



# The Health Advocate

Your voice in healthcare

## Chronic disease

**\$100 million to get Australia's  
health on track**

**Investing in preventive health**

**Shifting the treatment  
paradigm in osteoarthritis**

**Indigenous health support in  
Western NSW PHN**

**+MORE  
INSIDE**



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DEBORAH COLE

Chair of the Australian Healthcare and Hospitals Association (AHHA)

# Prevention is key in the fight against chronic diseases

**T**he prevalence of chronic disease is Australia's greatest health challenge. We, along with the rest of the world, are struggling to meet the demands of an ageing population, with one in four Australians having at least two chronic health conditions. Our already stretched resources are buckling under the pressure as we soldier on with a flawed system in need of fundamental change.

Where do we start? How do we tackle the rising rates of chronic disease in a way that is cost effective and delivers results? I've written previously about the importance of introducing value-based, integrated and patient-centred care, so this time I'd like to focus on the importance of prevention and early intervention.

Often by the time a patient presents at our practice, clinic or hospital, they are already suffering from one or more chronic diseases. Many of these could have been prevented if we had a system that supported people to make healthier choices, while taking into account the complex determinants of health.

We know that many of the chronic diseases that are crippling our health

system are preventable. We know that they share common risk factors like excess body weight and high blood pressure caused or exacerbated by lifestyle choices including a poor diet, sedentary lifestyle, smoking and excessive alcohol consumption. Over recent years we have also gained a better

understanding of how societal factors like income, education, conditions of employment and social support either strengthen or undermine the health of an individual or community.

Australia's National Health Survey 2015 found that the 20% of Australians living in the lowest socioeconomic areas were 1.6 times as likely as the highest 20% to have at least two chronic health conditions such as heart disease or diabetes. The evidence on health inequities

is clear, but adopting a social determinants approach keeps getting put in the 'too hard' basket by our seemingly impenetrable ties to conventional action and policy-making.

We need to take an evidence-based approach to identifying high risk communities and individuals. We then need to partner with these communities and individuals to reduce their risk of developing chronic

diseases. Reducing the risk factors associated with chronic diseases will result in a decrease in incidence of chronic diseases, which will in turn result in a decrease in premature deaths as a result of these conditions.

I know I am oversimplifying. I know this is a complex issue. But if we don't tackle these diseases with a preventive and holistic approach, we will never stop the cycle of treating the symptom instead of remedying the cause.

It's not all doom and gloom. There is some incredible work being done in the prevention and early intervention space throughout Australia, with more and more health professionals prioritising the social determinants of health in their models of care. The Health Care Homes model takes a holistic approach to chronic disease management by considering the physical, emotional, spiritual and cultural attributes that affect a person's overall health. The model also aims to incorporate social and welfare supports through linkages with services or supports that a patient may require.

While there are great people doing great work in this space, we need everyone on board with policies and interventions from all sectors and levels of society. We need to work together to analyse and understand the societal, cultural and behavioural factors that are contributing to the rising rates of chronic disease, and we need to get among the people and work with them and their communities to improve their behaviours and forge a healthier future [ha](#)

**“We know that many of the chronic diseases that are crippling our health system are preventable. We know that they share common risk factors like excess body weight and high blood pressure caused or exacerbated by lifestyle choices including a poor diet, sedentary lifestyle, smoking and excessive alcohol consumption...”**



**ALISON VERHOEVEN**  
Chief Executive  
AHHA

# Beyond health systems and funding

**A**t AHHA we are committed to universal and equitable access to high quality healthcare in Australia, and much of our work revolves around advocacy, research, communication, business services, evaluation, and education and training to that end.

Our 'core business' revolves around health systems, healthcare and funding, and how they are best adapted to changing circumstances such as the ageing of the population and the advent of chronic diseases—the theme of this issue of *The Health Advocate*.

But we also know that good health is multifactorial, and goes beyond systems, funding, healthcare services, and self-care activities such as eating and sleeping well, and being physically active.

The social determinants of health such as housing, families, and feelings of safety and inclusion in the community are also extremely important. So are environmental factors, including climate change.

Issues such as these affect different groups in our society in different, and sometimes unexpected ways that are not always universally understood or appreciated. This is why, at times we feel compelled to adopt and communicate positions on these 'upstream' issues in the interests of good health and health equity.

## MARRIAGE EQUALITY AND HEALTH

A good example is the issue of marriage equality and health. AHHA has recently issued a position statement on this. While we cannot reproduce the statement in full here, some of the major points are:

- LGBTIQ (lesbian, gay, bisexual, transgender, intersex and queer) persons are a minority population group that experiences poorer health outcomes than the general population.

- This can be attributed to 'minority stress', where LGBTIQ people struggle for validation and social acceptance.
- One of the examples of institutional discrimination against this group is the exclusion of same-sex couples from civil marriage.
- Civil unions or de facto status are not as respected as, or given equal weight to, marriage.
- Sexual orientation and choice of partner are fundamental human rights.
- Denying LGBTIQ persons the right to civil marriage reinforces stigma associated with minority sexual identity.
- The Australian Government should legislate for marriage equality. A national plebiscite is not required.

## CLIMATE CHANGE AND HEALTH

Climate change can also affect health significantly, which is why in late June we welcomed the release by the Climate and Health Alliance of its *Framework for a National Strategy on Climate, Health and Wellbeing for Australia*. AHHA is a member of the Alliance.

The Framework is a succinct and useful 'roadmap' that will support the Australian Government in taking a leadership role in protecting the health and wellbeing of Australians from climate change.

It is a fact that the 20 hottest years on record on Earth have all occurred since 1981, and the hottest year of all time was last year—2016. This succeeded the previous hottest year—2015—which was in excess of the previous record, set in 2014.

This is resulting in weather extremes—something Australia is particularly susceptible to. Floods, storms and heatwaves are occurring more often, and in many cases with greater severity. The effects on human health can be severe in terms of sickness, injury and even deaths.

Last November's thunderstorm asthma event in Victoria showed just how devastating a confluence of circumstances can be with climate change as an enabler. Around 8,500 people, struggling to breathe, sought hospital treatment in a time window of a few hours, and Victoria's intensive care wards experienced a 3,000% increase in asthma-related admissions. Nine people died. Ambulance and emergency services were overwhelmed.

There are many other knock-on effects of climate change. Warmer climates increase the range and prevalence of diseases such as dengue fever, parasitic diseases, and diseases resulting from exposure to various viruses and bacteria. Changes in prevailing weather can affect food and water security, and agricultural productivity, with follow-on consequences for people's health. Hotter temperatures can have occupational health and safety impacts, including on emergency services staff themselves. The negative effects of environmental change on people's mental health is also well-documented.

Air pollution combined with climate change can result in new chemical reactions in the air, leading to new effects on the people breathing it in. Some groups in a population may suffer the effects more than others, such as children, older people, those with pre-existing medical conditions, Indigenous Australians, and those least able to get to services or other safe places.

In terms of healthcare and hospitals, we think climate change is a threat multiplier to a sector already under pressure. It is important and sensible that our hospitals and health workforce is backed by coordinated national policies aimed at ensuring that healthcare services are prepared and able to respond to climate-induced health impacts. **ha**

# AHHA in the news

## June 2017 edition of *Australian Health Review*

The June 2017 edition of *Australian Health Review (AHR)* was for health system aficionados with an interest in unravelling various economic, workforce, treatment and system interactions, said the AHR's chief editor, Professor Gary Day.

*AHR* is the Australian Healthcare and Hospitals Association's peer-reviewed academic journal.

'The health system is an incredibly complex web of activity, and human and economic forces, and academics are increasingly using the available statistics to try to understand specialised parts of it, both from economic and outcomes perspectives.

'A necessary part of understanding anything as complex as healthcare is having an evaluation framework against which a health program or endeavour can be judged.

'In this issue, three University of Wollongong authors have described the origins and development of a simple yet comprehensive framework that has proven to be effective in evaluating innovations in health and aged care.'

'There are many health professions, particularly allied health professions, but it is hard to assess supply and demand issues because the necessary statistics are difficult to come by. Nevertheless, an Australia-wide research team has taken a look at 27 allied health professions in Victoria and teased out the many common concerns as well as marked differences. It's useful reading for those trying to get a grip on allied health workforce issues.

'Similarly, a team from Queensland and South Australia has taken a look at the most common allied health professions in terms of clinical care ratios—that is, the proportion of



time spent doing actual clinical care compared to other associated tasks. Unsurprisingly, the more senior you are the less time spent doing clinical work—the beauty of this article is that we can actually put some numbers to that.

'Another article assesses the effectiveness of subsidies to specialist outreach services in remote areas.

'An article of current national interest is on rates of growth in emergency department presentations in Australia, which are outpacing population growth considerably. In terms of age groups, the fastest rates of growth by far, if not in terms of raw numbers, are in the 85

and over group.

'The use of involuntary community treatment orders in mental health is the subject of an insightful study, as is a study of the contribution of mental health and alcohol and drug conditions to major injury trauma.

'Another insightful and high-interest article looks at the readiness of disadvantaged communities to engage with childhood obesity health initiatives. Money on such things can be simply wasted if the community is, for one reason or another, not ready to listen', Professor Day said.

'Also topical is an article on differences in experiences of workplace aggression among female and male medical practitioners in Australia. Broadly, males and females experience similar levels of aggression overall, except for specialists, where females experience more aggression than males.

AHHA is proud to support research through *AHR* that

contributes to the delivery of high quality, efficient and effective health services for all Australians.

**“A necessary part of understanding anything as complex as healthcare is having an evaluation framework against which a health program or endeavour can be judged.”**

## HAVE YOUR SAY...

We would like to hear your opinion on these or any other healthcare issues. Send your comments and article pitches to our media inbox: [communications@ahha.asn.au](mailto:communications@ahha.asn.au)

## Hospitalisations—preventing the preventable necessary, but not easy

‘Reducing preventable hospitalisations in order to improve health outcomes and reduce unnecessary healthcare system costs is a longstanding concern, but finding solutions requires effort, investment, research and system redesign’, Australian Healthcare and Hospitals Association (AHHA) Chief Executive Alison Verhoeven said in early June 2017.

Ms Verhoeven welcomed the issue being brought into the spotlight by the release of the Australian Commission on Safety and Quality in Health Care’s *Second Australian Atlas of Healthcare Variation*.

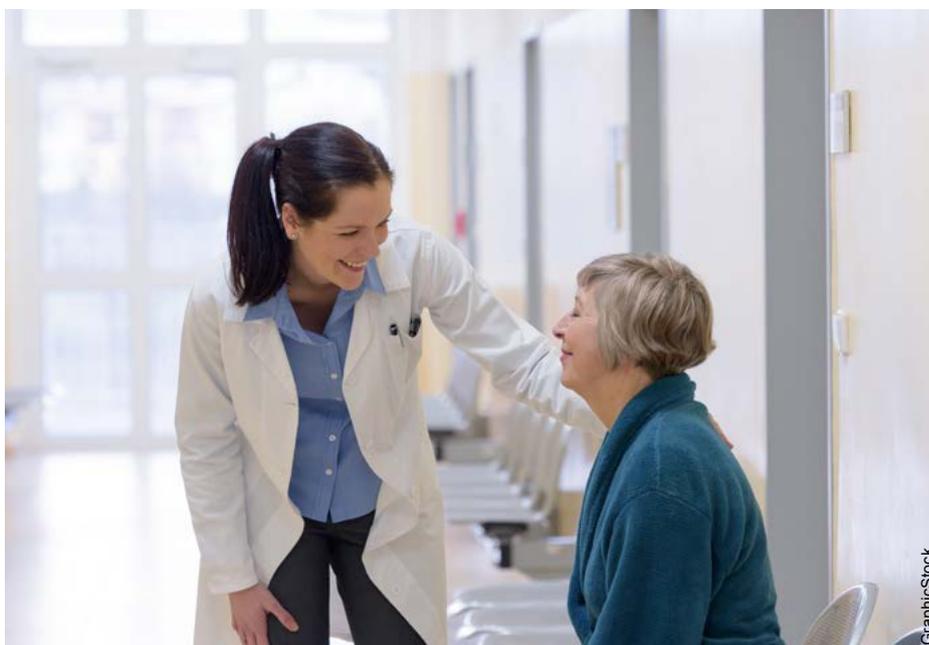
‘The report includes data on potentially preventable hospitalisations as they relate to chronic disease and 18 clinical conditions, and notes that the Australian healthcare system must shift to better integrated primary care with a focus on coordinated care to reduce these hospitalisations.’

