The Health Advocate

ISSUE 16• October 2012

The official magazine of the Australian Healthcare & Hospitals Association

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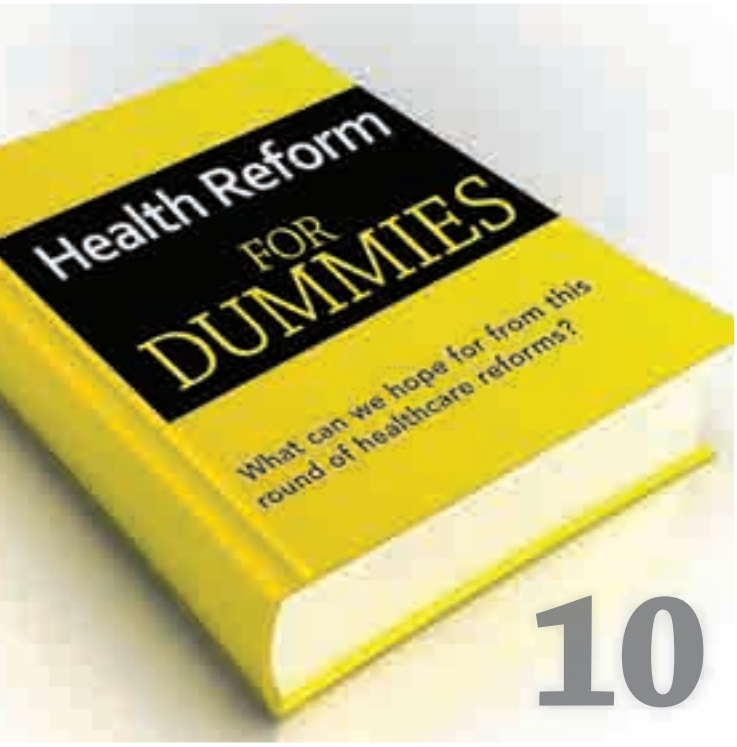

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From the AHHA desk

DR PAUL SCOWN
President of the Australian Healthcare and Hospitals Association

Voicing your concerns

The AHHA has been busy **representing you** across a range of **national issues**

BY THE time of publication, our annual conference will be well underway and many of you may be reading this while you are there.

This year, we have chosen the theme of 'measurement' and have applied this in many different ways with various topics and speakers throughout the packed program. The conference is titled 'The Quantum Leap: measurement - redefining Health's boundaries'. AHHA has partnered with the Australian Council on Healthcare Standards and the Women's and Children's Hospitals Australasia. Since I last wrote to you, the AHHA has continued to represent you across a range of activities. I would like to give you a quick update on three of these activities.

Oral and dental health

After nine years of campaigning for a public dental program, AHHA welcomed the Commonwealth Health Minister's announcement, on Wednesday 29 August, of a substantial dental package which supports all children whose families are eligible for Family Tax Benefit Part A and low-income adults who are most in need of dental care.

Health Minister Tanya Plibersek is to be congratulated for achieving this major win for the most needy in our community, and acknowledgement must also go to former Health Minister Nicola Roxon and the Greens for their important roles in delivering this package.

AHHA views this announcement as a solid foundation on which to build a Universal Oral and Dental Health Scheme for all Australians, similar to Medicare. We will now focus on the details of implementing the initiative.

Climate change

The AHHA publically supported a joint Climate and Health Alliance and Climate Institute Report titled 'Our Un-cashed Dividend: the health benefits of climate action', which was launched at The Canberra Hospital on 15 August. This report received considerable media attention. It is available on the AHHA website.

In conjunction with the Climate and Health Alliance, we convened the first Greening the Health Sector Policy Think Tank in Sydney on 22 August. The Think Tank asked: How can the health care sector in Australia play a leadership role in the transition to a 'clean energy future' by reducing its environmental footprint? The lead speaker was Professor Peter Orris from the USA, a Senior Advisor to the international organisation Health Care Without Harm. We hope to start an important conversation about how hospitals and healthcare providers can reduce their own carbon footprints. The Australian health system can be strengthened through the promotion of greater sustainability and improved environmental health. A Policy Issues Brief on this topic was drafted for the AHHA's Institute, and is available on the AHHA's website.

Refugee employment in health

A Policy Network, which AHHA jointly hosted with the Victorian Adult Migrant Education Service, developed a position paper (available on our website) with the aim of securing funding for employment pathways into health jobs for refugees.

We are now embarking on a series of meetings with politicians and bureaucrats at Federal and state levels to recommend the establishment and funding of demonstration projects that build on the knowledge and experiences of hospitals such as Calvary Hospital, Canberra and St Vincent's and Mater Hospitals, Sydney.

Essentially the pilot projects would trial, evaluate and expand successful, innovative refugee employment initiatives in these and other hospitals and health services. The objective is to document and share successful practice so that others in the sector can implement similar initiatives. The proposed pilot projects would take an industry based perspective, document the English skills, critical vocational skills and work experience required for sustainable employment. Commitment, including funding, from government will be required. ha

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Osmolality: approx. 1800mOsm/kg water. Osmolarity: approx. 1500mOsm/L. pH (after mixing): approx. 5.6. ***Excipients: Glycerol, Egg lecithin, dl-α-Tocopherol, Sodium hydroxide, Sodium oleate, Acetic acid - glacial, Hydrochloric acid, Water for Injections. **INDICATIONS:** Parenteral nutrition for adult patients when oral or enteral nutrition is impossible, insufficient or contraindicated. **CONTRAINDICATIONS:** Hypersensitivity to fish-, egg-, soya- or peanut protein or corn (maize) and corn products or to any of the active substances or excipients, severe hyperlipidaemia, severe liver insufficiency, severe blood coagulation disorders, congenital errors of amino acid metabolism, severe renal insufficiency without access to hemofiltration or dialysis, acute shock, uncontrolled hyperglycaemia, pathologically elevated serum levels of any of the included electrolytes; general contraindications to infusion therapy: acute pulmonary oedema, hyperhydration, and decompensated cardiac insufficiency; haemophagocytotic syndrome, unstable conditions (e.g. severe post-traumatic conditions, uncompensated diabetes mellitus, acute myocardial infarction, stroke, embolism, metabolic acidosis, severe sepsis, hypotonic dehydration and hyperosmolar coma). **PRECAUTIONS:** Monitor triglyceride levels to prevent overdose, which may lead to fat overload syndrome. Give with caution in conditions of impaired lipid metabolism which may occur in patients with renal failure, diabetes mellitus, pancreatitis, impaired liver function, hypothyroidism and sepsis. The medicinal product contains soya oil, fish oil, egg phospholipids and corn (maize) and corn products which may rarely cause allergic reactions. Cross allergic reaction has been observed between soya-bean and peanut. Disturbances of electrolyte and fluid balance should be corrected before starting the infusion. Give with caution to patients with a tendency towards electrolyte retention. In patients with renal insufficiency, the phosphate and potassium intake should be carefully controlled to prevent hyperphosphataemia and hyperkalaemia. Parenteral nutrition should be given with caution in lactic acidosis, insufficient cellular oxygen supply and increased serum osmolarity. Stop infusion immediately at any sign of anaphylactic reaction. In malnourished patients, slow initiation of parenteral nutrition is recommended as it may precipitate fluid shifts resulting in pulmonary oedema and congestive heart failure, and decrease in serum potassium, phosphate, magnesium and water soluble vitamins. *Smof* Kabiven is not to be given simultaneously with blood in the same infusion set due to risk of pseudo-agglutination. Monitor laboratory tests regularly including: serum glucose, electrolytes and osmolarity, fluid balance, acid-base status and liver enzymes. Blood cell count and coagulation should be monitored when fat is given for a longer period. Special clinical monitoring is required at the beginning of any intravenous infusion. The fat content of *Smof* Kabiven may interfere with certain laboratory measurements (e.g. bilirubin, lactate dehydrogenase, oxygen saturation, haemoglobin) if blood is sampled before fat has been adequately cleared from the bloodstream. **PREGNANCY AND LACTATION:** There are no adequate and well controlled studies in pregnant women, therefore the safety is not known. It is not known whether *Smof* Kabiven can enter maternal milk, therefore it should only be used during lactation if clearly needed. **ADVERSE REACTIONS:** Slight increase in body temperature, chills, dizziness, headache, lack of appetite, nausea, vomiting, elevated plasma levels of liver enzymes, tachycardia, dyspnoea, hypotension, hypertension, hypersensitivity reactions (e.g. anaphylaxis, skin rash, urticaria, flush), heat or cold sensation, paleness, cyanosis, pain in the neck, back, bones, chest and loins. **DOSAGE AND ADMINISTRATION:** The patient's ability to eliminate fat and metabolise nitrogen and glucose and the nutritional requirements should govern the dosage and infusion rate. The dose should be individualised with regard to the patient's clinical condition and body weight (bw). SEE FULL PRODUCT INFORMATION FOR MORE INFORMATION. <u>Dosage:</u> The dosage range of 13mL-31mL/kg bw/day covers the need of the majority of patients. Obese patients should be dosed based on estimated ideal body weight. The recommended maximum daily dose is 35mL/kg bw/day. *Smof* Kabiven is not recommended for use in children. <u>Infusion rate:</u> The infusion rate should not exceed 2.0mL/kg bw/h (corresponding to 0.25g glucose, 0.10g amino acids and 0.08g fat/kg bw/h). The recommended infusion period is 14-24 hours. <u>Method of and duration of administration:</u> Intravenous infusion into a central vein. The contents of the three separate chambers have to be mixed before use. *Smof* Kabiven should be used within 24 hours of preparation. **STORAGE CONDITIONS:** Store below 25°C. Do not freeze. Store in overpouch. Based on TGA Approved Product Information 20 January 2012.

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AHHA in the news

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We'd like to hear your opinion on these or any other healthcare issues. Write to us at **admin@ahha.asn.au** or **PO Box 78, Deakin West, ACT, 2600**

Dental package leaves health services smiling

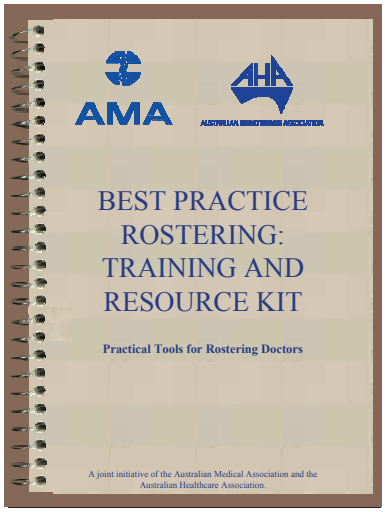
THE GOVERNMENT'S dental package of $4.6 billion will give the most vulnerable Australians something to smile about. After nine years of campaigning for a public dental program by the AHHA, we welcomed the announcement of this substantial dental package, which supports those who most need assistance.

Ultimately, AHHA would like to see a Universal Oral and Dental Health Scheme for all Australians, similar to Medicare. However, we acknowledge that this is difficult to achieve in the current economic climate and we see this announcement as a solid foundation on which to build in the future.

Plain packaging a breath of fresh air for hospitals

THE AHHA welcomed the decision by the High Court to uphold the Government's plain tobacco packaging legislation. "Nicola Roxon and the Government are to be congratulated on this win for public health which ensures that Australia continues to lead the world in tobacco harm reduction policies," said Prue Power.

"One of our great public health success stories of recent decades has been the massive shift in community attitudes towards tobacco use and a consequent reduction in the health and social impact of smoking. While smoking rates are now at historic lows, it is vital that we continue this progress by reducing the capacity of the tobacco industry to market their products, in particular to young people."



Safe hospitals need safe hours

THE AHHA welcomed the focus on safe working hours from the Australian Medical Association in its annual survey on this issue. To help support hospitals, some years ago AHHA collaborated with the AMA to develop the *Best Practice Rostering: Training and Resource Kit*. This is a valuable resource for public hospitals around Australia to assist them in planning their rosters to promote safe working hours for their staff.

It can be downloaded free from **ama.com.au/node/4068**

Australian launch of Global Green and Healthy Hospitals Network

A NEW global network of hospitals and healthcare organisations working together to reduce the environmental footprint of the healthcare sector internationally was launched in Sydney in August at an AHHA policy forum on greening the health care sector. It was one of a rolling series of launches taking place around the world in 2012.

The network was launched by Professor Peter Orris, Senior Advisor to Health Care Without Harm, which has led the establishment of the Network.

