The Health Advocate

Your voice in healthcare

Disability, Aged Care and Chronic Disease

Sectors in transition and under pressure

Cross-sector care simulation 2016
the ultimate ideas generator!

Sidney Sax Medallist 2016
Professor Helena Britt

+MORE INSIDE

The official magazine of the Australian Healthcare and Hospitals Association

ISSUE 39 / December 2016

PRINT POST APPROVED PP:100009739

Cover photo: GraphicStock

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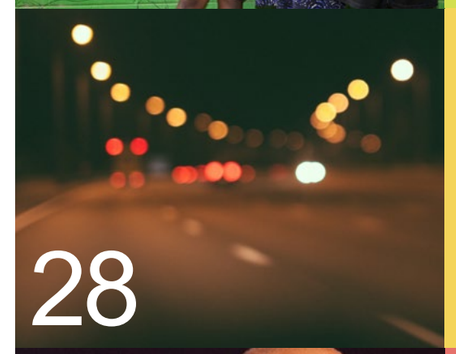


In depth

Briefing

Advertorial

From the AHHA desk

AHHA National Board 2016–17

Introducing the new **AHHA National Board.**

AHHA members recently elected its 2016–17 National Board, which represents the broad continuum of healthcare services including area, regional and district health services, hospitals, community and primary health centres, and aged and extended care facilities. The 2016–17 National Board comprises:

Dr Michael Brydon

Chief Executive at the Sydney Children's Hospital Network. Prior to the network forming, Michael worked at Sydney Children's Hospital, Randwick, for 27 years after completing his undergraduate Medical Degree at UNSW and his Fellowship of Paediatrics in the Randwick program. His other post-graduate qualifications include a Masters of Paediatrics and a Masters of Health Administration from UNSW.

Dr Paul Burgess

Public health physician with the Northern Territory Department of Health, with more than 15 years of experience as a dual qualified GP and public health physician. Paul has an in-depth understanding of what it takes to achieve healthcare improvement at both the system level and during face to face interactions with clients. With complementary skills in health services research and a solid background in international health policy and strategy, Paul is motivated to pursue better health for all by the most efficient means.

Jeff Cheverton

Executive Director Commissioning at North Western Melbourne Primary Health Network. An accomplished leader with 25 years change management experience in health and human services. Jeff enjoys creating and leading new initiatives and improving systems to benefit clients. Jeff has led system reform and service improvement initiatives in disability, housing, mental health and primary healthcare. Jeff was Deputy CEO of the Brisbane North Primary Health Network before joining North Western Melbourne Primary Health Network.

Dr Deborah Cole

Chief Executive Officer at Dental Health Services Victoria. Appointed in February 2011, Deborah has substantial experience in managing major public healthcare organisations. She has held CEO positions at Calvary Health Care and Yarra City Council as well as senior executive positions at Mercy Health and St Vincent's Health. Deborah was Director of The Royal Dental Hospital of Melbourne from 1995—1999 and previously held senior positions at the South Australian Dental Service.

Gaylene Coulton

Chief Executive Officer at Capital Health Network, the Primary Health Network for the Australian Capital Territory. Gaylene is an experienced CEO with a career dedicated to practising authentic values-based leadership. Gaylene has a consistent track record of spearheading business growth, organisational transformation and change management both within green-field and established healthcare environments. Gaylene has a deep understanding of health reform agenda drivers and extensive experience in providing strategic leadership and building relationships with key stakeholders to deliver on client commitments.

Nigel Fidgeon

Chief Executive Officer at Merri Health, Melbourne. Nigel has extensive executive management and CEO experience in leading and managing complex organisations across the public and private health sectors at both strategic and operational levels in acute and non-acute settings.

Dr Paul Dugdale

Director of Chronic Disease Management for Australian Capital Territory Health, Associate Professor of Public Health at the Australian National University and Director of the ANU Centre for Health Stewardship, which undertakes work on health department administration, clinical governance and the legal basis of health stewardship. Previously, Paul was ACT Chief Health Officer and held positions with the Australian Government Department of Health and New South Wales Health.

Walter Kmet

Chief Executive Officer at WentWest, delivering support and education to primary care and working with key partners to progress Western Sydney's health system. As the Western Sydney Primary Health Network, WentWest is focused on addressing both regional and national health challenges. Walter has 25 years' experience in commerce, healthcare and human services in Australia, South East Asia and the United Kingdom.

Adrian Pennington

Chief Executive at Wide Bay Hospital and Health Service, Queensland. Appointed in 2012, Adrian has more than 35 years healthcare experience with 20 years at executive and senior management levels, both within acute hospitals and leading national programs within the National Health Service, United Kingdom.

ALISON VERHOEVEN
Chief Executive
AHHA

Identifying and filling cracks in the system

AHHA's cross-sector care simulation tests policy initiatives at the interface between the disability, aged care, community and health sectors.

Australians using services across the healthcare and social services sectors may 'fall through the cracks' as they try to navigate complex and interwoven systems. Vulnerable persons such as those requiring multiple and ongoing health and social support services or those transitioning between these services are likely to be at greatest risk of disjointedness of care.

Based on the premise that the Australian healthcare and social welfare sectors are under-prepared to deal with rising rates of chronic disease, disability, and an ageing population, AHHA's 20 October cross-sector care simulation in Brisbane tested policy initiatives at the interface between the disability, aged care, community and health sectors with the aim of developing recommendations to support greater integration and patient-centred care.

Government responses to these issues have included the establishment of programs such as the Health Care Home trials to be rolled-out across 10 Primary Health Network (PHN) regions, individual aged care funding packages and the National Disability Insurance Scheme (NDIS).

Although such innovations are welcome, care across these various sectors is fragmented in terms of service delivery and funding responsibilities. System changes are needed to ensure the delivery of comprehensive and integrated person-centred care, with appropriate communication and transitions between care providers. Providing such care across the entirety of the patient journey will yield the best outcomes for patients, providers and systems, as well as generate system efficiency gains.

AHHA's simulation allowed participants to interact in a highly realistic but safe learning setting to test policies and structures in an environment where group dynamics have an integral role in participants' examination of the practical implications of the scenarios placed in front of the group. Learning in a simulation occurs not only through what people say and offer as ideas, but through closely observing and reviewing the interactions between the participants. These interactions can expose potential gaps in processes and service provision, as well as unintended consequences.

As participants worked through three scenarios, the free flow of ideas and the resulting interactions covered a very wide range of subjects and viewpoints. Nevertheless, nine recurring themes were prominent throughout all discussions:

- all sectors need to be guided by a clear, defined and shared purpose;
- person-centred care is key to patients using services best suited to them at the level they need, leading to less wastage and better patient outcomes;
- funding by outcomes, rather than outputs, is a natural corollary to person-centred care;
- shifting from competition and 'silos' to cooperation and breaking down of barriers is essential to person-centred cross-sector care;
- prevention and early identification have potential to mitigate health and welfare problems;
- outreach services within aged care settings on a regular and systematic basis would meet care needs and reduce hospital admissions;
- a focus on 'wellness' rather than health would ensure a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity;
- for some individuals, 'system wranglers' or care navigators could assist consumers and their carers to make optimal choices for care within current circumstances; and
- any reform of care services at the intersection of aged, disability and health care will need to have demonstrated economic benefits

In addition to these recurrent themes, a number of tensions ran throughout discussions in all three scenarios, highlighting the complex nature of care provision across disability, aged care, community services and health.

Participants grappled with the balance between centralised and local planning of services, issues of privacy against sharing of personal information and data to improve coordination of care, increased competition among service providers versus increased collaboration, and the tension between empowering and using families and carers against burdening them.

AHHA looks to leverage these findings in our advocacy work over the coming months as governments continue to implement and evaluate reforms in healthcare and social services.

Consumer engagement, value co-creation and person-centred care are increasingly well-recognised concepts in the healthcare and social services sectors, both in Australia and internationally. Moving toward a person-centred care approach is not a simple task, and doing so effectively will require significant collaboration between policymakers, practitioners, researchers, consumers and advocates.

AHHA's cross-sector simulation has added an important body of evidence as we work together for a healthy Australia supported by the best possible healthcare system. ha

AHHA in the news

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

Mental health, oral health in focus in Australian Health Review

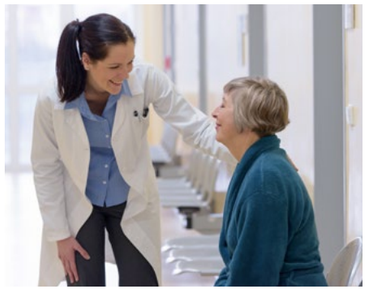
Technology's role in youth mental health reform, and Aboriginal and Torres Strait Islander oral health issues were among many topics explored in the October edition of the *Australian Health Review*.

Flying blind: trying to find solutions to Indigenous oral health by Andrea M. de Silva, Jacqueline Martin-Kerry, Alexandra Geale and Deborah Cole, is an extensive review of published evidence about oral health in Indigenous children in Australia, and trends in Indigenous oral health over time.

The authors found that there were wide gaps in data on dental caries (tooth decay) in young Aboriginal and Torres Strait Islander peoples, which needed to be addressed in order to develop effective strategies to combat poor oral health.

In *The role of technology in Australian youth mental health reform*, authors Jane M. Burns, Emma Birrell, Marie Bismark, Jane Pirkis, Tracey A. Davenport, Ian B. Hickie, Melissa K. Weinberg and Louise A. Ellis examined young Australians' use of online technologies in the context of general health and well-being (including mental health) to set the stage for a new model of integrated mental health care.

The proposed model, involving mobile apps, digital campaigns and e-learning, was designed to sit within the existing health system with the possibility of use as an adjunct to clinical care.



Designing health services with consumers: the way forward

Health care needs to ensure more consumer involvement in the design of services if it is to meet patient-centred standards expected of today's health services.

A September Evidence Brief from AHHA's Deeble Institute for Health Policy Research and Consumers Health Forum of Australia (CHF) provided recommendations for health service providers, including hospitals and Primary Health Networks (PHNs), to increase the role of consumers in designing healthcare services.

