The Health Advocate

ISSUE 14• June 2012

The official magazine of the Australian Healthcare & Hospitals Association

Your voice in healthcare

Legal update

Advance Care Directives

An age-old problem

Addressing oral health in aged care

New dimensions in telemedicine

Trialling high-definition, three-dimensional applications

Improving models of aged care

ALSO in this issue

- Choosing the right super fund
- Who's moving in the health sector
- AHHA news and more

More people in health and community services choose HESTA than any other fund

Your super fund can make a lifetime of difference

- ✓ Run only to benefit members
- ✓ No commissions
- ✓ Low fees

SUPER RATINGS · SUPERRATINGS PLATINUM SUPER 2012 · 7 YEAR PLATINUM PERFORMANCE 2005–2012 · 5 YEAR PLATINUM PERFORMANCE 2007–2012 · SELECTING SUPER AAA QUALITY INDEPENDENT RESEARCH CONDUCTED BY RAINMAKER INFORMATION. LIC 2003070

HESTA

An Industry SuperFund

hesta.com.au

Issued by H.E.S.T. Australia Limited ABN 66 006 818 695 AFSL No. 235249 Trustee of Health Employees Superannuation Trust Australia (HESTA) ABN 64 971 749 321. Consider a Product Disclosure Statement before making a decision about HESTA products, call 1800 813 327 or visit our website for copies.

The Health Advocate

AHHA Council and supporters

AHHA Board

The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation, the protection of its assets and the quality of its services. The 2011-2012 Board is:

Dr Paul Scown (VIC)
National President
Dr David Panter (SA)
Immediate Past President
Ms Siobhan Harpur (TAS)
National Vice President
Mr Felix Pintado (VIC)
National Treasurer
Ms Kathy Byrne (QLD)
Member
Prof Kathy Eagar (NSW)
Academic Member
A/Prof Annette Schmiede (NSW)
Member

AHHA National Council

The AHHA National Council oversees our policy development program. It includes the AHHA Board above and the following members:

Dr Patrick Bolton (NSW)
Ms Helen Chalmers (SA)
Ms Rosio Cordova (NSW)
Ms Jan Currie (NT)
Dr Martin Dooland (SA)
Ms Kerrie Field (NSW)
Ms Anna Fletcher (Personal Member Representative)
Ms Sheila Holcombe (NSW)
Mr Graeme Houghton (TAS)
Mr Graem Kelly (VIC)
Ms Elizabeth Koff (NSW)
Dr Yvonne Luxford (Associate Member Representative)
Mr Andrew McAuliffe (NT)
Mr Chris McGowan (WA)
Prof Keith McNeil (QLD)
Mr Ross O'Donoughue (ACT)
Mr Michael Pervan (TAS)
Ms Barbara Reid (ACT)
Ms Joan Scott (ACT)
Mr John Smith (VIC)
Mr Mark Sullivan (VIC)
Ms Sandy Thomson (WA)
Dr Annette Turley (QLD)
Mr Robert Wells (Academic Member)
Dr Barry Catchlove (International Hospital Federation)

Secretariat

Ms Prue Power
Chief Executive Officer
Editor, *The Health Advocate*
Ms Terrie Paul
Director Membership and Business Services
Dr Anne-marie Boxall
Director Institute for Health Policy Research
Ms Susan Baxter
Policy and Publications Coordinator
Ms Sue Wright
Office Manager
Mr Dennis Strand
News Editor
Ms Laura Maher
Web and Database Editor

Australian Health Review

Australian Health Review is the journal of the AHHA. It explores healthcare delivery, financing and policy.

Prof Andrew Wilson
Editor in Chief
Dr Anne-marie Boxall
Editor
Dr Simon Barraclough
Associate Editor, Policy
Dr Richard Hecker
Publisher (CSIRO Publishing)

AHHA Sponsors

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

Primary sponsors

HESTA Super Fund
Good Health Care

Event sponsors

Holman Webb Lawyers
PricewaterhouseCoopers

Other organisations support the AHHA with Institutional, Corporate, Academic, and Associate Membership. To find out about joining the AHHA and having your organisation listed, contact Terrie Paul.