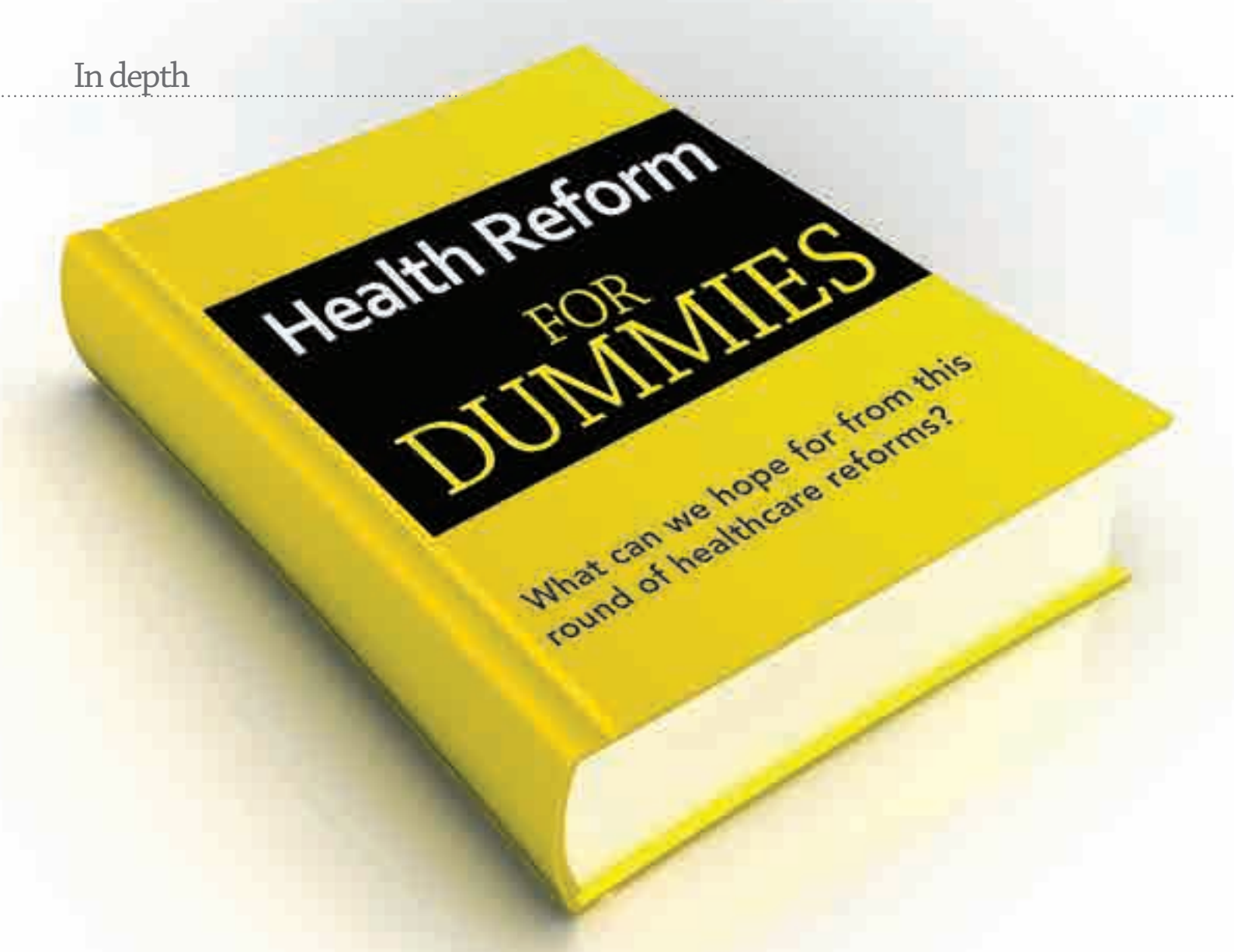
He said: "It's fantastic to see the AHHA become a founding member of this network. There is great enthusiasm for this network around the world with organizations representing over 5000 hospitals and health care settings already signed up globally."

Electronic health records debut

THE AHHA welcomed the commencement of Personally Controlled Electronic Health Records (PCEHRs) and urged consumers, healthcare providers and governments to support this new initiative to ensure it delivers maximum benefits to the health of the community. PCEHRs have the potential to significantly improve the effectiveness and efficiency of health care in Australia. If implemented properly, PCEHRs will result in more coordinated and better targeted care for consumers.

Carbon reduction a healthy choice: new report

THE AHHA welcomed a new report into the health benefits of climate action. Our *Uncashed Dividend: The Health Benefits of Climate Action* is jointly produced by the Climate and Health Alliance, a national coalition of health groups, including the AHHA, and The Climate Institute. Our current polluting practices cost Australia billions of dollars every year in health costs. This important report explains the health impact of climate change and shows how we can improve the health of Australians and save billions of dollars by cutting carbon pollution. ha



HEALTH REFORM is undertaken periodically in the advanced economies because of changes in demography, technology, politics or society's values. It is usually incremental and, as in the current case of reform in Australia, the initial objectives are met only partially because of political compromises.

Reform in Australia is always difficult because of the fraught nature of Commonwealth/state relations. The flavor of the current reform processes is documented in National Partnership Agreements between the Commonwealth and the states and territories.

It will be interesting to assess now what we might expect from the current suite of reforms and score our progress in five or 10 years.

Local Health Networks

From 1 July 2012 we have local hospital networks – a system of devolved governance which is intended to give communities greater control over hospital and community-based health services. It is also intended to give clinicians a greater say in the governance and management of health services.

The best we can hope for: A feeling of community ownership of health services, characterised by local involvement in planning, contribution to priority setting, understanding of rationing and rationalisation of services, and a vigorous, informed debate in the community about the future of services.
We'd settle for: Tokenism that doesn't harm the work of health services.
We need to avoid: Parochial priority setting and political battles waged in the local media that distract governing bodies, clinicians and management from their duties.

Activity-based funding

Activity-based funding of acute services is intended to drive greater equity and openness in funding and efficiency. It is the worst way to fund acute health services, except for all the other ways.
The best we can hope for: Real openness in funding, improved equity in funding, greater efficiency and rationalisation of some services which are financially unsustainable.
We'd settle for: Openness.
We need to avoid: A quasi-market that encourages decisions that are at odds with community values, and dogmatic application of a national efficient price which renders efficient services unviable.

National performance monitoring

Performance monitoring is essential to informing decision-makers and the community about the effectiveness and efficiency of their health services. In practice, every performance measure is criticised, especially by those closest to the issue being measured. Mannion and Braithwaite[1] identify 20 'salutary lessons from the English National Health Service' under the headings: poor measurement; misplaced incentives and sanctions; breach of trust and politicisation of performance systems. Performance measures are now published online.
The best we can hope for: Measurable, improved performance in selected areas, reduced variation in performance among health services and improved understanding at political, management and community levels of what is good performance without collateral damage.
We'd settle for: Absence of collateral damage.

GRAEME HOUGHTON
Chair, Tasmanian Health Organisations; Adjunct Associate Professor, School of Public Health, Faculty of Health Sciences, La Trobe University

We need to avoid: Significant, widespread, adverse unintended consequences, extensive gaming, measurement fixation, tunnel vision and the other risks identified by Mannion and Braithwaite.

Medicare Locals

It is hoped that Medicare Locals will help strengthen primary care and rebalance primary, secondary and tertiary care. In particular, they will strengthen after hours primary care services and strengthen continuity and comprehensiveness of care.
The best we can hope for: Measurable improvement in after-hours services, reduced attendance at emergency departments for category 4 and 5 patients.
We'd settle for: Some innovative trials of new models of care.
We need to avoid: Funds being applied to Medicare Locals without results being evaluated.

Australian National Preventive Health Agency

The best we can hope for: Significant, measurable reductions in the burden of disease as a result of some major, sustained, cost effective initiatives which are integrated with each other and the broader health services.
We'd settle for: Measurable reductions in the burden of disease for targeted groups.
We need to avoid: Funds being spent on programs that are not cost-effective, with priorities being determined by pressure groups.

E-health

The best we can hope for: Improved efficiency, safety and effectiveness through availability of: fully electronic patient histories organised to meet the immediate needs of clinicians anywhere, any time; decision support for clinicians, anywhere, any time; ordering of investigations and review of results anywhere, any time; medication management; access by citizens to their own history anywhere, any time.
We'd settle for: An electronic health record and medication management.
We need to avoid: A fragmented approach in which different jurisdictions and agencies work along their own trajectories – ie a replication of the 19th Century railway gauge problem.

Health Workforce Authority

There are many examples of innovative and very effective use of skilled clinicians undertaking tasks outside their customary professional roles in accordance with best practice guidelines and under appropriate supervision. They are usually isolated innovations which are dependent on leadership by individuals and interpersonal relationships and are not widely adopted.
The best we can hope for: Improved efficiency, safety and effectiveness through the application of appropriate skills to clinical tasks in accordance with evidence and best practice rather than occupational boundaries.
We'd settle for: A few large-scale, evaluated, systematic innovations in use of skills.
We need to avoid: Inflexible commitment to traditional demarcation of professional roles.

Dental health

The best we can hope for: Regular preventive assessment and treatment for all Australians, regardless of means.
We'd settle for: Regular preventive assessment and treatment for all children and low-income adults. After nine years of campaigning, the Commonwealth Government has announced an entitlement scheme for around 80 percent of children who will receive $1,000 every two years (worth $2.7 billion over four years) and an additional $1.3 billion (over four years) for states and territories to provide dental care to low-income adults.
We need to avoid: regarding dental care as less important than other forms of primary health care.

Mental health

The best we can hope for: Urgent assessment and treatment of all psychological and psychiatric crises; continuing case management for all chronic mental illness; elimination of mental illness as a cause of imprisonment; elimination of discrimination and stigma on the grounds of mental illness.
We'd settle for: Nationally consistent service planning framework supplemented by well-funded public mental health programs in all state and territories to ensure predictable, uniform, timely, community-based and integrated services for people with mental illness.
We need to avoid: Regarding mental health as less important than other forms of health care.

Closing the Gap

The best we can hope for: No significant difference between life expectancy and other health indicators for Indigenous and other Australians.
We'd settle for: Nothing less.
We need to avoid: Defeatism. ha

Reference

1. www.ncbi.nlm.nih.gov/pubmed/22616961

Reflecting on the US experience, there is a lot to be **grateful for** and much to be **proud** of in Australia

Health reform & broccoli

SINCE LABOR came to government federally in 2007, Australia has been grappling with the tricky business of health reform – how to provide universal access to high quality health services to an ageing population; how to deal with the rapidly growing burden of (mostly preventable) chronic disease and how to ensure our hospitals and other health services are properly and sustainably funded for the long term. Australia is not alone: these same questions are confronting governments around the world.

Health reform has been at the centre of heated, often bitter political debate in the United States for almost all of President Obama's current term of office. After a protracted congressional debate, the Patient Protection and Affordable Care Act was signed into law in March 2010. Almost immediately, legal challenges brought by opponents of the reforms got underway. These culminated in a case before the US Supreme Court, which was heard earlier this year. The Court's decision in June to uphold the most important aspects of the health reform laws was therefore a momentous one.

DR ANGELA PRATT
Health and public policy consultant

"We live in a society where the basic right of universal access to health care is no longer at issue. And to get to this point, the highest court in our land didn't need to spend three days talking about broccoli"

The 'Obamacare' reforms are designed to extend health insurance to the approximately 50 million Americans who currently have no coverage at all. This demographic includes what we might call 'working families' in Australia: people in work – so not poor as to qualify for Medicaid (for some people on very low incomes), or Medicare for the elderly and disabled – but not in jobs where insurance is provided by their employer or where they can afford to buy it themselves. It also includes a sizeable group of people who are considered 'uninsurable' and have been denied health insurance by insurance companies.

The most important element of the Obama reforms is the requirement for people who don't have health insurance to purchase it. This would be accompanied by subsidies provided to assist people on low and middle incomes with the cost of buying insurance and new laws to prevent insurers denying coverage to people with pre-existing conditions, or dropping someone's insurance when they get sick. People who don't purchase insurance will face a tax penalty.

It is this 'individual mandate' to purchase health insurance which will extend coverage to the tens of millions of Americans currently uninsured. It was the most contentious aspect of the reforms and was at the centre of the Supreme Court challenge to Obama's reforms.

I was in the US earlier this year when the Supreme Court was hearing the constitutional challenge to President Obama's health reform laws brought by a number of state attorneys general. Some of the arguments made in that case as to why Obama's reforms should be struck out by the Court as unconstitutional would make an Australian's mind boggle.

