatives.

The Sustainable Health Review can provide the platform, impetus and focus to achieve many of these success factors; assuming in doing so it aligns with and complements other reforms across the ecosystem (such as progression of the Mental Health Plan, the roll-out of NDIS, and the Health Care Home pilots).

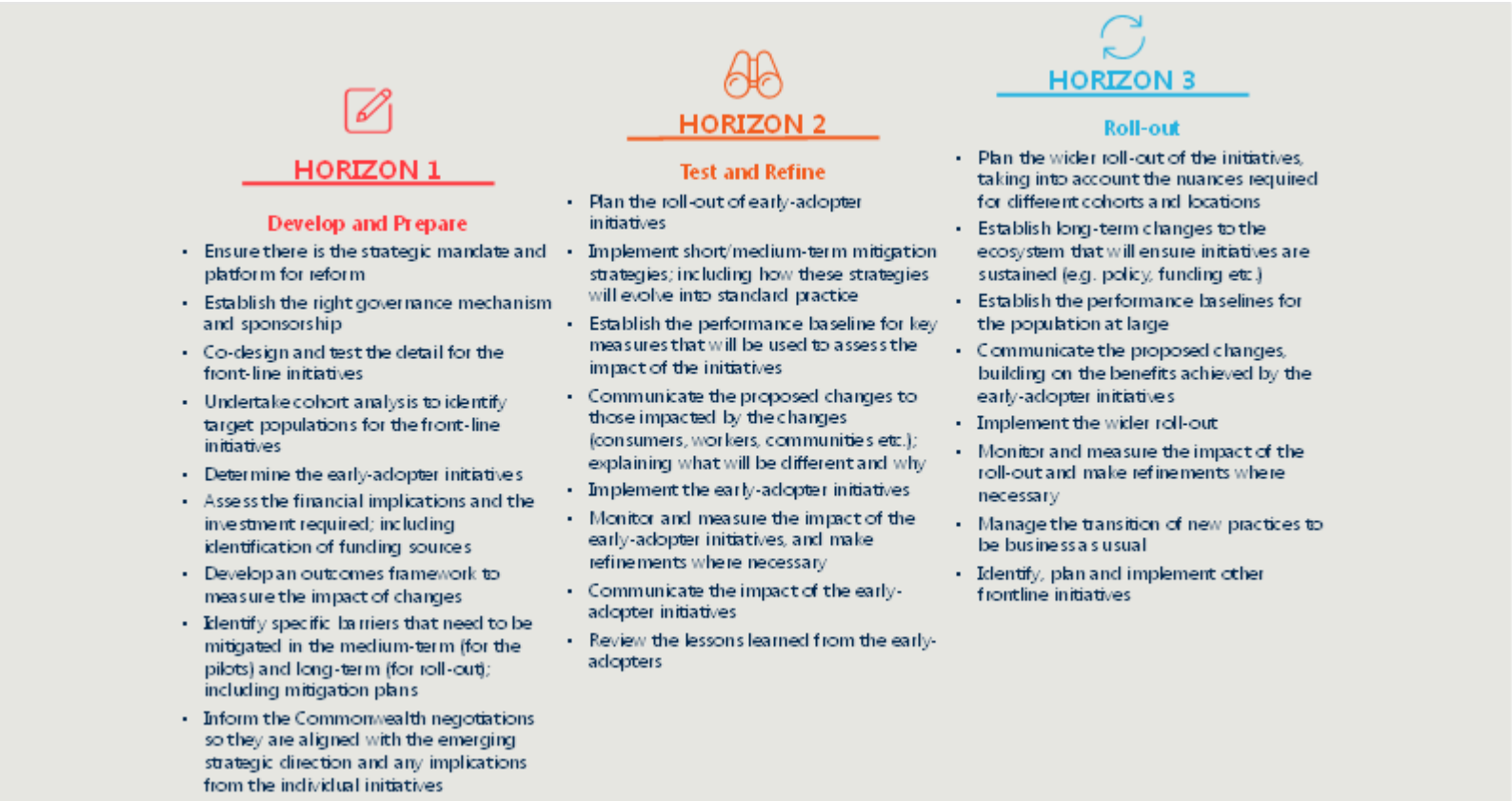
4.3 A phased implementation approach over three horizons can guide the staged implementation of the reforms

One possible approach to implementation is to utilise the three horizon model that has proven to be a successful approach to innovation and organisational development. The three horizons provide focus to long-term change that is expected to last multiple years:

- **Horizon One** focuses on establishing the case for change, designing what the future state looks like and establishing a staged plan for moving from the current state to the future state. In practice, the development of these strategic directions are the first step in this horizon.
- **Horizon Two** is a transition period, where small scale initiatives can be tested, wider ranging reforms can be planned and the appropriate environment for sustainability can be prepared.
- **Horizon Three** sees implementation of the reforms and the bedding in of business as usual practices.

Figure 12 illustrates the key activities in each horizon that the program to establish person-centred and integrated would need to undertake. Timeframes for each horizon would need to be established during the next phase of the Sustainable Health Reform. As a guide, in New South Wales, the Integrated Care Demonstration sites were launched in 2014 (effectively moving into Horizon Two) and the Department has recently started to put in place the mechanisms to roll-out integrated care models on a larger scale – such as establishing an operational framework for integrated care – thereby moving into Horizon Three over the next 12 months.

Figure 12: Three successful examples of whole of system integrated care



4.4 State-Commonwealth negotiations are a critical enabler for change

The negotiations are just part of the strategic opportunity for the State. Having two funders and multiple service commissioners across the ecosystem is a challenge, and this challenge is often used as a reason why the service systems cannot be further integrated. Assuming that the Commonwealth/State funding divide is not going away, the WA government needs to maximise the funding potential from the Commonwealth by supporting WA's consumers and providers to be better at accessing and utilising the funds that they are eligible for. Rather than urging the Commonwealth government to **push** more funding to WA or allocating State government funding to **substitute** for Commonwealth effort (as has traditionally been the case), the negotiation strategy should focus on identifying means to:

- Support eligible consumers and providers to **pull** funding from the Commonwealth's primary demand driven funding mechanisms (including the MBS, PBS, NDIS and aged care programs).
- **Remove barriers** that prevent take-up of Commonwealth funded services in WA, including revisiting rural and remote cost loadings,
- Identify **targeted interventions** for specific high risk cohorts to reduce dependency on long term, more acute and higher cost services, consistent with the Commonwealth Government's insurance based approach to the NDIS and investment based approach to welfare reform.
- Reduce fragmentation of funding and service provision by **pooling funding** and **jointly commissioning** where the State and Commonwealth governments fund related services (e.g. Aboriginal health).

This approach is consistent with the conclusions in *Shifting the Dial*[23], which advocated that Australia's health system should place the individual the centre of the care and support they require; shift towards greater integration of services; ensure regional flexibility; and address the fragmentation of funding models.

[23] Productivity Commission (August 2017), Shifting the dial, 5 year productivity review

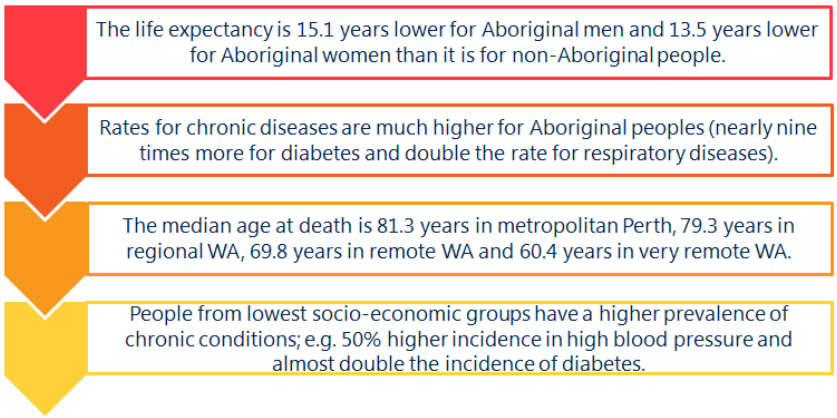
Appendix A – Problem Definition

The following section provides additional research to accompany the overview provided in Section 1.

