The Health Advocate

ISSUE 1 • OCTOBER 2009

The official magazine of the Australian Healthcare & Hospitals Association

Your voice in public healthcare

Our health system

John Deeble on the performance of public hospitals

GP Super Clinics

Problem or solution?

Will our healthcare system survive the ageing process?

Tony Sherbon tells us how SA is coping

Evaluating Multi-Purpose Services

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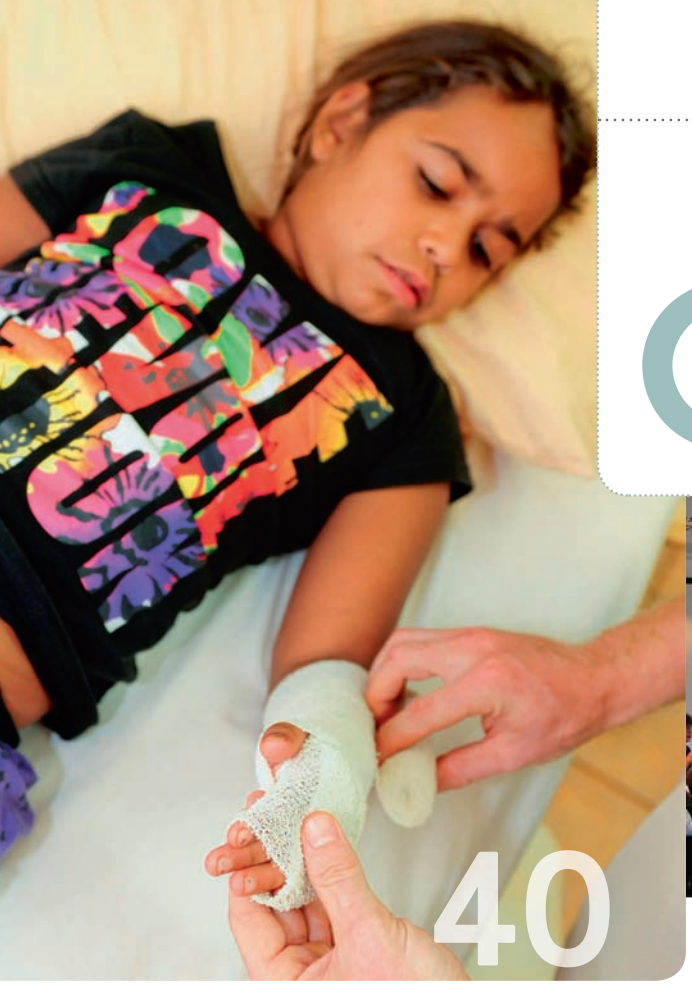

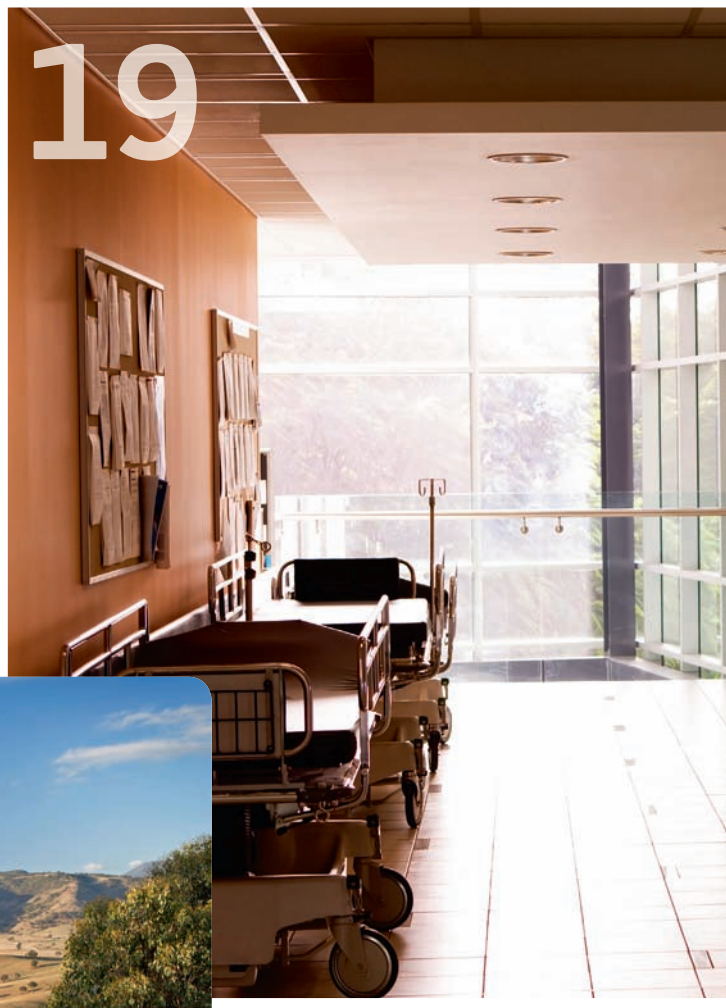

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DR DAVID PANTER

President of the Australian Healthcare and Hospitals Association

President's report

Welcome to the **first edition** of the official magazine of the Australian Healthcare and Hospitals Association – ***THE HEALTH ADVOCATE***

THE AUSTRALIAN Healthcare and Hospitals Association (AHHA) is the only national organisation that represents public healthcare services in Australia. We provide the best networks that connect clinicians, managers, academics and government at a national level.

The magazine is an exciting new development for the AHHA – one that, as President, I have been keen to implement. When I worked in the UK in the National Health Service, we looked forward to reading the *Health Service Journal* that gave us a handy synopsis of significant developments, issues and appointments across the health sector.

In a similar vein, *The Health Advocate* will put you in touch with the latest debates and issues in the Australian health system. I know you will find our columnists and guest authors of the highest calibre, and expect that you will get a laugh or two! I encourage you to engage in the discussions we spark in the magazine, by writing us letters, contributing articles from the coalface.

The AHHA's greatest strength is its capacity to link professionals throughout the healthcare sector with policy development, advocacy and high quality publications such as the *Australian Health Review*, our internationally recognised peer-review journal, and of course this new magazine. The AHHA employs an innovative policy development process using *Communities of Interest* to build consensus positions on key issues facing the Australian healthcare system as a whole. The AHHA's policies always propose practical solutions – in some cases these are small, contained projects designed to have maximum impact, while others relate to the high-level need to achieve better integration of services and funding systems that promote this integration.

Australia is currently undergoing a major health reform process aimed at improving the quality of healthcare in all settings while achieving better efficiency and accountability. The Australian Government established the National Health and Hospitals Reform Commission in 2008, and it has recently made its final recommendations following significant engagement with the Australian community. The AHHA is now critically involved in exploring the implications of many of these recommendations.

The key reform areas to which the AHHA is contributing include:

- **Nationally coordinated, consistent and interoperable electronic health infrastructure and solutions;**
- **Improved data collection and benchmarking for health service monitoring and innovation;**
- **Better integration, planning and funding of health services, particularly across primary and tertiary care settings, including overall governance of the health system;**
- **Increased funding and consistency for oral and dental health nationally;**
- **Managing demand for acute care, particularly in emergency departments; and**
- **Leadership and workforce development aimed at affecting culture change.**

The AHHA has fantastic opportunities for hospitals, other health services and health-related companies to get involved in these and other key policy issues across the country. Visit the AHHA website at *www.aushealthcare.com.au* for more information, or contact us on 02 6162 0780 or by email at admin@aushealthcare.com.au.

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A **snapshot** of the **issues** that matter to the AHHA

In the news

KPIs for improved data collection

IN RESPONSE to controversy over reporting by some Victorian hospitals of waiting list data, AHHA argued for improved data collection and the development of appropriate performance indicators for hospitals. AHHA stated that the community has a right to know how their hospitals are performing relative to each other and over time. This requires accurate and comprehensive data collection and the development of a transparent system of performance measurement.

To achieve this, AHHA proposed the development of a National Set of Key Performance Indicators to monitor the performance of all hospitals and health services. This would involve the collection of data relevant to these indicators, which would be fed back to providers and be used to inform internal quality improvement processes. These data would also be made publicly available to ensure consumers are aware of how well their hospitals compare with others.

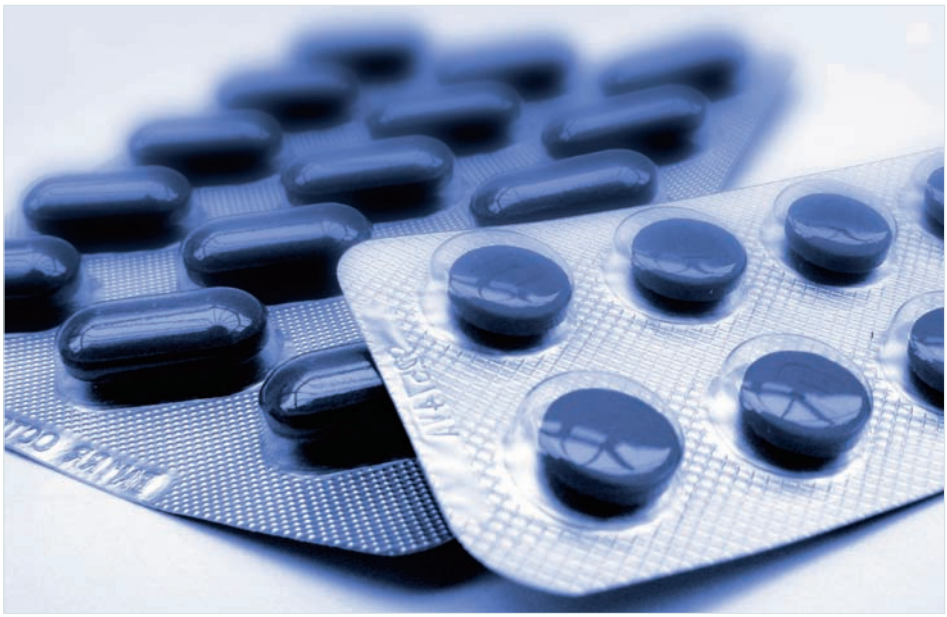
Pharmaceuticals research

AHHA PROMOTED the May edition of the *Australian Health Review*, which focussed on pharmaceuticals and the PBS. Media releases highlighted four key articles from this edition. Widely reported in the media was an article that claimed that Australians are paying more than Americans for several common medicines. The author argued for a new approach to pricing generic medicines to address this issue.

Another article reported research that found that changes to the price of PBS medicines have a significant impact on demand and may undermine the objectives of Australia's National Medicines Policy. Specifically, the study showed that increases in co-payments and safety-net thresholds could act as a deterrent to having a prescription filled.