The main argument made by the opponents of the reforms is that the 'individual mandate' to make people buy something is an unacceptable expansion of the Congress's powers to legislate. If Congress can legislate to make people buy health insurance, what else can it legislate to make them buy? Broccoli? Where will the violation of individual rights and free choice end?

That's right – the question of whether the Obama reforms are the thin edge of the wedge that could result in people being forced to buy broccoli was actually debated, apparently at length, during the three days of hearings. (Google 'Obama Supreme Court health care and broccoli' and you will see what I mean.)

I was reading the newspaper coverage of the hearings one day on the subway in New York, when a woman stepped into the train carriage begging for money. She was begging because she suffered from Multiple Sclerosis and could not afford the medication she needed to treat and manage her condition. Because of the disabling nature of her condition, especially without the medication she needed but couldn't afford, she was finding it hard to get a job. Because she didn't have a job, she couldn't get insurance. Because she couldn't get insurance and didn't have a job, she was struggling to look after her children.

As I read more about the hearings over the next few days, I thought a lot about the woman on the subway. I wondered what she thought about the argument that her individual liberties were being violated by reforms designed to ensure she has health insurance which would provide her with access to services and medicines to help manage her disease. And I thought about the choices the current system was providing her with – like the choice of whether to use the money she'd raised begging on the subway to buy essential medication, or to feed her kids.

Coming from Australia, the fact that such a large part of the American body politic remains so staunchly opposed to universal health care is genuinely perplexing. I don't really understand how it can seriously be argued that a scheme which will provide health insurance for everyone can be viewed as an infringement of individual liberties. Surely the opposite is the case – the absence of universal health care means not every citizen is free to exercise their individual liberties, because as in the case of the woman I met on the subway shows, their lack of access to that most basic of enablers, health care, so often prevents them from doing so.

Australia's health system isn't perfect. The national health reforms put in place by Labor since 2007 probably aren't perfect either – that's the nature of the political and legislative process through which they were established. But reflecting on the US, there is a lot to be grateful for and much to be proud of in Australia. Thanks to important reforms introduced by Labor governments past, we now live in a society where the basic right of universal access to health care is no longer at issue.

On the strength of this solid foundation, in the last few years while there has at times been robust debate over how reform is best achieved, there are very few people who argue it isn't necessary – to ensure an already world-class health system stays that way into the future. And while not all clinicians and providers agree with every aspect of Labor's reforms, there is a real sense in the sector that now is the time to get on with the job of making them work. And to get to this point, the highest court in our land didn't need to spend three days talking about the merits or otherwise of making people buy broccoli. ha

A version of this article originally appeared on the ABC's The Drum website.

Facilitating efficiency and **transparency**

The Independent Hospital Pricing Authority's **role and responsibilities**

THE INDEPENDENT Hospital Pricing Authority (IHPA) was established as part of the National Health Reform Agreement reached by the Council of Australian Governments in August 2011.

IHPA is independent of all governments but is bound by its legislation (National Health Reform Act 2011). It works with the Commonwealth, states and territories to implement a nationally consistent approach to activity based funding (ABF), which will facilitate greater efficiency and transparency in the funding of public hospitals. More specifically, IHPA is responsible for:

- determining the national efficient price (NEP) for healthcare services provided by public hospitals where the services are funded on an activity basis
- determining the efficient cost for healthcare services provided by public hospitals where the services are block funded
- publishing this and other information in a report each year for the purpose of informing decision makers in relation to the funding of public hospitals.

The Commonwealth Government will use the NEP to determine Commonwealth funding to Local Hospital Networks.
Key IHPA achievements to date:

DR TONY SHERBON
Chief Executive Officer,
Independent Hospital
Pricing Authority

"IHPA is committed to obtaining accurate activity, cost and expenditure data from jurisdictions on a timely basis"

- release of the first NEP Determination for 2012-13 at $4,808 per National Weighted Activity Unit
- release of the *Pricing Framework for Australian Hospitals*, providing a detailed explanation of how the NEP was determined
- publication of a *Three Year Data Plan* setting out plans to improve data quality and collection.

How was the pricing framework developed?

IHPA consulted widely with Commonwealth, state and territory governments through established advisory committees and undertook an extensive public consultation process to inform the NEP Determination 2012-13 and the final pricing framework.

In November 2011, IHPA commissioned a literature review that examined international best practice in ABF and payment reform. Following on from this a set of draft principles was released in January 2012, informed by a review of relevant intergovernmental agreements and legislation.

In February 2012, consultation meetings were held across Australia and nearly 100 written submissions were received on a discussion paper. This feedback was analysed and the draft principles were modified to develop the final pricing framework.

History of ABF and diagnosis related groups

Australia has had over two decades of experience in researching, planning and implementing ABF in public hospitals. The Commonwealth Government commissioned three studies[1] between 1988 and 1990 to identify approaches to the implementation of diagnosis related groups (DRGs) in Australia. Options examined included the Commonwealth funding public hospitals directly using open-ended DRG case payments; and the Commonwealth using DRGs as the basis for distributing capped hospital funding grants to states.

Five states have either implemented or are in the process of implementing Casemix (ABF) funding, but the models used have significant design differences.

Next steps for IHPA

To be able to set a NEP that accurately reflects the reality faced by public hospitals, IHPA is committed to obtaining accurate activity, cost and expenditure data from jurisdictions on a timely basis to meet its strategic objectives and statutory obligations. While there have been considerable improvements in the consistency of cost allocation methods applied across states in recent years, IHPA recognises that there needs to be further improvements.

The costing data used to set the national efficient price is annual cost data from the National Hospital Cost Data Collection. It provides the basic data that allows IHPA to cost each public hospital service.

However, the classification systems in use for Emergency Departments and for non-admitted services are being used for the first time, and the activity and costing data for these are less mature than for acute admitted hospital services. For this reason, both classification systems will be substantially reviewed and redeveloped in coming years.

This will include the revision of DRGs to meet the needs of the National Health Reform Agreement, including the development of a new classification system for mental health. IHPA has started work with the National Mental Health Commission, health departments across all jurisdictions, as well as clinicians, professional organisations, mental health carers and consumers to develop a pricing arrangement that will support contemporary models of mental health care.

For more information about IHPA and copy of the Pricing Framework please visit **www.ihpa.gov.au** ha

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Mental health is **important business**

Introducing Australia's new **National Mental Health Commission**

IT'S A GREAT responsibility to be the Chair of Australia's first National Mental Health Commission. In fact it's the greatest responsibility I've ever had.

While I believe that Australia has a good health system by international standards, it has two profound weaknesses: mental health, and Indigenous health – to which mental health is a very significant component. Mental health needs to be a higher priority for governments and the community at all levels. Mental health is important business.

The National Mental Health Commission is a new, independent body established to tell the truth about mental health services in Australia – the good and the bad, the gaps and the shortcomings. And it's of great significance that we are located in the Prime Minister's portfolio. The Commission is the first of its kind to have a national whole-of-government scope, and a whole-of-life view – from health to employment to housing to stigma and discrimination. This signifies a commitment at the highest level to our mandate, hopefully ensures we meaningfully engage with COAG on its Ten Year Road Map for Mental Health and gives us an opportunity for the Commission to provide independent advice, showcase successes and make a case for improvement to the highest level of government.

> **"Mental health needs to be a higher priority for governments and the community at all levels"**

Every Australian deserves to know how the 'mental health system' is performing and the contribution other sectors are making to people's lives. Later this year the Commission will produce its first Report Card. It is a short timeframe from our inception but the careful development of the Report Card will help us to understand how Australia is meeting people's needs, creating a baseline to track performance year on year. Over time the Report Card will create a case for change and continuous improvement.

Health Reforms

I want to now deal with an issue that can't wait till our first Report Card comes out. It is about avoiding untoward consequences from National Health Reforms, chiefly the Activity Based Funding one.

Under the reforms the Commonwealth will soon be paying 50 percent of the increase in state and territory hospital expenditure. This will give states major incentive to move mental health into hospitals. This reverses the work of many years in which we have been trying to keep people with mental illness out of hospitals wherever possible and supported to stay well in the community. Years of effort in moving to contemporary and innovative practice threaten to be undone.

We believe it is better for people to be treated in their community, very often by excellent non-government organisations, with links to services such as rehabilitation, housing and employment, rather than in hospital beds in a clinical or hospital setting, except in acute cases. They can also be with or near their families and friends. Costs are usually lower. This is a people centred approach that considers their whole life, not just health aspects.

The activity based funding focus on public hospital services also artificially slices up an ideal system of integrated, cross sector, community based support which should focus on what the person wants and needs, not where the money comes from.

Moreover, there are claims in the mental health community that mental health spending already has an undue bias towards hospital spending. Especially where there are expenditure cuts, many believe the first thing to go is community services and the last thing to go is hospital services, causing further imbalance. All of this makes the reforms of great concern.

Our concerns are compounded by the national pricing system reforms. Under Activity Based Funding, funding flows to hospitals on the basis of the average cost of each service. This works well for many health 'transactions' such as a standard knee operation, where operating theatre and bed times and other costs are often standard and undebatable. While the Commissioners broadly support the pricing reform agreed by the Council of Australian Governments (COAG) which tries to match dollars to need and demand and outcomes, we're worried about the application to mental health and you need to know about it.

First, it is unpredictable as to how long treatment can take. It may take a day, it may take 6 months. It is difficult to run an average pricing system in this setting. In addition, although a pricing system provides some powerful incentives for hospitals to work efficiently, there can also be some undesirable effects – undue pressure to get patients out of hospital quickly, even in standard clinical matters, gaming, and so on. Those undesirable side effects can be magnified with patients with mental illness.

If governments get the design of Activity Based Funding and its associated pricing wrong for mental health, it could drive investment and activity back into hospitals – going against the trend of the last decades – and seriously undermine effective and efficient care.

This, I believe, isn't consistent with the spirit of the COAG agreement, with evidence based best practice models or the most efficient use of highly sought after mental health funds.

The Independent Hospital Pricing Authority has issued their pricing framework and do seem to have heard us, as have the Government, which is very gratifying and we are pleased to be on their mental health working group.

But we are still concerned about how this will roll out, and will continue to be an active participant so that good decisions are made.

Our pushback on pricing and our willingness to work with governments for a better system is the first example of what a National Mental Health Commission can do uniquely. ha

Extract from the speech to the National Press Club, Canberra, 1 August 2012. Full transcript at www.mentalhealthcommission.gov.au/index.cfm

PROFESSOR ALLAN FELS
Chair, National Mental Health Commission

The future of healthcare

Prue Power reflects on the challenges of the National Health Reform, asking **'where to next?'**

THE ONGOING debates around 'reform processes' in health indicate that it is difficult to arrive at the best policies and structures which support achievement of governments' goals for accessible, universal, equitable, safe, cost-effective, efficient and well-governed healthcare. All national health systems struggle with this. The reasons why health goals are difficult to achieve include:

- Simply achieving consensus on the relative importance of goals is difficult where socioeconomic and political objectives are nearly always in contention.
- Ideological debates about private versus public often hinder rational discussion of the best approaches to policy and structure.
- Empirical information about healthcare processes and outcomes is insufficient to fully inform best possible planning.
- And in Australia, there is the lack of agreement on appropriate roles between the different levels of government in our federation of states and territories.

Health sector challenges

There are, despite the National Health Reform agenda, substantial challenges for the sector. These appear on many fronts constantly and simultaneously. The challenges, as I see it, are:

Access: While our system provides a universal entitlement to health care, not everyone in our community is always able to access health services. There are some real gaps and inequities. This difficult problem requires a mix of responses including targeted programs for low socio-economic groups and workforce reform.

PRUE POWER
Chief Executive Officer,
Australian Healthcare and
Hospitals Association

"The continuing advances in health and medical technologies will always present secondary challenges for our sector"

Health technologies: The continuing advances in health and medical technologies (including pharmaceuticals) will always present secondary challenges for our sector. Once developed, these innovations rapidly diffuse throughout the world. They precipitate, often in an unplanned way, increased costs and radical reshaping of our institutions, treatments and care settings, as well as the roles of healthcare professionals. I suggest that we do not have sufficiently forward-looking mechanisms to monitor and plan for their impact.

Role of hospitals and return of the generalist physician: Some propose that the emerging science of genomics and 'personalised medicine' may obviate the need for hospitals in the future. Let's assume for now, however, that there will be the need for high-acuity, high-technology hospitals for a while yet. The hospital, as a centre for sophisticated and costly technology, has resulted in increasing levels of specialised medical knowledge. In fact generalist medicine barely exists today.