The health and wellbeing of Western Australians is generally good…although there are clear issues with equity

Despite the generally good outcomes (See Section 2.31.2); consumers and governments experience a range of issues both within and between the service systems. Some outcomes for specific cohorts remain poor.

Figure 13: Outcomes for specific cohorts of Western Australians[24]

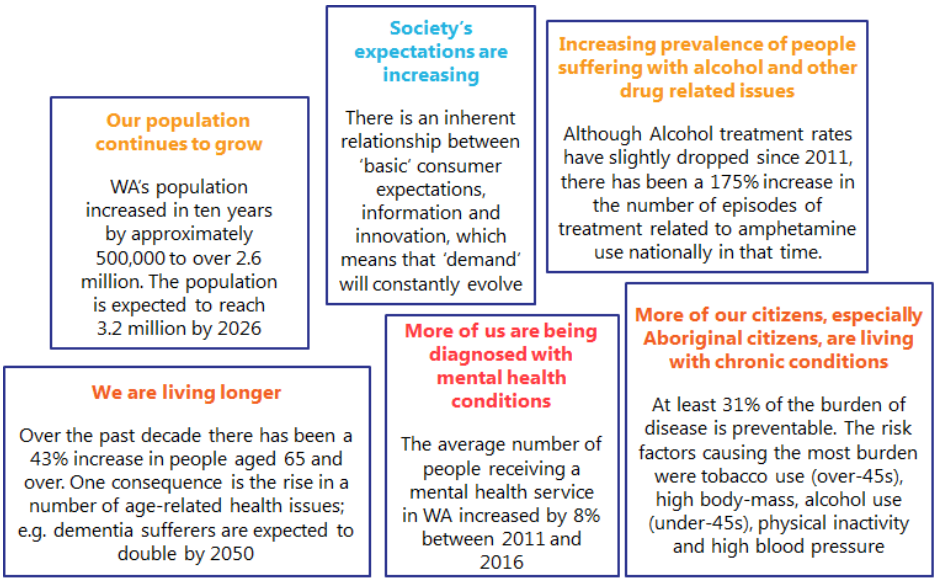


The needs and expectations of consumers are changing

The health and wellbeing ecosystem is experiencing changing demand for services but is responding slowly. Some service providers are looking at innovative ways to address the changing demands; but these demands will only be met if the established service systems are more connected to enable an individual's needs to be addressed holistically. Figure 14 (overleaf) summarises the changing expectations for the ecosystem.

[24] Sources: DoH (2015) WA Aboriginal Health and Wellbeing Framework 2015-2030; AIHW (2015) Aboriginal and Torres Strait Islander Health Performance Framework 2014 - Western Australia; DoH (2016) Health and Wellbeing of Adults in WA, 2015.

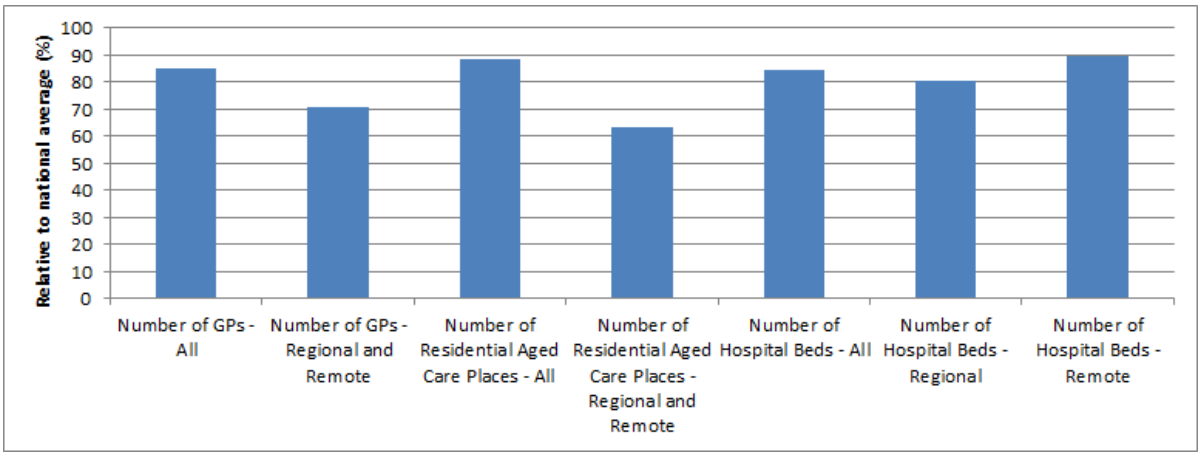
Figure 14: Changing demands on health and wellbeing services[25]



Consumers can find it hard to access appropriate services

The ecosystem operates in service silos, where services are designed to best utilise the specific funding models. For example, hospitals are built around funded activity and reducing the cost of a single occasion of service; and GPs optimise their services around ten minute appointments. In some cases, funding models (including pricing frameworks) designed nationally may not adequately incentivise providers in WA, resulting in under-provision of services. As a result of these supply and demand factors, key services in WA have significantly lower capacity than the national average, as illustrated in Figure 15. There are significantly fewer GPs, residential aged care beds and hospital beds per capita than the national average. In the case of GPs and aged care beds the capacity is significantly less in rural and remote WA.

Figure 15: Relative capacity of Western Australian services compared to the national average[26]



[25] Sources: DPLH (2015) *Population Report No. 10, Medium term population forecasts for Western Australia 2014 to 2026 and Subregions 2016 to 2026*; ABS (2017) *Population by Ages and Sex, Regions of Australia*; Deloitte Access Economics (2011) *Dementia Across Australia: 2011-2015*; AIHW (2017) *Medicare-subsidised mental health related services tables 2015-16*; DSC estimates on the potential number of West Australians eligible for a service under the proposed NDIS model

[26] Sources: AIHW (2017) Hospital resources 2015–16: Australian hospital statistics; Productivity Commission (2017) Report on Government Services 2017; AIHW (2017) Explore services and places in aged care

Consumers have less access to services in rural and remote areas

The challenges of accessing appropriate services are compounded in rural and remote WA, where distance, a dispersed population, high costs and workforce challenges combine to make it often unviable for providers to offer services (so called "thin markets"). As a consequence, the State government (through the WA Country Health Service) has historically provided disability and aged care services as the *'provider of last resort'*. This includes the Commonwealth and State funded Multi-Purpose Service program that provides integrated health and aged care services in rural and remote areas where stand-alone hospital or aged care facilities would not be viable.

The recent *Legislated Review of Aged Care*[27] confirmed the relevant of such approaches, but noted that they tend to crowd out non-government provision of and can limit the extent of choice and control available to consumers. Creating sustainable provision of consumer-centred services in rural and remote areas is not straightforward and requires considered and continued market stewardship by governments across service systems. The Productivity Commission recently called for a *'more considered approach'* to the issue of thin markets with regards to the roll out of the NDIS[28], including the use of more flexible funding and targeted measures.

There is an overreliance on acute based services

The impact of insufficient access to the right services at the right time in the right place is often that consumers spend too much time in acute settings, which is both undesired by consumers and expensive for governments. For example:

- The ten-year Mental Health Plan for WA[29] noted that an estimated 40% of people receiving care for their mental health issues within a hospital setting could have been cared for in a lower cost community-based subacute facility were the facilities available.
- The recent Legislated Review of Aged Care[30] noted that (nationally) '*the current mix of services may not be appropriate to match the areas where there are the greatest levels of unmet demand, which appears to be for higher-level home care packages'*; and recommended the introduction of a new level of home care packages designed to '*allow people with higher care needs to stay at home longer*'.
- 86% of Australians die in hospital or residential aged care; compared to 70% or less in countries such as New Zealand, the USA and France; this is despite a survey in South Australia identifying that 70% of the population would *prefer to die at home*[31].