The brief, *Consumer co-creation in health innovating in Primary Health Networks*, was authored by Rebecca Randall (CHF), with contributions from AHHA and participants in a recent workshop jointly presented by AHHA and CHF, *Consumer Engagement: How can PHNs & LHNs involve consumers in co-creation to improve healthcare?*

"It is becoming more widely recognised across the health sector that consumer engagement and patient-centred care are central concepts of an optimal health system," CHF CEO Leanne Wells said.

Deeble Institute Director Susan Killion noted that moving toward a consumer-centred health system is not a simple task, and doing so effectively will require more attention being paid to change management than is currently the case.

Australia getting healthier, but inequality must be addressed

AHHA welcomed the release of the Australian Institute of Health and Welfare's (AIHW's) *Australia's health 2016* biennial report in September.

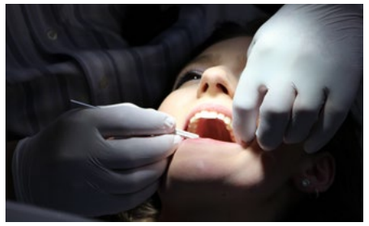
"The report confirms that Australians are in good general health and that we compare well internationally, including that Australian lifespans are extending and that death rates are falling," AHHA Chief Executive Alison Verhoeven said.

"Amid the ongoing discussion around the burden of health expenditure, it is important also for health and political leaders to note that health expenditure growth rates are slowing. The largest proportion of increased expenditure in acute care has been for people aged 50 or older, emphasising the need for care reform around Australia's ageing population."

However, the report also pointed out ongoing areas of health inequality in Australia, driven by socioeconomic factors and social determinants. Communities suffering socioeconomic disadvantage continued to have systematically poorer health, including lower life expectancy, higher rates of chronic disease and higher smoking rates.

"This is an opportunity for health leaders and the Commonwealth Government to heed the report's message that lifestyle factors and social determinants are significant contributors to ill-health, and to address the issues of health inequality and the importance of reform across all of our care systems," Ms Verhoeven said.

"This report also highlights the importance of data in health planning. Health data collection across Australia should be more widespread and better integrated to allow us to better understand the patient journey."



Good news for kids: dental care extracted from Omnibus Bill

The announcement by federal Labor that it had negotiated the removal of proposed budget measures related to dental health from the Omnibus legislation is very good news for children, said Alison Verhoeven, AHHA Chief Executive.

The focus on preventive oral health care for children, as provided in the Child Dental Benefits Schedule (CDBS), would be substantially diminished if the Government's proposed Child and Adult Public Dental Scheme (caPDS) is implemented in its current form. Waiting times would increase as families unable to afford private dental care are forced back into the public system. Access to preventive care for children would also be substantially impacted, as adults with immediate and urgent care requirements would need to be prioritised.

"We can't afford not to take care of our children's teeth," says Alison Verhoeven. "More than 90% of adults and 40% of young children have experienced tooth decay at some stage in their life. Three out ten adults have untreated tooth decay, and only four out of every ten adults see a dentist regularly for check-ups. The situation is even worse for Aboriginal and Torres Strait Islander people, those who live in rural and remote areas, and those who experience socioeconomic disadvantage."

The best time to start caring for our teeth is in childhood, with investment in preventive care so that we reduce the cost, pain and ill health associated with poor oral health.

Proposed cuts to ABS Patient Experience Survey should concern us all

Reports that the Australian Bureau of Statistics is considering cutting its Patient Experience Survey should be of concern to everybody who wants health policy based on evidence rather than anecdote, say the Consumers Health Forum, and AHHA.

The Australian Bureau of Statistics Patient Experience Survey collects data on access and barriers to a range of health care services across the system, including primary care, hospitals, pathology and diagnostic imaging. It has been used by researchers, policy makers and health service providers and because it is annual they have been able to track changes over time.

"Without reliable data we have no way of monitoring the impact of reform."

Alison Verhoeven, AHHA Chief Executive said, "It is a false economy to end such valuable data collections on patient experience and access to a range of healthcare services at a time of multiple reform processes across the health sector. Without reliable data we have no way of monitoring the impact of reform, and could end up wasting limited financial resources along the way."

"A lot of people are putting time and effort into redesigning the system and they need to know that the changes are providing benefits to health consumers using the system — this would be a short-sighted move, given the person-centred focus of the current reform processes."

"The Patient Experience Survey must continue to help design and build a 21st century health system in Australia that is sustainable and delivers the quality of care that Australians expect and deserve'" Ms Verhoeven said.

Don't mess with doctor and patient choice for private patients in public hospitals, health chief says

"The right of privately-insured hospital patients to choose their own doctor, whether in a private or public hospital, is fundamental to Australia's health care system and should not be tampered with", Alison Verhoeven, AHHA Chief Executive, said.

Ms Verhoeven was responding to claims that the Turnbull government's new Private Health Ministerial Advisory Committee has unexpectedly made public hospital billing of private patients a "priority issue for reform".

"Currently about $1 billion of the $14 billion or so paid out by health insurers every year is to public hospitals for treating privately-insured patients as private patients within public hospitals", Ms Verhoeven said.

"What the private insurers and private health industry want is that they not be billed for those services, and that governments pick up the tab. But to do that you would have to remove the patient's right to choose their doctor in a public hospital as well as the right to choose where they are treated.

"The Private Health Ministerial Advisory Committee has no public sector representation in its membership, yet they want to have a major say in how public hospitals are run and funded, to their advantage. They are not willing to put some of their funds towards services provided by public hospitals, but are quite happy that the majority of their doctors and nurses were trained in the public system at no cost to them, to say nothing of the $6 billion a year the government spends subsidising private health insurance." ha

Cross-sector care simulation 2016 the ultimate ideas generator!

Reform processes and the interface between disability services, aged care and health.

AHHA's cross-sector care simulation 2016, held in Brisbane on 20 October, was a resounding success judging by the enthusiasm and flow of ideas from participants.

The simulation was based on the premise that the Australian healthcare and social welfare sectors are under-prepared to deal with the burdens of rising rates of chronic disease and disability, and an ageing population. Government responses to date have included the establishment of programs such as the Health Care Home trials to be rolled out across 10 Primary Health Networks, individual aged care funding packages and the National Disability Insurance Scheme.

Although such innovations are welcome, care across the disability, aged care, community services and health sectors is fragmented in terms of service delivery and funding responsibilities. System changes are needed to ensure the delivery of comprehensive and integrated person-centred care, with appropriate communication and transitions between care providers.

Providing such care across the entirety of the patient journey will yield the best outcomes for patients, providers and systems, as well as efficiency gains.

Three teams of invited participants were asked to work through three scenarios over the course of the simulation. The scenarios focused on: funding mechanisms, and timeliness and appropriate access for patients; service delivery models and workforce issues; and technology to improve patient outcomes and developing a shared planning mechanism.

A substantial number of observations were made throughout the day in the discussion points, suggested innovations, and hurdles and barriers raised by participants. The free flow of ideas, and the resulting interactions, covered a very wide range of subjects and viewpoints. Nevertheless, the following recurring themes were prominent:

Shared purpose and values: Any reform of funding and care provision at the interface between the disability, aged care, community and health sectors needs to be guided by a clear, defined and shared purpose, and unambiguous definitions of what we as a community and as a nation are trying to achieve in terms of outcomes, timeliness and access.

Person-centred care: Person-centred care was seen as the key to patients using services best suited to them at the level they needed, leading to less wastage and better patient outcomes. It was also seen as the key to taking account of individual circumstances, including factors such as remoteness, and differing availability of suitable staff and infrastructure.

Funding by outcomes: Funding by outcomes was seen as a natural corollary to person-centred care. It has many potential benefits in terms of transparency, accountability and efficacy. But this would need wholesale sweeping changes to current funding systems, and attached accountability systems for public money. This suggests that outcomes funding is a solution for the medium to long term — stop-gap funding solutions may need to be implemented in the meantime.

Competition to collaboration: A move from competition and 'silos', to cooperation and breaking down of barriers, is essential to beginning the process of reform at the interface of the disability, aged care, community services and health sectors.

> "The simulation was based on the premise that the Australian healthcare and social welfare sectors are under-prepared to deal with the burdens of rising rates of chronic disease and disability, and an ageing population."

Early identification and prevention: Prevention and early identification activities were seen as having a large potential benefit in terms of mitigating health and welfare problems that could potentially be resource-intensive later if left undetected. Therefore prevention and early identification were seen as a vital component of any reform package or system catering for complex care needs related to aged care, disability and chronic disease.

Outreach services: There was support for a broad set of outreach services to be provided within aged care settings on a regular and systematic basis to meet care needs and reduce hospital admissions.

Wellness rather than health: Successful services and care at the interface of the disability, aged care, community services and health sectors involves considering the full spectrum of physical, mental and social wellbeing rather than just diseases or health conditions alone.

Role of system wranglers: For some individuals, there is currently a need for system wranglers or care navigators, especially in the absence of development of a reformed system that better lends itself to well-coordinated technical solutions. Learning from the experiences of wranglers should be essential when developing new systems to cater for people accessing services at the interface of the disability, aged care, community services and health sectors.

Financial justification: Any reform of care services at the intersection of aged, disability and healthcare will need to have demonstrated economic benefits. ha

To read AHHA's full simulation 2016 report visit ahha.asn.au/simulation2016.

Sidney Sax Medal 2016
Helena Britt

Recognising years of dedication and leadership in health research.

The Australian Healthcare and Hospitals Association is proud to announce Professor Helena Britt as the winner of the 2016 Sidney Sax Medal, following on from last year's recipient, Professor Len Notaras.

The Sidney Sax Medal is awarded to an individual who has made an outstanding contribution to the development and improvement of the Australian healthcare system in the field of health services policy, organisation, delivery and research.

"We are proud to present this medal to Professor Britt in recognition of her years of leadership and dedication in health research, particularly general practice research," AHHA Chief Executive Alison Verhoeven said.

After beginning her career as a research psychologist, Professor Britt has worked in market research, educational research and general practice research. Professor Britt's work in the GP sector has spanned 37 years.