The growing area of 'nanomedicines' was the subject of a challenging article that outlined the issues that these products raise for Australia's drug regulation system, particularly in the areas of safety and quality. The article argued that Australian regulatory practices need to change to ensure Australian consumers can receive maximum benefit from these products.

Finally, AHHA highlighted the results of a study of 'special pricing arrangements' for the PBS. This investigation found 73 medicines on the PBS where special pricing arrangements had been applied and where the prices appearing on the Schedule of Pharmaceutical Benefits might differ from those considered 'cost-effective' by the PBAC. The authors argued for greater transparency in these arrangements to ensure the community is aware of their impact on the price and availability of medicines.



In the news

Have your say...
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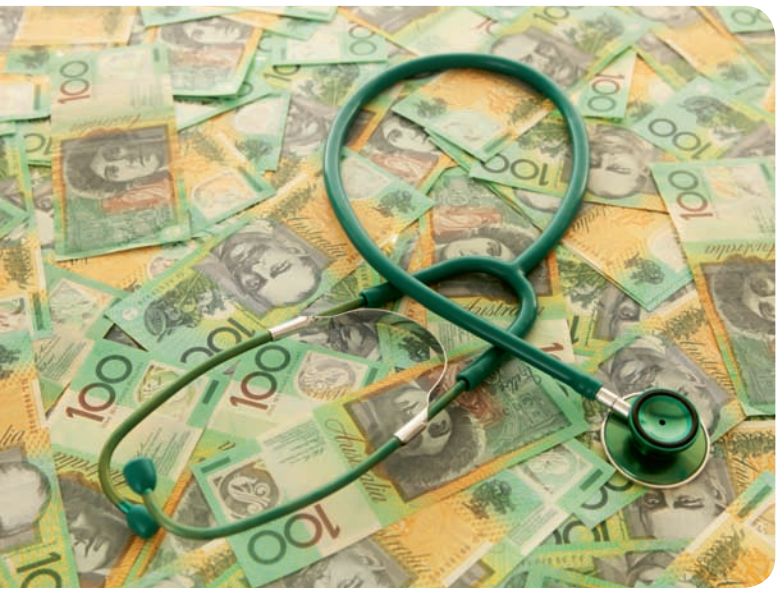

Health infrastructure lost out in the budget

IN THE LEAD UP to the Federal Budget, AHHA expressed concerns about reports that the Federal Government may walk away from its $10 billion commitment to the Health Infrastructure Fund, announced in last year's Budget. AHHA argued that its members and healthcare providers had been counting on the funding to replace or upgrade equipment, adopt new technologies and establish new facilities.

AHHA's media statements pointed out that healthcare is one of the major growth areas of the Australian economy, employing approximately 11 per cent of the workforce, and that additional health funding can create new jobs to meet the increasing demand for health services.

In response to reports that the Government would means test the private health insurance rebate, AHHA argued for the funding saved through this measure to be put into health and hospital infrastructure.

After the Budget was brought down, AHHA welcomed the funding announcements for health infrastructure projects but expressed disappointment that the funding for hospitals and health service facilities fell short of the $5 billion promised in the 2008-09 Budget.

AHHA urges consultation over CSO positions

IN APRIL, WE welcomed the NSW Government's announcement of an additional $485 million over the next four years for public hospitals, as part of its response to the Garling Inquiry into acute health services. AHHA stated that the Garling Inquiry has confirmed our long-standing concerns that public hospitals in NSW, and indeed elsewhere in Australia, are severely under-funded and in a crisis situation.

In supporting the findings of the Garling Inquiry that additional funding and staff are required to improve the quality of patient care within hospitals, AHHA urged the NSW Government to consult closely with the hospital sector to address this need, including the creation of an extra 500 ward-based Clinical Support Officer positions.

Safety and quality

THE AUGUST edition of the *Australian Health Review* (AHR) included articles on quality and safety issues, three of which were highlighted in media releases. They included a study that found that single patients, those from non-English speaking backgrounds and the elderly are most likely to be kept in hospital longer than necessary. The research examined data collected from a quality improvement project that aimed to improve the discharge process via a dedicated facilitator. The reasons for most delays were the patients' medical conditions, as well as waits for consultations, diagnostic and allied health services.

Another article highlighted research that found a 'medical model' of Hospital-in-the-Home (HITH), where a doctor is solely responsible for care, was associated with significantly decreased length of stay and scheduled or unscheduled hospital reviews and admission rates. The study also found this model results in no changes in unexpected post HITH reviews and hospital emergency department rates.

The final AHR study reviewed the risk factors associated with cardiovascular disease (CVD) in migrants to Australia. It found that the overall prevalence, morbidity, mortality and risk factors of CVD vary among ethnic groups due to a range of factors. These factors include birthplace, age, socioeconomic status, education, culture, and genetic composition. In addition, fluency in English and job and life satisfaction in Australia has also been associated with CVD risk.

On the basis of this study the authors recommend that additional research be undertaken into the risk-factors for CVD among immigrant groups. This includes culturally sensitive, targeted intervention programs to decrease modifiable risk factors for cardiovascular disease, such as obesity, physical inactivity and smoking.

AHHA responds to the NHHRC

IN RESPONSE to the final report from the National Health and Hospitals Reform Commission (NHHRC), AHHA released a statement welcoming the Report but warning that expert input from the hospital sector was required to ensure the recommendations could be implemented successfully. The AHHA acknowledged that the NHHRC had highlighted the main problems of the healthcare system, including a lack of coordination between sectors, an inadequate focus on prevention and inefficiencies at many levels. The AHHA expressed its commitment to working with governments at all levels to implement the recommendations and ensure they deliver the intended benefits.

Events and meetings

AHHA events provide the opportunity to openly discuss the **big issues**

IN EACH ISSUE of *The Health Advocate* you can read about the events and meetings that are organised and presented by the AHHA. We are a very active Association and hold many events for the benefit of members and the broader health community. These range from AHHA branch seminars in all states and territories and invite-only Think Tanks, to our strategically focused policy workshops.

Our Executive Director, Prue Power, also speaks regularly at other conferences throughout the year.

If you have attended an event hosted by the Australian Healthcare and Hospitals Association and you would like to contribute a brief report, please email us at **admin@aushealthcare.com.au**.

Kerry Hogan Ross of DLA Phillips Fox, speaking at the NSW Health Law Seminar

Policy Think Tanks: your chance to get engaged in national policy

THE AHHA holds two Policy Think Tanks each year. They complement our other events and meetings with very clear outcomes generated for policy development and subsequent advocacy campaigns.

This year, our Policy Think Tanks provided the chance to further delve into the following issues:

- **Governance of the health system**
- **Multi-purpose services in regional areas**
- **Clinical handover**
- **Managing demand for acute care services (focusing on hospital emergency departments)**
- **Disparities in hospital care for Indigenous Australians with cardiovascular disease**
- **Culture change** (See *Affecting culture change in the health system*, page 13**).**

The Policy Think Tanks are highly valued by the AHHA policy groups and other delegates alike. They are structured to present the existing policy, which has generally been developed using a community of interest model. They provide attendees with the opportunity to help guide the fine-tuning of the papers along with the best options to move the practical recommendations forward at organisational and political levels.

Policy Think Tank, 21 August 2009

Traven Lea, Heart Foundation, Policy Think Tank

Affecting culture change in the health system

THE AHHA is currently developing a policy position on the critical issue of culture change in health services and organisations. We are still very much in the iterative phase of this policy and exploring how it interrelates with our other policies. However, we have taken several opportunities to hear from leading thinkers and practitioners throughout the year. This is building up a very compelling case for changing the ways in which health systems, institutions and professionals respond to the needs of the community.

We began in April with a presentation to our NSW branch from Julie Cogin. This coincided with the first results from the Special Inquiry into Acute Care Services in NSW undertaken by Peter Garling. Julie brought a perspective to organisational behaviour and change from outside the health sector, in her capacity as Associate Dean for the Australian School of Business at the University of NSW. There is no doubt that the health sector benefits from such objective views of its operations, and this approach can help further in the development of our policy.

The specifics of health care culture were further elucidated at our invitation-only Think Tank in July, hosted by Tress Cox lawyers in Sydney. The Think Tanks are a chance for high profile health leaders to come together under Chatham House rules to discuss key issues in the system. Pieter Degeling brought extensive experience in both the Australian and UK health systems, presenting some quite shocking data on staff mental health and possible solutions including the standardisation of high-volume predictable clinical work. Judith Healy, from the Regulatory Institutions Network at The Australian National University, gave us a perspective on changing clinical practice and behaviours using a bottom-up approach that is driven by patient safety imperatives. This focused on the 3 Cs theory for reducing variation and errors in surgical practice – correct patient, correct site, correct procedure. Over time, the standards can change, as they have already done since the 3 Cs were first trialled. Regrettably, there is still some resistance to such 'regulation' of practice.

Judith Healy and Peter Baume, Think Tank TressCox

Our Policy Think Tank in August provided another opportunity to discuss culture change with a new group of professionals. Annette Schmiede, an AHHA National Councillor from NSW, presented a very lively and succinct appraisal of the cultural problems in the healthcare. Key issues considered on the day included the impact of culture and attitudes on patient outcomes, and the need for simple measures that can evaluate the effect of changes in system and professional behaviours.

The AHHA is continuing its work on culture change in collaboration with state governments, along with clinicians and leaders from across Australia. If you're interested in getting involved, please contact the AHHA.

Events and meetings

Hon Paul Lucas MP, Queensland Deputy Premier and Minister for Health

AHHA Branch Seminars

Paddy Phillips SA Chief Medical Officer

THE HONOURABLE Rob Knowles, former Victorian Health Minister and member of the National Health and Hospitals Reform Commission, spoke about directions suggested in the final report of the Commission in Melbourne and Hobart during April.

In collaboration with the Heart Foundation, the AHHA was pleased to have Professor Roger Boyle from the National Health Service speak at seminars in Sydney and Canberra during May. Roger spoke of the great advances made in stroke and coronary care in the UK and engaged directly with cardiologists and other clinicians in discussions around applying similar principles in Australia.

In Brisbane, in July, we welcomed the Honourable Paul Lucas MP, Minister for Health and Deputy Premier of Queensland. Minister Lucas spoke of the need for professionals and areas to work together to pull in the same direction. He emphasised the need to focus more on responsibility and accountability in clinical, managerial and financial terms.