Where there are deficiencies in service provision, especially in primary care and aged care, then this manifests itself in extra demands being placed upon WA's hospitals, either through delayed discharges or through higher Emergency Department (ED) presentations (whether due to the consumer's condition deteriorating through lack of appropriate support, or because ED presentations are both free to the consumer and simple to access):

- **Delayed discharges:** The number of medically fit older persons awaiting discharge from a metropolitan hospital to an aged care service (residential or home based) is increasing, with an average of 110 older persons at any time waiting discharge in 2016, compared to 58 in 2010[32].
- **Potentially preventable hospitalisations:** In 2015, the Department of Health assessed that there were over 64,237 potentially preventable hospitalisations[33] that year that could potentially have been avoided

[27] Tune, D. (2017) *Legislated Review of Aged Care*
[28] Productivity Commission (2017) *Position Paper: NDIS Costs*
[29] Mental Health Commission (2015) Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives.
[30] Tune, D (2017) *Legislated Review of Aged Care*
[31] Grattan Institute (2014) *Dying well*
[32] Department of Health (2016) *Preliminary internal advice from System Policy and Planning Division*
[33] AIHW definition- *conditions where hospitalisation is thought to be avoidable if timely and adequate non-hospital care had been provided*

if timely and appropriate care was provided in an *adequate non-hospital setting* (for example, admissions related to Cellulitis, Angina and Chronic Obstructive Pulmonary Disease)[34].

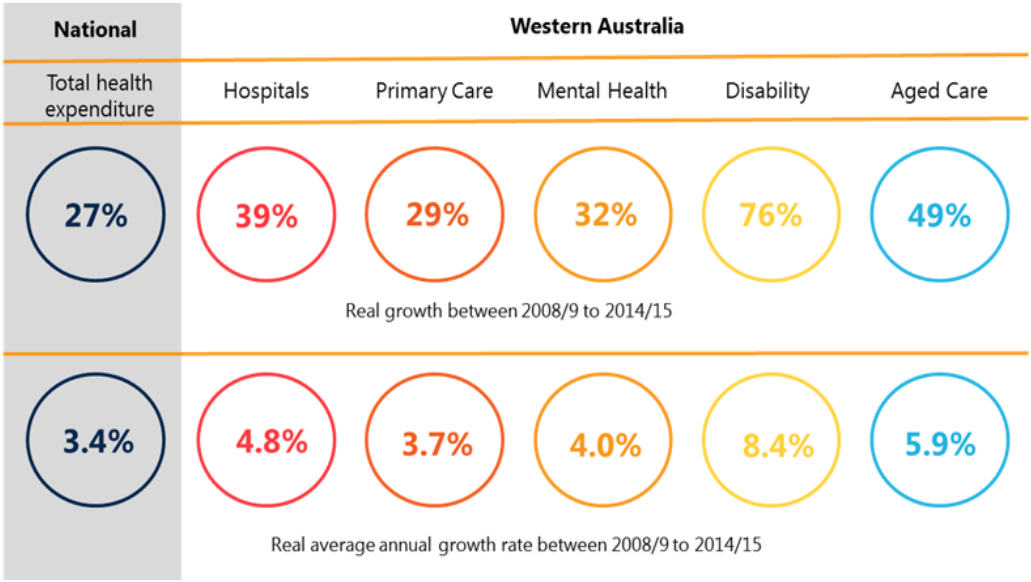
- **Inappropriate ED attendances:** In 2016, one in five (19.5%) of all ED attendances in WA could have been avoided. This has decreased from over 23% in 2011, but with over 1million ED attendances across the state this remains a significant issue. In a national survey of ED attendees 22% of patients surveyed indicated they could have been treated by a GP; with GP costs and appointment availability highlighted as the two main reasons for attending an ED instead[35].

Although there is a growing awareness, expectation and evidence base that individuals should only be cared for in 'institutions' if there is an absolute need for their continuing health and safety, it will take time to shift the current levels of demand to other types of provision.

Financial and workforce sustainability are under mounting pressure

Partly as a result of the issues outlined above, expenditure in all five service systems has increased rapidly in the period 2008 - 2015. Figure 16 shows that, in real terms, the five service systems have all grown more than the national average with only Queensland growing at a higher rate.[36]

Figure 16: Real growth rates from 2008/9 to 2014/15



The rate of expenditure growth in the public hospitals and acute mental health services is unsustainable for the State. Containing the growth in 'WA Health' expenditure is a key driver of the SHR.

The ongoing reform of the aged care sector is seeking to address a range of issues, not least the impact of the 'baby boomer' generation entering old age and the likelihood that the current level of government funding (about 75% of overall costs) will be unsustainable in the next 10-15 years without '*an increased proportion of costs being met by the consumer*[37]. At the heart of aged care policy is the intent to 'uncap supply'; but this cannot be considered until the mix of government/individual contributions is addressed.

[34] Analysis undertaken by Epidemiology Branch, Public Health Division, Department of Health WA in collaboration with the Cooperative Research Centre for Spatial Information (CRC-SI). Generated using data from the Hospital Morbidity Data System, Purchasing and System Performance Division, Western Australian Department of Health.
[35] AIHW (2015) *Healthy Communities: Use of EDs and GP services in 2013-14*. DoH (2014) *National Health Performance Authority, 2014*.
[36] All recurrent health expenditure by State (AIHW)
[37] Tune, D (2017) The Legislated Review of Aged Care

The limit on the supply of NDIS services is related to eligibility rather than specific capping of supply. Whilst it is expected to see a significant increase in eligibility and therefore demand, the ability to service this demand will be constrained by the system's ability to meet demand. One of the biggest challenges to meet demand will be that the workforce is insufficient, and potentially needs to double over the implementation period.

This is a challenge for all five service systems, not least because all five service systems are competing for similar staff, and all five service systems rely on significant levels of volunteers. Workforce shortages are prevalent in all workforce groups:

- Nationally over 40% of residential aged care facilities have reported a shortage of Registered Nurses[38].
- A shortage in Allied Health professionals has been highlighted as a major risk to the NDIS roll-out[39].
- WA has the lowest rate of Medical professionals (411 per 100,00 persons, compared to a national average of 444) [40]