Until June of 2016, Professor Britt was Director of the Family Medicine Research Centre at the School of Public Health of the University of Sydney. As Director of the Centre, she established and then ran, for nearly 20 years, with her colleagues, a rolling survey of 100 patient encounters from 1,000 randomly chosen medical practitioners every year, known as the Bettering the Evaluation and Care of Health (BEACH) program. From that database of 100,000 patient encounters a year came a wealth of information about patient characteristics, GP characteristics, patterns of attendance, conditions reported, conditions treated, medicines prescribed, pathology tests ordered and much more.

"We are proud to present this medal to Professor Britt in recognition of her years of leadership and dedication in health research, particularly general practice research."

The BEACH study was the first national survey to highlight the high proportion of GP attendances for mental health conditions such as anxiety and depression, compared with other types of health conditions. The study was also able to identify useful information such as highlighting a big drop in rates of GP prescribing of antibiotics for colds between 1988—89 and 2003—04 (after highlighting the high level of prescribing prior to this time span).

Professor Britt continues to be involved in supporting ongoing BEACH analyses in other parts of the University of Sydney, following the Centre's closure, providing invaluable data on Australian general practice.

"Professor Britt's work has been essential to the development of health policy and practice for the past 20 years, and will remain a highly-valued resource in the future," Ms Verhoeven said.

Professor Britt has been a member of the International Classification Committee of the World Organisation of Family Doctors for nearly 30 years.

She has written more than 200 published journal articles and 37 books on general practice clinical activity, with topics ranging from adverse patient events, multi-morbidity and disease prevalence, to primary care clinical terminology and classifications and many others.

This exceptional list of achievements and years of dedication underline Professor Britt's leadership in the health sector and her great focus on improving healthcare services and health.

Upon receiving the Sidney Sax Medal, Professor Britt acknowledged the Family Medicine Research Team as an "amazing group of very experienced researchers, the loss of which is devastating to primary care research".

Professor Britt noted that while the data collection would still have currency in the short-term, its value would diminish over time without renewed commitment to the collection of quality general practice data in Australia.

Once again, the AHHA would like to congratulate Professor Britt on receiving the prestigious Sidney Sax Medal 2016 and thanks her for her outstanding contribution to Australian general practice research. ha

Health Care Homes

Federal Minister for Health, Sussan Ley, on the Commonwealth's reform program.

Since my appointment as Minister for Health in December 2014, I have been committed to working in partnership with the health care sector to address the long term challenges facing the system. The greatest of those challenges is the rising incidence of chronic disease in our community.

Chronic disease places an enormous burden on our health system, with almost half of all preventable hospital presentations attributed to chronic disease. More importantly, it can be incredibly difficult for people living with chronic and complex conditions to navigate the system to access the care they need. Also for those responsible for their care — the doctors and nurses working in primary care — the system is not set up in such a way to support and reward them for providing the right care, in the right place, at the right time.

In June 2015, I established the Primary Health Care Advisory Group (PHCAG) to examine these issues. The Advisory Group consulted nationally to gather an understanding of the issues and barriers facing patients and providers in the management of these chronic and complex conditions. Central to the recommendations of the Advisory Group was a staged implementation of a patient-centred approach to delivering quality care to Australians with chronic and complex conditions — the Health Care Home model.

"Approximately $93 million will support the clinical service delivery under stage one. This funding is made available through the redirection of MBS funding and will be delivered to Health Care Homes as bundled payments."

We have had ongoing consultations through advisory groups and stakeholder briefings to inform the design of stage one of the Health Care Homes implementation. These collaborative discussions are guiding the development of resources and supports to aid the process of transformation for the practices that become Health Care Homes.

The Health Care Home model builds on the lessons of previous coordinated care trials and presents us with a chance to reform the way we provide care for people living with chronic and complex conditions. The Health Care Home is an evidence-based, coordinated, multi-disciplinary model of care that aims at improving efficiencies and promoting innovation in GP practices. It is consistent with similar models adopted successfully around the world, including the United Kingdom and New Zealand, and reflects the attributes of many high performing primary care practices here in Australia.

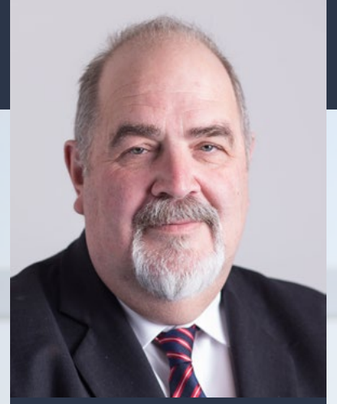
The approach offers doctors and nurses greater flexibility to shape care around the needs of the patient and maximise the patient's role in their own care. It also supports providers to work at the top of their scope of practice through team based approaches and better use of group sessions, and technology for regular communication with patients and other health care providers, including through the use of My Health Record.

Stage one will see Health Care Homes established in approximately 200 practices in 10 regions across Australia, with services set to commence from 1 July 2017. An expression of interest process will occur soon, asking practices in the selected regions to nominate their interest in becoming a Health Care Home.

Approximately $93 million will support the clinical service delivery under stage one. This funding is made available through the redirection of MBS funding and will be delivered to Health Care Homes as bundled payments. This removes the current restrictions associated with the MBS items and allows the practices the flexibility to design their services, workforce and roles around the needs of their patients and to work more effectively with this complex patient cohort.

Importantly, we will not have all the answers by 1 July 2017. The Government is providing an additional $21.3 million to establish, support and evaluate stage one. Stage one of the Health Care Homes implementation will be formative at all levels and will inform future decisions for national rollout.

For those practices selected to participate in stage one, the formal process to become a Health Care Home starts early in the New Year. The model also offers practices more broadly an opportunity to consider new approaches to care. In recognition that service delivery models are evolving in the Australian health landscape more broadly, I encourage all health care providers to consider how their practices might adopt the characteristics of the model, the My Health Record, and opportunities to deliver patient-centred primary health care. ha



DAVID BOWEN
Inaugural CEO
National Disability Insurance Agency

The NDIS: an ordinary revolution

Why the **NDIS** benefits all Australians.

The simplest ideas often have the biggest impact.

This is the case of the world-leading National Disability Insurance Scheme (NDIS) — built on the basic premise of assisting people with a disability to live an ordinary life.

How does it do this? The NDIS will provide all Australians under the age of 65 with a permanent and significant disability that affects their functional capacity with the reasonable and necessary supports they need to live an ordinary life.

The NDIS works individually with people with disability because we know each person has different needs, preferences and aspirations.

This could mean more help with personal care, practical mobility supports such as motorised scooters and home modifications, access to allied health services or help returning to work.

For some people who have lived their life with limited choice and opportunities, the achievement of an ordinary life, is in itself an extraordinary outcome.

The Scheme is not just for those living with a disability — it provides peace of mind to every Australian that if one day you, a family member or a friend is affected by disability, the NDIS is there.

The sustainability of the Scheme is a central focus. This means monitoring of spending pressures, scope creep and cost shifting — supports are not unlimited and will not be for luxury items.

The NDIS is not a welfare system — it is an insurance scheme, and the difference is important.

It takes a lifetime approach, meaning it invests in an individual early on, for as long as they need it — the very purpose of the NDIS is to make disability supports a means to an end rather than an end in themselves.

Some people will receive the support they need to achieve their goals and will exit the Scheme. The NDIS will always be there if they need support again.

We are already seeing this with the early intervention support for children provided by the Scheme. One NDIS participant, Jack, joined the NDIS when he was three, received supports necessary for his circumstances and is now at a commensurate development level with children of his age and has therefore left the Scheme. If Jack's development falls behind in future, the Scheme would be there to assist.

The NDIS makes not only good social sense, it is sound economic policy. By 2020, the Scheme is expected to have generated up to 70,000 new full-time jobs, and the Productivity Commission has said it expects the NDIS to boost Australia's Gross Domestic Product by one per cent by 2050.

More broadly, the Scheme will also raise awareness about the rights and needs of people with disability and lead to social change. It will generate a wealth of data that will inform best practice approaches to disability.

The NDIS is a dramatic shift from the legacy system of governments' block funding to institutional providers. Choice of providers and control of funding is now in the hands of those living with a disability, their families and carers.

This will encourage the growth of service providers offering diverse supports.

We are already seeing positive results with the successful completion of the three-year NDIS trial at the end of June 2016 that showed 35,695 participants were accepted to the Scheme, 3,500 providers registered and more than $2.4 billion was committed for supports.

Most importantly, 95 per cent of people rated their experience during this trial as either good or very good.

Half of the participants in the trial received disability services for the first time.

For many people, such as Teisha, a participant from Victoria diagnosed with multiple sclerosis 20 years ago, the NDIS is the first major support she has received outside of a short stint on the disability pension.

Her NDIS supports, including visits to a neuro-physiotherapist, have improved her mobility and helped her to work.

The NDIS has now moved into the three-year transition phase to national roll-out with the number of participants expected to grow to 460,000 by 2019—2020, and annual expenditure of $22 billion doubling previous government funding.

The NDIS is only part of the National Disability Strategy, with almost one in five Australians, or 4.3 million people, living with a disability.

Not everyone will be eligible for the NDIS. Entry into the Scheme is determined primarily using a functional assessment, rather than a medical diagnostic, approach.

The Scheme is designed to work side-by-side with health, education and other universal services that people with disability need to access. The NDIS it is not responsible for providing these services.

For hundreds of thousands of Australians, the NDIS will achieve an extraordinary outcome — the chance to live an ordinary life. ha

pixabay.com/en/woman-crutch-old-walk-walking-791541/

An integrated healthcare system

Future pointers from Star Trek?

Dr Bronwyn Morkham, Young People in Nursing Homes Alliance

In *The Voyage Home,* the 4th film of the Star Trek franchise, the crew of the starship Enterprise travel back to the 20th century to avoid planetary catastrophe in their own time. When a crew member sustains a brain injury, the film begins a rolling commentary on the backward nature of 20th century medicine. In one scene, the crew search a hospital for their fallen comrade. The ship's medico, Bones McCoy, passes an obviously unwell older woman lying on a trolley and asks what her problem is, to which the patient replies, "Kidney dialysis".

McCoy's frustrated response of, "Dialysis… what is this, the Dark Ages?" allows him to give the woman a pill to swallow that cures her. Later, McCoy passes the woman, surrounded by incredulous medical staff, with the patient joyously exclaiming, "The doctor gave me a pill and I grew a new kidney!"