This is not an optimal outcome for the care and management of our growing numbers of aged and chronically ill. These patients are often admitted with multi-system decline and do not fit in to the specialised model. There is an urgent need to resuscitate the generalist physician role and to redesign our hospital admission procedures to facilitate more seamless options for the management of these people.

Sustainability: Sustainable healthcare is a new area of focus for the AHHA and is topical at the moment with the introduction of the new carbon tax. The health sector is responsible for seven percent of the carbon emissions from all buildings. Energy used by buildings (both residential and commercial) accounts for around 20 percent of our greenhouse gas emissions in total, so seven percent of that 20 percent is a relatively small slice of the overall carbon pie in Australia. But it is not an irrelevant one. As you will all know, hospitals are high-energy buildings – a factor of both the energy-intensive equipment that they use (such as diagnostic imaging and operating theatre equipment), and that they operate 24 hours a day, 365 days per year. So while hospitals won't be affected directly by the national carbon price, they may experience some flow-on in the form of higher energy prices. Which means it is now timely and appropriate for the health industry to face the question of its own environmental impact. Many hospitals around the country are already considering how to implement greater energy efficiencies.

As healthcare providers start to examine and measure their energy use and carbon profiles, they learn that the environmental impacts associated with supplying services, including energy and water use, waste disposal and transportation costs, are significant. There are likely to be economic benefits (if small) of improving our performance in this area, but the more important impact will be on public health. The health sector should be pivotal in triggering debates that advocate improving pharmaceutical management, avoiding toxic chemicals, removing routine use of antibiotics in meat production and reforming food policies that support unhealthy food choices. It is also timely to be thinking about the preparedness of the health sector for dealing with the impacts of climate change more generally.

The consumer movement: Healthcare providers are learning that that the patients' needs, expectations and evaluations of their care are of prime importance in determining future policies and are valid indicators of quality. A universal principle underpinning contemporary quality practice is that 'quality is defined by the customer'. Acceptance of this principle remains a challenge for health system policy makers and providers. But, inevitably, it will be a powerful force in the way that health policy is developed.

It is true to say that Australian healthcare reform has avoided 'revolutionary' change. Any modifications have been dominated by incremental variations on a financing theme.

Determining the appropriate direction for health reform is vexed by the different political and social objectives of all nine governments in the system, not to mention our not insubstantial private sector and the myriad of stakeholders. Any lasting improvements in the performance of the health system will depend on significant change in the relationship between the Commonwealth and states. While large-scale reforms to our federation might be unlikely, it is possible to clarify the roles and responsibilities of governments in relation to health care. Therefore, considerable challenges remain. ha

Extract from a speech to the Tasmanian State Health Conference, 6 September 2012

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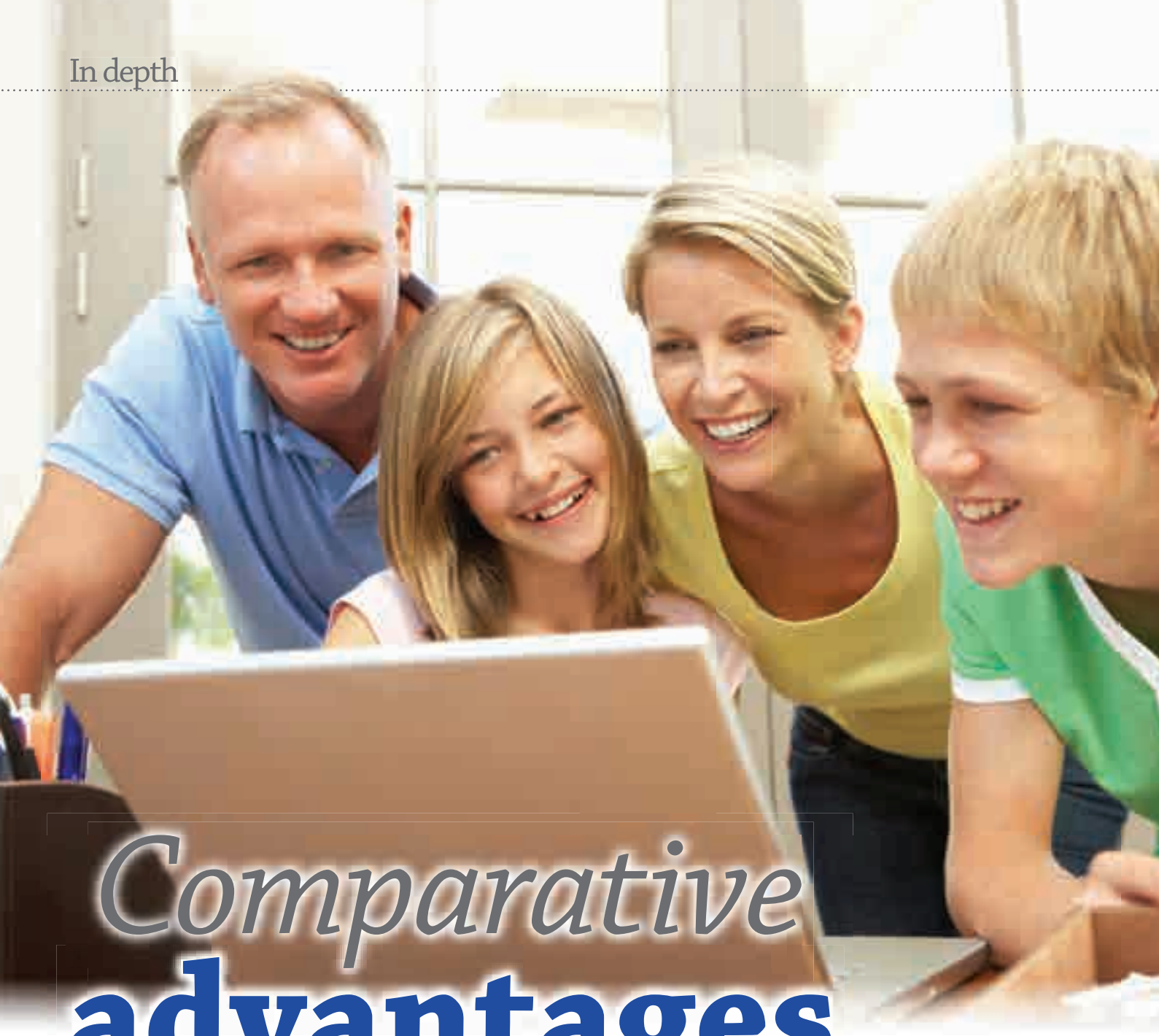

Comparative advantages

Diane Watson gives us her take on the positives of nation-wide **comparative performance reporting**

THE CREATION of the National Health Performance Authority (NHPA) is built upon the principle that all Australians should have access to comparative performance information on hospital and healthcare services.

The value of this new organisation[1] lies in its commitment to monitor and report on the comparable performance of healthcare organisations and health outcomes across Australia. As the first organisation to report quarterly on both hospitals and the new primary healthcare organisations across the nation, the NHPA will open up a window for all Australians to learn about their local health system in a way that enables comparison fairly and transparently on a national scale.

The NHPA's reports will identify performance trends and issues across two streams of healthcare – Hospital Performance and Healthy Communities. Our reports will inform debate on health system improvements at the local level, with the aim of stimulating, supporting and tracking change across Australia. The NHPA will not be static, but will be recognised for providing insightful, comparative information about health outcomes and the equity, efficiency and effectiveness of healthcare organisations. Through producing and developing our performance indicators, and working in tandem with the other health reform bodies, we hope to bring a new energy into efforts to improve healthcare in Australia.

Our reporting methodology is focused on transparency and accountability, and has

"The NHPA will open up a window for all Australians to learn about their local health system"

DR DIANE WATSON
CEO, National Health Performance Authority

been built in line with the Performance and Accountability Framework[2] and relevant legislation. This framework, developed by the Council of Australian Governments, outlines almost 50 health system indicators that cover both hospital and community care. Where possible, all indicators will be reported by both Indigenous and non Indigenous status.

The NHPA will identify those hospitals and communities that are achieving excellence or poor performance in some or all indicators. This is not an act of 'naming and shaming', but is intended to identify where efforts are needed to improve care for the benefit of patients. Through developing this system of reporting, Australia will be joining a group of leading countries, such as the UK and Canada, which have accelerated improvements in patient care by publishing timely, accurate and comparable information on healthcare organisations.

Comparative reporting of this kind allows for a two-pronged approach to increasing knowledge on health performance in a way from which both consumers of healthcare and healthcare professionals can benefit.

For Australian consumers, our reports, whether accessed online or in print, will provide a great way to get accurate and accessible information on healthcare organisations in order to enhance understanding of local performance.

For the healthcare industry and its workers, knowledge of their comparable performance can be used to reward excellence and support efforts to improve. States and territories, as managers of the public hospital system will have new information on the performance of their hospitals relative to others across the nation.

Overall, the benefits of the Authority's work will flow to patients, clients, health providers and health system managers. It will improve safety and quality in the system, lift performance in the public and private sectors, embed efficiency and sustainability and improve integration between primary care and the hospital sector.

One of our key objectives is to build and maintain strong, respectful relationships with all of our stakeholders through engagement and insightful reporting. Through developing these connections, and asking for input and evaluation, the NHPA can enact an effective national approach to developing healthcare reporting in Australia.

The NHPA will not be operating in a bubble. Part of our aim is to engage in ongoing consultation regarding our reporting activities, data sources and indicators, and work with the Australian community to create the best source of comparative healthcare information. In this way, we can work together towards building a strong healthcare system right across Australia. ha

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Addressing Australia's **dental decay**

The Commonwealth package for improving oral and dental care provides **a solid foundation for the future**

DR MARTIN DOOLAND
Executive Director
Statewide Services
Directorate AHS
SA Health

"A third of Australians are avoiding or delaying dental treatment because of cost"

THE PROBLEMS with dental care in Australia have received a lot more public attention in the last few years. I am not surprised by this, as a third of Australians are avoiding or delaying dental treatment because of cost and this barrier is extending well beyond pensioners into middle income groups.

Until the Commonwealth Minister announced, on 29 August, a $4 billion package for improving oral and dental care, state and territory public dental services were only funded to treat about 15 percent of adult concession card holders each year. Double this number of card holders have been paying for their own, intermittent and frequently compromised treatment in the private sector. Not surprisingly, low-income adults have very poor oral health outcomes.

The situation for children is less severe with around 80 percent having a dental visit in any one year. However, 20 percent of children missing out on regular dental care is scarcely acceptable. Many states and territories have high quality school and child dental services, but these programs have been struggling in recent years and coverage has fallen below 50 percent as public dental services shifted their focus to reducing waiting lists for low-income adults. Details of the six-year package are:

- $2.7 billion for around 3.4 million Australian children who will be eligible under the Family Tax benefit Part A for subsidised dental care capped at $1,000 per child over a two-year period (commencing 1 January 2014). Most parents will be able to take their children to private dentists or public dental programs to receive Commonwealth funded dental treatment. Importantly, this program frees up millions of dollars of state/territory funds currently committed to school/child dental programs. The Commonwealth will insist that these funds are reinvested in other aspects of their public dental programs, such as for low income adults and the reorientation of existing programs to focus on groups that require more active and tailored programs.
- $1.3 billion under National Partnership Agreements with states/territories for around 1.4 million additional services for adults on low incomes, including pensioners and concession card holders, and those with special needs – they will have better access to dental care in the public system (commencing 1 July 2014).
- $225 million for dental capital and workforce strategies provided to support expanded services for people living in outer metropolitan, regional, rural and remote areas.

The 2012-13 Federal Budget allocation of $349 million of time limited funding over three years to state and territory public dental services to reduce public dental waiting lists is a valuable precursor to these initiatives.

Although a long way short of funding a universal dental scheme for all Australians, a long-term aim of the AHHA, the package provides a solid foundation for the future and a plan to normalise oral health services to make them more available on an ongoing basis. Problems of access to health services are not 'cured' by one-off injections of funding. The last thing the Australian community needs is a dental plan that a change of government will overturn – as has happened repeatedly in the last 40 years.

As mentioned above, AHHA's goal is for dental care to be part of Medicare and have the protection of the wide community and bipartisan support that Medicare enjoys. However, simply including dentistry in Medicare is not cheap – probably a net $5-6 billion per annum depending on what treatments are covered. So reform of dental services needs to be in stages that can lead to a universal dental program within Medicare by logical steps as funding allows.