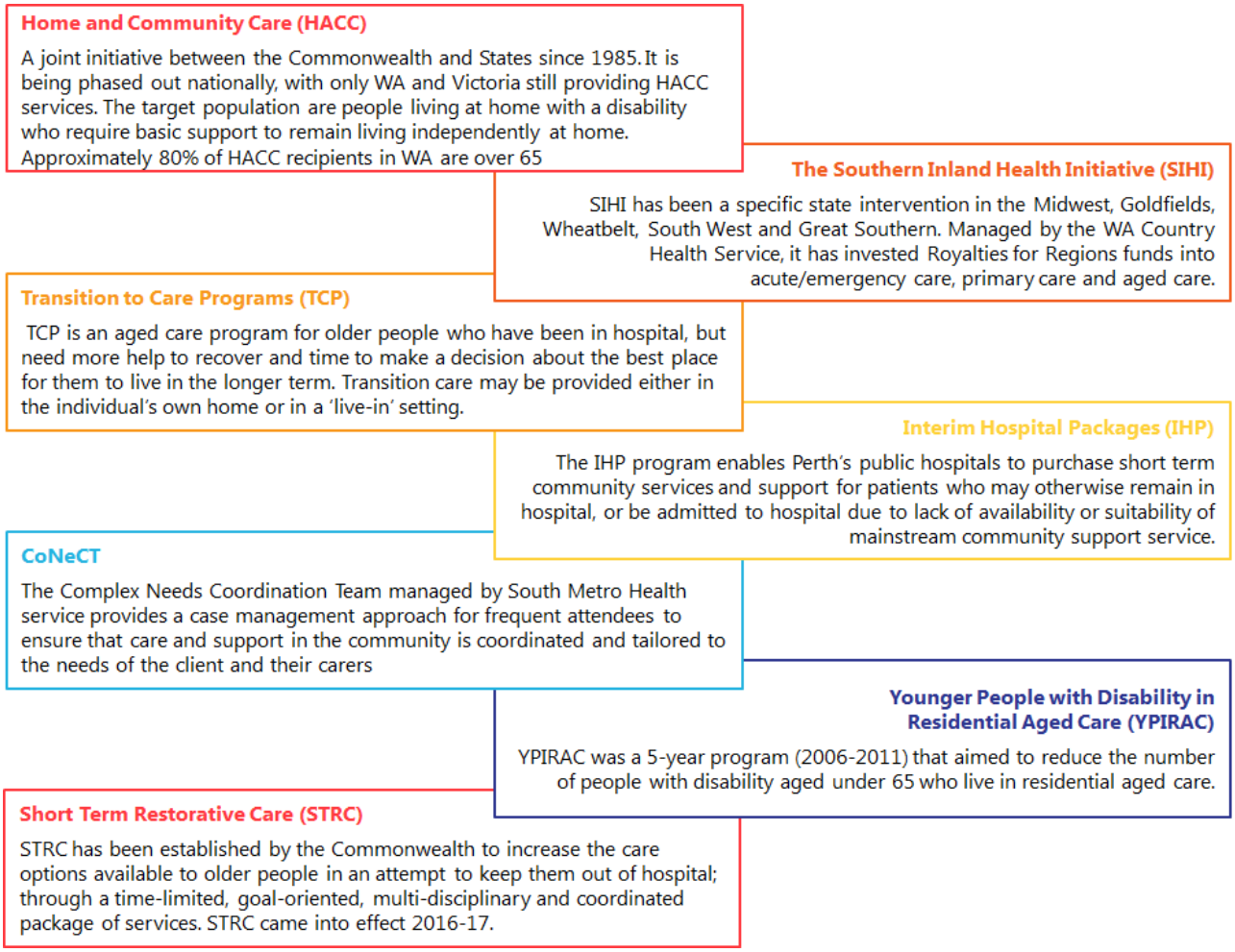
These shortages are despite the system's efforts to attract and retain health professionals through higher than average wages (on average WA's health workforce is the second highest nationally, after the NT[41] - although this is not the case for all professional groups) and a high reliance on volunteers; especially in remote and rural communities.

Governments have introduced solutions to mitigate some of the issues but further reform is required

As the service systems have evolved, the Commonwealth and State Governments have sought to mitigate gaps in service or provide services that are designed to manage the interface between service systems. These solutions often deliver good outcomes, but in general these services mitigate issues rather addressing root causes. Examples of these system specific solutions are show in Figure 17 (overleaf). These services alone have been provided to thousands of Western Australians at a cost in excess of $250m per annum.

[38] DoH (2016) *The Aged Care Workforce*
[39] NDS (2016) *State of the Disability Sector*
[40] APHRA (2016) *Annual report*
[41] AIHW (2016) *Australian hospital statistics*

Figure 17: Examples of services that have been introduced to address systemic issues



Appendix B – Interjurisdictional research

The following figures provide an overall summary of the key interjurisdictional examples drawn on for this report.

Figure 18: Summary of reforms and achievements in the United Kingdom

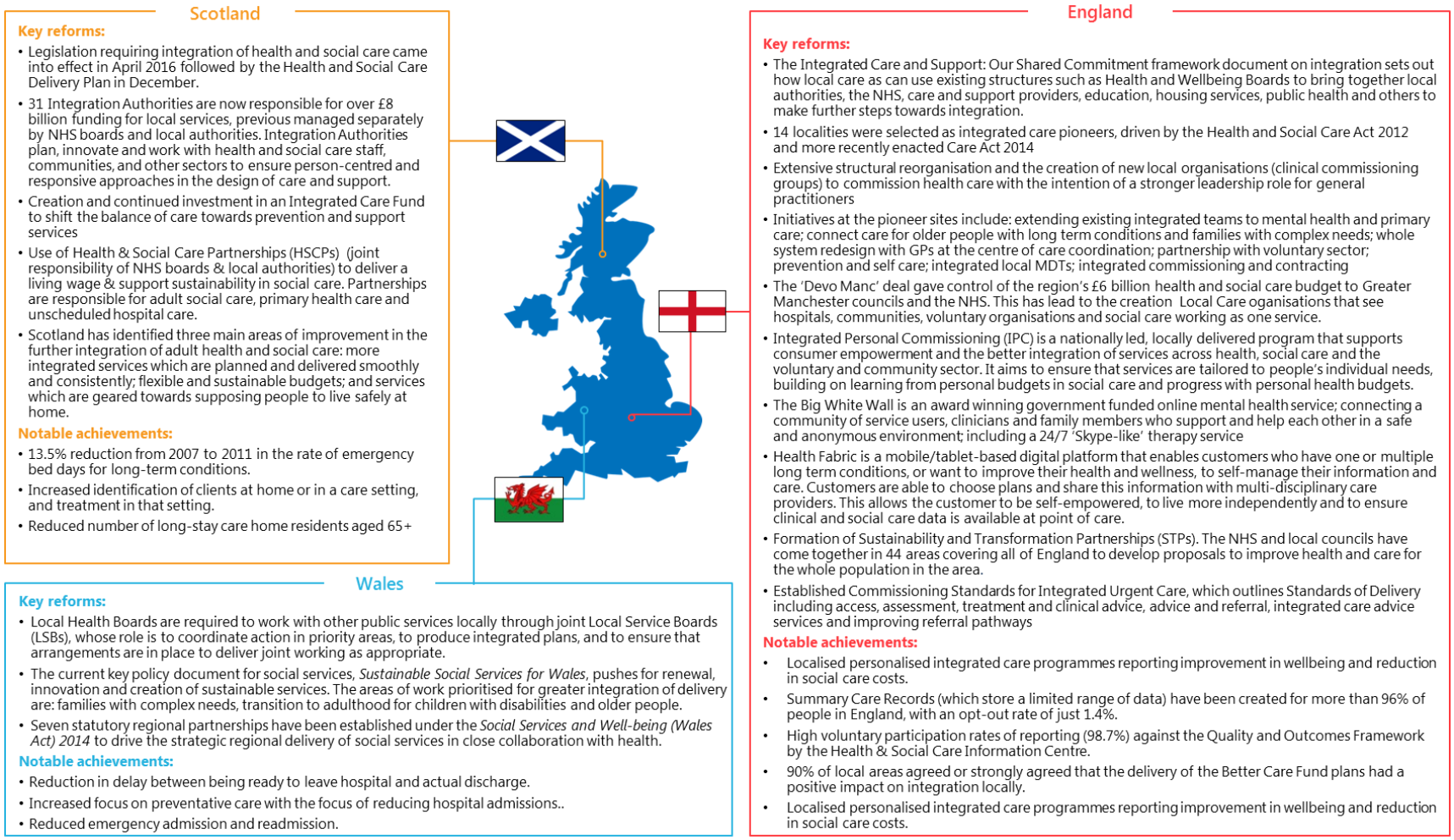


Figure 19: Summary of reforms and achievements in selected countries

Canada

Key reforms:

- Provinces and territories have primary responsibility for delivering health and social care services and supervising health care providers. Federal funding is distributed on a per capita basis.
- The Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA) model is focused on integrating health & social services in alignment with medical management. Features of the PRISMA model include: coordination among services, single point of entry, case management, unique assessment tools, individualised service plans, & information tools. After four years of implementation, the PRISMA model produced significant reductions in the prevalence & incidence of functional decline, reduced ER visits & increased client satisfaction & empowerment.
- There are partnerships among university researchers, the provincial government, regional health & social service planning & funding authorities as well as mangers from the home & community care service centres.
- Ontario Province gave 75% funding on a per capita basis to local bodies to commission services & used the other 25% to support cross-province initiatives & specific envelopes for minority groups
- Application of IT, data exchange, electronic medical record & sharing across acute care facilities, with view functionality available in other facilities.