The report shows substantial variations, up to a factor of 16, in hospitalisation rates across Australia for five chronic conditions—chronic obstructive pulmonary disease (COPD), kidney infections and urinary tract infections (UTIs), heart failure, cellulitis, and diabetes complications. According to the report, these five conditions comprise almost one-half of all potentially preventable hospitalisations in Australia.

Ms Verhoeven said the AHHA had recently held a Think Tank on Preventable Hospitalisations, involving experts from around Australia.

‘Presentations by leading health experts demonstrated the complexity of the issue. For example, what does “preventable” actually mean? Hospitalisations for people with chronic illnesses in rural and regional areas with limited community services may not be readily preventable. The Commission notes the potential value of telehealth initiatives in addressing this.

‘Hospitalisations may also not be



preventable where an alternative service was available at a cost, but the patient could not afford it, or were unaware of it, or did not know how potentially serious or urgent the condition was. Attention to health literacy and better engagement of patients in service design are required.

‘But, our Think Tank sessions also showed that the number 1 predictor overall of a potentially preventable hospitalisation, above all else, was proximity to a hospital.

‘This could be related to equity issues, and there is some evidence from the Commission’s report that procedures such as Caesarean sections and spinal fusions are more common in city areas where people are more likely to be able to afford any associated costs, and where these clinical services are offered.

‘Our Think Tank sessions acknowledged the potential for integrated care initiatives such as Health Care Homes to contribute

to a solution—however the program as it is currently designed will need substantial modification in order to maximise its potential.

‘Our health system needs to move towards a value-based system that is patient-centred and rewards efficient, effective and equitable care that produces demonstrable outcomes, rather than a system that rewards number of occasions of service, as happens now.

‘Addressing health and social inequalities, making better use of data and technology, promoting better engagement between service providers and patients, improving hospital discharge processes, and a stronger focus on advanced care planning are all part of this’, Ms Verhoeven said.

The AHHA Think Tank Communique on Hospital Avoidance and Prevention is available at [ahha.asn.au/event-reports/preventable-hospitalisations-think-tank-may-2017](http://ahha.asn.au/event-reports/preventable-hospitalisations-think-tank-may-2017).

# Access to allied health services



Reducing the impact  
of chronic illness.

**A**ustralia is increasingly battling to reduce the impact of chronic illness on the health and wellbeing of the community.

The National Strategic Framework for Chronic Health Conditions, notes, however, that our current health system in Australia is largely based on an acute model of care, and is not well structured to deliver optimal care for people with chronic conditions.

Our current system is not ideal because chronic illnesses are often dealt with most effectively through careful, long-term management. They require an approach that ensures consumers are supported to understand and manage their chronic condition. They also require a focus on prevention before the chronic illness develops, and throughout the life of the illness, to minimise or prevent progression of the illness and associated complications and disabilities.

#### **ACCESS TO ALLIED HEALTH SERVICES**

Allied health services can be crucial in helping people to manage their health, whether through the assistance of a psychologist to manage a mental health condition, a physiotherapist to manage a physical health issue, or an occupational therapist to manage in a situation where a person's functionality has been affected.

The Australian health system consists of a complex web of public and private health services and funding structures. These have been, on the whole, successful in providing access to medical services—and Australia rightly prides itself on this.

Compared to access to medical services, access to allied health services is much more limited. For many chronic illnesses, the maximum number of Medicare-rebatable (i.e. Commonwealth-funded) allied health services falls well below guidelines for appropriate care. Rebates also typically cover a modest proportion of the cost of care, resulting in significant out-of-pocket costs (and treatment disincentives) for consumers.

State- and Territory-funded community health services, while generally of low cost or no cost to consumers, vary widely in the volume and kinds of allied health services they are able to offer, with many services having long waiting times.

#### **CARE TO THOSE WHO NEED IT MOST**

The Murdoch Children's Research Institute reported in 2016 that 'families of low socioeconomic status, from minority ethnicity and those in rural regions have more difficulty accessing primary, specialist and allied health services; they are often deterred or hindered by long wait times, costs, lack of awareness and language barriers'.

This is of particular concern given that chronic illnesses disproportionately affect Australians who experience social disadvantage, whether by income, employment status, education or place of residence. Indigenous Australians are particularly affected by chronic illnesses, displaying much higher levels of chronic disease such as diabetes, heart disease and cancers, and depression.

#### **SHORT-TERM THINKING**

The impact of the current approach to funding of allied health services and the treatment of chronic diseases and conditions is that while it may limit costs to government in the short-term, it will increase the cost to government in the long run. Diseases and conditions that have not been managed early will be more expensive to treat later on when they are much more serious.

If we use the example of heart disease, the Heart Foundation estimates that every heart attack in Australia costs an average of \$25,000 in direct health costs, and \$281,000 in total costs. Yet an appropriate, coordinated, early intervention within the primary care sector could help prevent a future heart attack and is likely to cost far less.

#### **TIME TO CHANGE THE APPROACH**

Tackling the impact of chronic disease requires a coordinated approach across the entire health system—from prevention, to early diagnosis and intervention, to continuous care and disease management. The new Health Care Homes initiative recognises the need for change and may ultimately lead to better outcomes. Yet the first stage risks failure by continuing the current focus on medical interventions rather than coordinated support delivered by a range of health professions.

Similarly, the National Strategic Framework for Chronic Conditions identifies barriers to accessing allied health services, but stops short of pushing for reform. Making allied health services more accessible through higher levels of public funding will help ensure that patients with chronic conditions receive the care they need, with potential future savings to the health system. <sup>ha</sup>

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*Allied Health Professions Australia (AHPA) consists of 22 national allied health professional association members and a further four associations with whom it is formally allied. The collective membership of these 22 national associations is almost 100,000 allied health practitioners, with more than 12,000 working in rural and remote localities in Australia. AHPA and its association members play a key role in promoting the role of allied health practitioners and in advocating for their needs.*



**FRANCA MARINE**  
Policy and Government Relations  
Manager, Arthritis Australia

IN DEPTH

# Shifting the treatment paradigm in osteoarthritis

## CONSERVATIVE STRATEGIES FOR THE MANAGEMENT OF OSTEOARTHRITIS

Improved non-surgical management of osteoarthritis in primary care could save the health system over \$170 million a year by reducing demand for expensive knee replacements.

Osteoarthritis (OA) is a highly prevalent condition that affects 2.2 million or 1 in 10 Australians. It is one of the leading causes of chronic pain, disability and lost productivity in Australia, costing the health system over \$2.1 billion and the economy around \$22 billion annually.

Yet OA tends to be poorly managed in Australia. Two-thirds of people with OA report they are faring badly with their condition, 57% do not receive appropriate care according to current guidelines, and most GPs report dissatisfaction with the care they are able to provide to people with OA.

Few people with OA receive the advice, care and support they need to actively manage their condition before it gets worse. Instead, care is mostly palliative, with a focus on painkillers and surgery, including knee arthroscopy (which has repeatedly been shown to be of no benefit in OA), and joint replacement.

Conservative (non-surgical) strategies such as self-management education, weight loss and exercise are recommended in clinical practice guidelines as the first line of treatment, but are underutilised. Weight loss and exercise are effective in reducing OA symptoms, can stop the condition getting worse and can avoid or delay the need for surgery. Yet only 8% of people with OA try to lose weight to manage their condition, and referral to an orthopaedic surgeon is more common than referral to a physiotherapist for management.

## POTENTIAL SAVINGS TO THE HEALTH SYSTEM

In addition to the personal benefits for people living with the condition, increasing uptake of conservative management for OA could yield substantial savings to the health system. We spend more on joint replacements for OA, around \$2 billion a year, than on any other hospital procedures, but a significant proportion of these procedures could be avoided. For example, a conservative management program offered to people on the waiting list for joint replacement surgery in some hospitals in NSW saw 10% of participants come off the waiting list because they no

longer required surgery. Recent modelling suggests that improved non-surgical management of severe knee OA could save the health system over \$170 million a year by reducing demand for expensive knee replacements.

The potential to reduce demand for joint replacement surgery is likely to be even higher if more effective conservative management was implemented earlier in the disease course and in primary care.

## SUPPORT FOR CONSERVATIVE MANAGEMENT OF OA INCREASING

In recognition of these benefits, support for conservative management of OA is increasing.

Most recently, the Australian Commission on Safety and Quality in Health Care has launched a new clinical care standard for OA of the knee. The standard provides guidance to healthcare professionals and people living with knee OA on the best way to manage the condition. Topics covered include assessment and diagnosis of the condition, patient education, self-management and review, conservative treatment options including medications, weight loss and exercise, and specialist referral for this common chronic condition.



The clinical care standard emphasises the importance of patient-centred care, team care and the role of general practitioners, specialists and allied health care professionals in helping people living with knee OA to manage their condition. A copy of the care standard and additional resources for both clinicians and consumers are available at [www.safetyandquality.gov.au/our-work/clinical-care-standards/osteoarthritis-clinical-care-standard/](http://www.safetyandquality.gov.au/our-work/clinical-care-standards/osteoarthritis-clinical-care-standard/).

In addition, a number of jurisdictions and hospitals across the country now offer hospital-based conservative management programs to people on the waiting list for joint replacement surgery. And, in New South Wales, the Better Value Health

initiative is rolling out models of care across the State that include models to support conservative management of OA in primary care as well as through hospital-based programs. The introduction of the Health Care Homes trial may also help to support more effective management of OA in primary care for those that are eligible.

Arthritis Australia and its affiliates across the country continue to provide information, resources, and self-management education programs, focusing on conservative management, for people living with OA.

In particular, the OA-specific MyJointPain.org.au website, developed by Arthritis Australia in collaboration with medical

experts, features a range of evidence-based online tools and in-depth information to help people with OA to understand and manage their condition. An evaluation of the website over the first 12 months of its operation found it supported significant improvements for users compared to non-users in self-management, lifestyle, physical activity and weight reduction. Clinicians can refer their OA patients to the site, which is available to use free of charge.

These developments are promising, but there is still substantial scope to improve the management of OA in Australia to alleviate the growing personal, social and economic burden of this painful and debilitating condition. **ha**

# New integrated chronic disease services

WA Primary Health Alliance Midwest regional manager Jodie Green and Panaceum Group chief executive officer Richard Sykes.



## WA Primary Health Alliance (WAPHA) has commissioned new services in the Midwest to improve the health of people who suffer from chronic diabetes, cardiology or respiratory conditions.

**W**A Primary Health Alliance (WAPHA) is delivering new Integrated Chronic Disease (ICDC) services in WA's Midwest region to improve the care and health of people at risk of, or who suffer from, chronic diabetes, cardiology or respiratory conditions. There is a particular focus on people in remote areas and people who are disadvantaged.

WAPHA Midwest Regional Manager Jodie Green said the new services will see teams of health professionals travel to remote areas to coordinate care and support individuals to manage their chronic conditions, with GPs remaining at the centre of patient care.

The WAPHA 2016 Population Health Needs Assessment report for the Midwest revealed possible preventable hospitalisation rates for chronic conditions in the Midwest were 5.6 times as high for Aboriginal people as for non-Aboriginal people.

Ms Green said the Needs Assessment report informed the design of the new integrated services, as did feedback from community and stakeholder engagement activities.

The Alliance decided to offer the new services opportunities through an Expression of Interest process, encouraging organisations to apply.

'WAPHA held information sessions on the new chronic disease model prior to

the EOI going out, to ensure that potential respondents understood the requirements behind the new services', Ms Green said.

'These sessions were held in Carnarvon and Geraldton and generated strong interest.'

The Integrated Chronic Disease Care (ICDC) model allows GPs to refer patients to a Care Coordinator who works with the patient to arrange appointments with the multidisciplinary team and assists the client to navigate the system.

Service teams will also coordinate and link clients living in the more remote towns to available telehealth services to ensure ongoing care.

The new Integrated Chronic Disease Services involved collaborating with GPs, the Midwest Regional Clinical Commissioning Committee and other key partners and stakeholders, to ensure the needs of local communities within the Midwest, Gascoyne and Murchison districts are met.

'Collaboration and trust among WAPHA and each of the service providers has been integral to introducing these positive changes to primary healthcare in our region', Ms Green said.

The Geraldton-based Panaceum Group, a multidisciplinary health and medical service provider, has been contracted by WAPHA to work with local allied health professionals to implement the new ICDC services.