One part of reform in the oral health sector that has drawn less comment is workforce. Much of the debate has been around the number of dentists and how to get them to country areas. However, the type of provider has received far less policy attention. There needs to be a root and branches review that identifies the type and complexity of treatments Australians will need in future years, and designs the oral health provider that will provide them at an affordable cost. My reading of the data says the vast majority of Australians will need basic primary dental care including check-ups, prevention and simple fillings. Yet we are training large numbers of dentists that are able to provide complex crowns, bridges, dentures and implants. This is a very costly model.

The Dental Health Reform package will replace the Medicare Teen Dental Plan with a more comprehensive program for children. The Chronic Disease Dental Scheme (CDDS) will also be closed. While the CDDS has funded dental treatment for large numbers of people, the new dental health reforms are better targeted and should result in greater long term improvements in the oral health of the Australian population.

There have been a number of false dawns in oral health reform as the attention of governments has been drawn away by competing policy agendas. At last we can see the sun shining over the horizon.

FRESENIUS KABI
caring for life

FRESENIUS KABI
Caring for life

Committed to improving the quality of life of critically and chronically ill patients through innovative products and a focus on therapy and care.

When pharmacist Dr Eduard Fresenius took over the Fresenius family pharmacy in Frankfurt in 1912 he had big ideas. A skilled pharmacist, Dr Eduard Fresenius built a small laboratory and started experimenting, developing innovative products to meet the needs of his customers.

Yet even Dr Eduard Fresenius could not have imagined that the company he started would grow to become a world leader that it is today.

Fresenius Kabi's oncology, anaesthesia and IV drugs are indispensible in the emergency, intensive care and surgical departments of thousands of hospitals worldwide. Its comprehensive portfolio of infusion solutions provides hospitals with products for fluid substitution and blood volume replacement. Fresenius Kabi is also one of the few companies to offer both parenteral and enteral nutrition. This range of products ensures patients receive comprehensive nutrition to support their recovery.

All these products are supported by specialised medical devices that improve the convenience and safety of application for both medical professionals and their patients.

Innovation for total patient care

Dr Eduard Fresenius' focus on developing products that make a difference in the lives of those who use them remains integral to Fresenius Kabi.

"If there's one thing that has been a hallmark of Fresenius Kabi it is innovation," says Peter Nolan, Fresenius Kabi's Pharmaceutical Division Director.

"Our range of products, the containers they come in and the devices used for infusion and transfusion, as well as the ways Fresenius Kabi manufactures these products, are all highly innovative. It's a big part of the Fresenius Kabi fabric.

"By developing such a wide range of products specifically for people who are critically ill, Fresenius Kabi aims to provide these vulnerable patients with access to state-of-the-art products in all areas of treatment; total patient care for the critically ill.

"We can provide a comprehensive portfolio of products and services for chronically or critically ill patients, including administration of the drugs through application technology" says Peter. "From the needles and lines connected through the port to the pump and the IV drugs, fluids or nutrition the patient requires during surgery or treatment. Furthermore our range also covers areas of transfusion technology, such as apheresis and autotransfusion."

Fresenius Kabi is also researching a total cancer care concept, which aims to ensure patients receive the individualised nutritional support they need before, during and after treatment.

"Ideally we would like to see a nutritional profile developed for each cancer patient as soon as they are diagnosed, even before surgery or chemotherapy," says Peter. "This

Fresenius Kabi aims to provide vulnerable patients with access to state-of-the-art products in all areas of treatment; total patient care for the critically ill

would allow us to determine what nutrition the patient requires during treatment or if they should be given particular supplements to take home after treatment.

"There is a lot of research that suggests if you provide nutritional support to patients during their cancer journey they manage their side effects better and ultimately recover more quickly.

"These types of programs have the potential to reduce the burden of health as they may shorten the length of hospital stays as well as lessen the number of infections and complications, all of which can decrease costs for hospitals.

"Really that's our aim for everything we do: improve the quality of life of critically ill people by providing quality products and supporting the health professionals who treat them.

"The quality of the company's products is essential in this aim and quality management is taken seriously. All the company's employees are very aware that the products they produce are for very sick patients.

"I think our employees feel real pride in working for us because the products really can make a difference to people's lives," says Peter. "The staff are also very aware that they have a responsibility to those patients. A great example is our oncology compounding. We produce around 200,000 individual patient-specific doses each year across our three compounding centres.

"Because our people are so integral to our success we are very committed to them. We invest quite heavily to ensure they enjoy coming to work each day and can grow with us."

Fresenius Kabi in Australia

The company's ability to provide its products in a timely manner and at a competitive price has been bolstered by a commitment to local manufacturing. To better service the Australian market, local operations were established in 2004.

Here, Fresenius Kabi is best known for its oncology compounding. The centres in Melbourne, Sydney and Brisbane service more than 180 hospitals nationally. The local centres mean the majority of orders are turned around in under 24 hours.

Fresenius Kabi has also recently invested in robotic automation to support its competence in oncology compounding. RIVA (Robotic Intravenous Administration) is considered the gold standard in compounding technology and has the capacity to produce up to 45,000 units of chemotherapy drugs each year. RIVA uses automation technology to compound intravenous drug products for syringes and IV bags, resulting in a high level of accuracy and efficiency. The technology also reduces human operator exposure to cytotoxic drugs, creating a safer compounding environment. These are all important factors to both employees and patients in the healthcare system.

"We have TGA licensed facilities in Sydney, Melbourne and Brisbane and plan further geographic expansion as the business grows. Fresenius Kabi, through a subsidiary, holds a pharmacy license co-located at the Sydney facility, which allows us to provide clinical services at the same time as the compounded drugs. We are a one-stop-shop in that regard.

"We'd like to build on our foundations by developing an e-health portal where patients can go to find more information on the treatments they are receiving. We want to make the portal accessible and simple. It's another way we can provide support to a patient during their journey."

To achieve all this, and continue the company's rapid growth, Fresenius Kabi has already committed to ongoing investments in its products, services and its people in locations right across Australia.

"We're here to stay," says Peter.

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Private hospitals: Spectators, barrackers or players?

For National Health Reforms to succeed, private hospitals **need to feel like players**

AT THE June 2011 Australian Healthcare and Hospitals Association National Health Reform Simulation, I was a spectator. Few private colleagues were involved and there was little engagement from the various reform-oriented stakeholder groups towards the private sector.

One year later, I'm a barracker. Uncertain, hoping National Health Reform will offer opportunities to develop innovative services through partnerships with new government sector entities like Medicare Locals, but fearing that it may suck up time and resources for no tangible patient or commercial benefits.

Uncertainty stifles private sector engagement. We need clarity to raise and commit resources in expectation of return. The disruptive threat and unpredictability of National Health Reform has receded; we hope it will deliver opportunities in the medium term, but for now we focus on our own plans, keeping lines of communication open, awaiting developments. New national bodies like the Independent Hospital Pricing Authority (IHPA) and the National Health Performance Authority (NHPA) are forming. Existing bodies such as the Australian Commission for Safety and

DR MICHAEL WALSH
Chief Executive,
Cabrini Health,
Melbourne

"Success requires recruitment and engagement of private health as a player. I don't feel like a player yet"

Quality in Health Care, the Australian Health Practitioners Regulation Authority and Health Workforce Australia are increasingly influential. Fledgling local bodies – Medicare Locals and Local Health Networks are concentrating on internal organisation. For the time being, it's business as usual from a private perspective.

Five issues arose from the Simulation.[1]

1) Commonwealth and state governments were challenged to demonstrate leadership, partnership and greater collaboration. The term 'system manager' has crept into policy jargon to describe state and territory health departments' roles in change management.

As a private provider, I see little evidence of improved Commonwealth/state leadership. However, national bodies are impacting – for example, new National Safety and Quality Standards[2] and new national health professional registers and notification requirements.[3] States are preoccupied with public hospitals rather than the system, lacking a strategy for private service provision other than short-term gap plugging. I hope that growing demand and shrinking government sector capacity may lead to new 'system manager' thinking about how to make better use of private sector capability.

2) Concerning funding, the IHPA has introduced activity based funding and the National Efficient Price (NEP).[4] The NEP is based on the average cost of public hospital services across Australia and its impact on Local Health Networks is dampened by the 2008 Commonwealth/State Health Care Agreement which has two years to run. Although public and private costs and costing methodologies differ, health insurers will note movement in the NEP over time to inform their price negotiations. Numbers of private patients in public hospitals have increased in recent years.[5] IHPA adopts a 'no change' policy approach to existing arrangements, setting a 'discounted' NEP for private patients. Any impact on patients choosing to be 'private' in public hospitals remains to be seen. For the future, efficient price will undoubtedly progress from average cost to some new definition of efficiency, impacting private patient activity in both sectors.

3) The NHPA, responsible for performance reporting, has released a performance and evaluation framework.[6] The Authority can require private hospitals to provide performance data. Currently, 250 private hospitals contribute voluntarily to the 'MyHospitals' website. Private hospitals are concerned that proposed efficiency indicators may complicate health insurer price negotiations. Some access data such as elective waiting times is not collected in private hospitals. It is too early to assess NHPA's impact. Larger private hospitals should be able to comply with NHPA data requirements, but day hospitals and small, specialised facilities may struggle.

4) Concerning local governance, evolution of Local Health Networks and Medicare Locals and their impact on delivery of effective, integrated care, there is no noticeable change yet. Key integration points for private providers are around admission and discharge, mediated by referral relationships between general practitioners and specialists. These processes are not an immediate priority for Medicare Locals, which focus on after-hours general practitioner availability and eHealth.[7] Private hospitals have the will and potential to work with Medicare Locals but where we fit in with eHealth and other initiatives remains unclear.

5) Regarding delivering a better deal for patients through a strong consumer focus, private hospital customers are doctors and patients. Our doctors and patients commit their own resources to deliver and receive care at our hospitals and patients have a choice of providers. Consumer focus is necessary to succeed in private health, but not sufficient. The new National Safety and Quality Standard 2, *Partnering with Consumers*, raises the bar and private hospitals will need to respond.

National Health Reform aims to deliver "better access to services, improved local accountability and transparency, greater responsiveness to local communities and provide a stronger financial basis for our health system into the future".[8] Success requires recruitment and engagement of private health as a player. I don't feel like a player yet. ha

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Is health workforce reform **working?**

The establishment of Health Workforce Australia opens **new opportunities for reform**

PROFESSOR PETER BROOKS
Director Australian Health Workforce Institute, University of Melbourne

"Providing for the ageing population and chronic disease, and working out how we pay for it, will be the major challenge for the health system over the next 20 years"

HEALTH AND social care makes up the largest workforce in Australia (1.3 million) and is the most rapidly expanding. Providing for the ageing population and chronic disease, and working out how we pay for it will be the major challenge for the health system over the next 20 years.

With this in mind, the Council of Australian Governments established Health Workforce Australia (HWA) in 2009. Funding to the organisation is significant – $1.4 billion over a three-year period, and it has an ambitious plan to make Australia's health workforce 'self-sustaining' by 2025.

HWA has a broad brief in four major areas:

- workforce planning policy and research
- clinical education
- innovation and reform of the health workforce
- recruitment and retention of international health professionals.

It will also consider the adequacy and availability of workforce data. Within that broad brief a number of valuable documents have been produced in fields including:

- modelling the health workforce
- developing competency frameworks for health professionals
- international flows of health workers
- simulation learning environments
- clinical placements
- non-medical prescribing
- new models of care
- rural and remote workforce.

Much of this work has been outsourced to consultants (including universities) but increasingly, research is being carried out 'in house'. A major workforce modelling project[1] by HWA has just been released suggesting that we will need to recruit about 107,000 nurses and 2,700 doctors by 2025 if we are to continue to deliver services as we do now. This model provides for a number of iterations, dependent on changing parameters such as productivity of the workforce, retention and community demand for services.

Altering each of these parameters has a significant impact on the numbers, as one might expect. For example, an increase in productivity of five percent (remembering the Productivity Commission Report into Australia's health workforce, still one of the best commentaries on this field, suggested that the health system was probably 15-20 percent inefficient), would mean a shortage of 87,000 nurses, but an excess of 3,000 doctors – a very different scenario. What if we really got serious about reducing the impact of obesity that drives around 30 percent of the burden of chronic disease? That would also impact significantly on numbers required. This exercise shows that while modelling is a tool, and an important one, it is subject to a large number of interpretations and any predictions need careful scrutiny.