Notable achievements:

- Significant reductions in the prevalence & incidence of functional decline & reduced ED visits
- Substantial improvement in the delivery of case management services for senior

Spain

Key reforms:

- In the state of Catalonia, they have implemented integrated health care organisations with population-based purchasing systems.
- In Catalonia consumers have been empowered by being allowed access to their personal health record, provided with detailed performance information on the service providers and access to an online marketplace which allows them to book appointments with specific providers.
- The integrated care program in Catalonia has established a 'Digital health ecosystem' that links personal health records to primary and secondary care providers, a data analytics hub and an online marketplace.
- In Alzira, they have had a publicly financed, privately provisioned health system since 1999. Healthcare management delivers a provision in a health area of Valencia and the local government are charged a per capita fee depending on the population

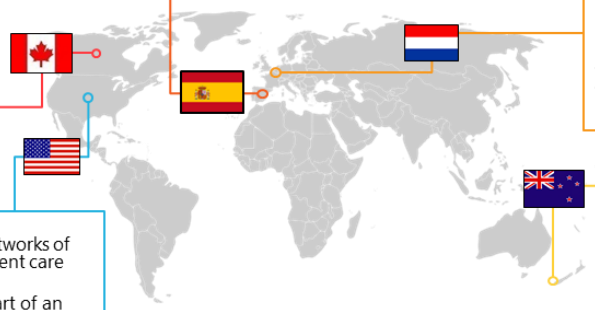
Netherlands

Key reforms:

- At the municipal level, integrated cooperation in the social field is seen as condition for creating suitable care for vulnerable citizens, and has been implemented since 2015 by 'social neighbourhood teams'. Some social neighbourhood teams are composed of exclusively social work, community building and district nursing, while other further include youth work, child and youth care, mental health care, addiction care, debt resolution and volunteering.
- Designated nine pioneer sites in 2013 representing partnerships among providers, insurers, and other stakeholders, with a focus on integrated clinical and community services.
- One of several countries to introduce personal budgets for long-term care to provide greater choice and flexibility for individual consumers. The program focuses on older people and people with disabilities; giving them a choice of receiving 'in-kind' care with standard providers or applying for vouchers to spend on personal care services
- Progress in the area of information-sharing and technology developments has been limited by political concerns in relation to privacy regulations.
- Bundled payments have been introduced for implementation of integrated services for individuals suffering from diabetes, COPD and vascular disease. This involves a single fee being paid to a 'care group', comprising multiple providers.

Notable achievements:

- Reduction in hospital admission rates for people with Diabetes
- Increased consumer satisfaction, giving them greater influence upon and access to a wider choice of services.



United States

Key reforms:

- Accountable Care Organisations (such as Kaiser Permanente) are networks of doctors, hospitals and other healthcare providers to coordinate patient care and they are incentivised to deliver that care efficiently.
- Kaiser has defined roles for 'Patient Care Navigators' that work as part of an interdisciplinary team, supporting members to identify appropriate services, sharing community resources and practices with members and ensuring that the care team meets the consumer's requirements.
- The Institute of Healthcare Improvement developed the "Triple Aim" framework to describe an approach to optimising health system performance. The three aims are 1) improving the patient experience of care, 2) improving the health of populations, and 3) reducing the per capita cost of health care
- The Medicare and Medicaid EHR Incentive Program provides incentive payments to physicians and hospitals to adopt, implement and demonstrate meaningful use of certified Electronic Health Record technology.
- MercyHealth, an accountable care organisation, used IBM Watson to analyse disparate data source to identify at-risk patients across their 450 health facilities and provide them more comprehensive care.

Notable achievements:

- In 2014, the 20 ACOs in the Medicare Pioneer Program and 333 in the Medicare Shared Savings generated $411 million in total savings but after paying bonuses, the program resulted in a net loss of $2.6 million to the Medicare trust fund.

WHO

Key reforms:

- The Framework on Integrated People-Centred Health Services (IPCHS) was adopted ort by Member States at the World Health Assembly in May 2016
- The Framework outlines five key strategies for integrated people-centred health services: engaging & empowering people & communities; strengthening governance & accountability; reorienting the model of care; coordinating services within & across sectors; & creating an enabling environment.
- Supports health system stakeholders worldwide by advocating & partnering for change, building momentum & fostering innovation, preparing toolkits, providing technical assistance, promoting & facilitating the use of indicators, & providing support to develop capacity

New Zealand

Key reforms:

- Invested in 9 pilots of integrated care in 2010. In 2013, NZ moved to implement a governance model across the entire country, aimed at integration by requiring an alliance between each DHB (District Health Board) and corresponding PHOs (Primary Health Organisations). Alliance goals include shifting services from hospital to primary care or creating new arrangements combining elements of both service domains to, for example, reduce avoidable hospitalisation or improve chronic condition management.
- New regional macro-level networks involving a wide range of organisations in planning, funding and delivering services, new meso-level networks of PHOs, and a new Pacific-led PHO to better co-ordinate service and build a critical mass for the Pacific Sector in Auckland
- Devolution of services to Māori communities and the development of whānauora ('family well-being') models of care
- In Canterbury the introduction of integrated care has relieved pressure at hospital services and reduced the use of care homes. It has done so by increasing investment in services in the community, both to avoid inappropriate admissions and to ensure timely discharge from hospital. This is underpinned by investment in the primary care system. The underlying principle is 'one system, one budget'. This is a good example of a self-contained case study that gives enough substance without being too long.

Notable achievements:

- Evidence of reductions in ED admissions (especially of patients aged 65+) Acute growth remaining at demographic growth for a decade.
- 70% of the health system is managed with 'real-time' information.

Figure 20: Summary of reforms and achievements across Australia

National / Commonwealth

Key reforms:

- The Commonwealth Home Support Program builds upon previous home support programs to create a streamlined source of support for frail and older people living in the community and their carers.
- Various data integration and linkage projects through the Multi-Agency Data Integration Project
- The National Framework for Protecting Australia's Children 2009-2020 was introduced by COAG and aims to provide an integrated response across States and Territories, and across sectors.
- Regional approach led by PHNs to transform Commonwealth mental health funding and program delivery, coupled with a new stepped care approach
- The Health Care Homes trial is a new model of primary health care funding and service delivery that enables eligible patients to enrol at a GP, which becomes their health care home base. This will support patients to better manage their conditions and navigate the system
- Home Care packages have been allocated to aged care consumers who will be able to direct government funding to the providers of their choice
- Increasing the useability of My Health Record, including an opt-out trial in Nepean Blue Mountains, though overall there has been slow take up, and there have been privacy and compliance concerns
- HealthEngine is an online health marketplace, changing the way consumers access and use healthcare services by providing access to information and technology to finding and book health appointments online.
- The Regional Assessment Service (RAS) for aged care helps to identify clients' and carers' needs for support and their goals for greater independence and wellbeing. It also provides in home, face to face assessments, conducted independently from service provision, which ensures assessors consider the full range of options.