SA Branch Seminar, August 2009

Our South Australian branch was treated to an enlightening and entertaining presentation from Professor Paddy Phillips, Chief Medical Officer for SA. Paddy gave us a rundown on improving clinical practice, including through the establishment of a Clinical Senate and clinical networks. While these are not new ideas, they continue to provide innovative opportunities for clinicians to help drive better patient care and ultimately system reform.

In our most recent branch seminar, the AHHA worked in partnership with the Australian College of Health Service Executives NSW and DLA Phillips Fox to deliver a very informative session on ethics in clinical practice and management. Our Vice President, Dr Patrick Bolton, chaired the meeting, with participants fully engaged in this interesting health-law topic. ha

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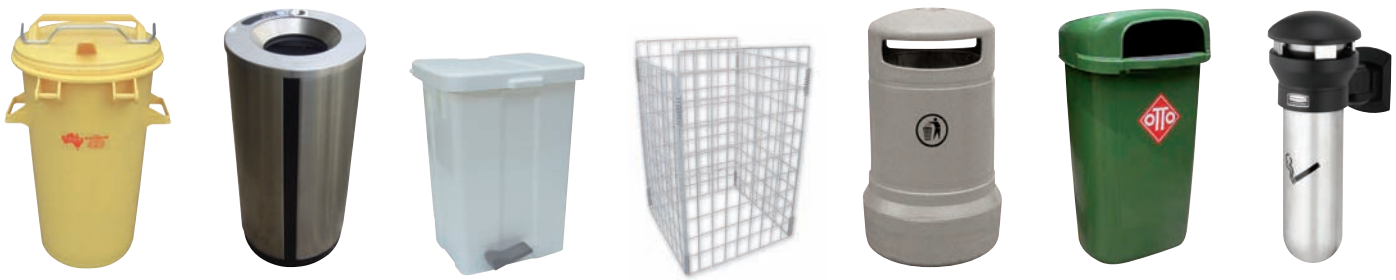

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View from the top - SA Health

Tony Sherbon looks to the future to address an **ageing population** and increased demands on the **healthcare system**

DR TONY SHERBON

Chief Executive of SA Health and a former Treasurer of the AHHA

SOUTH AUSTRALIANS are living longer than ever before. Advancements in medical care, coupled with greater education and community awareness about healthy lifestyles, has meant greater life expectancy.

However, increased longevity is creating pressures on our health system. By 2012, there will be a predicted 11 per cent increase in the number of hospital admissions. That will mean an extra 43,750 admissions each year.

To address this growing demand, SA Health has developed South Australia's Health Care Plan 2007-2016. The Plan is a blueprint for reforming our health system and identifies key areas of focus including:

- **Better coordinated hospital services;**
- **A responsive health workforce for the future;**
- **GP Plus Health Care Centres, with more primary health care services;**
- **More elective surgery;**
- **Less pressure on emergency departments, and**
- **Improved management of chronic diseases.**

The Plan will address the health challenges of an ageing population, the increasing incidence of chronic diseases, international workforce shortages and ageing infrastructure.

The Plan will impact on acute and primary care sectors and significantly assist general practice in providing primary care services and thereby reducing the demand on acute services. As such, SA Health has developed a range of Clinical Networks and Service Plans that focus attention on prevention and primary health care as well as specialist services in hospitals.

To further address rising demand on the health care system, new GP Plus Health Care Centres provide a focal point for primary health care services and complement general practice. Two centres have already been established with plans to open 10 centres statewide. The Centres are having an impact on reducing hospital admissions. In the first year of the Aldinga GP Plus, attendances at the Noarlunga Hospital ED after hours dropped by 18 per cent.

The Plan also outlines the most significant single investment in health care in South Australia's history. The South Australian Government is developing the new Royal Adelaide Hospital, a $1.7 billion state-of-the-art facility that will become Australia's most advanced hospital. The hospital will be based upon a new model of care that will take a patient centred approach to health.

This financial year, SA Health is investing significant funds into programs or initiatives aimed at reducing the growth in demand for hospitals in the areas of primary prevention, early intervention, disease management, hospital avoidance and early discharge.

In the primary prevention area, South Australia is the first Australian state to introduce the French EPODE approach to reducing childhood obesity. The *Obesity Prevention and Lifestyle* program (OPAL) is an initiative that brings together local, State and Federal Governments, communities, schools, workplaces, businesses and community organisations to support children and families to eat well and be active.

Ultimately, at the heart of the SA Health Care Plan is the health and wellbeing of all South Australians. This Plan will create a new system that will meet our state's future health needs and continue to provide South Australians with the best possible health care.

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le plus ça change

Prue Power presents **recollections** of a retiring **health economist**

DR JOHN DEEBLE

Emeritus Fellow at the Australian National University, and architect of Medicare

The AHHA has recently published an occasional paper, this year's prestigious Chalmers Oration at Flinders University Medical School (23 July 2009) given by Dr John Deeble AO, Emeritus Fellow, The Australian National University. John is one of Australia's best regarded health economists and is known as 'the architect of Medicare'. John's deep interest and long experience of the health system, which he describes as "one of society's most complex creations", was reflected in this important oration. I have focused on certain elements which relate mainly to medical and hospital services, specifically, the data showing how well the public hospitals have performed, contrary to the popular media hype. I hope that this article whets your appetite for more – please contact AHHA for the full version. The following excerpts summarise his main conclusions.

On Australia's health care performance

By any standards the Australian healthcare system performs well. Life expectancy at birth has been steadily increasing for over a century and is now second only to Japan (plus the two tiny enclaves of Iceland and Luxembourg). Until quite recently that resulted mainly from lower infant mortality and fewer deaths at younger ages. However, since 1970 life expectancy at 65 has risen dramatically. Improvements in both the quality of services and access to them must have contributed to that.

On efficiency

Using OECD figures for 2006, Australia compares well with many of its peer countries in terms of the proportion of Gross Domestic Product (GDP) spent on health. However, over the 10 years from 1996 to 2006, we had the highest rate of growth in 'real' expenditures per person of all the comparable OECD countries. Most of it came from higher service use. Spending on medications grew rapidly, due to some extraordinary increases in both prices and apparent volumes over the four years from 2000 to 2003. Spending on public health and community health services also rose at above the average rate but they remained relatively minor parts of total health expenditure.

That leaves the medical and hospital components that absorb nearly 60 per cent of

all health spending and are the subject of most policy debate. In dealing with the complex issues surrounding the funding of this sector, John concentrated on the twelve years from 1996 to 2008, the second half of Medicare that saw some significant policy changes.

On medical services

On the medical side, almost all out-of-hospital care is provided by doctors in private practice and because fee-for-service payment systems require it, the information on their services is comprehensive and detailed. It is also available for in-hospital care to private patients, 85 per cent of whom use private hospitals. We do not know the detailed medical content of services to public patients in public hospitals, in-patient or out-patient, although there are ways in which the overall volume can be estimated.

Based on Medicare statistics which cover nearly 90 per cent of all private practice work, the growth in the number of services per person has been quite striking. In the twelve years from 1995-96 to 2007-08, doctor consultations per person fell by 6 per cent but diagnostic services, mostly pathology and imaging, rose by 62 per cent and procedures increased by 32 per cent. The shift was, in many ways, only the continuation of past trends but it has accelerated significantly in recent years. We have had, in effect, an epidemic of both diagnostic investigations and procedures.

On hospital use

Not surprisingly, this growth has flowed over into the hospital system, which is where most procedures are done. In assessing hospital performance, the usual process is to compare public and private hospital separations for the whole population and to draw conclusions on performance from that. Over the 12 years to 2007-08, per capita admissions to public hospitals rose by only 12 per cent while overnight admissions actually fell. In private hospitals, overnight admissions increased by 16 per cent and same-day admissions more than doubled. On that simple basis, the private hospitals clearly did better than the public ones.

However that is not the right comparison, partly because the public sector is much bigger than the private one and percentage changes are misleading, but more importantly because the two systems serve quite different populations – defined partly by socio-economic and insurance status and, more subtly, by the types of patients that they treat. If the number of public patient admissions is related to the number of people who relied on Medicare alone and the number of privately insured admissions is related to the insured population alone, the conclusion is quite different. Between 1995-96 and 2007-08, the public hospitals increased their public patient admissions per person covered by 47 per cent, whereas the use of privately insured people has grown by only 5 per cent per person. Medicare-only people now go to hospital 16 per cent more often than privately insured ones, who are supposed to be the ones with better access.

The public hospitals have actually performed extremely well. They certainly do not deserve the on-going public and media criticism, focused mainly on waiting lists for elective surgery. However most people and most commentators will not believe the evidence. If they have done so well, why do waiting lists persist?

> Public hospitals do not deserve the on-going criticism, focused mainly on waiting lists for elective surgery

On the public hospitals' problems

Put simply, demand has overwhelmed them. However much of the pressure has come from system change. The 1996 to 2008 period saw a major shift in Commonwealth government policy towards supporting private treatment with the introduction of a Private Health Insurance Rebate, an income-related surcharge on the Medicare levy and a massive publicity campaign. Over that period the hospital-insured population rose from 34 per cent to nearly 45 per cent. The stated aim was to reduce the pressure on public hospitals. In fact, very few patients moved – only about 4 per cent. After two years, growth in both public and private hospital admissions resumed its long-term trend. The pressure on public hospitals has not abated at all.

The main reason is that the 2000-01 PHI changes have completely reversed the risk profile of the insured and uninsured populations. Instead of a self-selected group of relatively high hospital users, private insurance now has a larger, younger, more affluent and healthier population for whom diagnostic investigations and elective surgery are major treatments of choice. Although they go to hospital less often, that is where much of the growth in procedures has gone and the private hospitals have accommodated it. The public hospitals now serve a smaller population but they have more of the old and disadvantaged

people, take nearly all of the emergency cases and admit many more of the complex medical patients who stay longer and occupy beds.

The published statistics show it clearly. In its 2004-05 hospital report, the Australian Institute of Health and Welfare included an analysis of the Diagnosis Related Groups (DRGs) that showed the largest increases over the preceding four years – that is, since the full private health insurance reforms began – by type of hospital and grouped according to whether the DRGs were surgical, medical or 'other'. In public hospitals 21 per cent were classified as surgical, 72 per cent were medical and 7 per cent were 'other'. In the private hospitals, the figures were 41 per cent surgical, 38 per cent medical and 21 per cent 'other'. And the proportion of patients who died in public hospitals was three times greater than in the private ones.