Service mapping workshops were held

to work through the changes to service delivery arrangements. Hosted by WAPHA, the mapping workshops were attended by all Midwest allied health teams from the WA Government's Country Health Service, as well as the Panaceum Group's ICDC team. Allied health professions represented at the workshops included podiatry, physiotherapy, exercise physiology, dietetics and diabetes education.

The attendance of Care Coordinators from the ICDC team ensured that they met providers and vice versa, and that there was a shared understanding of referral pathways.

WAPHA has commissioned the WA Centre for Rural Health (WACRH) to undertake an evaluation of the Midwest ICDC service to track outcomes, access for clients to the multidisciplinary teams and the level of service collaboration in this new team-based delivery model. 

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**WA Primary Health Alliance is supported by funding from the Australian Government under the PHN Program.**



# Reducing medical errors

New report looks at reducing medical errors in hospital EDs.

In the hectic setting of an Emergency Department (ED), accurate and timely information is key—but many departments do not have workspaces that enable staff to communicate effectively.

A new research report, *Emergency talks—designing emergency departments to maximise staff communication*, found that simple design changes to EDs could prevent many medical mistakes and make vulnerable frontline staff feel more secure in terms of their safety.

The report was a collaboration between international design practice HASSELL, the University of Melbourne Centre for Health Policy, the Monash Health Partnership at Deakin University, and the Commonwealth Department of Industry. It won the Design Research Award at the European Healthcare Design Congress 2017 in London. The study was conducted in four Western Health and Monash Health public hospitals in Melbourne, and included international literature reviews, staff surveys and focus group sessions.

Working with the University of

Melbourne, HASSELL found that in pressured emergency departments, healthcare staff lacked opportunities to check critical patient information with colleagues, and support each other in stressful situations.

Dr Lucio Naccarella, from the University of Melbourne's Centre for Health Policy, says this lack of clear communication has a negative impact on service delivery.

'Emergency department nursing and medical staff are highly trained professionals committed to delivering the best care possible—however the physical design and layout of emergency departments does not support discreet peer-to-peer discussions, which we would expect in modern healthcare.'

'Staff are generally always visible and within earshot of patients and their families, and vice versa—even in triage and waiting rooms—which can leave all parties anxious about privacy.'

HASSELL Principal and healthcare design specialist Megan Reading, a former nurse, says that HASSELL has taken a unique

staff-centred approach to solving these problems.

'For staff, emergency departments are workplaces, and as with other workplaces should balance the need for business efficiency with individual employee needs.'

'Presently the lack of suitable space in hospital EDs means staff use corridors, store cupboards and patient screening curtains to get a hurried moment to confer, leading to possible miscommunication, lapses in patient confidentiality, and feeling over-exposed to aggressive members of the public.'

HASSELL researcher, Michaela Sheahan, says that hospitals 'grapple with how to improve outcomes for patients and staff all the time', but mostly they look at patient experience as the driver for change.

'The needs of staff can be overshadowed, and our research shows that staff are especially concerned about safety. It's an underlying stress they feel continually, which has a significant impact on the work environment.'

'Our ideas are very much driven by



L-R: Bernice Redley, Michaela Sheahan, Ruzica Bozovic Stamenovic (Judge) and Lucio Naccarella

**“Studies indicate that miscommunication is responsible for up to 80% of such errors.”**

how we can support nurses and doctors by giving them the spaces they need to exchange vital information, improve morale, and avoid stress and staff burnout’, says Sheahan.

The research report showed that ED staff need workplaces that:

- provide spaces for patient-related case talk and personal talk that fosters connections among staff
- provide spaces to work out of sight and unheard (when necessary) while allowing refuge from stressful situations
- allow for separation from patients (one Melbourne hospital reporting more than 100 violent incidents in a month),

balancing the need for a professional clinical environment with ‘hotel-like’ barrier-free comfort for patients

- include small, flexible, multi-purpose spaces that provide visibility and connectedness while optimising awareness and control of environment
- make it easy to use formal communication systems, e.g. workstations, mobile technology, computers, to capture relevant informal communication among staff.

The solution lies in creating ED workspace designs with small, adaptable spaces that allow a ‘line of sight’ across the ED but are acoustically separated from patients. Examples include:

**Small glazed spaces**—these provide a visual connection between patients and staff while limiting the chances of confidential conversations being overheard. A smaller space is also less likely to attract ad hoc storage of equipment or clutter.

**Standing desks**—these convey to staff and patients that a space is transitory and conversational. High desks with computer

terminals also limit the possibility of random equipment storage and provide an opportunity for fast recording and transfer of patient documentation.

**‘Sit and go’ booths**—these contain chairs and a writing surface, thereby inviting short but comfortable informal meetings. A low height partition enables visual connection, but provides some protection from interruptions. **ha**

*The full research report can be downloaded at [www.hassellstudio.com/docs/emergency-talks--designing-emergency-departments-to-maximise-staff-communication.pdf](http://www.hassellstudio.com/docs/emergency-talks--designing-emergency-departments-to-maximise-staff-communication.pdf).*

**Research team**

*Dr Lucio Naccarella, Centre for Health Policy, The University of Melbourne*

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# Investing in preventive health

Is Australia spending enough?

**C**hronic disease imposes a significant burden on individuals, families, employers and the health system alike. Heart disease, stroke, chronic kidney disease, type 2 diabetes and lung disease are common among the Australian population, and chronic disease generally accounts for 83% of all premature deaths.

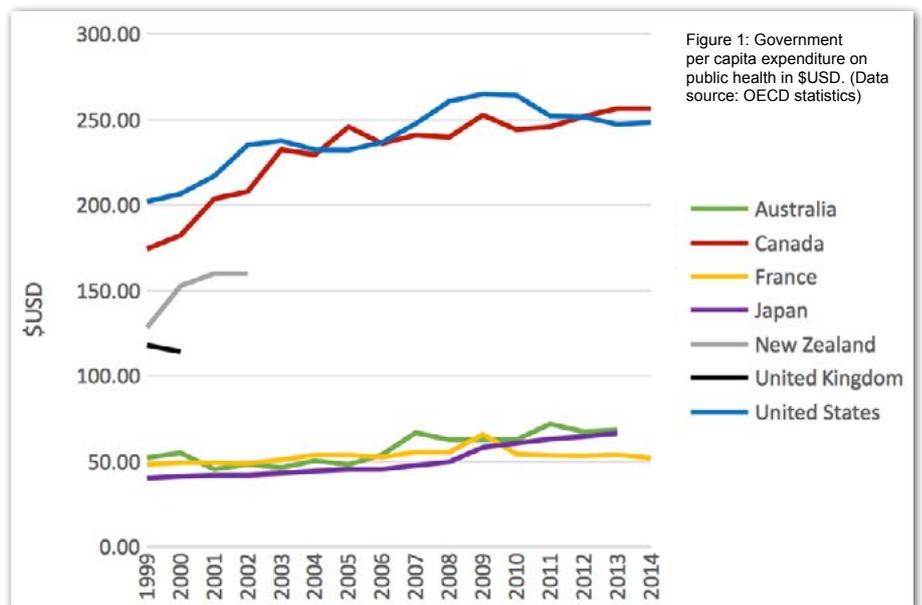
Such conditions are largely preventable, which raises the question of whether we invest enough in preventive programs and policies that aim to decrease such alarming statistics.

## EXPENDITURE ON PREVENTION IN AUSTRALIA

According to the Australian Institute of Health and Welfare, Australia spends just over \$2 billion per year on public health. This is just \$89 per person or 1.34% of total health care spending.<sup>1</sup>

In constant prices (i.e. taking inflation into account) this is about the same amount per person as was spent a decade ago, and less than what was spent in 2007 when the Commonwealth invested in its vaccination program against the human papillomavirus (HPV).

Internationally, Australia appears very much 'middle of the pack', ranking 16th of 31 OECD countries in terms of per capita spending. Canada, New Zealand, the United Kingdom and the USA all appear to spend



more on preventive health than Australia—with Canada and the USA reportedly spending almost 5 times as much per person (Figure 1).

## ARE WE SPENDING TOO LITTLE?

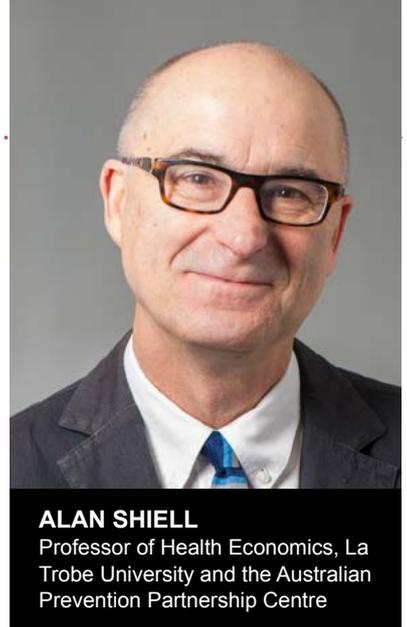
Such comparisons prompt speculation that we are spending too little on prevention. However, this thinking is misguided. For one thing, it fails to take into account what health gains we could buy with any increase in spending. Caution is warranted because, with the exception of Indigenous health,

health status in Australia is every bit as good as in countries that report spending more on prevention.

To address the question of whether we should spend more on prevention we need to conduct a thought experiment and consider the possible uses of a small increase in the prevention budget, let's say 5% per annum, or about \$100 million per year, and compare the benefits to be gained from the best of these options to the 'losses' incurred from



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**“Thankfully, there is now a substantial body of evidence pointing to the fact that prevention can represent good ‘value for money’ and much of this evidence originates in Australia.”**

activities that might need to be curtailed to release the resources needed to fund the change.

If the value of the benefits exceeds the opportunity costs, then there is a strong case to expand spending on prevention. Though framed here in terms of efficiency, the exercise is readily adaptable to include improvements in equity as part of the benefit should one wish. Economists refer to this sort of thinking as ‘marginal analysis’.

### EVIDENCE TO SUPPORT AN INCREASE IN EXPENDITURE

An essential part of marginal analysis is evidence on the cost-effectiveness of preventive health interventions. Thankfully, there is now a substantial body of evidence pointing to the fact that prevention can represent good ‘value for money’ and much of this evidence originates in Australia.<sup>2-4</sup>

This evidence shows that some preventive interventions are ‘cost-saving’ in the sense that they improve health outcomes and reduce overall costs to the health system, while many others are cost-effective in that they improve health outcomes at a cost that is considered reasonable according to the standards currently applied by authorities such as the Medical Services Advisory Committee (MSAC) and the Pharmaceutical Benefits Advisory Committee (PBAC).

Not all prevention activity is effective,

however, let alone cost-effective—but, overall, the available evidence suggests that we could improve the health of Australians and do so at little or no cost if we were to increase spending on prevention.

Therefore, the view that we could—and probably should—increase spending on prevention is based not on international comparisons of expenditure, but on evidence from cost-effectiveness studies and consideration of the opportunity cost of giving greater priority to prevention.

### WHY ARE WE NOT SPENDING MORE?

This naturally raises the question of ‘Why then do we not spend more on prevention?’.

There are a number of possible reasons, but we put forward one suggestion for consideration—Australia does not have the institutional structures for evaluating the cost-effectiveness of preventive interventions or for supporting their scale-up and sustained funding.<sup>5</sup>

On the evidence side, we have the Medical Services Advisory Committee (MSAC) examining clinical interventions and the Pharmaceutical Benefits Advisory Committee (PBAC) looking at medicines—but no body similar to the National Institute for Health and Care Excellence (NICE) in the UK with a remit that includes public health.

On the funding side, we rely too heavily on short-term, issue-related funding initiatives

that act as a barrier to long-term strategic planning. Reconsideration of institutional structures to support investment in preventive health could be a step towards reducing the burden of chronic disease and improving the health of Australians in an effective and efficient manner. [ha](#)

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IN DEPTH

# Hospitals taking on sugary drinks

**T**he rising prevalence of obesity represents an important public health challenge in Australia, with 63.4% of adults overweight or obese in 2015.<sup>1</sup>

Obesity increases the risks of heart disease, type 2 diabetes, stroke and some cancers. In addition, unhealthy weight gain raises the risk of premature death, resulting in a range of societal and economic costs. Healthcare sector costs alone are \$8.6 billion annually.<sup>2</sup>

Increased availability of sugary drinks and lower-cost processed foods are major factors driving this epidemic. Just one 330 mL can of cola contains 10 teaspoons of sugar, more than a child's daily recommended allowance.<sup>3</sup> Sugary drinks are a significant source of calories, with 4 in 10 Australians aged 2 years or over reported drinking sugary drinks on the day prior to the 2012 Census.<sup>4</sup> This is concerning, given that drinking a 600 mL 'single serve' bottle of sugary drink each day for a year equates to consuming roughly 23 kg of sugar.