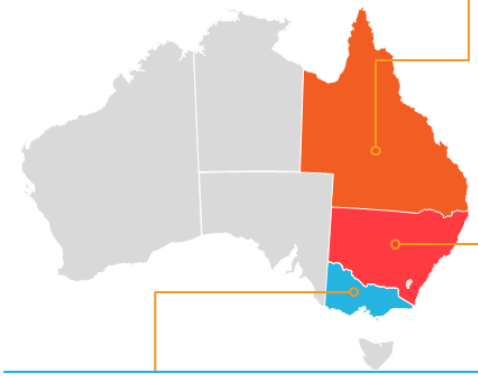
Queensland

Key reforms:

- Undertaking transformational reforms across health, child and family services, disability services, domestic and family violence and social services with a focus on service integration, prevention and early intervention, shifting to an outcomes focus, and regulatory reform to reduce compliance burden.
- Introduced a 'Health Service Integration' Framework with four key enabling outcomes (clinical leadership and governance, service re-design, organisational and workforce development, and outcomes-based incentives)
- Implemented structural changes to form regional Hospital and Health Services which have formed strong connections with PHNs to deliver reformed funding and governance arrangements to deliver a shared vision and single strategy for patient focused integrated care.
- Established an Integrated Care Innovation Fund ($35 million) with the primary aim of investing in new ideas for integrating care

Expected benefits:

- Increase productivity and value for money. Focus on delivering a connected health system that puts the patient first.
- Improved health equity and access for Queenslanders from early to end stage disease
- Increased confidence and health literacy of Queenslanders to ensure that the health system is responsive to their needs.
- An evidence based, continuous quality improvement process to ensure enhanced service delivery that is sustainable



New South Wales

Key reforms:

- Integration of care is one of three strategic directions outlined by the NSW State Health Plan: Towards 2021.
- The strategy has committed $180 million over six years to implement innovative, locally led models of integration of care.
- Three areas drive the strategy: 1) Integrated Care Demonstrator Sites, 2) Funding innovators to deliver local services, and 3) Developing State-wide enablers
- The updated NSW Integrated Care Monitoring and Evaluation Framework guides the overall approach to monitoring and evaluation of the NSW Integrated Care Strategy NSW Health (2016a).
- The Integrated Care Demonstrator Site in Western Sydney has focussed on individuals suffering from three specific chronic conditions. It has introduced shared care plans, individual care facilitators and integrated hospital and community based teams.

Notable achievements:

- Reduction in emergency department presentations and hospital admissions and readmissions
- Reduced hospital length of stay for inpatients referred to RASS
- Increased number of NSW Ambulance incidents managed as non-transports and patients who are provided with alternative pathway referrals instead of presenting to hospital
- Improved time from presentation to definitive treatment of skin cancer patients
- Strong patient engagement with PROMs and Patient Report Experience Measures (PREMs)
- Strong GP engagement with provider surveys.

Victoria

Key reforms:

- The Roadmap for Reform in child & family services, homelessness & social housing reform, the 10-year mental health plan and Health 2040 each aim to support enhanced integration & coordination of targeted services, early intervention, and person-centred care.
- Developed and implemented the Victorian Public Health and Wellbeing Framework to monitor performance against key measures
- Established Service Coordination Practice Standards which describe the processes and outline the desired consumer outcomes and good practice indicators for each element of service coordination
- Established a Continuous Improvement Framework in 2012, as a tool to help service providers implement service coordination across Victoria. It helps providers to monitor and continuously improve how they implement and practice service coordination; enables an agreed process for organisations to monitor service coordination; helps providers assess their service coordination readiness for new services, and identifies infrastructure and practice changes that are needed.

Notable achievements:

- Single set of state-wide guidelines that outline agreed standards for service coordination practice for consistent client care within and between services
- More clients with chronic diseases receive care from multidisciplinary teams that include state-funded and private providers.
- Over 80% of primary care providers are working on improved systems of care with the GP sector including accessing the right services and coordinated care planning.

Appendix C – Consultation process

This report was developed in consultation with a range of stakeholder between August and December 2017. There were three main forms of stakeholder engagement that were undertaken:

- **Project Coordination Group (PCG)** – the role of the PCG was to provide relevant direction and guidance for the project, consider the implications of ideas and proposals on broader health, aged care and disability service systems in WA and the impact on consumers. Membership of the PCG included representatives from the Department of Health, the Sustainable Health Review, service providers and consumer representatives.
- **Facilitated workshops** – three half-day workshops brought together a set of core stakeholders across WA Health, related service systems, service providers, peak bodies, consumer and carer representatives as well as the SHR Chair and Secretariat. A discussion paper was developed for each workshop and shared prior to Recommendations in this report were iteratively developed and tested at these workshops with the input from these stakeholders.
- **Targeted interviews** – two rounds of targeted interviews with key stakeholders to test the direction of the recommendations and the development of the report. Interviews were conducted with the Health Services, Mental Health Commission, WA Primary Health Alliance, service providers and consumer advocates

Figure 21: Timeline of consultation

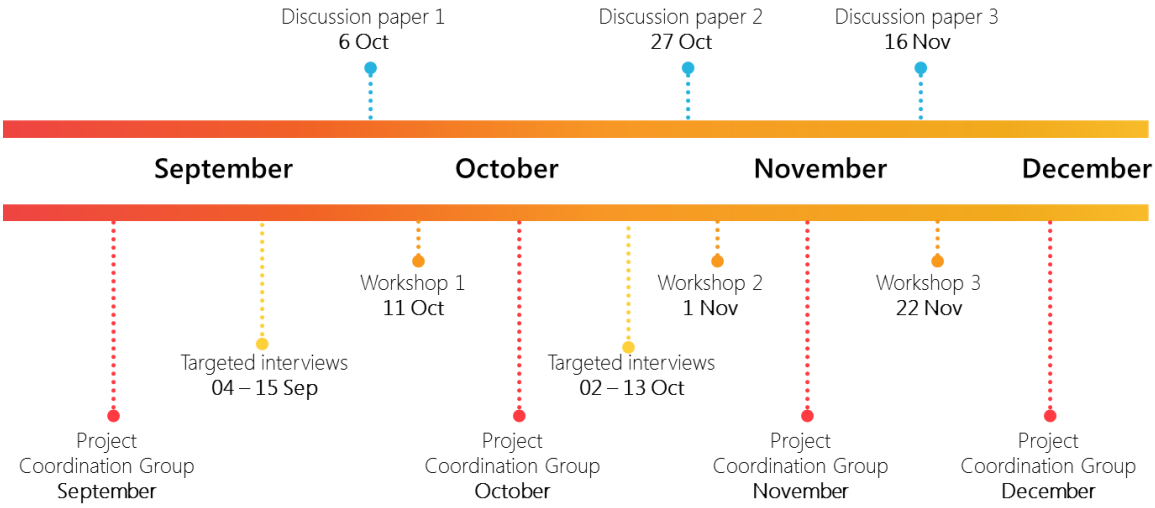


Figure 22: Workshop process overview

Appendix D – The five service systems

The following figures provide an overview of the five service systems referred to in this report.