It is impossible to believe that these patients came from anything resembling the same populations. The public hospitals just don't have the room or resources to provide both the essential services that their clients need and do all the elective work as well. They have rural responsibilities, teaching functions and an emergency department obligation that the private hospitals do not have and one that is growing at a much faster rate than in-patient care. Emergency and out-patients take an estimated 30 per cent of public hospital budgets which have been tightly constrained for years and for reasons that have little real regard for what they have to do. Relatively little has been spent on increasing capacity, although that varies between States. The last two years have seen a minor lift in public capital expenditures on health, but prior to that 'real' capital spending had hardly changed for more than 10 years.

On the current reform debate

Although there are many worthy proposals for improving the delivery of healthcare, John believes the only sector in which change could fundamentally alter both the structure and the economics of the system is the organisation and financing of hospital care. It is the political problem and the cost problem as well. Hospitals and the medical services provided in them take nearly 40 per cent of all Australian health expenditures and all of the suggestions for financing reform are really concerned with hospital care above all else.

John then described why the public and private hospital sectors should be complementary, not competitive, and his views on the best ways to provide financial support to the private sector, including comments on the controversial private health insurance rebate. He then went on to talk about the extent to which financing arrangements, which are the only devices that most democratic governments have, can actually affect the delivery of healthcare. Contrary to many commentators, he suggests that no health financing system in the world has ever changed the basic delivery structures that preceded it or altered the way in which providers were paid. Whatever the potential advantages, the costs of conflict are too great. Financial tools can however, influence where services come from, particularly when they operate on patients rather than providers.

John's final comments were about how extraordinarily resilient the healthcare system is and how it manages to absorb enormous technological developments while steadfastly resisting the structural and organisational changes that those developments require. "The more things change, the more they stay the same" and most of the arguments and disputations now are not much different to fifty years ago. Le plus ça change...

This is an important and thought provoking paper that I urge anyone in the hospital and healthcare system to read. – *Prue Power*

Note: contact the AHHA to obtain a copy of this occasional paper, or visit our website at *www.aushealthcare.com.au*.

Are we there yet?

DR STEPHEN DUCKETT
President and Chief Executive Officer of Alberta Health Services in Canada. He was a member of the National Health and Hospitals Reform Commission and formerly in Queensland Health

Stephen Duckett discusses why **implementation** is the issue

THE HEALTH policy world is replete with good ideas. Every commentator worth their socks comes forward with recommendations for policy change. Typically many of them attack the usual suspects: the blame game, underfunding, and incompetent politicians. Their preferred nostrums wipe away politics, often the States, and when advanced by the more naive clinicians, wipe away all the bureaucrats as well. But translating good ideas into real change on the ground requires (at least) three important steps. First, we need an idea or policy proposal and we have no shortage of those; secondly, the decision to adopt the idea; and thirdly, implementation. A critical factor for new policy ideas is implementability and that is where many founder.

A critical step

The National Health and Hospitals Reform Commission made 123 recommendations. It placed a significant focus on implementation, the final report also costing its recommendations (and identifying savings too). The recommendations were crafted to provide clarity about what needed to be done and in some cases provided a pathway for reform.

But it is the middle step that is the critical one. No matter how good the policy ideas advanced by the Reform Commission are (and obviously, as one of the authors, I think they're good) and no matter how implementable they are, without a decision to implement the Report will languish on the book shelves. This is why the final report of the Commission was focused on the pathway to implementation.

The Prime Minister has now embarked on a tour of major hospitals (and to a lesser extent other health facilities), to test the waters on one of the recommendations of the Reform Commission (namely, that the Commonwealth assume responsibility for 40 per cent of the efficient costs of inpatient activity in public hospitals) and two of his own ideas, not recommended by the Commission, (about 100 per cent Commonwealth funding). That he has chosen only one of the 123 recommendations could be seen as a good or bad thing. Does it mean the other 122 will be implemented? Or is he going to ignore them and hope they go away? The recommendation for activity-based funding of hospitals requires significant political negotiation but that was made on the assumption that other recommendations, such as the Commonwealth assuming full responsibility for primary care, were also implemented. The primary care recommendation is complex but extremely important for positioning the health system for the longer term.

The Reform Commission was a Health AND Hospitals' Commission – not either or. The Commission didn't recommend major expansion of acute facilities (despite this being the policy of choice of hospital-based advocates), because we recognised the interdependencies. If we can get people out of hospitals quicker (to sub-acute facilities) then we will free up access in acute care (but we'll do it more efficiently and probably higher quality as well). If we can improve the health of the population or improve the functioning of the primary care sector, we could reduce the rate of people with 'ambulatory care sensitive conditions' (currently taking up almost 10 per cent of acute beds). If we free up acute beds, we reduce exit block from emergency departments, if we can look after more acute (urgent) patients in primary care we reduce overcrowding in ED waiting rooms and improve performance there.

So, the Commission's recommendation of a 40 per cent Commonwealth stake in hospital acute care would expose them more directly to the cost of their current policy failings in primary medical care, aged care and so on. The Commission's Report urged the Commonwealth to take action NOW on primary care, understanding the complexity and that it would take a long time for policy reform to turn into improved care.

> It would be misguided policy if consideration of hospital funding squeezed out the other implementable ideas in the report

It would be misguided policy if consideration of hospital funding and the Commonwealth-state shuffle squeezed out the other implementable ideas in the Report. The Commonwealth's proposals at the upcoming COAG conferences should be judged in terms of their response to the whole report not just the pages about 40 vs 100 per cent. ha

GP super clinics

Prue Power asks, are they the **best solution** for an already over-whelmed **healthcare system**?

PRUE POWER
Executive Director of the Australian Healthcare & Hospitals Association

THE AHHA applauds the Government's determination to look at new ways of delivering primary and community health services. However, in relation to the GP Super Clinic Program, the big question is – can the expenditure of $275m on 31 GP Super Clinics advance the health sector towards a more coordinated, efficient system?

The objectives underpinning the initiative are laudable. They state that GP Super Clinics will:

- **Provide well-integrated multidisciplinary patient centred care;**
- **Be responsive to local community cares and needs;**
- **Demonstrate enhanced coordination with other health services;**
- **Demonstrate a partnership approach to local health service planning; and**
- **Demonstrate efficient and effective use of Information Technology including an electronic information system that can make patients' medical records available to all practitioners (including allied health professionals) at the GP Super Clinic and to external providers as appropriate.**

However, it is easy to write such words. We have heard rhetoric like this many times over the years – but how much advancement has there really been?

Rhetoric

We heard similar sentiments with the GP reform agendas in the early 1990s. We heard it with the coordinated care trials around 2000. And we have heard it numerous times in association with the endless stream of expensive IT health consultancies commissioned by governments over the last 20 years. Despite the good intentions underlying these initiatives the reality did not match the rhetoric so some wariness is understandable when looking at the GP Super Clinic initiative.

This point is not made to criticise but to recognise the difficulty and challenge of achieving real change in the Australian health sector with its confusing, multiple layers of governance; its powerful, well-resourced vested interest groups; and the complex financial flows underpinning the sector.

> Achieving real change in the Australian health sector is difficult, with so many factors at play

The AHHA's overall view is that unless some of the broader "whole-of-system" initiatives suggested, for example, in the National Health and Hospitals Reform Commission's final report are also implemented, the GP Super Clinic program will prove a lost opportunity.

Public hospitals, represented by the AHHA, have a particular interest in the primary care sector. This is to ensure an efficient, effective and available primary care service that can assist in reducing the number of hospital admissions particularly of older people with chronic diseases. Ideally, the best functioning primary care system ensures conditions are managed effectively in the community by guaranteeing that primary care services are widely available.

What does the evidence suggest?

There are some studies and commentaries from Australia and from the UK offering insights into this complex area. The lesson the AHHA takes from this experience is that, while the GP Super Clinic concept will potentially provide many benefits for Australians, it is unlikely the clinics will significantly reduce demand on hospitals, even if rolled out widely across Australia beyond the initial 31 sites now funded. This statement refers specifically to reductions in demand for admissions of patients with chronic illnesses.

Commenting on the results of the Australian

The Hon Nicola Roxon MP – Minister of Health and Ageing (left) with Catherine King MP – Fedral Member for Ballart (right); also pictured seated below.

First GP Super Clinic opened in Ballan, VIC

Australia's first GP Super Clinic was opened by The Hon Nicola Roxon MP – Minister for Health and Ageing and Catherine King MP Federal Member of Ballarat in Ballan on Monday 14th September.

After considerable Federal Government funding and 12 months of community fundraising the Ballan hospital built this multi-milliard dollar facility. Ballan's new Centre for Community Health is the first of 31 GP Super Clinics to open in Australia, making it a national first.

The new centre includes 17 consulting rooms, an increase from three, and a range of full time and visiting health services including: general practice, 24-hour emergency care, dental, physiotherapy, dietetics, podiatry, occupational therapy, psychology, pathology, echo cardiograms, audiology, district nursing, community health nursing, women's health clinics, chronic disease management, drug and alcohol support services, welfare support services, emergency relief and transport connection.

Glenn Rowbotham, CEO, Ballan District Health Care

Photo credit: Moorabool News

coordinated care trials in the *Medical Journal of Australia*, Esterman and Ben-Tovim considered that one basic premise behind the trials, that better coordination would lessen hospitalisations, was misconceived and suggested that better care coordination may actually reveal significant unmet needs therefore increasing rather than reducing demand. This point is raised by the AHHA not to suggest that such need should not be met but to point out that the GP Super Clinics will not necessarily reduce demand for hospital services (*Medical Journal of Australia* 177 , 4 November 2002 'The Australian Coordinated Care Trials: Success or Failure?' 470).

A recent article in the *British Medical Journal* quotes Rebecca Rosen from the Nuffield Trust, "There is very little robust evidence that integrated care can reduce admissions" (BMJ May 23 2009, Joined Up Thinking, 1238-1239).

An environmental reality check

General practice and the whole-of-system financing are the environmental realities in which the GP Super Clinics must operate and that, in the AHHA's view, will work against success of the initiative unless reformed.

General practice financing

In June 1991, The Australian National University reported on a "general practice financing think tank" attended by government officials, academics and many "experienced and respected leaders of the general practice community" which found that "...the system does not adequately reward general practitioners, does not encourage health promotion and prevention, does not promote continuity of care... It promotes the 'quick fix' mentality, entrepreneurial practice, excessive referral for laboratory and specialist opinion, and superficial responses to complicated problems."

Is the situation all that different now, in 2009? The AHHA contends there is an obvious incongruity in government policy in regard to GP financing. On the one hand the government is promoting GP Super Clinics that must provide "integrated multidisciplinary patient centred care". On the other hand the same government spends almost $4 billion per annum through the system of GP Medicare rebates under an MBS structure that facilitates very profitable, high volume, rapid throughput general practice – the antithesis of "integrated multidisciplinary patient centred care".