We may be a while away yet from McCoy's instant kidney cure, and we are certainly some distance away from reversing brain injuries by applying a small gadget to the skull, as McCoy did to cure his comrade's brain injury. Medicine in the 21st century is certainly not medieval, but it can't yet cure as completely as McCoy's interventions could.

And therein lies our dilemma… we've been pretty good at saving and sustaining lives, but not so good at providing the supports that patients left with complex health and other needs require, post health intervention. Indeed, despite the significant investment health services make, the net result can be poorer health and life outcomes for individuals with this complexity of need. The lack of any systemic response for this group means that, despite lacking the resources and capability to do so, disability and aged care services are often expected to pick up the slack, while supporting their health needs places extra demands on already stretched health services to neatly complete a cycle of diminishing returns.

One way to address this endemic problem is to develop pathways of connected care that draw on multiple human services programs to deliver the care and supports those with complex needs require. Rather than working separately as they currently do, programs such as health, aged care, mental health, disability and employment services need to work together to incorporate their services into an integrated whole.

Instead of simply passing patients with complex needs over to disability, mental health or aged care as health services tend to do at discharge, health would stay in the game. As well as developing connected care pathways, partnering with programs like the National Disability Insurance Scheme (NDIS) may, for example, reveal the need for new service responses that health networks are ideally placed to deliver, such as workforce development programs, shared services and specialised service coordination.

Health services might also partner locally with aged care and disability providers to deliver outreach programs that provide the health input and oversight needed to enable those with intensive health needs to remain in their own homes… something currently unavailable in the community. Partner contribution and genuine collaboration by individual programs with each other is needed to take advantage of these opportunities and deliver viable connected care responses.

The *Living Longer Living Better* aged care reforms that focus on keeping older people at home for longer, and the arrival of the NDIS with its focus on improved social and economic participation for its members, means the demand for new and improved community health responses is only going to get greater. Both reforms offer an exciting opportunity for health networks to think differently about delivery of existing services outside hospital walls; and how, in collaboration with other programs, new health responses can be developed to the mutual benefit of all. McCoy would certainly demand it be so! ha

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First published in the Australian Society for Medical Research October 2016 newsletter, available at www.asmr.org.au

Photo by Joanna M Foto

KRISTIN MICHAELS
CEO
The Society of Hospital Pharmacists of Australia

SHPA's view on the future of pharmacy remuneration and regulation

Federal Health Minister Sussan Ley has stated on a number of occasions that one of the Federal Government's primary goals is to ensure that 'every dollar spent on health lands as close to the patient as possible'.

The aim is admirable: the effectiveness and cost of health care must be seriously reviewed from time to time and, within that context, opportunities to explore new approaches to medicines management must be evaluated.

The Review of Pharmacy Remuneration and Regulation is a legitimate and well-considered undertaking to deliver recommendations to government around the efficient funding and purchasing of key professional pharmacy services. It is the largest and most wide-ranging review any government has attempted in the 26 year history of the bilateral Community Pharmacy Agreements between the Federal Government and the Pharmacy Guild of Australia. As such, it is deserving of widespread engagement and support.

SHPA's primary recommendation to the King Review is that funding for services provided by pharmacists should focus on the achievement of good health outcomes for patients, rather than simply funding the dispensing processes. This change in focus is imperative if we are to provide effective support for Australia's ageing population and the growing incidence of chronic disease.

Pharmacists work in a range of settings, and achieve expertise in medicines post-registration through professional experience and advanced training. SHPA members operate at the highest levels of pharmacy and healthcare. They demonstrate the greatest expertise in the design and development of professional pharmacy services to support positive patient health outcomes in public and private hospitals, where over 20% of PBS expenditure is incurred.

"The more time spent on bureaucracy means less time afforded to deliver patient-centred care and cognitive pharmacy services to achieve improved health outcomes for all Australians."

Many government-funded clinical pharmacy services today, such as the Home Medicines Review program, have been scaled from hospital-led innovations. This continues with evolving services such as smoking cessation clinics, anti-coagulation clinics and opioid de-escalation clinics in the outpatient setting.

To provide this high quality care, pharmacists in hospital pharmacy departments often have to navigate through the complex, multiple funding programs and associated rules necessary to access Commonwealth-subsidised medicines.

Outside of the PBS, hospitals also have their own formulary, Individual Patient Usage drugs for advanced and complex conditions, Special Access Scheme drugs for therapies not available in Australia, and the list goes on.

The more time spent on bureaucracy means less time afforded to deliver patient-centred care and cognitive pharmacy services to achieve improved health outcomes for all Australians. SHPA has always believed that a single funder for all medicines, regardless of the patient setting, would be optimal.

That is why SHPA has also called for the separation of remuneration for the supply of a medicine and professional pharmacy services. The funding model for professional pharmacy services must accurately reflect contemporary pharmacy care and the needs of patients and consumers.

It is only through the implementation of a new paradigm of pharmacy that we can improve the quality use of medicines, and make inroads into the 230,000 medicines-related hospital admissions each year. ha

Photo by Joanna M. Foto

HealthHack 2016

Karmen Čondić-Jurkić, Michael Thomas, Carmen Baillie, Tom Robinson
Canberra HealthHack Organisers

Team CITeX — winners of the inaugural HealthHack Canberra 2016

Participants, judges and organisers of HealthHack Canberra 2016

HealthHack is a 48-hour hackathon event aimed at helping medical researchers, health professionals and students to find digital solutions to the problems they encounter in their daily work. Experts are invited to pitch their ideas to programmers and developers who form into small groups around each idea based on their interests and skills. Each expert works closely with their group for 48 hours in a friendly and productive environment before presenting their masterpiece on the final night.

For researchers and healthcare professionals, HealthHack can help to create a proof-of-concept for a particular idea, to reimagine an existing concept or to create something truly inspiring. For programmers, it's a great opportunity to hone their skills and make new connections, work directly on interesting problems with domain experts, and gain a deeper understanding of healthcare and medical research. HealthHack enables formation of cross-disciplinary networks and relationships — working in diverse groups encourages cross-pollination of ideas and the development of innovative new solutions. Participating in the event also provides an opportunity to spend time with people who are passionate about health and medical research, education, science, software development, engineering and design.

HealthHack is a free event run under Open Knowledge Australia, and organised by volunteers. This non-profit event turns four this year and it is held concurrently in Sydney, Melbourne, Brisbane, Perth and Canberra over the weekend of 14–16 October. The inaugural event in Canberra attracted 53 participants, batting well above its average, with roughly 100 participants at the Melbourne and Sydney events.

At the Canberra event, nine pitches were given on the Friday night, with six teams ultimately forming. Problems were wide-ranging:

- Visualisation software to help doctors target radiation treatments more effectively (TeamX)
- Improving citation management (CITeX)
- Resisting impulsive behaviour for delayed gratification (Impulse)
- Identification and sorting of seeds and grains (SeedID)
- A tool to improve NDIS management for all parties (Simplify)
- Super-resolution MRI imaging techniques (SP4MRI)

After a day-and-a-half of developing and coding their ideas, the final pitches were given on Sunday afternoon. The task of deciding the prizes for HealthHack was left to our esteemed judges: Dr Deborah Kuchler, the executive chairman of the Hospital Intellectual Property Group; CEO of Health Horizon and serial entrepreneur Marcus Dawe; and Kylie Walker, CEO of Science & Technology Australia. The best overall team title was awarded to the CITeX team for developing a quick and accurate algorithm (99.7%!) for removing duplications from libraries in reference management software.

Dr Andrea Parisi (Australian National University), the CITeX team leader, explained the motivation behind her idea: "as a researcher working on systematic reviews, manual sorting of duplicates can take two to three weeks and there is no automatic way of comparing the number of references quickly and efficiently. With CITeX, the program we created, this can be finished in less than one minute."

Team Impulse was awarded the Best Commercial Potential title. This team, under the leadership of Dr Janie Busby Grant (University of Canberra), has developed an app prototype, which should help individuals making better decisions now for their future selves.

> **"Experts are invited to pitch their ideas to programmers and developers who form into small groups around each idea based on their interests and skills."**

The award for Best Design went to TeamX for finding a great solution for 3D visualisation of the internal organs close to the radiation treatments that might suffer from the excessive radiation dosage. This should allow doctors to identify a more efficient dosage regimen faster, while reducing damage to the neighbouring organs.

The Spirit of HealthHack award went to team Simplify for their efforts in building a platform that connects people with special needs to relevant service providers, as well as to government portals, notifying the user whether the service is covered by the NDIS scheme.

Participants learned how to develop their ideas to a proof-of-concept or a working prototype. Perhaps more importantly, they had to learn how to communicate their ideas more effectively and concisely due to the time limits imposed on pitches. For without communication of ideas, the options for the progression of an idea are severely limited — a message that was emphasised by Dr Deborah Kuchler.

The support from the Canberra community astounded all the organisers. Without this support, this event would not have been possible. The Canberra Innovation Network (CBRIN) provided the venue and expertise on hosting an event such as HealthHack. The Australian National University and Data61 provided financial support. CBRIN, Entry29, JetBrains, Amazon Web Services, Azure and Blue Chilli donated prizes.

Beyond material support for HealthHack, the Canberra scientific and entrepreneurial communities were enthusiastic, passionate and willing to help out. It was a moving experience for each of the organisers, and very much reflected the community spirit in innovative areas in the Australian Capital Territory.

We hope to see you at next year's HealthHack! ha

ahha 70 celebrating 70 years as the voice of public healthcare

The way forward

2017 and beyond

As AHHA approaches the end of its 70th anniversary year, the organisation is looking to the future and planning how to face emerging and new challenges in 2017 and beyond.

AHHA advocates for its members in the name of a healthy Australia, supported by the best possible health system. To do this, the Association will continue to conduct research, educate and influence the healthcare system to achieve better health outcomes, improved patient and provider experience, and greater equity and sustainability.

Working with our members in our 71st year, AHHA will:

- Work to enhance the health and wellbeing of Australians through improved standards in primary, acute, community and aged care;
- Seek to improve health service provision and health outcomes by developing, providing, disseminating and promoting research and education;
- Support the delivery of high quality healthcare by promoting evidence-informed practice and advocating for funding models that support primary, acute, community and aged care services;
- Support the health sector through the provision of business, education, advisory and consultancy services, and by connecting the diverse contributions of health practitioners, researchers, policy makers, and consumers;
- Promote and support universally accessible healthcare in Australia for the benefit of the whole community;
- Focus on innovation that enhances integration of care, including development of new models of care, and funding models that support health reform that responds to emerging issues.