Figure 23: Aged Care in WA

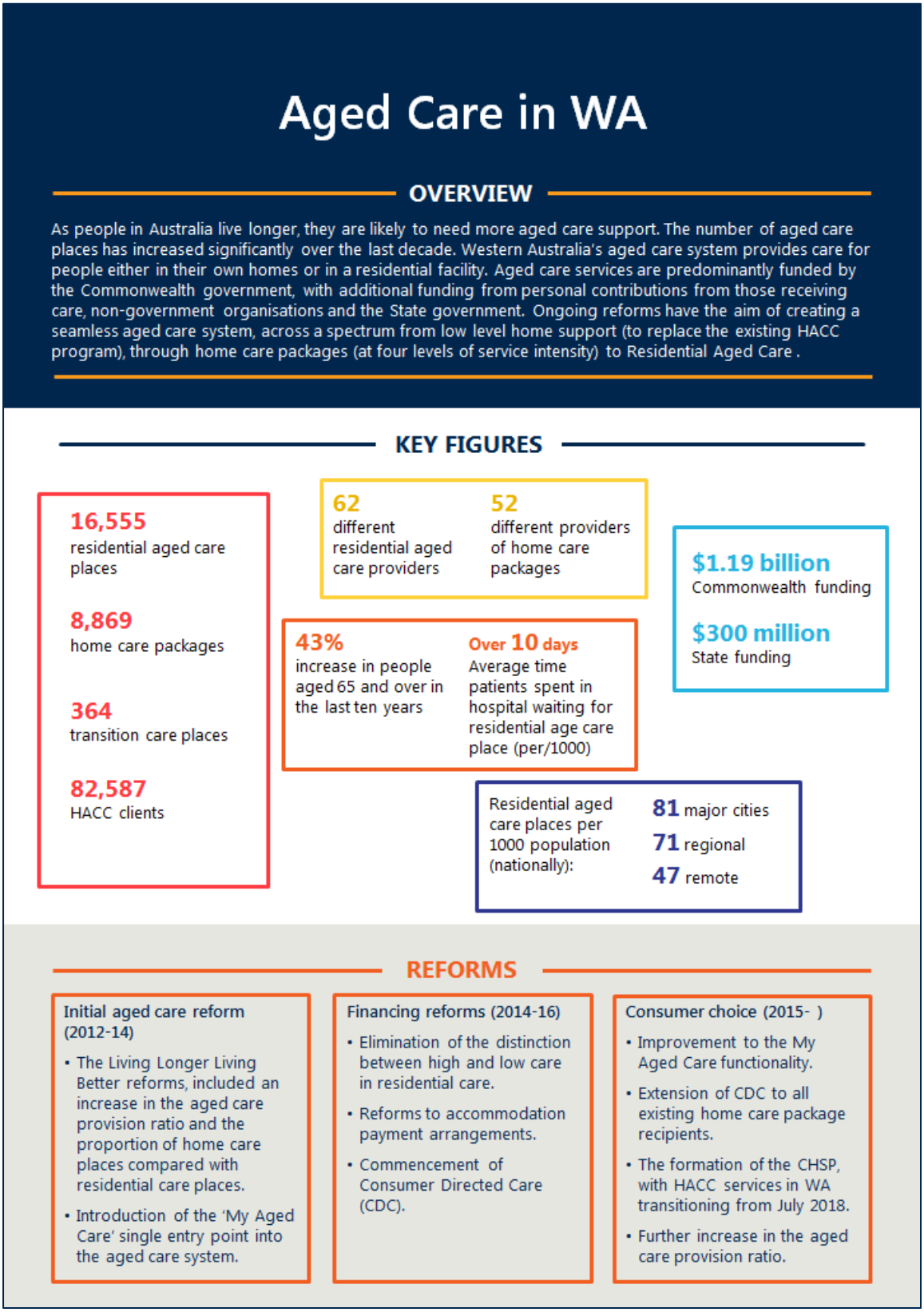


Figure 24: Disability services in WA

Disability services in WA

OVERVIEW

Over the past 25 years the WA government has provided support and care to people with permanent and significant disability (a disability that substantially reduces their functional capacity or psychosocial functioning). The WA disability sector has been at the forefront of many of the innovations that have now become the cornerstone of disability service delivery nationally, such as community-based care, individualised funding, and local area coordinators.

The sector has grown considerably in line with increased funding directed to the sector and ongoing reform. The ongoing reforms within the disability services sector has laid the foundation for the current national and state rollout of NDIS.

KEY FIGURES

25,665
People currently receiving care

39,731
Potentially the number of people who could be eligible to receive an NDIS package by 2019/20

214
different registered service providers

7,800
FTEs working in disability

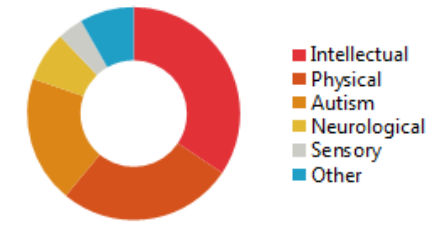
149
Disability sector organisations received funding in 2015/16

$158 million
Commonwealth funding

$726 million
State funding

$35,486
Average cost per person

5 most common disability types



NDIS (nationally) is estimated to drive a:

55% increase in people receiving care

100% increase in the number of jobs in the disability sector

92% increase in expenditure on disability services

REFORMS

The National Disability Insurance Scheme (NDIS)

On 12 December 2017, the State and Commonwealth Governments announced that the NDIS will join the nationally delivered NDIS, with the National Disability Insurance Agency (NDIA) assuming responsibility for the delivery of the NDIS in WA from 1 July 2018. By 2020, every eligible West Australian will be able to participate in the NDIS.

The NDIS aims to provide recipients more choice and control over how, when and where their supports are provided. The scheme differs from previous approaches in that: (a) it adopts a person-centred model of care and support; (b) it is an insurance-based scheme — it takes a long-term view of the total cost of disability to improve participant outcomes and to meet the future costs of the scheme; (c)funding is determined by an assessment of individual needs rather than a fixed budget.

The state disability sector will experience significant growth and changes in how services are delivered and funded.