What is the relevance of all this for the current GP Super Clinic initiative? The present program is not about the government owning, managing and financing practices under new streams of funding. Successful applicants for the 31 initial sites get a capital grant from the Commonwealth to develop the facility but no on-going funding. The entity must then operate under the current financing arrangements, that is, under the MBS.

The AHHA is not convinced that the on-going economic model under which the Super Clinics must operate will be viable. They may promise to deliver a different style of care involving practice nurses, nurse practitioners and other allied professionals to receive the Commonwealth's capital grant, but can this be a viable approach if they are to deliver the resource intensive, multidisciplinary care expected? Or will they be forced to adopt a high throughput style of care to survive, a style often typical of what is now happening more generally across general practice?

Whole of health system financing

There is then the broader funding environment or, to put it bluntly, the "cost-shifting" and "blame-shifting" which impedes real change in our fragmented health financing system.

The AHHA believes the need for new models of care will not be met by simply fiddling with the structure of the MBS. More fundamental changes to Australia's health financing arrangements will be required if current and emerging demands are to be met. The GP Super Clinics, properly structured and appropriately financed and integrated effectively with other community services, could be a critical part of that solution. This will require more radical changes in funding arrangements than is envisioned.

The aims of the GP Super Clinic program will be compromised if these basic issues are not dealt with. Let us hope the Federal Government does not back away from its 2007 election commitment and the aims expressed when the NHHRC was established. The government must be prepared to address these fundamental impediments to the creation of a better coordinated, more efficient Australian healthcare system.

The AHHA believes that governance and financing mechanisms must be developed that allow those at service and regional levels more power and control to develop "models of care" that take account of local needs and local circumstances. A mechanism that allows genuine pooling of State, Commonwealth and private funds must be developed so that regional entities can facilitate the development of such locally appropriate models of care.

This outcome can be achieved in ways that would see retention of the underpinning principles of Medicare and of national payment mechanisms such as the MBS and PBS complemented by the development of a national hospital benefits table.

To take an example of what the AHHA means by "models of care", consider the management of the health needs of the residents of a large aged care facility in an Australian regional city where a GP Super Clinic has been established. Real coordination of care in such an environment will involve a model of care that allows for genuine coordination and integration of the services provided by GPs, specialists, hospitals, other healthcare providers and aged care facilities.

The AHHA would go further and suggest that the well-intentioned aims of the GP Super Clinic program can only be achieved if there is some re-shaping of financing mechanisms and some genuine devolution of management to local and regional entities including some ability at the local level to pool funds to support relevant programs.

The time is right

Currently a major debate is occurring around these issues driven by the various inquiries established by the Rudd government. Also, one assumes the Commonwealth, as part of the Super Clinic program, will conduct a robust evaluation to assess initiative outcomes.

In summary, the AHHA supports the Federal Government's intentions and preparedness to consider new ways of providing primary care. But, thirty-one stand-alone autonomous GP Super Clinics scattered around the country are not going to change the health system. The risk with the GP Super Clinics is that little will be achieved unless more significant changes are made to the governance and financing of the health system.

***Prue Power** delivered this speech at the GP Super Clinics Conference held earlier this year in Sydney.* ha

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MARK SULLIVAN

Chief Executive Officer of Dianella Community Health Limited

Facing challenges

Mark Sullivan gives three cheers for the **NHHRC**

THE NATIONAL Health and Hospitals Reform Commission (NHHRC) report is out. It is clear that the reforms to healthcare will be staggering. It is supported by, and congruent with, the recently released primary care directions and preventive health agenda. But let us also step carefully.

Not far off

In Victoria we are very proud of our health system. We have a unique network of approximately 40 community managed and owned health services. Dianella is a typical community health service employing around 270 staff delivering a range of services including health promotion, dental, salaried general medical (bulk billing), specialist medical, allied health, mental health, disability, early childhood and aged care services to the northern suburbs of Melbourne. We have a catchment of around 100,000 people which includes some of the most disadvantaged areas such as Broadmeadows. We are incorporated as a company limited by guarantee and registered as a charity independent of government.

So we are not far from the NHHRC's vision of Enhanced Primary Healthcare Centres delivering the full spectrum of health services. We know that if the government accepts the challenge put forward by the NHHRC there will be very interesting and even exciting times ahead for us. From my point of view there is a lot to like in the NHHRC's proposals.

But it's not going to be a piece of cake. Community health can trace its roots in Victoria back to the Whitlam Government's health reform agenda. I served on the inaugural board of a community health service in 1977 (I was very young), so I can say that I have seen the development of community health from its earliest beginnings. I well remember all those eager community health workers dressed in flowing tie-dyed Kaftans and clogs bouncing around the suburbs looking for trees to hug. In those days we didn't call community health a service, it was more than that – it was a group of starry eyed devotees who had signed on to a "movement" that was going to change the world.

We got an awful lot right – the need to concentrate on the social determinants of health and the compelling need to engage with and reflect your community probably chief amongst them. But we also got an awful lot wrong. We thought that it would be easy to have clinicians work together – it isn't. Our biggest mistake was underestimating just how hard it would be. To achieve efficient, efficacious, integrated services takes time and sustained effort over many years. Even now, over 30 years later, we continue to refine and develop our multidisciplinary intake and service models.

As we step forward with the reform agenda we have to be careful that the decisions we make now will help those most at need in our communities. And we have some very recent lessons of reforms going wrong.

Challenges arise

By way of example, if I go back just a few years I did not have any particular difficulty employing psychologists to work in Broadmeadows. Suddenly psychologists are as scarce as hens' teeth. Now for some of our services we really need the skills and expertise that psychologists bring. Yet while I put larger and larger ads in the newspaper, I continue to get fewer and fewer applicants. Where are they? They've moved to the leafy eastern suburbs of Melbourne to work with the worried well in the land of the generous co-payment. A move made possible by the Commonwealth's Medicare Mental Health item numbers.

I rang a psychologist I know who is very skilled and used to work in community health to try and entice her back to the poorer side of town. She was very frank in her assessment. "Mark, you want me to come and work in Broadmeadows with traumatised refugees and victims of domestic violence, when I can earn twice the money seeing middle aged men in Brighton going through their mid life crisis? Get serious!"

When the Howard Government introduced the Medicare Mental Health numbers I am damned sure it was not their intention to essentially rip resources out of communities like Broadmeadows. They had the best of intentions – but unfortunately the road to hell is paved with good intentions.

> In those days we didn't call community health a service – it was starry eyed devotees signed on to change the world

So as we embark on what even Nicola Roxon is happy to acknowledge as a brave set of reforms, let's also ensure that we heed the lessons of the past and ensure that those most at need are also those most advantaged by these reforms. ha

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JUDITH DWYER

Professor of Health Care Management at the Flinders University School of Medicine, South Australia, and a manager of health services

Health reform, anyone?

Judith Dwyer shares her thoughts on the matter

HAVE YOU had it up to here with good ideas that promise not only to make everything better but also to save money? And what are the chances that the National Health and Hospital Reform Commission's 123 recommendations (240 if you count the extra dot points within), or even a coherent subset of them, will reach implementation? And when will that be?

We're all guessing, but here are my predictions: first the timing – it will be after the next federal election and (while I'm predicting), that means after March 2010. As to how much will be implemented – if Labor wins, then whatever is in the platform will happen, or be seen to happen. This is an interesting aspect of policy-making these days – it's something of a once-in-an-election-cycle event. The same is true if the Coalition wins – but it's harder (yet) to pick what might be in their election platform.

The report offers something for everyone, including things that need to happen anyway – like electronic health records – and things that are much broader than the health system – like making healthy choices easier. So some of the report will certainly be in both platforms. But the core questions for the health system are about funding and accountability – who pays and who's responsible for what?

The first one is easy really – mostly the Commonwealth will end up paying, because they're the only ones who can afford a health system. They're rather good at paying – witness Medicare, the most efficient health insurer in terms of transaction costs. But the Commonwealth has made a virtue of not running anything much – at least, not any actual healthcare. And most in the healthcare business agree that things should stay that way.

There are a few things to feel good about in all this. All long-suffering health care providers please note – the blame in the game falls on governments this time, not you. It's all about making governments accountable, by getting system settings right.

Which brings us to the tricky question: how can authority and payment systems be aligned to support and reward good care while also making it possible for ordinary human beings not in possession of a divining rod to find their way through the system at a price they can afford? There are a lot of good ideas about this in the Commission's report. Getting rid of the split in responsibility for primary healthcare would be a great start. Putting someone in charge of coordinating all care needed by each person with complex and chronic conditions would be a blessing. An investment strategy for Indigenous health to fund care proportionate to need might let us begin to end a national shame. And it would be great if we could all afford to keep our teeth to the end.

But the Commission's recommendations on some core questions are equivocal. They seem to have pondered the likelihood of radical policy change actually happening, given our national fondness for incrementalism and the fierce stakeholding on all sides. Then gone promptly off in search of what is feasible, as you do. So they seek to unite primary health care, but introduce a new split in mental health. They acknowledge that public hospitals and their patients endure both capped funding and continual growth in demand, but leave them (almost alone of major providers) dependent on the terribly limited capacity of states and territories to pay.

And if on the other hand our political leaders wake up one day and think what the hell, it ain't broke but let's fix it anyway, we could trash universalism and go to selective Medicare. It would solve a big problem for the private health insurers – current rules leave them offering a partial product – but would bring to an end our capacity to provide roughly equivalent care to all regardless of ability to pay. The end wouldn't happen fast – but risk rating is a very inexact science, and cream-skimming would be a business imperative. A slow but inexorable shift of resources away from the poorest and sickest of us would follow. I don't think either party will take this on – too risky electorally – but I do know that the lobbying for it has been intense, sustained and well lubricated.

> All long-suffering health care providers please take note – the blame game falls on governments this time, not you

The Prime Minister has asked all of us to get involved in the consultations and 'end the blame game once and for all'. It's time for public healthcare providers to be heard, so have a go. And bring some patients with you. ha

Revitalising rural health care

Ensuring a **bright future** for
Multi-Purpose Services in Australia

LYNDON SEYS

Chief Executive Officer of Alpine Health in Victoria, and chair of the joint AHHA and Australian College of Health Service Executives' policy group looking at the Multi-Purpose Service program

IN 2008, the National Health and Hospitals Reform Commission released interim recommendations for the reform of Australia's health system. One provided for the expansion of the Multi-Purpose Service program. This program has been in place since the mid 1990s with the aims of sustaining small rural health services and ensuring their long-term viability. With a focus on improving health by bringing primary healthcare and aged care together, the program has developed as a national rural health service delivery strategy. Today more than 150 Multi-Purpose Services operate across Australia (except ACT) and most are our smallest rural and remote health service organisations.