Some of the outputs of HWA, such as the review of Physician Assistants (a delegated model of care which is being developed in a number of European countries, New Zealand and Canada and has its roots in the US), seem to have fallen by the wayside to some extent. While the consultant's report was positive that this workforce could contribute significantly to the health system, rather than develop a national approach to registration and regulation, the Health Ministers recommended that the jurisdictions be allowed to register these professionals on a state-by-state basis. An opportunity for national health reform missed once again.

The establishment of HWA comes at the same time that we have a national approach to registration through the Australian Health Practitioner Regulation Agency (AHPRA), and thus there is an opportunity for these two organisations to work together and really drive a reform agenda. Currently there is little evidence that this is occurring. This is particularly evident with the training of health professionals, where registration authorities allow lack of consistency in training of professionals between universities and jurisdictions.

For example, the number of clinical contact hours for nurses to be registered varies between universities and states; and refusing to allow students of one discipline to be supervised by teachers from another discipline seems irrational. This poses significant challenges for rural and remote training and inter-professional training. These 'turf wars' really need to stop and HWA and AHPRA could help to take a leadership role in brokering some of the issues. Currently, HWA is specifically excluded from matters of accreditation, which is the sole purview of the Accreditation Boards, which tend to be extraordinarily conservative.

The work of HWA is fundamental to the workforce reform agenda. It needs to foster innovation, be willing to take risks and work with the education sector, regulatory authorities and the professions to ensure that patient outcomes are enhanced. It will also, as will all governments, need to address the elephant in the room – the cost of health care – and consider whether there is a better way of remunerating health professionals (particularly doctors) than an uncapped fee for service system. This has to be linked to fundamental industrial reform, which has to recognise that illness is not a Monday to Friday, 8am to 5pm phenomenon and that significant public infrastructure investment needs to be better utilised.

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Health reform & older people

What do the health reforms mean to **older Australians?**

THE HEALTH reform process is ambitious, complex and of great importance to the wellbeing of older Australians. Older people are the major users of the health system. However this is still not really understood within the health system. On one hand it is obvious, but on the other it always seems to surprise. Today, people aged 65 or older account for 18 percent of the population. This is expected to increase to 25 percent by 2051.

We have seen significant advancement in the treatment of older people in many areas but COTA believes that the health arena remains riven with ageism and age discrimination to a degree that may exceed the much more publicised employment sector. By way of example we collect and report very little data for cohorts over 65 years and especially over 75 years. Yet people's health status and primary care needs can change dramatically over the years between 65 and 75 or 100 plus.

Aged care reform is regarded by the Commonwealth as an integral component of the health reform process. The *Living Longer, Living Better* (LLLB) reform package announced on 20 April 2012, while not going as far as COTA wanted and the Productivity Commission recommended, is nonetheless a major step forward for older Australians in need of support and care.

A major component of LLLB is a huge increase in the number of in-home care packages – an additional 40,000 over the next five years, increasing the number of such packages from 60,000 to 100,000. This might not be enough but it's a big change in a short time period.

Furthermore these 40,000 new packages are all to be offered on a Consumer Directed Care (CDC)

IAN YATES
Chief Executive, COTA Australia

"The consumer will have much greater control over the support and care they receive"

basis, and by July 2015 all the current 60,000 packages are to be converted to CDC. That means the consumer will at the least have much greater control over the support and care they receive, and at best will manage and decide the why, who, what, where and when of their support and care.

This is a profound cultural shift in the 'poor cousin' of health care that aged care has always been. Indeed the LLLB package proposes trialling CDC in residential care. What if we started trialling CDC in our hospitals and GP surgeries?

Another major feature of the LLLB reforms is the proposed Gateway that should provide objective, timely and authoritative information and advice, assess need, assess financial capacity and link people to the support and services they need and choose. What might be the parallel to this in the mainstream health system? It would involve e-health initiatives and a fully integrated system guide which GPs or some other body – a Medicare Local perhaps – provides.

The LLLB reforms are much broader than these components and seek a more sustainable and consumer focused aged care system. Implementation of these reforms is now underway through a range of strong consultative mechanisms that fully involve the aged care sector, especially consumer advocates.

So what about Local Health Networks, Medicare Locals and activity based funding?

The latter is probably the easiest. We have lived through casemix in several states over several iterations. We saw it ignore, then underestimate, age-related co-morbidities that combined with under-developed clinical practice for this age group, often necessarily resulting in extended hospital stays. We will wait to see whether the lessons of casemix have been learnt or ignored. If not learnt, we will be ready to make a lot of noise.

In regard to Local Hospital Networks (LHNs) we are frankly sceptical. We have observed for years that hospitals, whether alone or acting in concert with health departments, conspire to shove older patients into nursing homes without consideration of their wellbeing. We have significant questions about consumer representation on some LHN governing structures. We wait to see if LHNs have anything to do with improved quality.

Medicare Locals potentially offer older Australians a great deal of hope. They promise population based approaches to health as well as better integration of preventive, primary and higher levels of care and aged care. The vision is strongly endorsed, the 'how' is the question. There is no clear pathway connecting Medicare Locals and older people and their services. There is a curiosity but is there any incentive? We wait to see. We have no other route into the game so far. ha

Developing a framework for arts and health

Increasing recognition and support for the arts in health practice

THE NATIONAL Arts and Health Policy Forum held at Parliament House, Canberra on 27 June 2012 was an important step in strengthening recognition and support for arts and health practice in Australia.

The forum was opened by the Hon Simon Crean MP, Minister for Regional Australia, Regional Development, Local Government and the Arts. Although unable to attend in person, the Hon Tanya Plibersek MP, Minister for Health and Ageing recorded an opening address to forum participants and acknowledged that: "This forum is an important step towards increasing awareness of the many ways in which the arts can contribute to healthcare. It is a positive step to be looking at policies to underpin practice: policies informed by a strong evidence base."

The forum was organised by the Arts and Health Foundation (AHF) in association with its project partners the National Rural Health Alliance and Regional Arts Australia. The forum's objective was to give those working in arts and health an opportunity to inform the work of the Ministerial Working Group appointed by the Australian Government's Standing Council on Health to develop a national arts and health framework.

The Arts and Health Foundation believes that a national policy framework will help secure a more cohesive approach to knowledge sharing, sector development and increased resourcing for contemporary arts and health research and practice.

The forum was attended by 70 people including health professionals, philanthropic organisations, public and private sector health service organisations, artists and arts organisations, researchers, academics and staff from Commonwealth, state and territory governments' arts and health departments. The proceedings of the forum were webcast live which enabled hundreds of people to participate in the forum online during the day.

Forum participants discussed the scope of the proposed framework and agreed that it should embrace:

- health as more than an absence of disease
- the needs of the general community as well as the needs of people with particular health and wellbeing needs, including people living with disabilities
- people living in remote communities and Aboriginal communities
- the health and wellbeing needs of healthcare workers.

The forum defined arts and health practice as operating across the continuum of health services including community-based art and culture, art in the design of healing environments, art-based therapies, programs

Robyn Archer, singer, writer, director, artistic director and public advocate of the arts

Michael Kidd, Executive Dean, Faculty of Health Sciences, Flinders University

"A national policy framework will help secure a more cohesive approach to knowledge sharing, sector development and increased resourcing for contemporary arts and health research and practice"

in health care and the arts and humanities in health professional education.

Forum participants noted that health is no longer just the business of health agencies. The forum therefore recommended the widespread adoption of the framework by a diverse range of government agencies (housing, health, community development, arts, criminal justice, Aboriginal affairs, urban planning, development and infrastructure, rural, regional and remote development etc.) and corporate, philanthropic and non-government sector agencies.

The forum recommended that the framework build on the existing expertise and modes of practice in arts and health and be informed by an understanding of what organisations are operating in arts and health in Australia and how they work.

The framework also needs to include achievable and measurable objectives and time lines to support the acknowledgement and development of this practice, including identifying new pathways for bringing arts and health services together more effectively.

The AHF sees the need for the forum to continue as an ongoing entity informing the advice that the AHF provides to the Ministerial Working Group. AHF has established the Arts and Health PlaceStories website (placestories.com/project/8131) to connect people working in the sector so they can share information. This website can continue to play a useful role in mapping the arts and health sector and building the evidence base for arts and health.

The forum expects an effective framework to bring about the following changes in arts and health practice in five years:

- a national framework for arts and health that is easily understood and evidence based and that identifies clear outcomes so that the benefits of arts and health to the Australian people are clear
- widespread adoption of the framework by a diverse range of government agencies
- national, state/territory and local government acknowledgement and resourcing of arts and health practice
- philanthropy and the corporate sector showing increased support for arts and health practice. ha

By Deborah Mills, Director Policy and Strategy, Arts and Health Foundation

L-R: Dr Christine Putland, Independent Consultant Research and Evaluation Arts and Health, Southgate Institute for Health, Society and Equity, Flinders University; Ms Kim McConville, Executive Director, Beyond Empathy; Ms Michelle Dowden, Regional Manager Ngalkanbuy Health Service, Miwatj Aboriginal Health Corporation, Elcho Island

Top Left: A panoramic view of the Fresenius Kabi Australia pharmaceutical compounding centre site. Bottom Left: Local Mayor Nick Berman and Fresenius Kabi Finance Director Juan Villar unveil the foundation stone at the pharmaceutical compounding centre construction site. Right: An artist impression of the Fresenius Kabi pharmaceutical compounding centre.

FRESENIUS KABI
Caring for life

Cancer and hospital patients to benefit from new state-of-the-art Pharmaceutical Compounding Centre

Construction has begun on a new and innovative Pharmaceutical Compounding Centre that will supply high quality chemotherapy drugs and parenteral nutrition products to hospitalised and out-patients throughout Australia.

The $19 million facility located in northern Sydney, being built by pharmaceutical company Fresenius Kabi Australia Pty Limited will span 8,500 square meters and will house high tech compounding technology to produce cancer medication and parenteral nutrition for hospital patients in need.

More than one hundred people will be employed at the Mount Kuring-gai site during construction and over one hundred and fifty Fresenius Kabi Australia staff when the facility is operational.

Marking the start of construction, Ms Zita Peach, Managing Director and Executive Vice President South Asia Pacific said, "The significant investment in this site in Australia is dedicated to the needs of critically and chronically ill patients, and will provide access to state-of the-art products through increased capacity and benefits gained through innovative technology."

"Fresenius Kabi Australia currently provides compounded oncology and parenteral nutrition products to patients in over 180 hospitals and clinics throughout Australia, inclusive of public and private hospitals. This new facility will enable the availability of more medicines to more people," said Ms Peach.

Fresenius Kabi Australia is part of the worldwide health care company Fresenius Kabi and is one of Australia's fastest growing and innovative healthcare companies, providing high quality medicines and technology.

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Whose integration **is it anyway?**

Medicare Locals and Local Hospital Networks must **cooperate, collaborate and coordinate**

CAN MEDICARE Locals (MLs) and Local Hospital Networks (LHNs) cooperate and bring about the right care pathways and system re-design to create a linked primary health care and hospital corridor that will simplify the patient journey? Can this corridor reduce the complexity and improve effectiveness of clinical care? Yes: they must.

MLs and LHNs are new forms of local governance for health, with boundaries that largely align. They form the centrepiece of structural reforms under COAG's blueprint for an improved health system.

At the same time, the Independent Hospital Pricing Authority has been set up to develop a framework for public hospitals which includes a national efficient price and the introduction of activity based funding to deliver the right care, locally. Added to the mix for this formula there are now new drivers to consider, non-hospital options, the private and not-for-profit sectors, which have potential settings for delivery and/or partnership.

The ML and LHN relationship and the extent to which they are empowered by policy will underpin this. As many commentators have acknowledged, MLs are an opportunity to build stronger connections between acute hospital services and community care to reduce unnecessary hospitalisations and improve the outcomes for the chronically ill.

Cooperation, collaboration and coordination between MLs and LHNs is a formidable ask. This goes to the core of trust, judgement, flexibility, collective goals, a shared interest in system improvement, and 'better buys', negotiation and ultimately, measurably improved health outcomes. What is clear is the need to stop seeing episodes of reactive care as the norm, particularly for those with chronic and complex care needs and seize the opportunity to implement and evaluate different models that promote the notions of the care continuum and connected care – that move system design towards a more seamless approach.

Clinical leadership, governance and engagement are fundamental to this. MLs and LHNs working together offer an opportunity to support clinical literacy and engagement across sectors, to identify, develop and trial innovative models of multidisciplinary and integrated care and to translate the exemplars. To achieve this they need to find common ground. Quite rightly each sector wants its own 'books' to look good. Hospitals want to reduce waiting times, reduce bed stays and reduce unplanned admissions. In the primary care sector, MLs want to improve population health, increase community-based health care and better coordinate access to local services. Quality and safety, equity of access and good patient experience are imperatives for both sectors.