Figure 25: Mental health services in WA

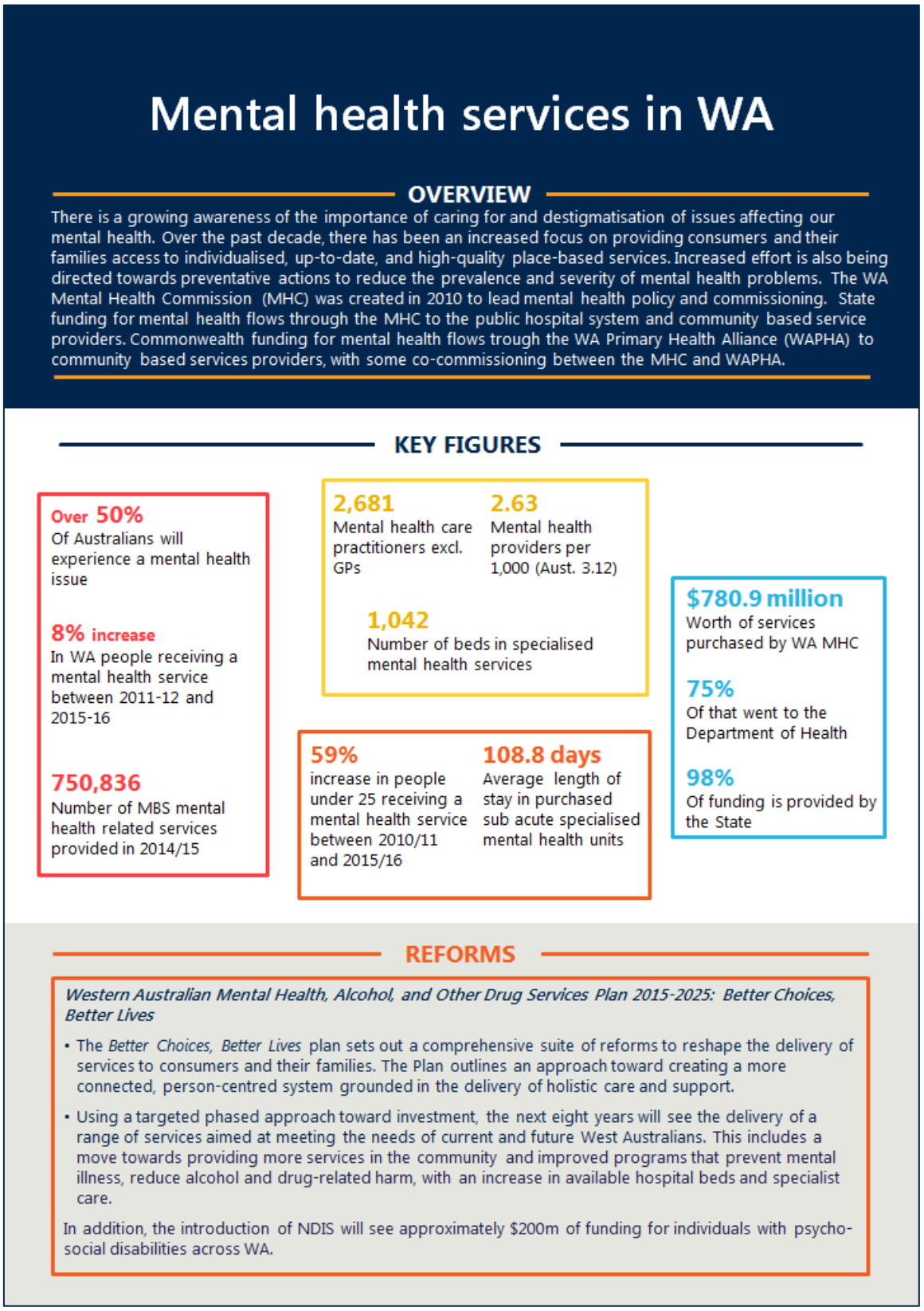


Figure 26: Primary health care in WA

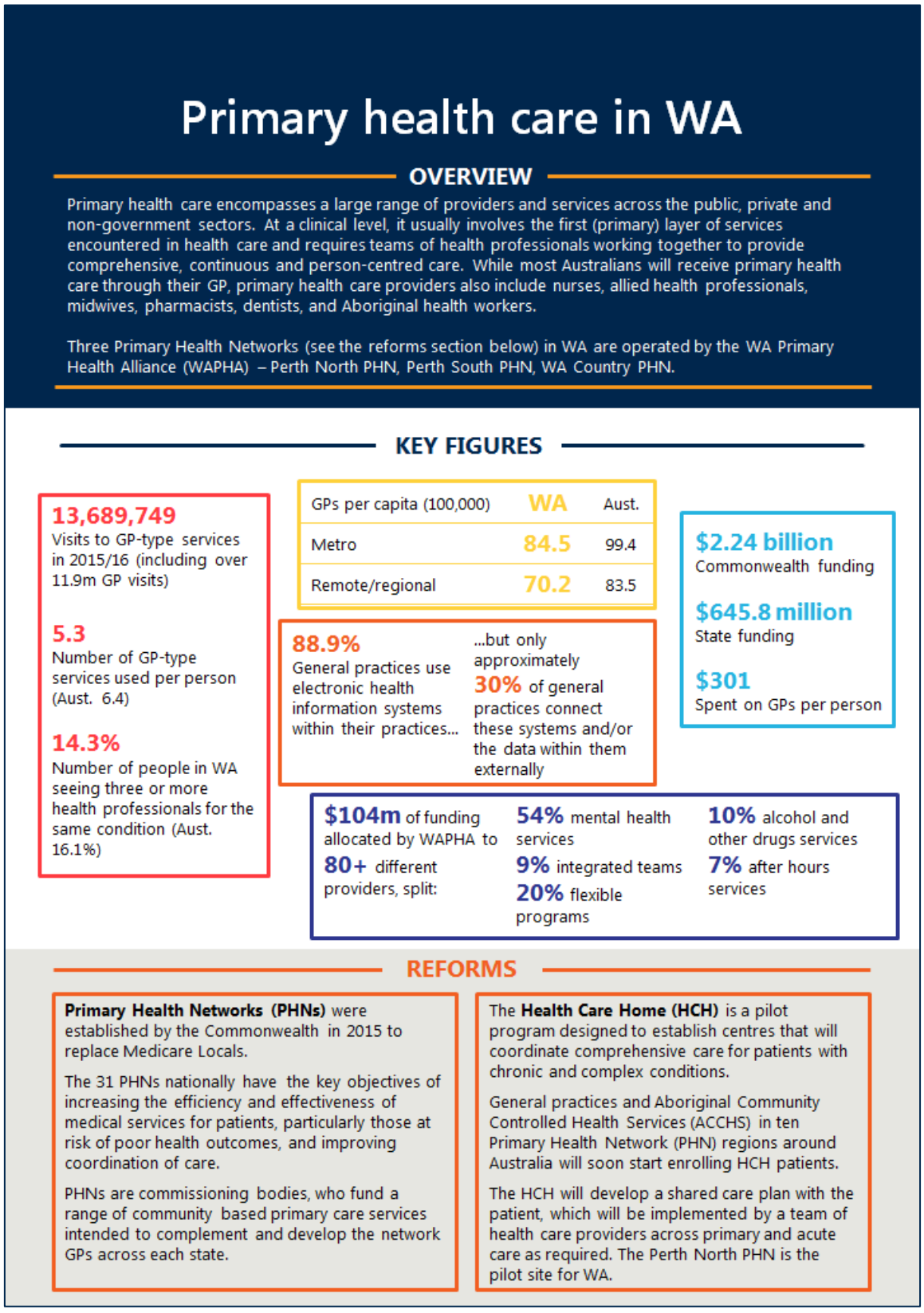
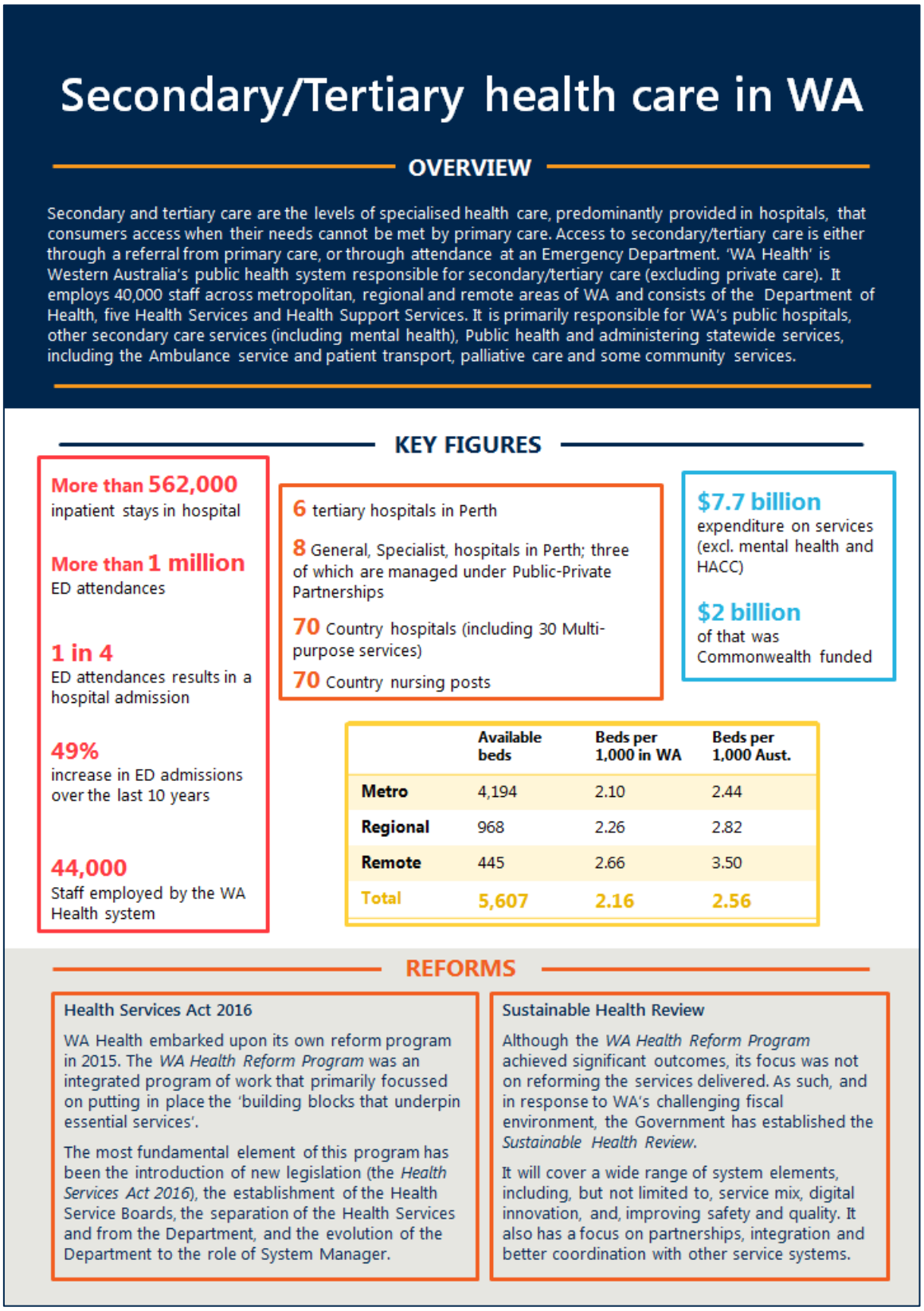



Figure 27: Secondary/Tertiary health care in WA