The release of the Commission's interim recommendations created an opportunity for a contribution from the field. In February 2009, the AHHA and ACHSE came together to coordinate a policy response, using the AHHA policy development process.

Information gathered

AHHA and ACHSE called for stakeholders interested in the Commission's recommendations to participate. More than 50 responses came from individual Multi-Purpose Services, policy makers and planners from state and territory government agencies, and academia. Three national teleconferences were convened to engage all stakeholders and to draw out issues, solutions and opportunities. A small writing team used the resulting information to develop a draft policy paper that was circulated for comments and used as the agenda for a policy Think Tank hosted by the AHHA in May 2009. This concluded the information-gathering phase and the writing team prepared the final policy paper, entitled Multi-Purpose Services In Australia.

It describes how some of Australia's smallest rural and remote health services have been able to survive multiple challenges thrown at them over the last 15 years by extraordinary economic, social, technological, educational and political change. Their basis in population health planning and primary healthcare service delivery models has enabled the communities to retain basic services and expand those relevant to them.

The recommendations

The most obvious feature of Multi-Purpose Services is their diversity, characterized by the range of services they provide and the structural, funding and legal mechanisms established to secure local services in accordance with community expectations. Diversity has led to inconsistencies across the Multi-Purpose Service program in key areas of service planning, governance and accountability, funding, and accreditation. Notwithstanding this, innovation in service design and delivery has been possible – attributable to an ability to pool funds, develop and deliver flexible services and forge strong local relationships.

Our major recommendation in response to the Commission's approach is that the Multi-Purpose Service program be rejuvenated and expanded based on a national evaluation to identify critical success factors. Our understanding of these factors falls out of the policy and program design of the Multi-Purpose Service model – and an evaluation carried out almost a decade ago in Victoria. As such, they present a good starting point for enquiry into the possibilities for rejuvenating the Multi-Purpose Service program nationally. The factors are:

- **Service planning based on population health planning principles taking into account local health needs defined by local communities including Indigenous people;**
- **Strong local relationships, particularly structures and processes for engaging local communities in planning and health decision-making, health service delivery and management, and evaluation;**

> The Multi-Purpose Service program should be rejuvenated and expanded based on a national evaluation

- **Strong local governance, management and leadership – creating a strong local health service entity with which the community can identify and the establishment of single health service entities protected by legislation with corporate and health governance responsibilities;**
- **Commitment from the Commonwealth, states and territories to continued funding of a range of basic acute, aged care, community care and community health services under the single entity; and**
- **Accountability mechanisms that include prescribed reporting of financial, service and quality outcomes as well as accreditation.**

While state governments (and other stakeholders) have undertaken a small number of evaluations to determine the effectiveness of the Multi-Purpose Service program, there has been no formal national evaluation. Anecdotal evidence finds the Multi-Purpose Service program is a sustainable model of integrated health service delivery.

A national evaluation of the program would be valuable in identifying the critical success factors and providing lessons for programs seeking to address current and future integrated primary health service delivery challenges in an environment that is very similar to the one that saw the model emerge.

DR PATRICK BOLTON

Associate Professor and Vice President of the Australian Healthcare & Hospitals Association

Public vs private

The health **insurance** conundrum **continues...**

THE HOSPITAL I work at received its annual budget letter recently. Two things are different. First, we got it earlier in the financial year than usual. Second, the real additional funds are tiny. Most of the growth in expenditure is expected to come from increased revenue. That in turn is largely expected to derive from getting patients to use their private insurance.

I think it was Stephen Duckett who said: "I have two types of health insurance – the one the government provides and the one the government makes worthwhile for me". This works for me. I think the Australian public hospital system compares favourably with the private sector and can't really understand the value proposition for an individual taking out private cover.

I have private cover because, after tax, it is cheaper for me than not having it, and to keep my options open if, as I get older, I want to ensure my community rating price. It's certainly the case that some elective procedures are only available, or much more available, in the private sector. My insurance covers this, in that, although it has a large gap, it would not be catastrophic for me to pay the gap if I or a member of my family really needed a procedure. As a doctor I can remember feeling a bit shamefaced consulting specialists as a patient and acknowledging that I did not have private health insurance. I felt some peer pressure to conform to the industry values of privatisation, notwithstanding the other tradition that says doctors should treat their colleagues for free, or at least at the Medicare subsidised rate!

I struggle with the "business case" for an individual to use their private insurance in a public hospital. Is it going to make a difference to their health outcome? If the answer to this is "yes" then can such a difference be morally justified in the public system? If the answer is "no" then why should they use it?

There is no absolute answer to the moral question of equitable rights to access healthcare. Community members are at liberty to respond differently to health risks, as they are to the other vicissitudes of life. However, we know that social equality is the single greatest determinant of the health of communities in developed nations, a striking argument for equitable provision of healthcare.

The notion that an Australian public hospital might provide better care to someone who can pay for it strikes me as contrary to deeply rooted values held by those who work in those institutions and public notions of equity and mateship. This issue is likely to become more apparent as pressures for health resources increase.

One occasion on which being a private patient may make an important difference is choice of surgeon. Privately insured patients requiring planned surgery are able to make this choice before they are admitted to hospital. In general, if they choose to be admitted privately, they go to a private hospital, so the practical effect of this distinction mainly applies to emergency surgery. The nature of emergency surgery means that patients are rarely in a good position to give informed consideration of whether they should go private before they are operated on. It is not until the surgery is over that they are in a condition to do this.

Ironically, in many cases private patients end up facing out of pocket expenses not faced by public patients. This means that patients who elect to use their private insurance in a public hospital may be worse off than if they had remained public. This makes it difficult for public hospitals to persuade them to convert.

If public hospitals are successful at increasing the proportion of patients using their private health insurance, this will increase the cost of both private insurance and healthcare generally for no improvement in through-put or in health outcomes. This system is structured to create an inflationary spiral for healthcare costs, with plenty of incidental perversities. One has to wonder whether there would not be a better way to address these issues.

Postscript: After I wrote this, John Deeble was invited to comment on it. He's a hero of mine, so I was interested in what he had to say:

> *The idea of getting extra revenue from private patients is a peculiarly NSW practice, not nearly as strong anywhere else. And of course, it DOES have the effect of displacing public patients. In 2007-08, half of all the privately insured patients treated in public hospitals were in NSW. In that year 79.6 % of all NSW public hospital admissions were "public" compared with 87% in Victoria, 92% in Queensland, 88% in WA and 87% in SA. 'Public patient' admissions in NSW were the lowest per captia in the country, 26% lower than in Victoria, 10% lower than in Queensland and 15% lower than in WA and SA.*

Even without NSW there is substantial variation between the states. Another odd twist to the private health insurance debate.

The 2010 registration scheme

DEBRA CERASA
Chief Executive Officer of Royal College of Nursing, Australia

How does **national registration** affect you?

IT'S A REAL privilege for me to have the opportunity to connect with AHHA members in this new column, and to share news with you from the nursing world inside the walls of RCNA. I think a good way to start would be to have a bit of a chat with you about the national registration scheme that's due to be implemented in 2010.

Many of our members and their colleagues, who are nurses out in the 'real world' (as I like to call the front line of health care service provision!), have told us that they're feeling unsure about the implications of the July 2010 national registration scheme. No surprises there – as the foundations are only now being laid for this scheme, there's still very little concrete information available.

Potential for change

I'd like to focus on the nursing registration aspect of the proposed National Registration and Accreditation Scheme for Health Professionals. Both parts of the scheme are of equal importance, however I think it's important to start with looking at one of them in a bit of detail.

RCNA's perspective on the new scheme is that it's an opportunity for a really positive change as to how the nursing profession is regulated. Currently, nurses are required to pay their fees and complete the registration process for each state and territory in which they wish to work.

For example, the recent Black Saturday bushfires in Victoria provided an excellent argument for a national scheme. Nurses from South Australia were able to cross the border into Victoria to assist with the emergency response by enacting a cross border collaboration policy between the Nurses Board of Victoria (NBV) and St John Ambulance (SJA). This was a really fast, effective and collaborative move by two forward-thinking organisations. In other areas where such policies don't exist or don't work as efficiently, interstate emergency support can be delayed by the barriers that state-by-state registration creates. A national scheme will remove the need for these negotiations.

On a much more basic level, it's frustrating and expensive for individual nurses who move to a new state or territory and have to go through the cost and process of registering all over again in the same calendar year.

In terms of consumer health and safety, a national registration scheme should also close some of the gaps that exist in the current state-by-state system.

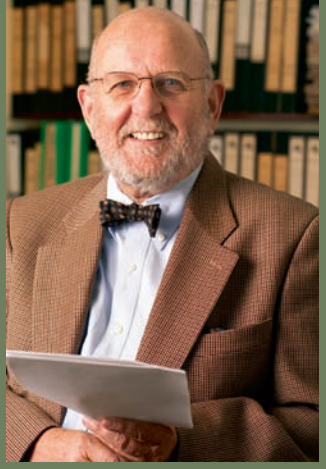
National requirements

A national register offers more streamlined management of complaints, disciplinary action and individual nurse records and will hopefully cut down on the (already rare) incidences of nurses who have been de-registered due to improper conduct in one state and go on to register, without detection, in another.

What we know so far about the scheme is that there will be a mandatory professional development component; nurses will be audited in order to demonstrate that they have undertaken a set number of hours of professional development over the course of a year in order to remain registered. The number of hours has not yet been set, but we do know that 10 per cent of the nursing population will be audited each year. This requirement creates an instant argument for broader provision of professional development opportunities for the nursing workforce and for support in that professional development from employers and professional bodies like RCNA.

> RCNA's perspective on the new scheme is that it's an opportunity for positive change as to how the profession is regulated

The recently appointed Nursing and Midwifery Board of Australia will oversee the scheme's governance structure and should assist in clarifying much of the missing detail that currently surrounds the scheme; watch this space for further updates! ha



GAVIN ANDREWS

Professor of Psychiatry and Director of the Clinical Research Unit for Anxiety and Depression at the University of New South Wales in St Vincent's Hospital, Sydney

Online distance treatment

Gavin Andrews discusses how the **web** is helping to treat **mental disorders**

I am excited by the possibilities of internet therapy for common mental disorders. Nothing I was taught prepared me for this. The internalising disorders of depressive and anxiety disorders account for six per cent of the burden of human disease and contribute more disability (DALYs) than common physical diseases like diabetes or arthritis. It is believed that they are associated with changes in chemical transmitters in the brain. If so, how could internet therapy work?