Cause for additional alarm is the fact that many interventions to treat established obesity are still ineffective. Therefore, prevention is always better than cure.<sup>5</sup>

## **BUILDING MOMENTUM FOR HEALTH LEADERSHIP**

Our current food environment (including our supermarkets, restaurants, convenience stores and advertising) exploits an individual's biological, psychological, social and economic

vulnerabilities. The result in most cases is that unhealthy foods become the easier option over healthier alternatives, which may be unavailable, or unaffordable. This creates a vicious cycle, reinforcing demands for foods of poor nutritional quality and that are high in sugar, fats and salt.<sup>4</sup>

There is a growing body of evidence that altering the food environment, including through price and visual cues, is required. In 2016, a World Health Organization report highlighted that a 20% increase in retail price significantly lowers consumption of sugary drinks, and is effective at reducing obesity, type 2 diabetes and tooth decay.<sup>6</sup>

## **LOCAL LEADERSHIP REFLECTING A GLOBAL SHIFT**

Based on the same science that is now driving a movement of price-related policy action around the globe, there are many examples of local leadership within the health sector creating promising results and wide ripples of change.

In 2015, the Alfred Hospital in Melbourne reduced sugary drinks sales onsite by 36,500 units a year without reducing overall drinks sales. They did this by increasing the price of the unhealthiest drinks and removing these sugary drinks from display at the main cafe, instead placing them under the counter and out of direct visibility. They used a simple traffic light system to classify nutritional value and portion sizes of drinks, and found a dramatic reduction in sales of the unhealthiest 'red' drinks, but also an equally

impressive increase in the healthiest 'green' drinks. This clearly showed the positive impact that bold vision and leadership can have at the hospital level, and dispelled concerns about resulting lost revenue.

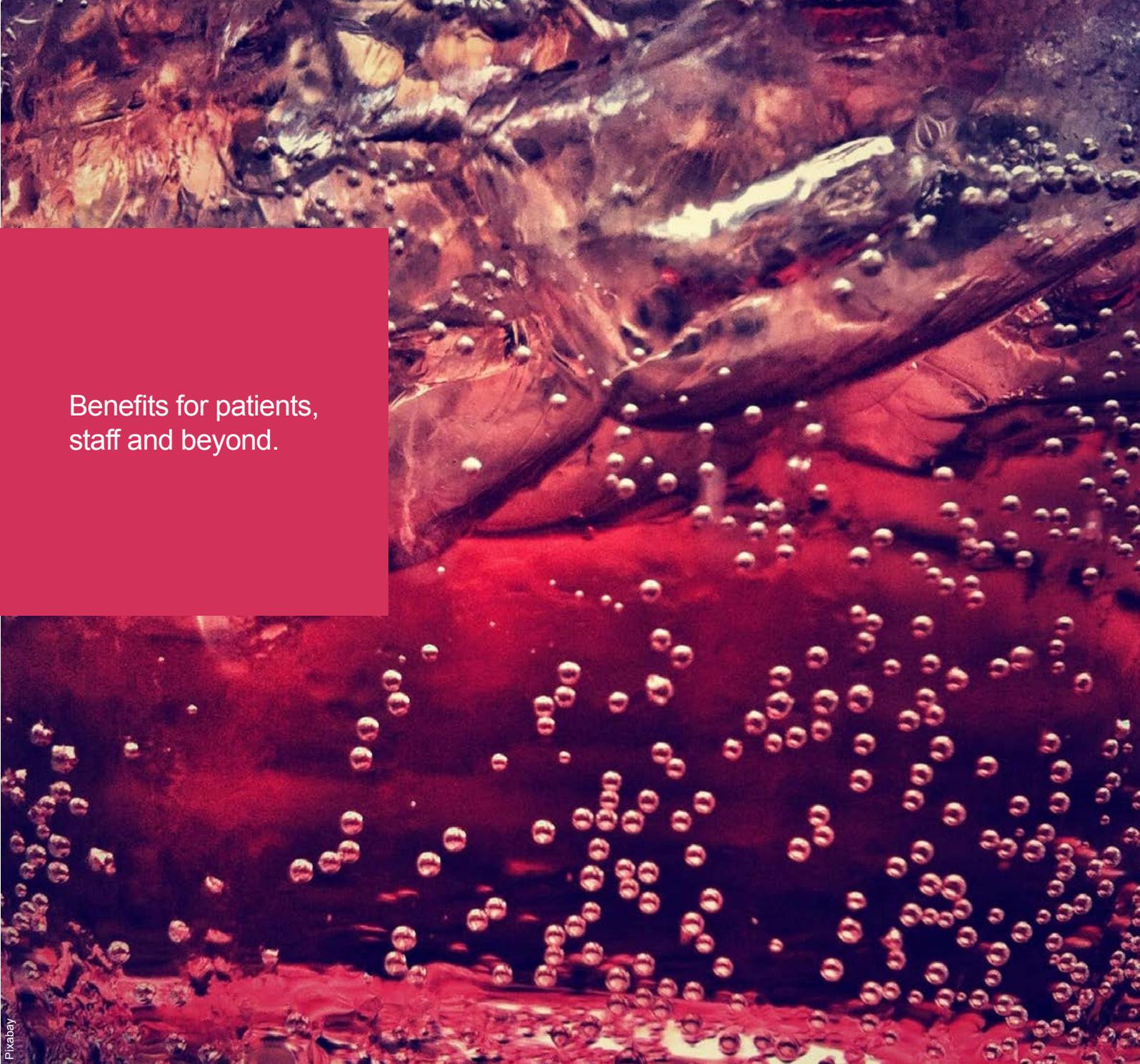
These findings support those published in the American Public Health Association Journal following a phasing out of sugary drinks in a hospital in Ohio, USA. This health initiative saw a lowering of beverage sales without any overall revenue loss.<sup>7, 8</sup>

In the UK, a slightly different approach has been taken, but with similar ambitions. The National Health Service (NHS) has recently introduced a policy to work with retailers towards reducing sales of sugary drinks to 10% of total sales within staff canteens and shops. If targets are not met, the NHS will phase out all sugary drinks by next year.<sup>9</sup>

An innovative initiative at Hinchingsbrooke Hospital, UK, saw a Michelin-trained chef reformulating menus to focus on locally sourced, fresh food. Patient satisfaction increased to 92% just 2 months after the healthier menus were introduced.<sup>10</sup>

Across the Tasman, New Zealand has taken an even more progressive position. From 2015, the government has enforced a ban of sugary drinks at healthcare sites, and some sites have also extended this to artificially sweetened beverages and juices. In 2016, the Ministry of Education also recommended the removal of sugary drinks from schools.<sup>11</sup>

New South Wales will become the first state in Australia to remove sugary drinks



Benefits for patients,  
staff and beyond.

from their health facilities in order to tackle obesity. This measure is expected to be in place by December 2017.<sup>12</sup> Thirteen health districts in Victoria's south west have also recently discontinued the sale of sugary drinks at their health facilities.<sup>13</sup>

#### **WHAT ARE THE BENEFITS TO HOSPITALS AND THEIR COMMUNITIES?**

Such initiatives are gaining momentum and recognition globally and nationally, with robust evidence emerging of their effectiveness. Strong leadership from hospitals—beacons of health in our society—is crucial in addressing obesity and protecting

the health of populations. Hospital-level programs to reduce sugary drink consumption support national and global efforts to improve population health, and are crucial for three reasons: benefits for patients; benefits for visitors and staff; and because they shape healthier societal norms.

#### **BENEFITS FOR PATIENTS: IT'S A PATIENT SAFETY ISSUE**

Hospitals, as institutions, represent health and healing to most in society. Poor nutrition is the leading risk factor for disease and disability in Australia, and therefore linked to a significant proportion

of hospital admissions.<sup>4</sup>

Evidence suggests that health promotion messages undertaken during times of illness are more likely to be effective at influencing behaviour change, not to mention the lack of consistency for patients being treated for obesity-related diseases like diabetes to be in environments with sugary drink vending machines, or stores selling fried foods. Therefore, hospitals present an important opportunity to support patients to make healthier choices, improve their food habits and better their longer-term health outcomes.<sup>14</sup>



## BENEFITS FOR VISITORS AND STAFF

Providing a positive food environment benefits staff and visitors, who often spend significant amounts of time in hospitals.

Australia's public hospitals employed approximately 251,000 full-time equivalent staff in 2010. Staff are important role models for patients and society—however studies have repeatedly shown that even health professionals find it hard to maintain a healthy weight.<sup>14,15</sup>

Simple changes to improve the food environment, making healthier choices available and the most affordable, will have health benefits for staff and the hospital community. Such benefits could also reach beyond health—improving the wellbeing and productivity of staff could save hospitals money.

## SHAPING HEALTHIER SOCIETAL NORMS

Sugary drinks have become dangerously normalised. Reshaping collective perceptions of these drinks will be key if we are to reduce their consumption and protect the health of Australians—especially our kids.

The role of hospitals in providing a positive example in our society, and sending a clear message to families and children, is key. In addition, hospitals must be cautious of the 'halo' effect that selling, allowing the advertising of, and housing vending machines for, sugary drinks may inadvertently have in their immediate and wider communities.

Ninety percent of people who are overweight do not realise it, therefore are unlikely to seek help or change behaviours unprompted.<sup>16</sup> Reducing or removing sugary drinks in hospitals also sends a powerful prompt regarding the harms associated with these products and accordingly could have beneficial domino effects throughout society.

## NEXT STEPS...

Implementing a sugary drinks program is not about banning or controlling access; it is an approach that is backed by evidence to support patients and staff in making healthier food choices.

Efforts such as those at The Alfred, New South Wales Health and Hinchinbrooke Hospital show what could be achieved if similar leadership is shown by health institutions and other organisations. 

*If your health institution or organisation is interested in finding out more about how to support your community in reducing consumption of sugary drinks, check out the resources below or contact us via email ([demaioa@who.int](mailto:demaioa@who.int)) or twitter ([@SandroDemaio](https://twitter.com/SandroDemaio)).*

*Dr Alessandro Demaio works for the World Health Organization in Geneva. Dr Sarah Blackstock is a Paediatric Registrar with the Imperial Healthcare NHS Trust in London. This article was written by both authors in their personal capacity. The views, opinions and positions expressed in this article are the authors' own and do not reflect the views of any third party.*

## Additional resources

The Healthier Hospitals Initiative provides a how-to guide for hospitals ([http://healthierhospitals.org/sites/default/files/IMCE/public\\_files/hhi-howto-foods-final.pdf](http://healthierhospitals.org/sites/default/files/IMCE/public_files/hhi-howto-foods-final.pdf)).

Fighting obesity through sugary drinks pricing (<https://www.thesaturdaypaper.com.au/2015/11/28/fighting-obesity-through-sugary-drinks-pricing/14486292002665>).

Is it time for a tax? (The *Health Report* podcast) (<http://www.abc.net.au/radionational/programs/healthreport/is-it-time-for-a-sugar-tax/8431118>).

Sugary drinks tax resources from the Obesity Policy Coalition (<http://www.opc.org.au/action-areas/sugary-drinks-tax.aspx>).

'The Impact of a tax on sugar-sweetened beverages on health and health care costs: a modelling study' (<http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0151460>).

Alfred Health's efforts in reducing the appeal of sugar-sweetened drinks (<https://www.alfredhealth.org.au/news/reducing-the-appeal-of-sugar-sweetened-drinks/>).

The Health Care Without Harm program offers information and hospitals within the US can pledge to promote healthy and environmentally friendly food options (<https://noharm.org/>).

'A sugary drinks tax: recovering the community costs of obesity' from The Grattan Institute (<https://grattan.edu.au/report/a-sugary-drinks-tax-recovering-the-community-costs/>).

The Physicians Committee for Responsible Health offers a toolkit for hospitals to provide heart healthy foods (<http://www.pcrm.org/heart-healthy-hospital-toolkit>).

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Photo: Jason Maloum/OxfamAUS

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**ROSEMARY CALDER**  
Director, Australian Health Policy  
Collaboration at Victoria University

IN DEPTH

# \$100 million to get Australia's health on track

Presentation at the *Prevention First* forum.