AHHA's vision for success includes cementing our status as a body that starts conversations, rather than just commenting on them. Events such as our Think Tanks along with our Innovation, Data and Mental Health Network meetings, allow AHHA to provide a space for health leaders and innovators to discuss sector issues and methods of reform, the outputs of which are the basis of our advocacy program along with the latest research produced through AHHA's Deeble Institute for Health Policy Research and our peer-review journal, *Australian Health Review*.

> **"...AHHA's broad and diverse membership facilitates an authoritative voice across the healthcare sector, and promotes an integrated health system."**

AHHA is focused on diversifying both our membership and our team, ensuring our members' voices are heard in the national policy agenda, making research the foundation of our advocacy and policy activities, and collaborate with members and like-minded organisations to advance our goals.

AHHA brings perspectives from across the healthcare system together to advocate for effective, accessible, equitable and sustainable healthcare focused on quality outcomes to benefit the whole community.

While the risk of managing potentially diverse and/or conflicting views of members exists, AHHA's broad and diverse membership facilitates an authoritative voice across the healthcare sector, and promotes an integrated health system.

The revenue stream of the business arm is critical to AHHA's financial viability, which like other not-for-profit peak bodies is challenged by fiscal constraints in the public and not-for-profit sectors. The overlap among the various activities of AHHA strengthens our capacity, credibility, influence and effectiveness.

AHHA has built its culture around transparency, collaboration, inclusion and balance. Guided by a renewed strategic plan, AHHA seeks to be both proactive and responsive, while mindful of membership interests, investments and trust.

An ageing population, a growing burden of chronic disease, a need for funding reform and the increasing cost of new medical technology will all continue to impact on the healthcare system in the near future. AHHA will continue to advocate for health leaders and governments to work together to provide a sustainable, equitable and accessible health system that delivers quality healthcare for all Australians.

AHHA's role in the next 70 years will doubtless evolve along with an evolving healthcare system, but we will continue to advocate for best-practice, efficient, universal healthcare supported by adequate, sustainable funding. ha

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Celebrating the 10th anniversary of the Awards

2016 Winners

10th National Disability Awards

www.idpwd.com.au

Recognising outstanding achievements in improving the lives of those living with disability.

International Day of People with Disability

The 10th National Disability Awards were held at Parliament House on 7 November 2016. The Awards, now in their 10th year, were hosted by Assistant Minister for Social Services and Disability Services, Jane Prentice.

The National Disability Awards are a major part of the Commonwealth Government's celebration of International Day of People with Disability.

Here are profiles of the 2016 National Disability Award winners and their outstanding achievements in improving the lives of people with disability.

For more information on the awards and winners, visit www.idpwd.com.au

Employer of the Year Award

Winner — Brisbane City Council, QLD

"DisABILITY ACTION at WORK is an innovative initiative that builds the knowledge, skills and work experience of participants and readies them for further employment opportunities. The program also expands the experience of team leaders and managers to promote inclusiveness." Lord Mayor Graham Quirk.

Excellence in Community Partnership Award

Winner — Dementia Friendly Kiama Project, Kiama Municipal Council, NSW

"A fully accessible, inclusive and enabling community is one that embraces diversity and champions participation for all. It's a community that recognises that we all benefit from supporting each other and that in order for a community to be sustainable economically, socially and environmentally, it needs to be truly inclusive." Nick Guggisberg, Manager Community and Cultural Development, Kiama Municipal Council.

Lesley Hall Leadership Award

Winner — Maurice Corcoran AM, SA

"I have a strong belief in social justice and equality of opportunity for all people and believe that my professional social work skills, together with my passion and commitment to facilitate change, allows me to genuinely improve life opportunities for people with disability in Australia."

Excellence in Inclusive Community Design Award

Winner — Shire of Collie, WA

"Watching people with disability have the same opportunities as the wider community to enjoy inclusive activities within the town they live in is rewarding and motivating for councillors and staff. The ability of people with disability to venture from their homes to enjoy interactions with community members is something that people without disability often take for granted." Julie Pelliciari, Community Development Officer, Shire of Collie.

Excellence in Inclusive Service Delivery Award

Joint Winner — Determined2, SA

"I don't see Determined2 as improving someone's life but creating the opportunity for people with disability or injury to empower their own lives through positive experiences and memories." Peter Wilson, Managing Director, Determined2.

Joint Winner — Nightlife Disability Service, VIC

"Nightlife helps people have real choice about when and how they are supported. By operating under Nightlife's service delivery model, people have the flexibility to design their own supports without being heavily constrained by the needs of the service, but instead have the freedom to choose when they are supported." Vincenza Nobile, Manager Nightlife Disability Service.

Excellence in Technology Award

Winner — Dr Peter Puya Abolfathi, Healthcare Innovations Australia, NSW

"When I first embarked on this project more than 13 years ago, I found myself in a world where advanced technology was not being commercialised for people with severe disabilities. My team and I, together with other technology developers with similar mindsets, believe that there are ways to create sustainable business models that create much needed technological solutions to those who need it."

Excellence in Education and Training Award

Winner — Tagai State College Student Support Services Team, QLD

"The Students Educationally At Risk System (StEARS) is designed to provide a framework that ensures a coordinated service delivery model for supporting our students with disability. Underpinning this system is our vision of high expectations and a commitment to excellence for our students with disability, which is ongoing throughout their life." Sophie Bitner, Acting Associate Principal.

Excellence in Justice and Rights Protection Award

Joint Winner — Kerri Cassidy, Chronic Cerebro Spinal Venous Insufficiency (CCSVI) Australia, VIC

"The work we have achieved has shown that people with MS deserve to be heard, that we have a valuable contribution to make and better research can be done with the inclusion of all stakeholders."

Joint Winner — Kairsty Wilson, AED Legal Centre, VIC

"My belief in social justice and human rights motivates me to improve the lives of people with disability. My reward is seeing the impact of my work on the faces of my clients when they achieve success. Successes are not always measured in monetary values; instead it is about empowerment and recognition that they have stood up for themselves."

NDIS and mental health: a Queensland snapshot

Does mental health fit into the NDIS?

KRIS TROTT
CEO Queensland Alliance for Mental Health and Member, Executive Leadership Group Community Mental Health Australia

JEREMY AUDAS
CEO Mental Illness Fellowship of North Queensland

The National Disability Insurance Scheme (NDIS) is a life-changing innovation in health care, designed for people with disabilities, and their families and carers. It includes people with a psychiatric condition that leads to functional impairment that requires support. The Scheme will be rolled out geographically over three years with people transitioning at different times according to their location.

The NDIS focuses on functional impairment and what support is required to enable people to live a quality, 'normal' life. Originally it was not designed to meet the needs of people who experience mental health issues, their family and carers; this cohort was brought into the scheme after it had been designed and is being imperfectly moulded to fit it.

The first regions in Queensland started on 1 January 2016 in Townsville and Charters Towers, for children and young people, and all eligible people from Palm Island. So what were the concerns raised during this early launch?

One issue raised was whether planners had the right skills and knowledge of mental illness, to sufficiently assess people with mental ill-health, an often cyclical disability, against eligibility criteria that focused on permanency. Another was that some packages did not include consideration for transport, particularly for Palm Island participants who may not be able to access services without transport support.

Palm Island participants often come from culturally diverse backgrounds and speak different languages. Participants faced challenges in describing their conditions given language and cultural issues. Some cultures do not have words to describe mental illness and often it is culturally inappropriate to talk about mental health.

Yet their existing service providers, who know them well, were often discouraged from providing support during the interview process. So designing an NDIS package may be problematic in this sector. Language must be considered when assessing a person with mental health issues, and support encouraged from someone they know, including providers.

Another concern is the lack of focus on mental health recovery in the underpinning guidelines. Worldwide, the focus on service provision is predicated on the basis of recovery or restoration of citizenship for people with a mental illness.

"Concerns about service access for those ineligible for the NDIS, such as people who do not have a permanent, or severe and persistent mental illness continue."

Concerns about service access for those ineligible for the NDIS, such as people who do not have a permanent, or severe and persistent mental illness continue. NDIS legislation dictates that the disability must be permanent, or likely to be permanent[1], however, many mental health issues are episodic in nature and do not fit into this definition of permanency. The cyclic nature of mental illness means that people need different levels of support at different times, with hospital admissions sometimes required.

Furthermore, there is a lack of clarity about what continuity of care will look like for those currently able to access block-funded services but who will be ineligible for the NDIS. There had been expectations that Primary Health Networks (PHNs) might play a role by provisioning services for people ineligible for an NDIS package, however the mental health guidance material developed by the Department of Health for PHNs suggests that the Australian Government wants PHNs to focus on clinical partnerships[2].

Historically, service providers have received block funding, and the services people with disability and their carers have received have been managed by providers. This will change under the NDIS, as people eligible for packages will have greater control and choice over how, when and from whom they receive services.

Service providers will enter into a client-driven environment and it is critical that they move to a service-focussed delivery model. Fundamentally it is the change to a market driven, commercial supply and demand scheme that will dictate how the sector operates. To compete in a more commercial market requires the market to be able to set such things as wage levels.

However, NDIS pricing structure limits what wages service providers can pay their employees, and the current pricing is considered too low[3]. This means that service providers may have insufficient funds to attract and retain staff qualified to assist people who experience complex mental health issues and exclude skilled and qualified mental health practitioners, professionals and peer workers.

This, in conjunction with issues around cash flow management, running dual systems, new IT systems, portal issues, workforce management and invoicing, are placing service providers under considerable pressure.

Cleary a lot more needs to be done to make a square mental health peg fit into a round NDIS hole. As we move into this new paradigm, we need to ensure that funding for programs is not removed before support arrives in all regions and that those ineligible for the NDIS continue to receive support.