How do MLs and LHNs decide what's to be tackled first? What data and information do they need to share? Will the task be multi-pronged to start with and is there capacity to manage more than one priority at a time? One Medicare Local may have to interact with more than one LHN, potentially creating competing priorities. The complexity is daunting; the challenge is exceptional but it must be met head on if we are to achieve genuine health reform.

Health system leaders at the crux of this exceptional challenge will very soon be at the cusp of developing models of care that will create evidence-based pathways designed to improve patient care. Watch this space.

AML Alliance's November 2012 National Primary Health Care Conference spans a number of topics across the health spectrum. Dr Norman Swan, respected medical journalist from ABC's Radio National's *Health Report* will once again inject rigour, inquiry and debate. A Grand Challenge Workshop 'Primary Care and Hospital Integration: Whose Integration is it Anyway?' will examine the ML and LHN integration. Followed by a Clinical Leadership Roundtable Dinner, the conference is an opportunity to join lead clinicians and advocates for health system change and to advance the opportunities for MLs and LHNs to partner and improve local health systems between hospitals and primary health care. ha

By the Australian Medicare Local Alliance

For information on the National Primary Health Care Conference, visit www.amlalliance.com.au/events/national-conference

Consumers Health Forum CEO, Carol Bennett; AML Alliance Transitional CEO, Leanne Wells; Federal Minister for Mental Health and Ageing, Mark Butler and AML Alliance Chair, Dr Arn Sprogis.

MARGRET MEAGHER
Exeuctive Director Arts and Health Australia and Founding Director of the Australian Centre for Creative Ageing

Thinking about health reform **creatively**

Margret Meagher believes arts and health programs should be part of healthcare reforms

THINKING CREATIVELY can unveil innovative solutions for a health system undergoing major restructure. There is ample evidence, both quantitative and qualitative, to demonstrate the place for arts in the delivery of health services.

Over the past two decades, arts and health has emerged as a defined field that complements medical treatment and clinical intervention. Arts and health broadly encompasses the environmental design of health settings and specific programs, delivered by professionally trained artists, to improve physical, emotional and mental health through engagement and participation in creative activities. Various artforms are utilized including music, singing, creative writing, painting and sculpture, theatre, dance and film-making.

An important aspect of arts and health is the rigorous evaluation of programs to provide data that underlines the social and economic benefits of programs. For example, arts and health programs have been shown as highly successful in such areas as cancer care, rehabilitation and mental health. Benefits include reduced reliance on medication to control pain, shorter stays in hospital, decreased levels of stress and anxiety and improved mood. This can also lead to fewer demands placed on hospital staff and an enhanced healthcare environment for all.

In the US, over 2,500 hospitals support arts programming with 79 percent employing arts and health program managers. Interestingly, investment in the arts in hospitals is expanding, despite current economic conditions, because the arts are increasingly viewed as an affordable means to strengthen health services, improve health outcomes, enhance the patient experience and reduce staff turnover.

Best practice in arts and health programs and the latest research data will be showcased at the Art of Good Health and Wellbeing international conference at Notre Dame University, Fremantle from 26 to 29 November 2012. Convened by Arts and Health Australia (www.artsandhealth.org), this annual conference brings together the leaders in the field, exploring how the arts can work most effectively in primary and acute care, community health and aged care in metropolitan, regional and rural areas.

At this year's conference, 35 international presenters will share their knowledge and experience, alongside a strong contingent from Australia. Experts addressing the conference include Robin Glazer, Director of the Creative Center in New York (www.thecreativecenter.org), which takes the world of art to more than 18,000 people living with cancer and other chronic illnesses each year. The organisation offers a hospital artist-in-residence program and supervises 20 artists working in 22 hospitals and hospice sites throughout New York City. The Creative Center has recently set up a blog 'Airwaves' for artists and administrators working in health, which provides regular posts from the field, project ideas, news articles and templates for administrative processes and evaluation.

This year's conference will also present one of the leaders in circus arts and health, Paul Miller, founder of Circus Mojo, based in Kentucky. 'Mojo Medicine' uses circus arts to engage children with illnesses, disabilities and emotional problems and make the hospital environment more friendly and fun.

Circus Mojo works in Cincinnati Children's Hospital Medical Center and Texas Children's Hospital, using humour as a coping tool while offering an opportunity for young patients to learn new skills. The goal is to diminish limitations and inspire confidence, increase coordination and improve behaviour. A bonus is the positive impact that Circus Mojo programs have on staff morale. Recently, Circus Mojo has extended its programming to work with young people and their families who are dealing with grief as a part of St. Elizabeth Hospital's Bereavement Program. It's a treat to watch Paul balance a wheelchair on his chin!

The field of arts and health offers creative and cost effective solutions to improving health service delivery. What 'better' way to facilitate successful health reform than to build in such a simple and proven pathway to enhanced health and wellbeing?

Fifty shades of **grey**

PHILIP DARBYSHIRE
Director of Philip Darbyshire Consulting and Professor, Monash University

Leadership is about how we engage with each other as people says **Philip Darbyshire**

EL JAMES' 'mummy porn' trilogy may be all the rage in the publishing world but our current worlds of nursing and health care are also shackled by grey domination. The S&M here however, refers only to Sameness and Mundanity.

During my formative years in nursing in the UK, there were a galaxy of nurse leaders who were colourful, articulate, passionate, visionary, powerful personalities; spokespeople for both the discipline and for health care. People like Ray Rowden, Bob Tiffany, Steve Wright, Liz Fradd, Jane Salvage, Phil Barker and others were regularly publishing, speaking, advocating and generally inspiring while also carrying on their 'day jobs' as nursing and service managers, educators and/or practitioners.

Look around the Australian health service and it is clear that all shades of grey and lifeless now have the whip hand. The corporatising of health care into ever larger and more monolithic state blocs seems to have sucked the life out of the idea that our leaders and managers should be colourful and have a personality of some sort. Bind this tightly with the soulless and impersonal domination of an average Human Resources 'department of no, you can't' and we can see how easily personality and individualism can be reformatted and overwritten with the notion that managers and leaders are simply interchangeable ciphers, to be shuffled around the public sector game board. Perhaps if we had the wisdom to model our health system on Apple rather than Albania, we may not be in such a mess.

Nurses tell me regularly that they either have little idea who their quasi-invisible Director of Nursing or CEO is or what they stand for. The chances are that such a 'leader' has risen without trace to their current role and that they are so devoid of personality and presence that their brother is an only child. Yet these are the people that we expect our nurses and health professionals to follow excitedly and enthusiastically into the brave new worlds of health reform. 'Yeah, right', as our kiwi neighbours would say.

This is not a plea for a 'cult of personality' approach to leadership but regardless of how much we wish that leadership was all about 'skills', or 'attitudes', it is not. It is about perceptions, relationships and how we engage with each other as people and colleagues around a common purpose and shared values. One of the silliest report titles in many a year emerged recently from the Kings Fund in the UK when they released *The future of leadership and management in the NHS: No more heroes*. Rub your eyes and re-read. No MORE heroes? I must have fallen asleep for the last decade and missed the first wave. Something makes me think that the business world will not be releasing a similar report explaining why they don't want another Lee Iacocca, Steve Jobs, Alan Weiss, Sara Blakely or Tony Hsieh.

Now, give your grey matter a workout. Imagine you are a TV producer or journalist and want a contact list of the top ten most engaging, articulate, passionate and knowledgeable nursing leaders or health CEOs in Australia. Who would be on your list? Now, as a *Health Advocate* reader, who would be in your top ten?

Let's hope that the task doesn't beat you into submission. ha

DR PATRICK BOLTON
Director of Cinical Services (Medical) at Prince of Wales Hospital

Reformers *do your worst*

Clear funding, clear targets, getting on with the job, **Patrick Bolton**

REFORM IS tired and I am tired of reform. From where I sit, helping to run a hospital and treating patients, Australia's recent health reforms bring to mind the aphorism: 'When the only tool one has is a hammer, everything looks like a nail'.

In reality it's business as usual. The process of service delivery has not been changed by the purported reforms and I don't expect it will be. However, we are required to jump through additional hoops in terms of reporting and accountability.

In NSW, where I work, activity based funding (ABF) is not activity based at all – we don't get paid in proportion to the amount of work we do. Rather, funding is provided on an historical basis, notionally determined by population need. There are defendable policy reasons for this, but the result is that ABF becomes a performance measure and an instrument by which health services are controlled, not a method of funding and a means to support local decision making.

I like to think of myself as left-wing, or at least having a strong belief in social justice, however I am concerned that I am falling prey to another aphorism: 'A young man who isn't a socialist hasn't got a heart; an old man who is a socialist hasn't got a head'.

I find myself increasingly in support of Friedrich Hayek, Thatcher and Regan's economic godfather in my opposition to bureaucracy. By all means government should set up the apparatus to fund health care and monitor its outcomes, but if what it wants is grass-roots driven reform, then it needs to get out of the way and let the people providing the services work out how best to do this.

For clarity, and in my own defence, I am not arguing here for the privatisation of health care. The evidence, such as it is, suggests that health care is most efficiently delivered by not-for-profit entities – public or private. What I am arguing for is clear funding, clear targets and allowing those designated to run hospitals to get on with their job. I can rely only on anecdote, but it does seem that the best hospitals have benefited from consistency of management rather than the revolving door engendered by serial reform.

There is no evidence that programs of reform improve health care and some reason to think the reverse, at least insofar as the transaction cost of change is not offset by the improvements delivered. This is not surprising when one considers the back and forth nature of healthcare reform in the UK and New Zealand.

The recent reform in Australia was not based on any clarity about what, if anything, was wrong with our healthcare system; nor were the objectives of the system or the reform articulated. I'd argue that the system is under selection pressure to do the best it can with the structures and resources it has because that is the intention of those who work in it. To the extent that this is the case it would be surprising if the kind of reform introduced in Australia led to improvement.

Reformers do your worst. The rest of us will get on with delivering care to those who need it.

The blame game

MICHAEL PERVAN
Deputy Secretary
System Purchasing and Performance, Department of Health and Human Services, Tasmania

Michael Pervan suggests it's time the health industry took the baton of reform

ON 13 MAY this year a special anniversary came and went so quietly that I bet many of you missed it. It is exactly four years since the media statement *Ending The Blame Game: Reforming The Health And Hospital System* was released by the then Commonwealth Minister for Health, the Hon Nicola Roxon.

Re-acquainting myself with the words of promise, the Commonwealth Minister announced that: "For too long, the blame game has hurt the health system – and hurt patients. This Budget heralds a new era of cooperation, collaboration and honest, open dialogue between the Australian Government and the states and territories on health".

The hospital system and public patients weren't prospering four years ago. There were around 50,000 patients over boundary on the elective surgery waiting lists nationally, ambulances were ramped outside emergency departments and there was a feeling of hopeless disengagement between the health system and its policy makers.

I vividly remember the excitement and hope that accompanied multiple visits to our Hospital by the former Prime Minister who surprised everyone with his detailed knowledge of the mechanics of the system and of what was and was not working. We believed we were having an open and honest dialogue with the Prime Minister himself that would lead to a better system, one where we focussed on the patient and their care instead of only the financial costs of treating the ill.

In the May 2008 media release, the Minister also mentions that the government had "established a National Health and Hospitals Reform Commission, to develop a long-term plan for tackling current and future challenges in the Australian health system". Everything seemed to be heading in the direction of genuine, positive change four years ago.

So after four years, have we designed and implemented a new system that was promised?

Well, we have Medicare Locals and Local Hospital Networks. While these are new descriptors, they are largely a governance veneer laid over existing health service structures. Service locations, profiles and models of care remain exactly where they were four years ago.

In response to a system where the Prime Minister himself condemned purposeless red tape, bureaucracy and over administration diverting scarce resources from patient care, we have a new Independent Hospital Pricing Authority, a National Health Performance Authority and a National Funding Pool Administrator. And to feed those agencies with data and reports, a supporting bureaucracy in all states and territories that collectively costs tens of millions of dollars. In return, six jurisdictions have been told that their systems are 'inefficient' and face being significantly financially penalised in the future by the new funding system as a result.

And we have around 50,000 patients nationally over boundary on the elective surgery waiting lists...

In discussions on health system reform you will often hear people quote some version of the maxim, 'every system is perfectly designed to produce the results it gets'. Perhaps what we haven't grasped yet is that if we are to achieve different results we must change the system and not simply increase the reporting and accountability of the old one.