## INTRODUCTION

On Wednesday 14 June 2017, I joined an invited panel discussion in Parliament House at the Prevention First forum *Prevention better than cure: spending to save Australian lives*.

I was invited to speak on how to spend \$100 million for preventative health in Australia. I used this opportunity to talk about the 10 evidence-informed priority policy actions identified by the nation's leading experts as described in the report *Getting Australia's Health on Track* (launched November 2016).

Chronic disease is the biggest health challenge of the 21st century. Australia lags well behind comparable countries in tackling the risk factors for preventable chronic diseases such as cardiovascular diseases, cancers and mental illness. National action must be focused on population-level interventions that target risk factors for preventable chronic diseases that are shared by many population groups and communities.

There is strong evidence about what works to achieve positive change and there

are numerous opportunities for governments, community and industry to act collaboratively for the benefit of all Australians.

## ACCOUNTABILITY AND ACTION FOR CHRONIC DISEASE PREVENTION

A national collaboration of chronic disease experts and organisations has produced targets for the year 2025 for the prevention and reduction of chronic diseases in our population, in line with the global agenda set by the World Health Organization.

This national collaboration also identified 10 priority policy actions that will help get Australia on track to reach the 2025 targets and significantly reduce preventable illness and disability.

### THE 10 PRIORITY POLICY ACTIONS ARE:

- Protect children and young people from unhealthy food and beverage marketing.
- Reduce salt content in processed foods and meals to decrease the risks of high blood pressure.
- Implement a health levy on sugar-sweetened beverages.
- Consistently implement volumetric tax on

all alcohol products and increase the current taxation rate.

- Enhance media campaigns to reduce smoking.
- Reduce health and mortality disparities in disadvantaged populations caused by smoking.
- Scale up supported vocational programs across Australia for people with a mental illness.
- Scale up primary care capacity in primary and secondary prevention of cardiovascular risks.
- Invest in comprehensive national measurement and monitoring of chronic diseases and their risk factors in the population over time.
- Invest in active travel initiatives to and from school to kickstart a national physical activity plan.

## SPENDING TO SAVE AUSTRALIAN LIVES

A preventative health budget of \$100 million could be used to implement some of the 10 measures as a down payment to prevent ill health and save Australian lives.

Two of the 10 policy actions are effectively

# TEN PRIORITY POLICY ACTIONS TO PREVENT AND REDUCE CHRONIC DISEASES IN AUSTRALIA

This complementary suite of priority policy actions will help get Australia on track to reach the 2025 targets and significantly reduce preventable illness and disability in the population. The priority policy actions were developed by Australia's leading chronic disease scientists, researchers and clinicians. Designed to tackle shared risk factors for chronic disease, these actions will drive change where it is needed most.



cost-neutral: reducing salt content in foods and changing marketing practices to protect children. These two require some modest private sector and government investment, and strategic policy adjustment.

Two of the priority policy actions will actually raise revenue: a sugar levy and responsible taxation of alcohol. This revenue could be directed into a preventative health budget.

The policy actions that would most benefit from the \$100 million, therefore, are:

**\$20 MILLION** to continue action on smoking, the leading cause of preventable death and disease in Australia. Mass media campaigns to help people quit and stay that way require ongoing investment. The campaigns need to be tailored for low socioeconomic status audiences, people with mental illness and Aboriginal and Torres Strait Islander people to help reduce health and mortality disparities in smoking.

**\$20 MILLION** to assist in reaching the 2025 target of halving the employment gap between people with mental illness and the general population. Vocational programs for

people with moderate and severe mental illness are effective, can be scaled nationally and help to reduce the financial distress commonly reported by people experiencing mental illness.

**\$20 MILLION** to help reduce biomedical risk factors for chronic disease through primary and secondary prevention of cardiovascular diseases. This investment would support targeted national screening and treatment—based on absolute risk assessment of cardiovascular disease in primary care settings for adults aged 45-74 years, and from 35 years onwards in Aboriginal and Torres Strait Islander populations.

**\$10 MILLION** could be allocated towards the cost of another Australian Health Survey for the year 2021. This will ensure that comprehensive measurements of the health of the nation occur at least every 10 years.

**\$30 MILLION** could help enable 3.7 million school-aged children to participate in free physical activity by walking, scootering or cycling to and from school. Over 70% of children and 90% of young people do

not meet physical activity guidelines, and by 2025 the target is to reduce this by at least 10%. Safe active travel options enable children, their families and the broader community to benefit from activity-friendly roads, footpaths and urban design.

## CLOSING COMMENTS

Immediate implementation of the 10 actions, which are proven to be effective and can be executed affordably, will help build a comprehensive approach to chronic diseases.

These 10 actions, however, are not nearly enough. Australia has existing national and state and territory policy measures aimed at reducing chronic disease incidence and prevalence; these must be continued and built on to tackle the diseases that now affect 1 in every 2 Australians.

Without a systematic, whole-of-population strategy aimed at prevention and early risk management, the ongoing rise in chronic diseases will harm more individuals and have an adverse impact on health expenditure and the broader economy. <sup>ha</sup>



**MICHAEL GILL**  
Founder, Dragon Claw

# Who really cares?

Dragon Claw is Australia's online community supporting 500,000 sufferers of rheumatoid disease, lupus and juvenile arthritis.

## 'PATIENT-CENTRIC' AND RHEUMATOID ARTHRITIS

The term 'patient-centric' makes everyone feel good. Health professionals who adopt the term may spend a little more time with a patient, may express more concern, and may try to push the policy envelope just that little bit further.

Thank you for this. But while the direction and sentiments are laudable, for people with potentially debilitating chronic conditions like rheumatoid arthritis, 'patient-centric' is more an aspiration than a lived reality.

While people may live with this condition for 24 hours every day, it is unreasonable, if not impossible, to expect round-the-clock patient-centric care from clinicians. Patients with a chronic condition may spend, say, four days a year in total with a clinician. If things are not going well, perhaps add another four days for time spent in hospital. That's still only 2% of the year.

Self-care in association with clinicians is a more achievable reality. We'll get back to that later. But first, let's take a very brief look at rheumatoid arthritis, my personal experience of it, and why I formed the 'Dragon Claw' online community.

## THE REALITY OF RHEUMATOID ARTHRITIS

Rheumatoid Arthritis (RA) is a systemic immune-mediated disease that can affect any part of the body. With RA, excess immune activity causes inflammation that usually leads to pain, fatigue, fever, stiffness, or a feeling of being ill.

Typically, RA attacks the musculoskeletal system, causing joints or tendons to become painful, swollen, or weak—which can lead to disability or permanent damage. The disease can also lead to problems with various organs, including the circulatory or nervous systems, eyes, skin, bones, heart, and lungs.

The disease affects about 2% of the

population (500,000 in Australia) and is 1.6 times as common in women as in men. Aboriginal and Torres Strait Islander people have a 40% greater incidence of the condition than non-Indigenous Australians.

## MY PERSONAL EXPERIENCE

I first experienced severe rheumatoid arthritis about seven years ago. I could not dress myself. My regular general practitioner did not seem to suspect RA at first—it was not until I was carried into his clinic that the diagnosis was made.

My three admissions to hospital did not fill me with confidence, as I felt that anything I said or questions that I had about my condition were politely disregarded. In short, much seemed to be left to me, and in a cloud of anxiety, I began furiously searching the Internet.

I discovered that medications, exercise, meditation and diet were all of key importance in developing my new concept of

**“It was a terrible shock to be in constant pain and to feel so alone. I desperately needed support from many skilled people, but felt that no one was going to assist me. I had to do it myself.”**

‘normal’ wellbeing. I found that listening to other RA stories and pooling the collective knowledge available was also extremely useful.

These experiences led to the birth of Dragon Claw, and its push towards self-care in association with the clinical world.

#### **DRAGON CLAW AND ITS WORK**

Dragon Claw is a group of about a dozen dedicated volunteers and 10 commercial partners now developing online solutions to questions and concerns such as those I experienced. We focus on just three chronic diseases—rheumatoid disease, lupus and juvenile arthritis.

We are moving rapidly and have launched our own website ([www.dragon-claw.org](http://www.dragon-claw.org)) which is now used by members in 12 countries.

Our concept is radical in that it promotes patient-centric self-care and attempts to provide coordinated care management.

It does not provide medical advice—but we are happy to support clinicians.

The website uses online technologies to provide community and support for people with rheumatoid arthritis, lupus and juvenile idiopathic arthritis, and their care-givers. Interested clinicians are welcome to join. We are privately funded and have not sought government support.

Dragon Claw is owned and operated by a not-for-profit company, Dragon Claw Website Developments Pty Ltd (ACN 169406982), which was established on 6 May 2014 and is registered in New South Wales.

Former President of the Australian Medical Association, Dr Mukesh Haikerwal, is our patron.

#### **FUTURE PLANS**

Our future plans revolve around building better support services. Some involve building predictive intelligence capability and others relate to telehealth.

Currently we are in the process of building a smartphone app specifically for rheumatoid and lupus sufferers. The design work is complete and we are slowly gathering the necessary financial support to build.

With Dragon Claw there is a quiet patient-led revolution going on within the health and medical world. It is a revolution about information access, equity of access and participatory medicine in order to reduce isolation and stress, and improve pain management. We believe that Dragon Claw is on the right track. **ha**

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**Michael Gill is founder of Dragon Claw ([www.dragon-claw.org](http://www.dragon-claw.org)) and a former Board member of the Health Informatics Society of Australia. He is a member of the BMJ International Patient Panel.**

**DRAGON CLAW**

**“A Reconciliation Action Plan is a framework of objectives and deliverables designed to foster relationships and empower organisations to more effectively engage with Aboriginal and Torres Strait Islander peoples.”**

# Reflecting on our own practices

AHHA launches inaugural Reconciliation Action Plan.

**W**ith the current range of health issues facing Aboriginal and Torres Strait Islander peoples, it is self-evident that those working to promote equality in the wider health sector should also be actively working to shape culture and attitudes within their own organisations. With the launch of our 2017-18 Reconciliation Action Plan, the Australian Healthcare and Hospitals Association (AHHA) has taken the time to reflect on our own practices and ensure that we are effectively contributing to realising a vision for reconciliation.

A Reconciliation Action Plan is a framework of objectives and deliverables designed to foster relationships and empower organisations to more effectively engage with Aboriginal and Torres Strait Islander peoples. It asks organisations to consider their own vision for reconciliation and to develop concrete mechanisms for making their workplaces more culturally safe and diverse. AHHA has taken the first step in our Reconciliation journey with the completion and launch of our 2017-18 REFLECT Reconciliation Action Plan.