There are many organisations involved in this massive change and we all need to work together, so no gaps arise between areas of responsibility, and ensure the great benefits of the NDIS are realised for everyone. ha

Kris Trott, Queensland Alliance for Mental Health and Member of Executive Leadership Group, Community Mental Health Australia
Jeremy Audas, Mental Illness Fellowship North Queensland and SOLAS

1. Federal Register of Legislation (2016) *NDIS (Becoming a Participant) Rules 2016*. https://www.legislation.gov.au/Details/F2016C00730/Html/Text#_Toc447096670

2. Australian Government Department of Health (2016), *PHN Mental Health Tools and References: Stepped Care*. http://www.health.gov.au/internet/main/publishing.nsf/Content/2126B045A8DA90FDCA257F6500018260/$File/1PHN%20Guidance%20-%20Stepped%20Care.PDF

3. Community Mental Health Australia (2015). *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project*. http://qldalliance.org.au/cmha-ndis-workforce-development-scoping-paper/

Queensland Alliance FOR MENTAL HEALTH
Peak body for the community mental health sector

ANNE CUMMING
Principal Advisor Cognitive Impairment, Australian Commission on Safety and Quality in Healthcare

The Caring for Cognitive Impairment Campaign

Improving knowledge and care practices to provide better outcomes.

While not a normal part of ageing, conditions such as dementia or delirium (conditions most commonly associated with cognitive impairment) are common among older people admitted to hospital in Australia. Nationally, 20 per cent of hospital patients aged over 70 have dementia and 10 per cent of patients in this age group have delirium on admission to hospital.

Despite this, cognitive impairment is often misdiagnosed or undetected in hospital. Improving knowledge and care practices to provide better outcomes and reduce the risk of harm to people with cognitive impairment in hospitals is a priority for the Australian Commission on Safety and Quality in Health Care (the Commission).

Patients in hospital with cognitive impairment are at much greater risk of adverse events and preventable complications. For example, patients with dementia are two times more likely to experience falls, pressure injuries or infections and six times more likely to develop delirium during their hospital stay. And older patients with cognitive impairment are at increased risk of unexpected death or early and unplanned entry to residential care.

Patients in hospitals may also be cognitively impaired due to other conditions such as an acquired brain injury, a stroke or intellectual disability. Patients with any form of cognitive impairment can find the unfamiliar and busy hospital environment very distressing. Sometimes staff may not feel confident about how to communicate and provide the right care.

There is evidence that delirium can be prevented with the right care. Harm can be minimised if systems are in place to identify cognitive impairment and the risk of delirium so that individualised strategies can be put in place.

Photo by Josh Boot

The Commission has a series of activities and resources to support healthcare organisations to address these issues which can be found at www.safetyandquality.gov.au, including:

- The A Better Way to Care resources
- A Delirium Clinical Care Standard to guide clinical practice
- Inclusion of cognitive impairment items in the draft Version 2 of the National Safety and Quality Health Service (NSQHS) Standards. The NSQHS Standards are designed to protect the public from harm and to improve the quality of health service provision. All hospitals and day procedure services and the majority of public dental services across Australia are assessed to ensure they have implemented the NSQHS Standards. Version 2 of the NSQHS Standards is expected to be released in 2017, with implementation in 2019.
- The Caring for Cognitive Impairment campaign to drive quality improvement in this area and to help prepare health services for the proposed new requirements in the NSQHS Standards.

The Caring for Cognitive Impairment campaign is a call for action to unite everyone who cares for people with cognitive impairment. Doctors, nurses, allied health professionals, health service managers, care and support staff, workers in primary health, community or residential care, patients and families can all make a difference. The campaign website also enables individuals to commit to the campaign, with individual certificates listing simple, straightforward steps tailored to the person's role. Those who commit also have access to streamlined resources, webinars and regular newsletters.

"There is evidence that delirium can be prevented with the right care."

Key organisations across Australia have joined as supporters to promote the importance of the campaign, including 152 Australian hospitals that are listed on the campaign website.

Many hospitals are demonstrating leadership in the delirium space by putting in place different initiatives to improve the recognition and care of people with cognitive impairment.

This campaign does not replace or duplicate local action. Rather, it provides a platform for collaboration and sharing of good practice. Those who join become part of a community striving to make a difference.

To join the campaign, go to the campaign website: cognitivecare.gov.au. ha

Mental health and the NDIS – recovery oriented support?

Ensuring the recovery focus of community-managed mental health service remains during transfer to NDIS.

Photo by Joanna M Foto

Mental health is undergoing a significant period of reform particularly in terms of the transition of funding for a number of federally and state funded mental health programs to the National Disability Insurance Scheme (NDIS). There are large impacts on funding for community managed mental health services in this process. Respite programs for carers are also impacted by the transition.

The overall concern for Community Mental Health Australia (CMHA) is how the reforms will respond to people with psychosocial disability and provide a workforce that is qualified to deliver the services people need, particularly within the NDIS structure.

While federal funding for such programs as Partners in Recovery, the Personal Helpers and Mentors Service, Day to Day Living and Mental Health Respite Carer Support is being transferred into the NDIS, many of the people with mental health issues currently supported by these services will not be eligible for NDIS funded support.

The NDIS pricing structure and its relationship to qualified mental health staffing is having a significant impact. Meanwhile, there seems to be a misunderstanding between what constitutes psychosocial disability support and what constitutes psychosocial rehabilitation. The skills and knowledge required are different with the NDIS pricing structure able to fund disability support, while being unclear about its reach into more complex supports.

This creates a potential imbalance in the provision of mental health support which should represent a balanced system of treatment, community-based rehabilitation and disability support.

A recently released report on work undertaken by CMHA, led by the Mental Health Coordinating Council in New South Wales, on the impact of the NDIS on the mental health workforce found that "… many service providers consider the NDIS to be a 'challenging' environment, with pricing constraints and perceived rigidity in the Catalogue of Supports (now the National Disability Insurance Agency/NDIA Price Guide) seemingly making it difficult if not impossible to remain faithful to a recovery model and to deploy and manage the workforce in a preferred manner."[1,2]

> "CMHA remains committed to the NDIS and the benefits that it can bring to the lives of people living with a mental health issues."

"The NDIS pricing does not officially set mental health sector workers' wages, however, it does have a significant influence over wages that mental health organisations are able to pay their employees. Some stakeholders have noted that pricing was not sufficient to purchase a suitably skilled workforce that engaged in complex 'cognitive behavioural interventions' as well as direct personal care."[3]

A 2015 report by VICSERV on the NDIS Barwon trial concluded that the NDIS was not effectively delivering rehabilitation focused services and that these services and disability support services are both important parts of the continuum of care for people living with a mental illness. The Commonwealth, state and territory governments should ensure both receive secure and ongoing funding.[4]

The CMHA report acknowledges that the impact of the NDIS on people living with a mental illness and service providers is in its early stages. However, it is important that key findings and recommendation that emerge from various reports and studies — particularly those of community managed mental health sector delivering services as they transition — lead to changes which will ultimately affect the quality and safety of service that is delivered to consumers.

CMHA remains committed to the NDIS and the benefits that it can bring to the lives of people living with a mental health issues. CMHA works in partnership with community managed mental health service providers to develop solutions to concerns. We provide informed input to decision makers to ensure reforms actually deliver what is needed to people living with a mental health issues. Importantly with this, it is vital to ensure that the recovery focus of community managed mental health services — which has come to inform the overall approach that is taken to addressing mental illness — is not lost. ha

1. Community Mental Health Australia (2015). *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project*. Sydney: Mental Health Coordinating Council.

2. The report was commissioned and funded by the Commonwealth Department of Social Services NDIS Sector Development Fund as part of the Mental Health Australia NDIS Capacity Building Project.

3. Community Mental Health Australia (2015). *Op. cit.*

4. Psychiatric Disability Services of Victoria Inc. Learn and Build in Barwon, The impact of the National Disability Insurance Scheme on the provision of Mental Health Services in the Barwon Launch Site. Key issues for consumers, families and the Victorian mental health services system. June 2015. Victoria: VICSERV.

CMHA is a coalition of the eight state and territory peak community mental health organisations. CMHA, through its state and territory bodies, has a direct link and contact to community sector organisations delivering services at the community level. CMHA provides a unified voice for over 800 community-based, non-government organisations who work with mental health consumers and carers across the nation and who are members of, or affiliated with, the various coalition members.

CMHA
Community Mental Health Australia

JOHN MCCARTHY
Head of Corporate Health
NAB

Meeting the challenges of funding growth in aged care

As the demand for aged care services continues to grow, **John McCarthy, Head of Corporate Health at NAB**, discusses some key issues currently facing providers and some of the successful business models operators are currently adopting.

Photo by Nathanael Otto

Australia's aging population is the nation's fastest growing demographic trend, with the number of those aged over 65 years estimated to more than double by 2055.[1] Undoubtedly, this increase has brought about both exciting growth opportunities and challenges for aged care providers.

According to a recent report by the Aged Care Financing Authority, Australia has around 200,000 residential aged care places while another 76,000 are needed to meet demand over the next decade. For many providers, this growth in demand has led to thinking about expansion either through investing in new stock or upgrading existing facilities.

Australia's Health Department estimates that the cost to meet this growing demand is around $33 billion before 2026. We know from our conversations with providers as well that funding growth is the biggest challenge at the moment and marginal players are struggling the most. This is the time providers are pushed to rethink their business strategy and make a choice about whether to remain in the sector or sell to a larger entity. If they stay, they need to think about how they can grow sufficiently to not only survive but prosper.

Historically, Australia's aged care industry has been highly fragmented and largely dominated by not-for-profit operators. However, we're now seeing a sophisticated approach to board governance and this is driving a much sharper strategic and operational focus. At the time of such enormous industry growth, aged care providers especially, not-for-profit and smaller family operators, need to think differently. Their biggest challenge is to continue to raise capital to meet both their social mission as well as growing demand.

In this dynamic market environment, we're seeing three key trends in funding models that are working optimally for aged care providers.

1. Separation of service provider and property owner

In overseas markets such as the US and UK, there is a clear distinction between the real estate owner and the aged care operator. We're seeing this model becoming popular in Australia now and the feedback from aged care providers who've adopted this approach has been very positive.

Most aged care businesses want to remain focussed on growing the operating side which means enhancing services, providing what users want and meeting the new Aging in Place model demands. This means acknowledging that they don't have the funds to acquire property as well as invest in their core business facilities, which in turn leads to assessing whether property sale and leaseback is right for them.