First the evidence: the late Jeff Richards at Ballarat showed that internet treatment for panic disorder was effective and his colleagues at Swinburne have continued his work. Our own work in eight randomised control trials supports his findings. We have now treated some 770 people over the web with social phobia, panic disorder, generalised anxiety disorder and depression, and the findings of most are published. (See for all references Perini et al Clinician-assisted Internet-based treatment is effective for depression: Randomised controlled trial. *Australian and New Zealand Journal of Psychiatry* 2009; 43:571). Hearing about **virtualclinic.org.au**, people apply for treatment, are assessed as meeting criteria for a disorder and are included in a research trial. Treatment for each of these four disorders consists of six lessons in which people follow a cartoon story of a person with the disorder learning how to recover. This is coupled with written homework of what they need to learn and do, supplemented with web postings from people who have previously done the program and additional resources about mental health strategies that might be useful. At the very least it is programmed learning, but it might just be treatment.

We have now completed eight randomised controlled trials in which a group with one of the four disorders is given the disorder specific internet program plus one to three hours of therapist time per patient and compared with groups given access to the program but no therapist, or to no treatment at all. The results in all four disorders are comparable – the superiority over no treatment is comparable to, or mostly better than, treatment from seeing a clinician and getting either medication or face-to-face cognitive behaviour therapy. For example, in our latest set of trials in major depressive disorder, 72 per cent of the people who met criteria for depression at the beginning no longer met criteria for depression after ten weeks using the program. Their improvement seems stable six months later. The programs at **virtualclinic.org.au** are powerful treatments. So, why is this so?

> Surely the relationship between doctor and patient is a critical variable. We don't know.

Surely the relationship between doctor and patient is a critical variable. We don't know. On average 80 per cent of people complete the six lessons, surely an indicator of acceptability, and say they find them logical, sensible, and valuable. And we find the patients logical, sensible and a pleasure to treat. The average person is some nine years older than people who are referred to our clinic and have that much more experience with illness and the usual treatments, and in this way should have a poorer prognosis. They range in severity from mild to severe, exactly in proportion to patients detected in primary care. We always believed the key variable in therapy was the relationship between clinician and patient. Little of that is operative here. So perhaps the key variable is not sympathy or empathy but clear and respectful instructions in the skills needed to recover. We don't really know. Perhaps readers or future trials will tell us. ha

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Governance in the healthcare setting

And how it relates specifically to **health and medical research**, e-health and new technologies

FOLLOWING ON FROM PREVIOUS ARTICLES ON **GOVERNANCE** IN *THE AUSTRALIAN HEALTH REVIEW*, THIS ARTICLE BRIEFLY EXPLORES GOVERNANCE ASSOCIATED WITH EMERGING TECHNOLOGY IN THE HEALTHCARE SETTING, PARTICULARLY IN RELATION TO **HEALTH AND MEDICAL RESEARCH AND E-HEALTH**

Health and medical research

HEALTH AND MEDICAL research governance issues include ensuring that:

- The organisation knows what activities are being undertaken;
- The people who undertake those activities are appropriately qualified, experienced and registered to undertake that activity;
- The organisation's insurance covers its proposed activities;
- If the clinical trial is sponsored by a third party (such as a pharmaceutical or medical device company), an appropriate Clinical Trial Agreement (including indemnity) is signed before the study is commenced with the correct parties;
- Adequate due diligence is undertaken on sponsors to be able to stand by their indemnities (given these economic times);
- Ethical, moral, religious and cultural considerations are appropriately managed and all required activities are referred to ethics committees;
- The Hospital's ethics committee is appropriately established, has notified its existence to the Australian Health Ethics Committee and operates within its guidelines;
- All relevant Health Department policies and procedures are complied with;
- The ownership of the intellectual property in the research will be appropriately secured - in this respect in the recent case of the University of Western Australia v Gray [2009] FCA FC 116 the Federal Court held that intellectual property in cancer treatments developed by Dr Gray whilst a member of the academic staff at the University was not owned by the University because a duty to research is not necessarily a duty to invent;
- The activities don't infringe the intellectual property, moral or other rights of third parties;
- The intellectual property is registered and protected;
- Adequate consent is provided;
- Published results are correct and not misleading or deceptive and research integrity is maintained;
- The intellectual property is appropriately assessed for commercial value and

ALISON CHOY FLANNIGAN

Partner at DLA Phillips Fox

commercialised or licensed;
- The organisation complies with legal obligations in relation to grant and trust funds for health and medical research;
- Human tissue is appropriately managed in accordance with ethical and legal requirements;
- Compliance with privacy laws is undertaken;
- There is compliance with occupational health and safety and public safety requirements if hazardous materials are involved;
- The rights of children and intellectually disabled people are protected; and
- Complaints are handled appropriately.

Governance issues are addressed in a number of laws, guidelines, policies and procedures that regulate the conduct of health and medical research in Australian health care facilities, including:

- The *Therapeutic Goods Act 1989* (*Commonwealth*) and the *Therapeutic Goods Regulations 1990* (*Commonwealth*), which require clinical trials using unapproved therapeutic goods in Australia to make use of the Clinical Trial Notification (CTN) or the Clinical Trial Exemption (CTX) schemes;
- *The Australian Clinical Trial Handbook* published by The Therapeutic Goods Administration (March 2006);
- The National Health and Medical Research Council National Statement on Ethical Conduct in Human Research; and
- Various State Health Department policies and directives.

E-health

E-health is becoming an integral part of Australian health care. This can include health call centres, providing health care services using Internet or telephone technology, electronic medical records, e-prescribing, online pharmacies and medical supply companies, digital diagnostic reports, etc.

Many health-related websites are now available to Australian residents, both located on servers in Australia and overseas.

Current Australian laws regulate these activities like any other health care activities. These include through therapeutic goods laws, privacy laws, medical registration laws etc.

E-health poses particular risks (which can be managed but not eliminated), including:

- Correct identification of patient and diagnosis without seeing the patient;
- Compliance of duty of care to follow up when adverse results are provided;
- Dealing with medical emergencies when the patient is remote;
- Compliance with the duty of care to give a warning advice or other information of the risks of death or injury associated with remote patient care; and
- Ensuring that the practitioners involved are appropriately qualified, experienced, registered and insured.

All State and Territory Medical Boards have reached national agreement for the registration of medical practitioners engaged in the practice of telemedicine. It has been agreed that in relation to a telemedicine service involving a doctor in jurisdiction A and the patient in jurisdiction B, the relevant jurisdiction from the perspective of registration should be jurisdiction B, that is the location of the patient at the time the service is provided.[2]

In relation to the various health Internet services and sites there is no additional requirement of licensing or regulation in Australia. We question whether additional regulation is required.

New technologies

New technologies are constantly being introduced in the healthcare setting. These include the use of robotic surgery or gene technology or using existing or traditional medicines for new uses.

These may be past the clinical trial stage; however, an assessment still needs to be made by all relevant people at the hospital as to whether such treatment should be used on the hospital's patients, whether ethical principles are complied with, adequate consent is obtained and appropriate insurance coverage has been procured. ha

Footnotes
1. For example, section 5P Civil Liability Act 2002 (NSW)
2. For example, refer to 'Telemedicine' Medical Board of Western Australia Policy August 2003; 'Telemedicine' Medical Practitioners Board of Victoria.

Indigenous health

RAHC has placed more than **150 health professionals** in the **Northern Territory**

The Remote Area Health Corps (RAHC) was established in late 2008 with funding from the Federal Government's Expanding Health Service Delivery Initiative in the Northern Territory (NT). RAHC is working in partnership with the Aboriginal Medical Services of the NT and the NT Department of Health and Families to provide health professionals for short-term placements to expand and support primary health services.

A further announcement in July confirmed that Australian government funding for RAHC will be ongoing for at least another year to continue the work it has been carrying out in the NT to date. Since its inception at the end of last year, the RAHC program has placed more than 157 healthcare professionals from a range of backgrounds and locations throughout Australia. Doctors, nurses and allied health professionals have been placed in over 40 communities across the NT to provide immediate support for primary health services in the area; and RAHC is receiving new requests for information about the available work placements daily.

Dr Lisa Studdert is the General Manager for RAHC. Lisa comes to RAHC from the Asian Development Bank (ADB) where her most recent position was as Head of Health Programs in Vietnam. Her work included leading projects in the areas of health systems reform, provincial health infrastructure development, health financing, health workforce, nutrition and HIV and AIDS. Lisa has a PhD in public health nutrition, is highly regarded in her profession and brings to RAHC enormous enthusiasm, experience and vision.

Lisa says: "RAHC is embracing the challenge of offering health professionals the opportunity to get involved on a practical level in improving health services in remote communities of the NT. We are resourced to do this in an innovative way and respond to needs identified by local communities. RAHC provides a new contribution to the efforts of others involved in Indigenous health programs across the country and will develop a sustainable and effective program. We want professionals to have a rewarding experience and to share this with friends and colleagues so we can get more healthcare professionals involved.

New services added

"The ultimate goal is for us to develop this pioneering program to exist far into the future so that health professionals see involvement with RAHC as an integral part of their career. We are committed to ensuring RAHC exists as a valued part of a comprehensive approach to improving Indigenous health in Australia."

The RAHC program initially started out to attract urban-based doctors, nurses and allied health professionals to work in primary health services for Indigenous people in remote areas of the NT but has now been extended to offer dental health professionals the same opportunity to get involved in these areas.

> RAHC is committed to improving health services in remote communities

"The extension of RAHC services to include dental health provision was a direct response to the requests of local communities in the NT," Lisa comments.

"We're making some good inroads and improving our ability to respond to the most urgent calls for support to primary health services. Adding dentists, dental assistants and oral health therapists to the list of skilled workers RAHC places will expand the range of expertise that we can place into the region and strengthen healthcare provision in the area."

The paid assignments are for short periods of three weeks up to three months enabling health professionals to maintain their professional and personal obligations at home while participating in efforts to expand and strengthen primary health services in remote areas.

RAHC encourages anyone who is interested in finding out more about the program to visit the website **rahc.com.au** or call 1300 MYRAHC.

Become an AHHA member

Help make a difference to health policy, share innovative ideas and get support on issues that matter to you

For more than 60 years, the AHHA has upheld the voice of public healthcare. The Association supports your access to networks of colleagues. It provides professional forums to stimulate critical thinking. It facilitates a collective voice across Australia and develops innovative ideas for reform.

AHHA values your knowledge and experience

Whether you are a student, clinician, academic, policy-maker or administrator, the AHHA values your skills and expertise.