Aboriginal and Torres Strait Islander peoples experience a significantly higher

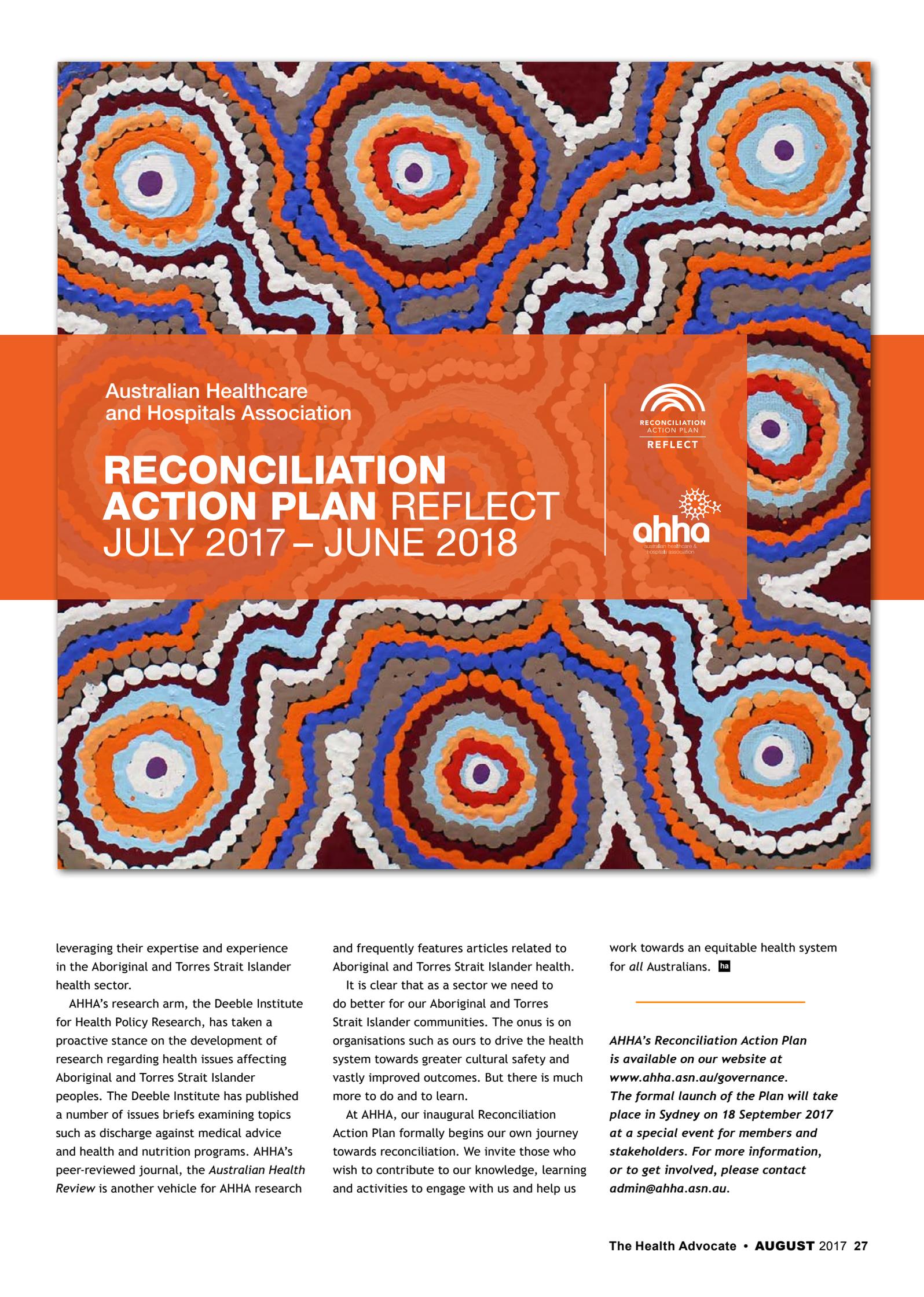
burden of disease and a reduced life expectancy in comparison to other Australians. Sustained comprehensive action is required to address inequities in health outcomes. Key to the ability to address health issues facing Aboriginal and Torres Strait Islander peoples is access to culturally appropriate health services. AHHA aims to support the transformation of the health system to one that provides culturally safe services, through the advocacy objectives set out in our Plan.

AHHA seeks to play a meaningful role in Closing the Gap in health outcomes and in addressing the institutional racism endemic in our care systems. We will do so internally by fostering respectful relationships with the Aboriginal and Torres Strait Islander health sector and by ensuring that every possible opportunity is extended to Aboriginal and Torres Strait Islander individuals. We will do so externally through our programs of advocacy, research, education, publications and events.

Addressing Aboriginal and Torres Strait Islander peoples' health disparities has been a significant focus for AHHA, but we are committed to working harder than ever. Through the Lighthouse Project, AHHA,

along with the National Heart Foundation, is striving to improve care and outcomes for Aboriginal and Torres Strait Islander peoples experiencing coronary heart disease. The project uses a quality improvement methodology delivered through a Toolkit for pilot hospitals. Using the Toolkit, hospitals are enabled to better identify Aboriginal and Torres Strait Islander patients, improve relationships, deliver culturally appropriate care and reduce instances of discharge against medical advice. The Lighthouse Project has been expanded into its third phase and we are excited to continue working on this excellent initiative.

We have worked to develop good relationships with the Aboriginal and Torres Strait Islander health community. AHHA actively works with the National Aboriginal Community Controlled Health Organisation (NACCHO) through a Memorandum of Understanding, developing policy, collaborating on joint advocacy campaigns and sharing our collective understanding of the health sector. As an external member of our Reconciliation Plan Working Group, NACCHO also contributes to the effective tracking and monitoring of our Reconciliation Action Plan by providing external input and



Australian Healthcare  
and Hospitals Association

# RECONCILIATION ACTION PLAN REFLECT JULY 2017 – JUNE 2018



leveraging their expertise and experience in the Aboriginal and Torres Strait Islander health sector.

AHHA's research arm, the Deeble Institute for Health Policy Research, has taken a proactive stance on the development of research regarding health issues affecting Aboriginal and Torres Strait Islander peoples. The Deeble Institute has published a number of issues briefs examining topics such as discharge against medical advice and health and nutrition programs. AHHA's peer-reviewed journal, the *Australian Health Review* is another vehicle for AHHA research

and frequently features articles related to Aboriginal and Torres Strait Islander health.

It is clear that as a sector we need to do better for our Aboriginal and Torres Strait Islander communities. The onus is on organisations such as ours to drive the health system towards greater cultural safety and vastly improved outcomes. But there is much more to do and to learn.

At AHHA, our inaugural Reconciliation Action Plan formally begins our own journey towards reconciliation. We invite those who wish to contribute to our knowledge, learning and activities to engage with us and help us

work towards an equitable health system for *all* Australians. 

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**AHHA's Reconciliation Action Plan is available on our website at [www.ahha.asn.au/governance](http://www.ahha.asn.au/governance). The formal launch of the Plan will take place in Sydney on 18 September 2017 at a special event for members and stakeholders. For more information, or to get involved, please contact [admin@ahha.asn.au](mailto:admin@ahha.asn.au).**

# HESTA Nursing and Midwifery Awards 2017

NT dialysis nurse, WA graduate and NSW pre-admission midwifery program share \$30,000 education and development prize pool.

**A** Northern Territory nurse who established a remote dialysis services for Aboriginal people, a Western Australian graduate nurse who achieved outstanding patient-centred care in mental health, and a New South Wales team that implemented an innovative pre-admission midwifery program received top honours at the 2017 HESTA Australian Nursing and Midwifery Awards for 2017.

These national awards, announced in Brisbane this year, are Australia's most prestigious for the sector, recognising nurses, midwives, personal care attendants, and assistants in nursing across three categories—Nurse or Midwife of the Year, Outstanding Graduate and Team Excellence.

HESTA CEO, Debby Blakey said this year's winners 'stood out from an exceptional group of finalists for their outstanding leadership and innovation in implementing new services and practices that provide enhanced health care outcomes and the highest standard of care'.

Awards sponsor Members Equity (ME) Bank provided a \$30,000 prize pool across the three award categories. Winners each received \$10,000 in an ME Everyday Transaction account to use for further education or team development.



## NURSE OR MIDWIFE OF THE YEAR

### SARAH BROWN

*Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation (Western Desert Dialysis), Gillen, NT*

Sarah was recognised for establishing the Alice Springs-based Western Desert Dialysis to provide social support services, allied health and 'on-country' dialysis services for Aboriginal people experiencing kidney disease.

Drawing on her experience as a remote area nurse and educator for Aboriginal Health Practitioners, Sarah worked closely with leaders from Pintupi Luritja communities to establish Western Desert Dialysis, ensuring all the services provided are culturally appropriate.

Sarah's outstanding leadership led to the expansion of Western Desert Dialysis' services to nine remote communities



throughout the Northern Territory and Western Australia.

“The services we provide, mean that people can live in their remote communities and receive dialysis treatment on-country. They live longer, have a better quality of life and an opportunity to pass on their heritage and cultural knowledge to their children and grandchildren,” said Sarah.

Sarah said the prize money will help fund new services in South Australia.

**OUTSTANDING GRADUATE**

**REBECCA RICH**

*Perth Clinic, West Perth, WA*

Rebecca was recognised for her commitment to achieving patient-centred care in mental health nursing.

As a graduate Rebecca pro-actively took part in formal and informal education activities to improve her skills and use them to help

improve outcomes for mental health patients. She completed online training with Children of Parents with Mental Illness, completed the ‘Mandatory Reporting Program’ with the Department of Child Protection, and completed a short course in Borderline Personality Disorder.

Rebecca said she plans to work on breaking down the stigma mental health patients often face, and will use the prize money to visit hospitals that treat personality disorders, find out how they’ve been successful, and bring this back to the Perth Clinic to help improve their services.

**TEAM EXCELLENCE**

**MATER (SYDNEY) PRE-ADMISSION MIDWIFE APPOINTMENT PROGRAM**

*Mater Hospital, North Sydney, NSW*

The Mater (Sydney) ‘Pre-admission Midwife Appointment Program’ provides holistic

multi-disciplinary care to women in the third trimester of their pregnancies, focusing on physical as well as emotional wellbeing.

This includes: screening for depression and anxiety, domestic violence screening, and assistance with concerns or social stresses.

The program was implemented with the support of the Gidget Foundation, which promotes awareness of perinatal anxiety and depression.

Antenatal midwife coordinator Sarah Tooke said the program makes patients feel more supported and listened to, which helps ensure that any risk factors are picked up early.

Sarah said the prize money would be used to provide ongoing training for staff, conduct formal research to self-evaluate and possibly fund a translator to help linguistically diverse patients. **ha**



**DR ANDREW COTTRILL**  
Medical Director, HCF

# How do patients feel about emerging health technologies?

A look at personalised medicine, gene therapy, artificial intelligence and associated issues.

**A**sk people how they feel about the latest healthcare technologies and you are likely to be met with an assortment of answers. As with any emerging medical technology, there will be debate about how and in what capacity health technologies should be applied.

Technological advancements in health are at present driving a trend towards more personalised treatment options that cater to an individual's needs and take into consideration individual characteristics.

Recently at HCF—Australia's largest not-for-profit health fund—we conducted the Health

Barometer survey, which looked at how comfortable Australians are with personalised medicine and using new and emerging healthcare technologies such as artificial intelligence (AI) and gene therapy.

The research generally found that while the advancement of technology is largely viewed in a positive light, there is a certain level of scepticism and uncertainty about how and why these technologies might be used within Australia's healthcare system.

We found that over 80% of 1,207 survey respondents felt comfortable with AI being used to diagnose common medical problems



and interpret test results, with nearly two-thirds (58%) believing AI is a major step in the right direction for earlier disease detection and reduced incidence of death. Nearly three-quarters (72%) were even willing to allow AI to be used to prescribe treatment for patients.

These findings suggest that Australians particularly see the benefits of technological advancements when there's a possibility of preventing disease.

With gene therapy, nearly two-thirds (69%) of survey respondents agreed or felt neutral that the benefits outweighed the potential



GraphicStock

risks, with only 11% disagreeing. Overall, 65% thought it acceptable to test healthy patients for mutations of genes known to cause cancer or other diseases. Some respondents were open to more controversial possibilities, with 41% saying they would use gene therapy to correct genetic defects in their children to prevent potential illness, if given the option.

It seems that many of us are also open to personalising our healthcare treatments, rather than adopting a 'one size fits all' approach—over one-third of respondents (39%) said they would treat an illness based on their 'genetic fingerprint'. Around 65% also

thought it acceptable to create personalised drugs based on an individual's genetic code, while 61% thought it acceptable to create personalised organs or limbs using 3D modelling and CT scans.

However, the research also showed that, associated with these less common technologies, respondents had privacy concerns with patient records, and concerns about confidentiality, and lack of use of human intuition.

On top of this, about 43% listed unnecessary procedures in the healthcare system as a cause for concern, while over

one-half (52%) said they were concerned about potentially inaccurate findings, and 65% raised the potential issue of rising costs of these technologies adding to overall healthcare system costs.

Personalised medicine using emerging technologies such as artificial intelligence and gene therapy offers exciting opportunities to improve the wellbeing of Australians. But we do need to consider the wider social and ethical implications, as well as the risks. Understanding the perspectives of patients is a crucial part of this process. **ha**

# Innovative pilot

Support for Canberrans  
with a chronic condition.

Capital Health Network (CHN), through the ACT PHN program, has introduced an innovative pilot program to help Canberrans with a chronic condition to ensure that they are accessing the services they need after being discharged from The Canberra Hospital.

CHN Chief Executive Ms Gaylene Coulton said the ACT PHN's Transitions of Care pilot program is supporting people with a chronic condition to better understand their condition and the support services available to meet their needs now and in the future.

'Our team is identifying patients at an early stage of chronic disease diagnosis so we can minimise the impact and progression of the chronic disease for both the patient and their carer.'

In the ACT, almost one in two people had at least one chronic disease or condition in 2011-12 (ACT Chief Health Officer's Report 2016). Patients diagnosed with a chronic

illness require multiple transitions of care across a variety of health care sectors, such as acute and primary health care settings.