Although initially, some operators found it uncomfortable moving on from the status quo, once they had done it, they wondered why they didn't consider this strategy in the past.

2. Expanding into new areas of operation

Diversification has always been another prevalent strategy to achieve growth.

NAB Health sees an increasing interest from aged care providers to introduce or improve services in home care. This is unsurprising as we know that more people are staying at home for longer and with much encouragement from the government.

The government has a target of 140,000 home care packages by 2021–22, which means an additional 68,000 packages need to be allocated between now and 2021–22.[2] While this represents an excellent opportunity in home care services, it means that providers will need to be very clear on their service delivery model and overall value proposition, in what will be a far more competitive market. Providers looking to diversify will also need to consider the amount of funding required to meet technology and back-end organisation needs, in order to run an efficient operation.

3. Alternative investment strategies for refundable accommodation deposits (RADs)

For most aged care operators, the investment capital and interest earned from their refundable accommodation deposits (RADs) is very important to their operational performance. In the current investment environment, aged care operators with well-structured investment management strategies are investing their RADs in diversified and conservative portfolios. This is generating returns which assist them to improve their services to residents and to better meet their mission statements.

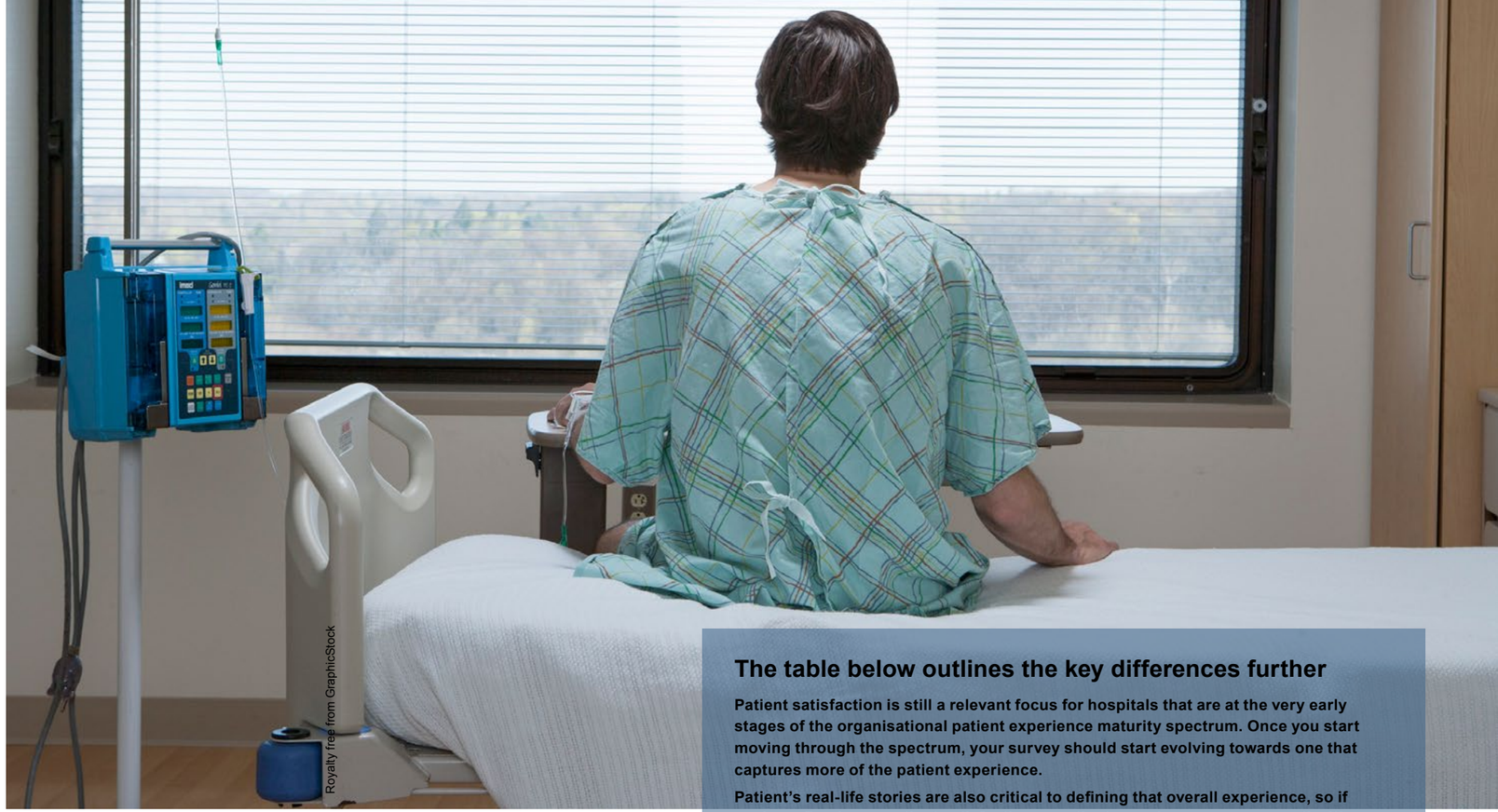
Overall, Australia's healthcare and social assistance sector has been growing at a rate of 3.6% year on year, faster than the pace of the national economy, recorded at 3.3% year on year. In addition, an aging population, advancements in medical technology and improved health awareness in the community suggest very good long-term prospects for the industry.

While the healthcare industry will continue to evolve with increasing demand, aged care operators need to leverage this window of growth opportunity now and revisit their business strategies in order to create better financial outcomes, as well as bring more value to patients and consumers. ha

1. 2015 Intergenerational Report
2. Aged Care Financing Authority's 2016 Report on Funding and Financing of the Aged Care Industry

You are the patient experience

Clarifying the difference between patient satisfaction and patient experience.
Dr Avnesh Ratnanesan, CEO of Energesse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I was fortunate enough to attend the Beryl Institute Conference on Patient Experience in Dallas Texas earlier this year. The Beryl Institute is one of the leading institutions worldwide on patient experience and over 1000 delegates were involved in the community gatherings as well as special interest communities on patient advocacy, pediatrics, and physicians.

Healthcare leaders discussed elements of supportive design from the University of California in San Francisco. The American Academy on Communication in Healthcare and Language of Caring conducted activities on relationship building with patients and strategy maps on effective improvement planning. Communications skills were regarded as advanced physician skills required for the current healthcare climate.

I witnessed an outstanding keynote from Cynthia Mercer discussing the importance of culture in an organisation and how staff want a purpose to work on, not a place to work in. Another keynote from TV show host and healthcare advocate Montel Williams captivated the audience with his inspiring message of overcoming the odds through his personal experiences within the US health system.

"These terms — patient satisfaction and patient experience — are used interchangeably, but they are different. Deciding which of these two aspects to measure is important in ensuring that you get to the crux of the patient issues you are investigating."

He emphasised some of the major healthcare challenges coming in the next few years with predicted acute staff shortages and rising demands from patients with chronic disease. Consumers and patients will still expect a good experience, despite these issues and they will be vocal about it, both in-person and online, so get ready for that!

A question that seems to require clarification is what is the difference between patient satisfaction and patient experience?

Whilst I'm not one for soft drinks, this example of how important the difference is, comes to mind. In the mid-1980s, to address a dropping market share, the Coca-Cola Company replaced the original-formula Coke with a sweeter 'New Coke' now infamously known as a 'huge mistake'!

While a blind taste test with 200,000 consumers had validated New Coke, the consumers had not been asked if they would give up the original Coke for the New Coke. The Coke 'experience' had not been considered i.e. there was no measurement of the symbolic value and emotional involvement consumers had with the original Coke.

Measuring certain elements of consumer preferences is one thing, holistically understanding the consumer is another. In the case of healthcare, the surveying process itself (not just the action taken based on the survey outcomes) should be continuously refined to reflect the evolving consumer, the modified hospital settings and the dynamic healthcare industry.

Often when we talk about how to measure the patient experience, we are often referring to how to improve on their patient satisfaction surveying methods. These terms — patient satisfaction and patient experience — are used interchangeably, but they are different. Deciding which of these two aspects to measure is important in ensuring that you get to the crux of the patient issues you are investigating. ha

1. 'Coca-Cola Lost Millions Because of this Market Research Mistake', Scott Smith, PhD, Jan 21 2013, www.qualtrics.com/blog/coca-cola-market-research

2. 'The Point of Care - Measures of Patients' Experience in Hospital - Purpose, Methods and Uses' - The Kings Fund - Coulter, Fitzpatrick and Cornwell, July 2009https://www.kingsfund.org.uk/sites/files/kf/Point-of-Care-Measures-of-patients-experience-in-hospital-Kings-Fund-July-2009.pdf

3. 'Review of Patient Experience and Patient Satisfaction Surveys conducted within Public and Private Hospitals in Australia' - Australian Commission of Safety and Quality in Healthcare, 2012http://www.safetyandquality.gov.au/wp-content/uploads/2012/03/Review-of-Hospital-Patient-Experience-Surveys-conducted-by-Australian-Hospitals-30-March-2012-FINAL.pdf

The table below outlines the key differences further

Patient satisfaction is still a relevant focus for hospitals that are at the very early stages of the organisational patient experience maturity spectrum. Once you start moving through the spectrum, your survey should start evolving towards one that captures more of the patient experience.

Patient's real-life stories are also critical to defining that overall experience, so if you've refined your patient satisfaction or patient experience survey recently, it's important to integrate all the data from your surveys, with patient stories and action them in real-time as much as possible. There are now technologies in Australia that can help you collect all this data in real-time, analyse patient emotions and pain points, and enable much more rapid action in primary and secondary care settings.