At times like this it is wise to remember that improvement is a journey that never ends. It is easy to dismiss where we are at with national health reform. It is harder to acknowledge our individual role in what happens next. Perhaps what we have is the administrative infrastructure and processes needed to support change, and what is required is for health services to take the baton and lead the improvements that we all proposed and promoted four years ago and to which I believe many of us are still committed.

Health Policy Research Institute

The AHHA launches the Deeble Institute

THE AHHA along with the Institute's seven Founding Partners are thrilled to announce the launch of the Deeble Institute.

The Institute was launched at the AHHA Congress in Sydney on September 25 by the Institute's Inaugural Chair, Professor Vivian Lin, and Dr John Deeble (AO) himself. The Founding Partners of the Deeble Institute are:

- Australian National University
- Griffith University
- La Trobe University
- Queensland University of Technology
- The University of Western Australia
- University of Canberra
- University of Wollongong

We are delighted that Dr Deeble has agreed to lend his support, and his name, to the Institute. Dr Deeble is one of Australia's most experienced and respected health policy experts. During his career, he worked as a health service administrator, academic and policymaker, so he understands the benefits that come from strengthening the connections between these people and organisations.

Many will know John Deeble as one of the architects of Medicare, but he started his career as a hospital administrator. It is here that he came to see firsthand the problems ordinary Australians faced when trying to access affordable health care. Driven by his compassion and commitment to social justice, John used his expertise in health financing and embarked on doctoral research that highlighted the problems with Australia's health system in the 1960s. More importantly, however, he and his colleague Dick Scotton went on to devise a scheme that would fix these problems and make health care affordable for all Australians. To their surprise, the scheme they devised was picked up by the Australian Labor Party in 1968 and adopted as one its flagship polices.

When the Whitlam Labor Government was elected in 1972, Dr Deeble left the safety and comfort of academic life and entered the rough and tumble of politics. There he worked tirelessly as a ministerial adviser to get Australia's first universal health insurance scheme, Medibank, up and running. Later, he returned as a ministerial adviser to the Hawke Government and helped implement Medicare.

Later in his career, Dr Deeble went on to make a valuable contribution to academic life in Australia and internationally. As an Emeritus Fellow of the Australian National University, a Sax Medallist and life member of the AHHA, Dr Deeble continues to generously share his enormous knowledge and experience in health care. Most remarkable of all, after all these years John's commitment to better health policy and a better health system remains undiminished. For all these reasons, and more, we are honoured to name our new institute the Deeble Institute.

With the excitement of the launch now over, the Deeble Institute is getting down to business. Already, we have produced a number of Health Policy Evidence Briefs for policymakers that synthesise and interpret the evidence in an important area of health policy, such as maternity models of care, food labelling, and fiscal measures for tackling obesity. We also have a number of collaborative research projects underway, but we're keen to hear about any ideas you have for research that will help improve our health system and health services.

To get involved in the Deeble Institute's work or to find out more about what we are doing, please don't hesitate to get in contact.

Contact:

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Director – Deeble Institute
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Email: aboxall@ahha.asn.au

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JustHealth Consultants

Taking the pain out of health needs assessments

FOR THOSE of you keeping count, all 61 Medicare Locals have now been rolled out across the country to improve the delivery of primary health care in their local regions. The final 25 organisations are the newest kids on the block, commencing operations on 1 July 2012.

Medicare Locals are charged with driving primary health care reform to improve health outcomes and reduce inequalities. Critical to achieving this, each Medicare Local must develop a pivotal understanding of the health needs of their population and use this information to inform their planning and decision-making. In performing this undertaking, Medicare Locals are expected to engage with Local Hospital Networks, local service providers and organisations and local catchment populations.

The Department of Health and Ageing has charged the newest Medicare Locals with the delivery of both an after-hours needs assessment and a general needs assessment of the health of their catchment by early 2013.

We expect that this all seems a bit ominous... but help is at hand.

JustHealth Consultants (JHC), the business arm of AHHA, draws its consultants from across the Australian health industry. Unlike larger consultancy companies, JHC is in the enviable position to attract renowned experts who undertake the work personally and do not divest it to more junior staff. Our team of experts deliver national expertise with geographic spread, substantial experience in undertaking similar projects and credibility in the field. JHC offers a range of high quality services specifically designed to support new and existing healthcare organisations in all sectors of the industry to meet their complex governance, organisational and quality assurance requirements.

JHC has recently completed a health needs assessment for the Nepean Blue Mountains Medicare Local (NBMML) in NSW and would like to extend our services to new and existing Medicare Locals nationally.

Our work with NBMML included a desk-top analysis of the health needs of four local government areas, face to face and online community consultations that attracted over 250 participants and compilation of a submission to the Department of Health and Ageing. This review is pivotal in the development of the NBMML strategic plan and will shape the priority action areas over the next three to five years.

JHC takes pride in ensuring its service provides value for money by offering competitive rates that are well within the reach of not for profit organisations. Members of AHHA receive additional discounts. Our knowledge and links with the sector, specifically the Department of Health and Ageing and the Australian Medicare Local Alliance add to the service offering.

Contact:

Terrie Paul
Director – JustHealth Consultants
Ph: 0438 373 538
Email: tpaul@ahha.asn.au

Who's moving?

Readers of *The Heath Advocate* can track **who is on the move** in the hospital and health sector, courtesy of the AHHA and healthcare executive search firm, Ccentric Group.

NICK O'CONNOR, former Director of Mental Health at Concord Hospital, is now the Clinical Director, Royal North Shore Ryde Mental Health Service.

Jonathan Carapetis, formerly the Director of the Menzies School of Health Research, has been appointed as the Director, Telethon Institute for Child Health Research

At Castle Hill Medical Centre, the new General Manager is **Mark Caldwell**.

In an overseas appointment, the University of Tasmania has announced the appointment of **Professor Thomas Marwick** as the new Director of the Menzies Research Institute Tasmania. Professor Marwick is currently Section Head, Cardiovascular Imaging, at the Center for Cardiovascular Imaging at the Cleveland Clinic in Ohio.

Leanne Laidler is returning to Australia from Asia Pacific Health Partners in Singapore to take up a position as Director of Nursing and Clinical Services at The Mater Hospital, North Sydney.

John Pitsonis, formerly CEO of Lake Macquarie Private Hospital, has been appointed Executive Director of The Mater Hospital, North Sydney.

Tim Smyth, formerly Deputy Director-General, Health System Performance at NSW Ministry of Health, is now Special Counsel at Holman Webb Lawyers.

Linda Edgerton has joined Primary Healthcare as National Manager of Hospital Imaging. She was formerly General Manager, Commercial Operations with Ramsay Healthcare.

Julian Maiolo from KPMG Health and Human Services is now with Paxton Partners as Associate Director.

Brett Dennett, formerly Director of Clinical Services at Lake Macquarie Private is staying local, but has joined Healthecare as CEO at Toronto Private Hospital.

However, **Brett Goods,** the former CEO of Toronto Private Hospital, is moving a short distance, and has transferred within Healthecare to Mayo Private Hospital, Taree as the new CEO.

In South Australia, **Lynn Bailey** is leaving her position as General Manager at Omega Senior Care to join Southern Cross Care as Regional Manager, SA.

Mark Lubliner, formerly Executive Director of Strategy at Cabrini Health is departing the organisation to assume the role of Group Director, Medical Services at St John of God Healthcare.

Bruce Dixon, former Managing Director of Healthscope has been appointed CEO of Spotless.

In a similarly clean break, Healthscope's former Chief Financial Officer, **Joe Czyzewski,** is taking the top financial job at Spotless.

CEO **Garry Smith** has left Auckland District Health Board to head up The Selwyn Foundation in New Zealand.

Alice Killen is now the interim CEO at the Skin & Cancer Foundation, Australia.

Sue Belsham has been appointed as the inaugural CEO of the North-West Hospital and Health Service in Mount Isa – the Queensland gulf city often known as the 'Oasis of the Outback.' ha

If you know anyone in the hospital and health sector who's moving, please send details to the Ccentric Group: editor@ccentricgroup.com.

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

THE AHHA supports your access to networks of colleagues. It provides professional forums to stimulate critical thinking. It facilitates a collective voice across Australia and develops innovative ideas for reform.

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As a member, you will have access to the association's regular professional development activities and to networking opportunities with colleagues across Australia through our stimulating networks and innovative events.

You will also receive the *Australian Health Review*, Australia's foremost journal for health policy, management and delivery systems (print and online), as well as our magazine *The Health Advocate*, up-to-the-minute email news bulletins and other professional information.

AHHA values your knowledge and experience

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

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

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

Your knowledge and expertise in these areas are valuable and you can have direct input to our policy development. Join our think tanks or participate in our national seminars or conferences. Our voice is authoritative and influential. It is heard via our high-level advocacy program and extensive media exposure.

Image: iStockphoto

Membership Fees 2012-2013

Student	Australian: $215	Overseas: $289
Personal	Australian: $289	Overseas: $397
Associate*	Australian: $1158	Overseas: $1577
Corporate	Australian: $1158	Overseas: $1577

*Companies providing products and services to healthcare providers

Institutional / Academic Members (Australian healthcare providers)		
Gross Operating Expenditure (x 1,000,000)		
Equal to or greater than:	**Less than:**	**Membership**
$0	$10	$1,864
$11	$25	$3,726
$26	$50	$8,699
$51	$100	$14, 567
$101	$250	$17,745
$251	$400	$23,625
$401	$550	$29,295
$551	$700	$36,330
$701	$850	$41,475
Over $850		$47,355

*Fee includes GST - valid from 1 July 2012 to 30 June 2013

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Trade news

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1. SmofKabiven® Product Information 20 January 2012
2. Australian Government Department of Health and Ageing Therapeutic Goods Administration. ARTG Medicines. Retrieved 30 April 2012 from http://www.ebs.tga.gov.au

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PLEASE REVIEW FULL PRODUCT INFORMATION BEFORE PRESCRIBING.

In this publication Minimum Product Information can be found on page 7.

Fresenius Kabi Australia Pty Limited, 964 Pacific Highway Pymble, NSW. PM2012.193b

Snippets

The last word

What's been happening since we last met?

IN JULY the Minister for Mental Health, Mark Butler, launched Australia's first national e-mental health online portal. mindhealthconnect.org.au is designed to provide a trustworthy source of information, support and a gateway to therapy for people seeking help for mental health disorders. Mr Butler said "We know that one in five Australians will experience a mental illness every year. We also know less than half of these people will seek treatment. This portal will allow people to access information and treatment as an alternative to traditional face-to-face services, in their own time, in an environment in which they're comfortable."

In a world first, it was announced that Australian schoolboys will be able to get the successful Gardasil vaccine, which will protect them against developing a range of cancers and bolster the effectiveness of this vaccine in women. Starting next school year, the Australian Government will fund the vaccine for boys aged 12 and 13 through school based programs under the National Immunisation Program. Year 9 boys will also be able to get the vaccine at school under a catch-up program for the next two years.

In July the NSW and Victorian governments joined forces in a partnership designed to move Australia towards a full National Disability Insurance Scheme.

In August the Federal Government welcomed the decision of the High Court of Australia to reject the legal challenge by big tobacco against Australia's world-leading plain packaging of tobacco laws saying that this is a victory for all those families who have lost someone to a tobacco related illness. Plain packaging will restrict tobacco industry logos, brand imagery, colours and promotional text appearing on packs. Brand and product names will be in a standard colour, position and standard font size and style. All tobacco products sold in Australia must be in plain packaging by 1 December 2012.

A record number of Australians joined private health funds in the previous financial quarter. Despite doomsday predictions that thousands would drop their cover after the government passed legislation to means test the private health insurance rebate, the opposite has happened. A record 132,366 people took out private hospital insurance in the June Quarter, the largest quarterly increase since 2007. Currently about 10,588,000 or 47 percent of Australians now have hospital cover.

The Australian Medicare Local Alliance, Australia's peak agency for Medicare Locals, was launched in August and along with the commencement of the third round of Medicare Locals on 1 July, it concluded the structural transformation of the primary health care system under National Health Reform. The Alliance's core business is to "advocate for primary health care and work with Medicare Locals to innovate and to strengthen the quality, safety and accessibility of community based patient care locally across the nation."

In August, Health Minister Tanya Plibersek announced a dental package of $4.6 billion over six years for the most vulnerable Australians. The package, to begin in 2014, supports all children whose families are eligible for Family Tax Benefit Part A and low-income adults who are most in need of dental care. ha

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