'We know that patients who are unable to advocate for themselves, including those patients with complex chronic diseases, are more vulnerable to misadventures occurring at discharge. Older people in the ACT face an increasing burden of chronic disease, dementia and cancer and are particularly at risk,' Ms Coulton said.

The ACT PHN's Transitions of Care team consists of three experienced health care professionals with a range of community and ACT health knowledge. Manager Transition Coordination Anais le Gall says the team is empowering clients to take control of their condition and helping them to navigate the health care system.

'When people return home from hospital they often feel overwhelmed, may forget what they're meant to do and don't know

the local services available or are unable to anticipate the services they may need in the future. We visit clients at home to help them and their carers link with and set up ongoing practical support. For example, we have been helping clients and their families access My Aged Care services such as community transport, and domestic services.'

The criteria for participating in the pilot include:

- being an ACT resident over the age of 40 years
- having at least one chronic condition
- having difficulty coordinating support
- having limited knowledge of the impact of the chronic condition.

'Many of our current clients are living with a chronic respiratory disease or a cardiac condition, or are older people with a chronic condition who have had a fall. We're also linking eligible clients in with condition-specific support groups and chronic care

L-R: Capital Health Network Chief Executive Gaylene Coulton, Manager Transition Coordination Anais le Gall, Transition of Care Coordinator Marnie Griggs and Transition of Care Coordinator Ros Treslove.



programs. These offer valuable opportunities like health coaching and information to better understand and manage their chronic condition,' said Ms le Gall.

ACT PHN's Basic Needs Assessment showed that poor communication between systems, health care sectors, health professionals, patients and carers were major issues in the continuity of care of a chronically ill patient. It resulted in:

- duplication of services
- delays to appropriate treatment and community support
- additional costs to patients and family
- patients experiencing an increase in emotional and physical pain
- delay in seeking treatment.

The ACT PHN Transitions of Care team believes it is essential that a client's GP is at the centre of their care.

'We really encourage clients to see their GP once they return home from hospital.

**“Our team is identifying patients at an early stage of chronic disease diagnosis so we can minimise the impact and progression of the chronic disease for both the patient and their carer.”**

Their GP is central to managing their care and to monitoring changes in their chronic condition over time', said Ms le Gall.

The pilot was established in collaboration with ACT Health and The Canberra Hospital, and runs until 30 June 2018. It is supported by funding from the Australian Government under the PHN Program. 

*Capital Health Network is the ACT's primary health network supporting health professionals to improve the coordination of care so that patients receive the right care in the right place at the right time. For more information about the ACT PHN Transitions of Care pilot program, call 02 6287 8015 or email [toc@chnact.org.au](mailto:toc@chnact.org.au).*





**DR ROCHELLE CHRISTIAN**  
Head, Scientific Evaluation Branch,  
Therapeutic Goods Administration

The Therapeutic Goods Administration is updating ingredient names used in Australia to align with international terminology.

# Update to medicine ingredient names

In different countries, the same medicinal ingredient can have a different name. The World Health Organization (WHO) sets the gold standard for medicine ingredient names. These are known as ‘International non-proprietary names’ or INNs.

As new ingredients are introduced into Australia, the Therapeutic Goods Administration (TGA) adopts the INN as the approved Australian ingredient name for use in medicines.

However, many older ingredients used in Australian medicines have out-of-date ingredient names that do not align with the WHO standard. By using these old ingredient names, the names of some medicine ingredients in Australia were ‘unique’—which can be confusing. We live and work in a global village, and keeping unique medicine ingredient names can result in problems:

- for Australians travelling internationally
- for Australian doctors trained overseas
- for Australians seeking medicine information online.

## CHANGING NAMES

The TGA is updating medicine ingredient names used in Australia to align with names

used internationally. Other countries have used a similar process, including the United Kingdom in 2003 and most recently New Zealand in 2008.

Some medicine labels and product information documents have already started to change. By April 2020 all relevant systems and documents should have transitioned over to using the updated ingredient names.

## WHAT TYPE OF CHANGES?

Some changes are minor, for example changing a ‘y’ to an ‘i’, and will not affect how the ingredient name is pronounced. This and some other examples are listed below.

PREVIOUS ACTIVE INGREDIENT NAME	UPDATED ACTIVE INGREDIENT NAME
<i>amoxicillin</i>	> <i>amoxicillin</i>
<i>cephazolin</i>	> <i>cefazolin</i>
<i>oestradiol</i>	> <i>estradiol</i>
<i>indomethacin</i>	> <i>indometacin</i>
<i>thyroxine sodium</i>	> <i>levothyroxine sodium</i>

Some changes are more significant. For example, *frusemide* is changing to *furosemide*.

For these products, medicine labels will need to use both the old and new ingredient

names, for example, *furosemide* (*frusemide*), until 2023. This will help consumers and healthcare professionals become familiar with the new names.

## ADRENALINE AND NORADRENALINE

*Adrenaline* and *noradrenaline* remain as the approved names for these ingredients in Australia. This decision was taken after feedback from stakeholders (industry, government and healthcare professionals), where most raised concerns about proposed changes to *epinephrine* and *norepinephrine* respectively. These concerns focused on potential risks to patient safety because of the substance’s high clinical significance and possible confusion between *epinephrine* and *ephedrine*.

There is therefore no plan to use *epinephrine* and *norepinephrine* as new ingredient names.

Instead, labels of medicines containing adrenaline or noradrenaline will include the international name (*epinephrine* and *norepinephrine*, respectively) in brackets after the ingredient name.

For example, medicines containing *adrenaline hydrochloride* will have



YOUR MEDICINE

YOUR KNOWLEDGE

Some medicine ingredients are changing to **new names**.

The changes will align the names with those used internationally. But don't worry – the medicines or their effects are not changing.



For more information visit  
[tga.gov.au/ingredient-names](http://tga.gov.au/ingredient-names)

**TGA** Health Safety Regulation

Printable posters and leaflets to help raise awareness of the ingredient name changes are available from the TGA website.

Find out more about the list of names that are changing on the TGA website.



*adrenaline (epinephrine) hydrochloride* on the medicine label.

By including this information on labels indefinitely, the TGA hopes to reduce confusion for health professionals and consumers.

**INFORMATION FOR HEALTH PROFESSIONALS**

New ingredient names have started to appear on medicine labels, in product information and consumer medicine information leaflets, and within medication software systems.

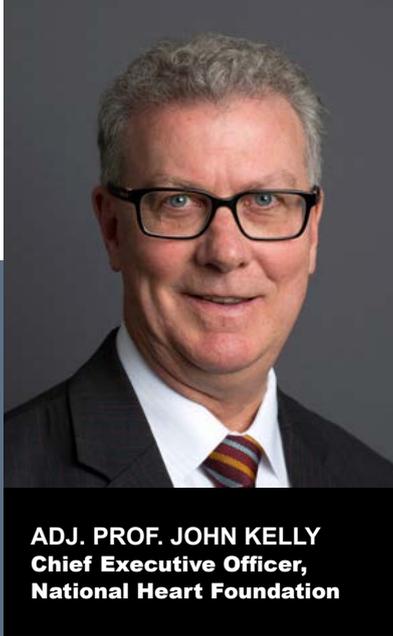
Depending on turnover, medicine labels using the old ingredient names will still be available on shelves while stock is run down.

Please take particular care when prescribing and/or dispensing medicines to ensure that the right product is selected. Some of the new ingredient names may also be unfamiliar to patients.

Health professionals are asked to reassure patients that only the name of the ingredient has been changed and there is no change to the medicine's formulation, quality, safety or efficacy.

TGA have developed a series of posters and leaflets you can download and use to help raise awareness about ingredient name changes. 

*More information and the list of ingredient names that are changing are available on the TGA website at: [www.tga.gov.au/ingredient-names](http://www.tga.gov.au/ingredient-names).*



**ADJ. PROF. JOHN KELLY**  
Chief Executive Officer,  
National Heart Foundation

IN DEPTH

# Preventing chronic diseases through physical activity

Are we on the cusp of change?

Chronic diseases such as cardiovascular disease and cancer are the leading cause of ill health and death in Australia<sup>1</sup>. In 2014-15, more than 11 million Australians had at least one chronic disease, and one-quarter of the population had two or more.

Conservative estimates say that one-third of the \$25 billion spent on health care in Australia each year goes towards preventable conditions.

Yet we know that 31% of the burden of chronic disease could have been prevented<sup>2</sup>.

At the launch of the report *Preventive health: How much does Australia spend and is it enough?*<sup>3</sup>, the Heart Foundation reinforced the message that a comprehensive national preventive health program is crucial for Australians living well and staying healthy for as long as possible.

Encouraging more Australians to be physically active is at the heart of any preventive strategy.

Data from the UK's Public Health England suggests that if people were sufficiently active, it could cut the rate of many chronic diseases by as much as 40%.

If more people met the recommended guidelines for physical activity they could reduce their risk of:

- dementia by up to 30%
- cardiovascular disease by up to 35%
- type 2 Diabetes by up to 40%
- colon cancer by 30%
- breast cancer by 20%.

Public Health England's 'Everybody Active Every Day'<sup>4</sup> national physical activity framework was born out of the realisation that, without prevention, the health costs from inactive 40-60-year-olds would send the UK Government broke.

Through a series of concerted campaigns, the UK has doubled its rates of people meeting the recommended guidelines of 150 minutes of moderate physical activity per week—from about 35% of men and 30% of women to about 75% and 60% respectively.

Increasing physical activity rates is a great public health investment—and none more so than encouraging walking.

Most people can walk—it does not cost any money to do, it is accessible, is a great way to spend time with friends (new and old) and is a wonderful tonic for one's mental health.

The winner of the Heart Foundation Walking program's Golden Shoe Award, Anne Whalan, joined a Heart Foundation Walking group 20 years ago after her husband suffered heart disease. But it also helped

her deal with difficult emotions following his death—Anne says the walking group helped keep her from becoming depressed and has kept her well enough to still be living independently at 90 years of age.

Heart Foundation Walking<sup>5</sup> is Australia's only network of free, community-based walking groups catering for different age groups. The Heart Foundation is delighted that we're going to partner with the Federal Government to boost these programs further over the next two to four years to reach even more participants.

In May, the Government announced that it would allocate \$10 million over two years to the Heart Foundation to lead the Prime Minister's Walk for Life Challenge, which will support more Australians to become regular walkers and encourage people to be more active.

The Federal Government is also on the right track in having 'preventive health through physical activity' as one of the four key pillars of its National Sports Plan<sup>6</sup>.

With the growing focus on prevention and physical activity, I feel that we are on the cusp of significant change.

This is great news for the Heart Foundation, which has worked for the past 60 years to encourage all Australians to lead healthier and



more active lifestyles for better heart health.

*Australia's Health 2016* shows that chronic disease is our greatest health challenge, and we—as advocates, as governments, as decision-makers—must roll up our sleeves and enhance preventive measures if we are to help more Australians to live longer, happier, healthier and more productive lives. 

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*In 2016, Adj. Prof. John Kelly returned to the heart health field after starting his career as a cardiac nurse. Most recently he spent four years as CEO of Aged and Community Services Australia and spent nine years on The Smith Family Board.*

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# Indigenous health support in Western NSW PHN

A new model for the Integrated Team Care program.

## A DIFFERENT APPROACH

The Commonwealth's Integrated Team Care (ITC) program is looking different in western and far western NSW compared to elsewhere in Australia—through a model aimed at supporting the region's Aboriginal chronic disease sufferers to access the care they need, with their GP remaining as their primary care provider.

In mid-2016, Western New South Wales Primary Health Network (Western NSW PHN) issued a request for tender for the ITC program across the 441,000 sq km of the region to address the chronic disease needs of the region's 36,000 Aboriginal and Torres Strait Islander people.

With an Indigenous population comprising almost 12% of the total population in the PHN region, the Western NSW PHN was determined to be on the front-foot in Aboriginal health, establishing an Aboriginal Health Council alongside the usual Clinical Councils and Consumer Councils.

The ITC tender was awarded, using a select tender process, to a consortium of Aboriginal community controlled health services: Maari Ma Health Aboriginal Corporation based in Broken Hill, and Bila Muuji Aboriginal Health Services, representing Aboriginal health services from 11 communities across western NSW.

## HOW THE NEW PROGRAM WORKS

The consortium's ITC program, named 'Marrabinya' (Indigenous Health Support Service) is a brokerage model, buying and arranging services and products required by Aboriginal clients as specified by the client's GP (either mainstream or through an Aboriginal medical service).