PATIENT SATISFACTION MEASUREMENT	PATIENT EXPERIENCE MEASUREMENT
DEFINITION: The degree to which the individual regards the health care service or product or the manner in which it is delivered by the provider as useful, effective or beneficial (Uni Lib of Med US)	DEFINITION: The sum of all interactions, shaped by an organization's culture that influence patient perceptions across the continuum of care (Beryl Institute)
ONE-DIMENSIONAL: Usually measuring hospital performance through one survey with limited domains/areas surveyed	HOLISTIC: Measuring hospital performance over a range of areas using multiple survey methods with wider range of domains surveyed
FOCUS: Meeting the clinicians' or managers' agenda	FOCUS: Issues that are most important to patients
SUBJECTIVITY: Responses driven by a patient's demographics/characteristics	HOSPITAL EXPERIENCE: Questions ask patients to report on their visit in detail
QUESTION DESIGN: May not give the patient an opportunity to give detailed comments about specific aspects	QUESTION DESIGN: Allows patients to provide details of a particular service, clinician or event/experience
SOME BIAS: Typically gets positive outcomes, at some expense of actual experiences	LESS BIAS: Gets factual, granular responses on actual experiences
EXAMPLE: 10-15% rated frontline service communication levels at 3/10	EXAMPLE: Clear details of frontline communication skills around a hospital episode

A date with PROSTMATE™

Australian prostate cancer app guides rural and remote men through patient journey.

Australian Prostate Cancer Research CEO Mark Harrison

An unmet need for men and families afflicted with prostate cancer drove the development of an Australian app which recently won a $32,840 international support grant.

Australian Prostate Cancer Research (APCR) developed the free PROSTMATE™ app in 2014, and CEO Mark Harrison is hopeful the grant will allow the team to press forward into the next phase.

"A lot of men, particularly in rural and remote areas, don't have access to any authoritative support and information following their diagnosis and during their treatment," Mr Harrison told *The Health Advocate*.

"The PROSTMATE™ app provides that authoritative information on treatment and diagnosis so men have a better idea of what they can expect and what they need to do."

The app is also a boon to specialists and clinicians, as it allows a patient to track their treatment history and sessions, and even log their mood and wellbeing during visits.

"Having all that information easily accessible allows clinicians to provide better-tailored care, particularly if a patient only goes to see a specialist once every three months or so," Mr Harrison said.

Rural-based users can even undertake a remote video consultation with APCR's team of prostate specialists from their own home.

The app also provides support for loved ones and family through its partner programs which allows them to join the patient journey.

PROSTMATE™ clinched one of two first prizes during a red-carpet announcement at the European mSociety of Medical Oncology (ESMO) Annual Congress in Copenhagen, Denmark. The Astellas Oncology C3 prize is a global challenge designed to inspire non-medicine innovations to improve the cancer care experience for patients, carers and their loved ones.

Attracting more than 100 C3 Prize entries from patients, carers, health care providers and technology entrepreneurs worldwide, PROSTMATE™ was recognised as one of only three winning entries.

"This award demonstrates Australia's leadership in developing world-class solutions for cancer care," Mr Harrison said.

"We are grateful to Astellas Oncology for leading the charge in changing cancer care for men across Australia."

Mr Harrison said the grant would finance the next phase of the app's development, which would involve further integration into clinical care and more telehealth involvement.

Along with two other international entries, Mr Harrison was named one of three inaugural C3 Prize winners after five finalists pitched their ideas live at Stanford University's Medicine X to a panel of judges, including Robert Herjavec, dynamic international entrepreneur, and star of the US- and Canadian-based television shows Shark Tank and Dragon's Den, respectively.

According to Mr. Herjavec, who chose to partner with Astellas Oncology as a judge following his personal experience as a carer for his mother who died from ovarian cancer in 2007, the winning submissions were assessed on plausibility, creativity and originality, and ability to operationalize/implement the innovative idea for future application.

"Based on my personal experience, PROSTMATE™ addresses major unmet needs, such as using technology to connect patients and the healthcare community when physical distance can be cumbersome," said Mr Herjavec.

According to Osamu Takenoya, Managing Director of Astellas Australia, the C3 Prize was designed to discover fresh non-treatment ideas and potential solutions from those with firsthand experience of the challenges patients and carers face on a daily basis.

"With the increasing diagnoses of cancer in Australia, there is a need for innovative tools and resources that may aid patients living with cancer and their carers to improve their quality of life," said Mr. Takenoya. ha

FRAN KILLOWAY
Chairman
Aspirante Foundation

Aspirante Foundation campaign to help people with disabilities

ABLE100 campaign will give away 100 free software licences to help people living with disabilities.

The Aspirante Foundation will give away 100 free software licences to people living with specific disabilities in the Greater Sydney area.

"We are excited to be able to share this software with members of our community living with disability. Through ABLE100, we want to open up communication, remove frustration and make a difference by providing tools which can assist with the everyday tasks which can become extremely challenging and overwhelming when living with disability," said Fran Killoway, Chairman of the Aspirante Foundation.

ABLE100 is a pilot program that will target specific users with disabilities including but not limited to amyotrophic lateral sclerosis (ALS) and motor neurone disease (MND), advanced stages of Multiple Sclerosis (MS), Parkinson's disease, muscular dystrophy or those suffering from the effects of stroke.

The software also has the capacity to assist those individuals living with Down Syndrome, Autism, Dementia and Alzheimer's Disease as well as providing support in the education, special needs and aged care sectors.

The Foundation and the ABLE100 campaign team will work closely with each user to understand more about their needs while testing the functionality of the software.

For the 100 licence recipients, the software will be available to them free of charge for as long as they need it, with the only requirement being daily use to understand how it meets their requirements.

"ABLE100 is a pilot program that will target specific users with disabilities..."

Designed to work across all operating systems and a range of hardware devices, ABLE100 offers 100 individuals the chance to interact with the software free of charge and encourages them to provide feedback on its functions and suitability, in line with each user's individual needs because it is not a one size fits all.

The Aspirante Foundation says ABLE100 offers more choice to people living with disabilities through new opportunities, alternative communication tools, assistance with everyday tasks and ultimately promotes social inclusion, helping to make families whole again.

Killoway notes the ABLE100 software is a sophisticated yet user-friendly platform which can be modified to suit the specific needs, lifestyle and requirements of the individual. A series of preferences allows each user to customise the presentation of information to match their cognitive and dexterity capabilities, using Apps and assistive tools such as cameras, switches and narrators in one place.

As an example, for a user who cannot speak, ABLE100 software will enable them to use the computer to speak on their behalf to communicate with friends, carers and others either by voice or email. This can assist with communication in many areas including: My Voice, My Needs, My Routine, My Fun, My Internet and My Self. These can be accessed even if a user is unable to use either a keyboard or a mouse.

The Aspirante Foundation is an Australian charity which was established principally to provide direct relief to people with disabilities and the disadvantaged by giving them access to technology and the internet. Access to technology and the internet facilitates social inclusion for people with disabilities.

The Aspirante Foundation is undertaking its work by firstly providing people with disabilities with the Frasil Browser. The Frasil Browser allows members of the community living with disability to use a computer or access the internet either for the first time or with greater ease. The Aspirante Foundation will also provide other technology solutions for the disadvantaged.

As Chairman of the Foundation, Killoway views her work as something that is vital, rather than optional.

"People with disabilities are just people, they deserve the same opportunities in life as everyone else, the same access to the internet, to entertainment and social networking, and most importantly, the freedom to make decisions about their daily lives, and to communicate with their loved ones and carers."

"This is a fantastic opportunity for those living with disability to trial the software and provide valuable feedback to the Aspirante Foundation." ha

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If you, or someone you know is living with or caring for someone with these disabilities, please visit www.aspirantefoundation.org to complete the online form. The Foundation will assess your suitability and respond to you directly.

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Breaking up is hard

Splitting your super doesn't need to be.
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With more than 25 years of experience and $34 billion in assets, more people in health and community services choose HESTA for their super.

The end of a relationship can be an emotional and traumatic time. You may feel anxious or overwhelmed about such a big change in your life. But it's important to know there are lots of places you can go for help.

Start by sorting out a few simple things, like your household budget, then work your way up to tackling the bigger money issues.

Your super fund can help you understand how your super balance fits in.

Where your super stands

When a marriage or de facto relationship breaks down, your super is treated like any other asset. It can be divided (by agreement or court order) and your spouse may receive some or, in some circumstances, all of your super.

Your spouse can request information about your super and your fund's Trustee is legally obliged to respond to the request and give effect to any agreement or court order.

Splitting laws cover the entire super account-splitting process, which requires Trustees to:

- provide initial information to an eligible person who enquires about the value of a super benefit
- flag an account so no payment can be made until the flag is lifted
- split a super benefit between the parties of the relationship, either by agreement or by court order.

Remember, splitting doesn't convert super into a cash asset. It's still subject to superannuation laws and is usually retained until retirement ages are reached.

Support for HESTA members

You might be surprised about how much support you can get as a HESTA member.

HESTA members have access to personal super advice at no extra cost. So, if you'd like to discuss your circumstances and options with an expert, call 1800 813 327. Our advice team will be happy to help.

The HESTA education team runs Money Makeover workshops with ME Bank to help members make — and stick to — a household budget and pass on money saving tips.

Our education and advice team can also discuss simple strategies to help you rebuild and keep your super on track. Even $10 extra per week can have a big impact on your balance over time.

Getting back on your feet

- Visit **hesta.com.au** or call us on 1800 813 327 for more about super splitting, boosting your balance and the advice available to members.
- Check out the comprehensive suite of education modules — available at **hesta.com.au/money101** — developed by Money101, an independent provider of financial education. The simple interactive modules have been designed to help HESTA members make more informed financial decisions.
- **moneysmart.gov.au** is a government website offering independent tips and tools to help you make the most of your money — inside and outside super.
- Read more about the super splitting process at **familylawcourts.gov.au**
- The Attorney General's Department has frequently asked questions on super splitting at **ag.gov.au** ha

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

The 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*). ha

To learn more about these and other benefits of membership, visit www.ahha.asn.au

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 2015-2016 Board is:

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Sydney Children's Hospital Network

Dr Paul Burgess
NT Health

Mr Jeff Cheverton
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Dr Deborah Cole
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Ms Gaylene Coulton
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Mr Walter Kmet
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Mr Adrian Pennington
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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**

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Ms Sue Wright
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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:

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Editor in Chief

Dr Simon Barraclough
Associate Editor, Policy

Prof Christian Gericke
Associate Editor, Models of Care

Prof Sonj Hall
Associate Editor, Health Systems

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The AHHA is grateful for the support of the following companies:

- HESTA Super Fund
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ISSN 2200-8632

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