The AHHA reflects your views and gives them a voice. Your ideas will help shape the AHHA's policy positions and our highly influential advocacy program.

Our focus is on improving safety and quality for patients and consumers in all healthcare settings. To do this we are working to achieve better service integration; enhanced information management systems; efficient financing models; targeted performance measures and benchmarking; and a sustainable and flexible workforce.

Your knowledge and expertise in these areas are valuable and you can have direct input to our policy development.

As a member, you and your organisation play a role in reforming the public healthcare sector by contributing directly to the AHHA's leading edge policies. We develop policies that reflect your views. Join our think tanks or participate in our national seminars or conferences. Our voice is authoritative and influential. It is heard via our high-level advocacy program and extensive media exposure.

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$10	$25	$3,300.00
$25	$100	$7,700.00
$100	$250	$16,500.00
$250	$400	$22,000.00
$400	$550	$27,200.00
$550	$700	$33,000.00
$700	$850	$38,500.00
$850	$1,000	$44,000.00
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***Fee includes GST - valid from July 1, 2009 to June 30, 2010**

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(See 2009/10 fee scale)

*Documentation required to verify status as a student. All prices for Australian membership include GST and are in Australian dollars.

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☐ **E-Healthcare Brief** - This weeks news and AHHA updates edited by the AHHA team (Tuesdays)

☐ **AHR Preview** - A reminder to check online for the current quarter's Australian Health Review

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Amount in AUD$ to be paid by cheque or credit card (maximum for credit card payments: $2,000).

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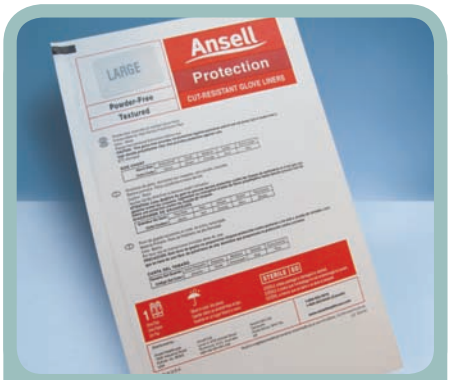
Trade news

Information from suppliers in the healthcare industry



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They are made with Spectra®[1] polyethylene fibre, a material lighter than Kevlar®[2]. Spectra® absorbs less water and conducts less electricity than Kevlar®, which helps to improve comfort and reduce the risk of static sparks.

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Caution: This glove liner does not protect against punctures and is not cut-proof, but is made from a high-strength polyethylene fibre that provides increased protection against cuts.
[1]Spectra is a registered trademark of Honeywell International Inc. [2]Kevlar is a registered trademark of E.I. de Pont de Nemours and Company or its affiliates.

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Super funds bounce back

ACROSS the world the media has been dominated for the last two years or so by a constant flow of bad economic and corporate news. Analysts are now far more optimistic and global share markets have factored in this more optimistic view.

Health Industry Plan (HIP) CEO, Ross Bernays has reported that HIP and its members have just experienced one the most productive periods in the history of the Fund returning around 14% to members over the last six months and that this experience has been shared by most superannuation funds with a growth perspective.

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Diary

The AHHA hosts a variety of events throughout the year. Watch this space for upcoming events near you.

October 2009

Date	Event	Location	Registration
Wednesday 28 October	AHHA ACT Branch Seminar with Mark Cormack	Canberra	Open registration

November 2009

Date	Event	Location	Registration
Friday 13 November	AHHA Think Tank	Sydney	Invitation only
Thursday 19 November	AHHA Queensland Branch Seminar with Mick Reid	Brisbane	Open registration
Friday 20 November	AHHA Special Think Tank – Former Health Ministers	Sydney	Invitation only
Tuesday 24 November	AHHA/Heart Foundation Parliamentary Roundtable	Canberra	Invitation only
Friday 27 November	AHHA/ACHSE South Australian Branch Seminar with Tony Sherbon	Adelaide	Open registration

Other events in November and December:

Tasmanian Branch Seminar (TBA)
Victorian Branch Seminar (TBA)
NSW Branch Seminar (TBA)

Who's who at the AHHA

PRUE POWER is Executive Director of the Australian Healthcare & Hospitals Association. Prue has worked in the health sector for most of her career, beginning as a nurse in Melbourne. She has held senior positions in the Australian Nursing Federation (ACT Branch), the Australian Medical Association, and has managed the AHHA since 2002. Prue also worked as advisor to The Hon Brian Howe MP, Minister for Health and Community Services.

Cydde Miller is our Policy & Networks Manager. In this role, she organises the policy and advocacy program for the AHHA, and is responsible for developing and maintaining the involvement of our key stakeholders and friends. Her background is in research and policy, particularly in education, and she's the best person to contact about getting involved in the work of the AHHA.

Jessica Fryer is our Office Manager, the position around which all our activities revolve. She is responsible for membership and subscriptions for the *Australian Health Review*. All information and inquiries should be directed to Jess in the first instance.

Catherine Fitzpatrick is our part-time Office Administrator – providing valuable assistance with a multitude of tasks.

Please contact us with any questions or concerns. See page 3 for how to get in touch.

Shown here: back (left to right) Cydde Miller, Catherine Fitzpatrick; front (left to right) Prue Power, Jessica Fryer.

Snippets

The **last** word

Q&A with…
Dr David Panter
AHHA President

What drives your passion to work in healthcare?

I moved from the academic psychology world to the health service delivery world in the mid 80's when HIV/AIDS hit my own community and I wanted to make a difference to the prevention and care people were receiving. I learned a lot about how those in need of services and those that provided services often had different expectations and understandings of what was possible. Almost 25 years later I'm still motivated by trying to improve the lot of both patient and clinician in the pursuit of healthier communities.

Describe what you do in the system…

I feel doubly fortunate for having not only the best health service job in the world, but for being able to do that job in South Australia. After years of operational management I'm now responsible for developing health service strategy and leading the health reform process in SA Health. This is a fairly unique role in that my responsibilities span the care continuum from prevention and primary care, through our GP Plus Program, to the most specialist hospital services, including the design and development of the new Royal Adelaide Hospital.

What's your most memorable experience since being in Australia?

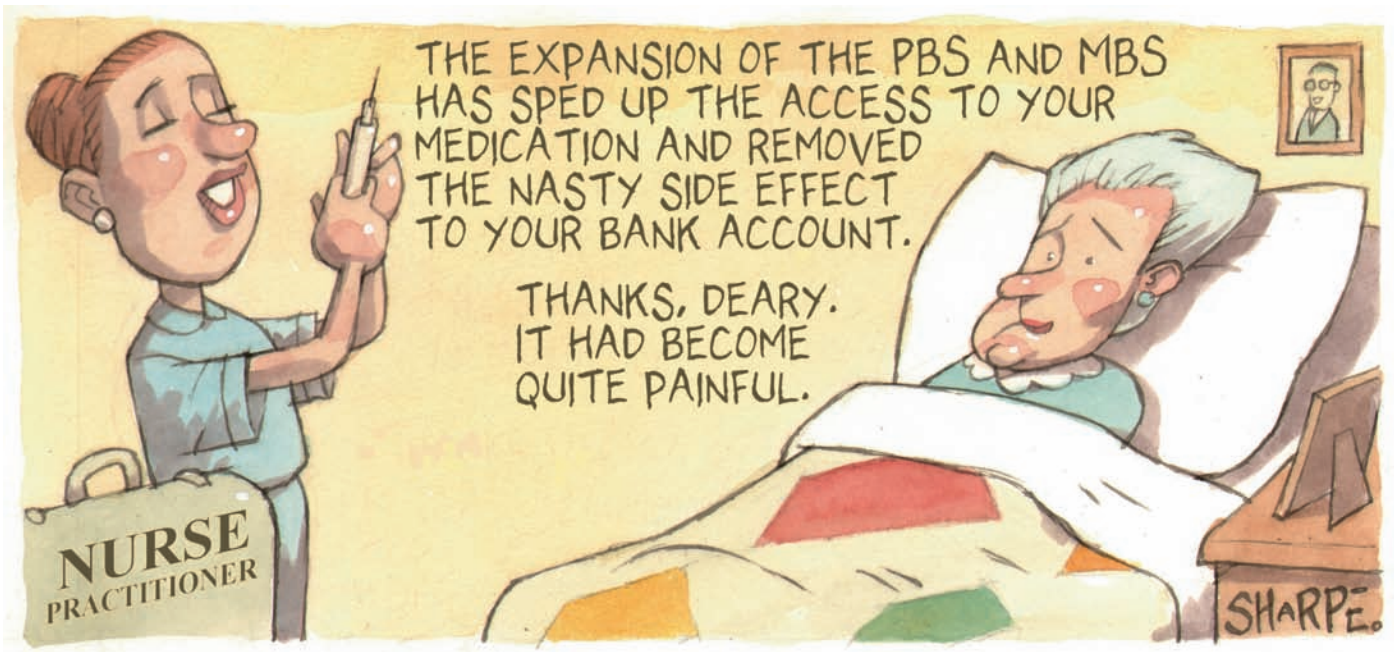
I've been here for almost five years and one issue that has been high on my agenda from the outset has been how to make a difference in health outcomes for the Indigenous community. I've been incredibly fortunate to meet with, and work alongside, a number of Aboriginal and Torres Strait Islander community members and they have all been gracious, patient and generous with their time. Whilst it should have happened a long time ago it was amazing to be there when the Australian Government finally said "sorry" to Indigenous people.

What do you look forward to?

Until she reached age 50 my sister had always favoured silver over gold. On her 50th birthday this changed when the silver jewellery was put away and replaced with only gold, including those little gold pumps women of a certain age seem to cherish. She grew into gold. For me, still in my 40's, I hang on to the silver jewellery but I have grown into gardening! For years I had no interest whatsoever but now am thoroughly addicted. So most evenings and weekends I'm out there pottering and there's nothing better!

Tell us one thing your colleagues may not know about you…

As Chief Executive of Brighton and Hove City Council on the south coast of England I gave permission for Fat Boy Slim to have his now legendary Brighton Beach Boutique event in the summer of 2002. This free event attracted more than 250,000 people to Brighton Beach to dance the night away, bringing the south east of England to a standstill. What a night – there's a DVD with the evidence! ha



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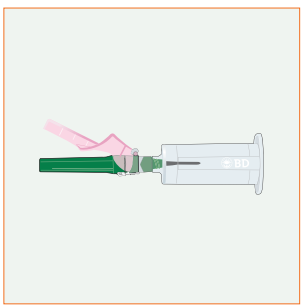

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