**The program comprises two key components:**

1. care coordination delivered by qualified health workers; and
2. funds to purchase supplementary services to assist patients to access health care.

Marrabinya's care model is based on the patient care relationship being principally between the patient and their usual treating doctor. When clinical and care coordination roles are undertaken by other parties, effort can be duplicated and care can become fragmented and 'siloes'. Marrabinya's intent is therefore to facilitate the care determined by the patient's GP, retaining the patient's GP as the principal primary care provider and coordinator.

Marrabinya's service model is based around the second key component of the ITC—supplementary services. Marrabinya functions as a brokerage service, purchasing the services referring GPs require for

their patients as part of their care. These services can include, for example, medical aids, travel and accommodation to attend health appointments, and payment of fees associated with specialist consultations, diagnostic testing and other health care services.

By focusing on the facilitation of supplementary services, the Marrabinya model enables 20% more funding than previously to be spent on the purchase of supplementary services for Aboriginal people with a chronic disease.

Clients can access Marrabinya's services on referral from their GP, which can be received via an 1800 telephone number, fax or secure e-referral. Clients need to have a current GP Management Plan in place (item 721 in the Medicare Benefits Schedule), and/or Team Care Arrangements (item 723).

Supporting a client's GP as the primary care provider in this way helps ensure that the client will have an up to date GP management plan for their condition, and encourages more Aboriginal and Torres Strait Islander health checks (Item 715) to be carried out in the region.

Marrabinya staff (65% of whom are Indigenous) are located in 10 communities across the region and are building excellent relationships with general practices and

“With an Indigenous population comprising almost 12% of the total population in the PHN region, the Western NSW PHN was determined to be on the front-foot in Aboriginal health, establishing an Aboriginal Health Council alongside the usual Clinical Councils and Consumer Councils.”

Aboriginal community controlled health services, supporting them to support their clients.

### KEY DRIVERS AND TRANSITION

The key drivers to the Marrabinya model are more services for Aboriginal people with a chronic disease, and supporting the client’s main primary care provider to be the client’s ‘health care home’ (to borrow the name of the Commonwealth’s new approach to integrated primary health care).

Although transitioning away from the previous mode of parallel service delivery (mainstream and Aboriginal medical services) was difficult for some clients and some GPs, it did not take long before clients and their doctors understood the new approach and embraced it.

### RESULTS

Since starting the Marrabinya service on 1 November 2016, more than 1,100 clients have been assisted with almost 1,900 different services delivered to the end of March 2017—a significant increase on the number of both clients and services provided under the previous programs in place. 

### THE JOURNEY FROM DIAGNOSIS TO EFFECTIVE MANAGEMENT FOR ABORIGINAL PEOPLE IN WESTERN NSW

The journey from diagnosis to effective management of a chronic condition for an Aboriginal person in western NSW is often complex and confusing, invariably requiring some travel away from home. Success is often thwarted by any number of obstacles.

The Marrabinya service works hard to ensure that all the obstacles to a client accessing the services recommended by their doctor for their chronic disease are removed—travel is arranged, accommodation is booked and paid for, appointments are made, and so on.

Getting a client from their home community to a larger rural centre or capital city for tests, surgery or treatment, can require taxi vouchers, petrol purchase, community transport, and/or bus, plane or train tickets.

Wherever possible, Marrabinya staff look to maximise claims that can be made to the Isolated Patient Transport and Accommodation Assistance Scheme (IPTAAS).

Many clients have to travel hundreds of kilometres from their home to access services, which can be daunting, and might make clients disinclined to follow through with their doctor’s recommended care.



**Marrabinya**

If you are an Aboriginal or Torres Strait Islander suffering from chronic illnesses such as:

- Cancer
- Cardiovascular Disease
- Diabetes
- Respiratory Disease
- Kidney Disease

You can access support for specialist treatment including:

- Fuel, Transport & Accommodation
- Gap Fees
- Medical Aids

For More Information Discuss with your GP or Call **1800 940 757**

Marrabinya is a brokerage service providing support to General Practice to improve access to Specialist services for Aboriginal and Torres Strait Islanders with a diagnosed chronic disease

**phn**  
WESTERN NSW  
THE AUSTRALIAN GOVERNMENT HEALTH

Marrabinya (Indigenous Health Support Service): *Marra* (meaning ‘hand’) is universal to most if not all Aboriginal languages across Australia, and *Binya* (‘stretch out the’) is Wiradjuri.

# BIOETHICS AT MONASH

## INTENSIVE BIOETHICS COURSE

1 – 4 DECEMBER 2017

This three-day professional development opportunity provides health professionals, members of human research ethics committees, and those with a general interest in bioethics, with an in-depth introduction to bioethics.

Take part in seminars and forums led by experts in bioethics focusing on topics such as:

- Ethical theory
- Clinical and research ethics
- Reproductive ethics
- End of life care and decision making
- Public health ethics

### WHERE

Country Place Retreat, Dandenong Ranges  
Victoria, Australia

### REGISTRATION

For early bird rates book before 31 August.  
Registration details and further information can be found at:  
[future.arts.monash.edu/intensive-bioethics-course](http://future.arts.monash.edu/intensive-bioethics-course)

## MASTER OF BIOETHICS

The Master of Bioethics at Monash explores ethical theory, applied ethics, healthcare ethics, research ethics, public health ethics, and related policy issues.

The program is well-suited to health professionals and scientists who face complex ethical issues in their working lives, as well as those involved in relevant aspects of public policy and law.

The course is designed to accommodate students with no prior background in ethics or philosophy, but is also suitable for graduates (from associated disciplines) who wish to pursue further studies in bioethics.

- Offered on-campus and online
- May be taken full-time or part-time (depending on prior education/experience, students may be able to complete the course in 1–2 years full-time or 2–4 years part-time)

For further information about the Master of Bioethics visit:  
[future.arts.monash.edu/master-bioethics](http://future.arts.monash.edu/master-bioethics)



**MONASH**  
University

40 The Health Advocate • AUGUST 2017

**MONASH**  
BIOETHICS  
CENTRE

# Taking action on family violence



**E**very year in Australia, on average, at least one woman a week is killed by a partner or former partner, and one in four has experienced physical or sexual violence by an intimate partner\*.

Super could be a much-needed lifeline to support women to escape abusive relationships.

HESTA has been talking with the Federal Government about changing super rules to allow family violence survivors, as a last resort, to access some of their super.

‘We need to take action now’, HESTA CEO Debby Blakey says. ‘Accessing super should be an interim measure and another tool that we can use to stem this tragic loss of life’.

‘Finances are too often a barrier for women trying to leave a violent relationship and, unfortunately, financial support for survivors of family violence is grossly inadequate.’

## WHAT NEEDS TO CHANGE?

There are very few ways for members to access super early: in financial hardship (defined as having been receiving Centrelink payments for 26 continuous weeks) or on ‘compassionate grounds’ (such as to stop the bank selling their home, pay for a dependant’s funeral or get medical treatment).

But early access to super is denied in instances of family violence.

‘We think it’s entirely appropriate that super regulations extend compassion to survivors of family violence to empower women with the financial means to escape abusive relationships’, Debby says.

## HOW DO WE MAKE CHANGE HAPPEN?

We know reaching out to our partners in community services is essential to making this happen.

We’ve been talking with a range of specialist family violence support service providers and experts in financial counselling, receiving their widespread support.

Now we need to convince the Government to change the super rules. 

\*Australian Institute of Criminology, 2015

*If you or someone you know is impacted by sexual assault or family violence, call 1800RESPECT on 1800 737 732 or visit [1800RESPECT.org.au](http://1800RESPECT.org.au)—in an emergency, call 000. You can find out more about the support services in your state or territory at [whiteribbon.org.au](http://whiteribbon.org.au).*



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# Become an AHHA member

Help make a difference to health policy, share innovative ideas and get support on issues that matter to you – **join the AHHA.**

**T**he Australian Healthcare and Hospitals Association (AHHA) is an independent national peak body advocating for universal and equitable access to high quality healthcare in Australia.

With 70 years of engagement and experience with the acute, primary and community health sectors, the AHHA is an authoritative voice providing: strong advocacy before Ministers and senior officials; an independent, respected and knowledgeable voice in the media; and a valued voice in inquiries and committees.

By becoming a member of the AHHA, you will gain access

to AHHA's knowledge and expertise through a range of research and business services.

The Deeble Institute for Health Policy Research was established by the AHHA to bring together policy makers, practitioners and researchers to inform the development of health policy. In joint collaboration with our university partners and health service members, the Institute: undertakes rigorous, independent research on important national health policy issues; publishes health policy Evidence Briefs and Issue Briefs; conducts conferences, seminars, policy think-tanks and workshops; and helps

policymakers, researchers and practitioners connect when they need expert advice.

The AHHA's JustHealth Consultants is a consultancy service exclusively dedicated to supporting Australian healthcare organisations. Drawing on the AHHA's comprehensive knowledge of the health sector, JustHealth Consultants provides expert skills and knowledge in areas including: corporate and clinical governance training; strategy and business planning advice; organisation design and improvement; health services planning and program evaluation; and board induction training.

In partnership with the LEI Group, the AHHA also provides

training in "Lean" healthcare which delivers direct savings to service provider and better outcomes for customers and patients.

To help share important developments across these various health research, policy and training spheres, the AHHA publishes its own peer-reviewed academic journal (*Australian Health Review*), as well as this health services magazine (*The Health Advocate*). 

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**To learn more about these and other benefits of membership, visit [www.ahha.asn.au/membership](http://www.ahha.asn.au/membership)**



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ahha  
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# More about the AHHA

Who we are, what we do, and where you can go to find out more information.

## AHHA Board

The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation, the protection of its assets and the quality of its services. The 2016-2017 Board is:

**Dr Michael Brydon**

Sydney Children's Hospital Network

**Dr Paul Burgess**

NT Health

**Dr Deborah Cole (Chair)**

Dental Health Services Victoria

**Ms Gaylene Coulton**

Capital Health Network

**Ms Jill Davidson**

CEO SHine South Australia

**Dr Paul Dugdale**

ACT Health

**Mr Nigel Fidgeon**

Merri Community Services, Vic

**Mr Walter Kmet**

WentWest, NSW

**Mr Adrian Pennington**

Wide Bay Health and Hospital Service, Qld

## AHHA National Council

The AHHA National Council oversees our policy development program. It includes the AHHA Board as well as a range of members. The full list of Council members can be found at: [ahha.asn.au/governance](http://ahha.asn.au/governance)

## Secretariat

**Ms Alison Verhoeven**

Chief Executive

**Mr Murray Mansell**

Chief Operating Officer

**Dr Linc Thurecht**

Research Director, Acting Deeble Institute Director

**Mr Krister Partel**

Advocacy Director

**Ms Lisa Robey**

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Policy Director

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**Mr Nigel Harding**

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**Mr Daniel Holloway**

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**Ms Freda Lu**

Assistant Accountant

**Ms Kate Silk**

Policy Adviser

**Ms Suhi Sudhakar**

Administration Officer

**Mr Matthew Tabur**

Executive Officer

**Ms Sue Wright**

Office Manager

## Australian Health Review

*Australian Health Review* is the journal of the AHHA. It explores healthcare delivery, financing and policy. Those involved in the publication of the AHR are:

**Prof Gary Day**

Editor in Chief

**Dr Simon Barraclough**

Associate Editor, Policy

**Prof Christian Gericke**

Associate Editor, Models of Care

**Prof Sonj Hall**

Associate Editor, Health Systems

**Dr Linc Thurecht**

Associate Editor, Financing and Utilisation

**Ms Danielle Zigomanis**

Production Editor (CSIRO Publishing)

## AHHA Sponsors

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- HESTA Super Fund
- Good Health Care
- Novartis Australia
- Price Waterhouse Cooper

Other organisations support the AHHA with Corporate, Academic, and Associate Membership and via project and program support.

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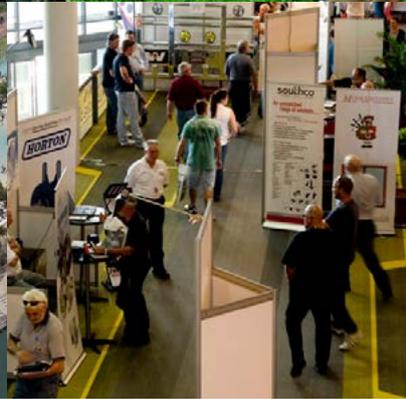
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