AHHA Office
Unit 2, 1 Napier Close
Deakin ACT 2600
Postal address
PO Box 78
Deakin West ACT 2600
T: 02 6162 0780
F: 02 6162 0779
E: admin@ahha.asn.au
W: www.ahha.asn.au

Editorial and general enquiries
Prue Power
T: 02 6162 0780
E: admin@ahha.asn.au

Membership and subscription enquiries
Terrie Paul
T: 02 6162 0780
E: tpaul@ahha.asn.au

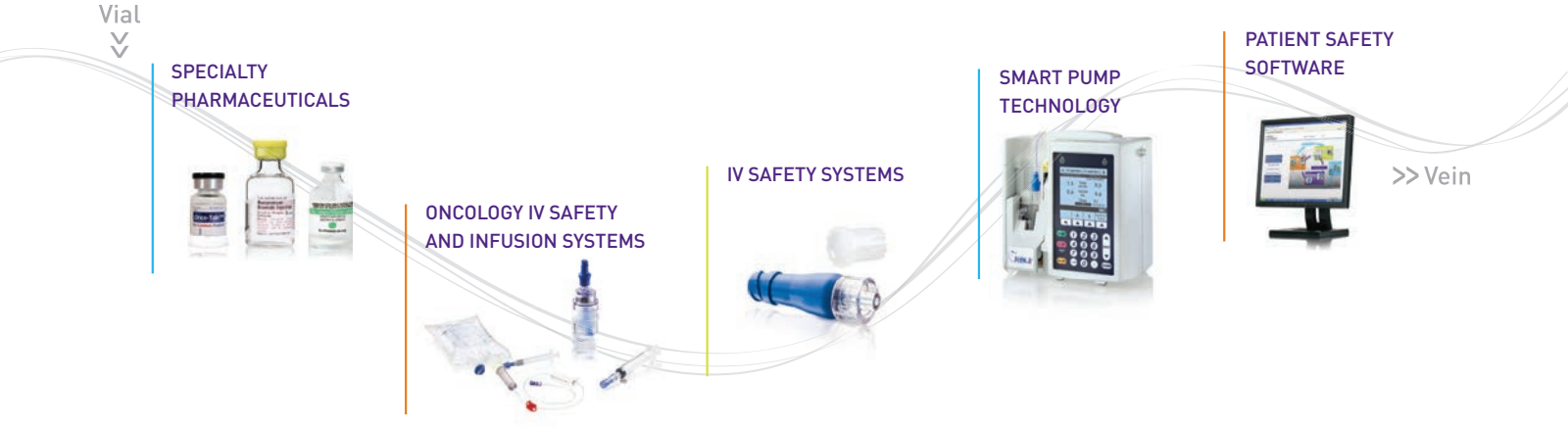
Advertising enquiries
Adam Cosgrove
Globe Publishing
T: 02 8218 3412
E: adam.cosgrove@globepublishing.com.au

globe PUBLISHING
CUSTOM MAGAZINES

The views expressed in *The Health Advocate* are those of the authors and do not necessarily reflect the views of the Australian Healthcare and Hospitals Association.

HESTA
An Industry SuperFund

GoodHealthCare



Hospira is the world's leading provider of injectable drugs and infusion technologies. Through its broad, integrated portfolio, Hospira is uniquely positioned to Advance Wellness™ by improving patient and caregiver safety while reducing healthcare costs.

WE LISTEN. WE THINK. WE DISCOVER. WE CREATE. WE ADVOCATE. WE INVEST.

Hospira

© Hospira Pty Ltd 2011 ABN 13 107 058 328 120101HOSP 01/2012

Contents

In depth

10 Managing complex care: the balance between acute and home care

12 Providing complex care in the community

14 We need to talk about death: reclaiming dying

16 Join the fight against dementia: making it a health priority

18 An age-old problem: oral health in aged care

20 Living longer, living better. NACA examines the aged care reforms

Briefing

22 New dimensions in telemedicine

27 Super benefits: choosing the right default fund

36 Legal insights: Cases involving Advance Care Directives

Opinion

31 **Models of palliative care**
Yvonne Luxford on helping people die well

32 **Creative ageing**
Margaret Meagher thinks it's the best way to age

33 **Models of care**
Judith Dwyer asks what's not to love?

34 **Planet of the apps**
Michael Pervan questions whether the PCEHR will improve quality of care

35 **This year's model**
Philip Darbyshire presents his model for big-picture thinking

From the AHHA desk

6 President's view

8 AHHA in the news

38 Activities from AHHA's member organisations

40 Book review

41 Congress 2012

42 Who's moving?

44 Become a member

46 Snippets and cartoon

DR PAUL SCOWN
President of the
Australian Healthcare and
Hospitals Association

The 2012-13 health budget

The Health Budget delivers a solid foundation to build on in the future

THE 2012 Federal Budget was handed down as this edition of *The Health Advocate* was going to print. The following is a brief overview of the key issues. You will also find more detail on page 8.

Despite difficult economic circumstances and the Government's pledge to return the Budget to surplus, it was pleasing to see funding for important investments in health able to be prioritised.

The AHHA strongly welcomes the $515m dental package, given our longstanding commitment to this issue. The package includes a big focus on 'blitzing' public dental waiting lists – which will help speed up access to dental care for those most in need. There is also funding for the public dental workforce, dental infrastructure in rural areas and oral health promotion. While we welcome this much needed funding boost, it falls a long way short of universal access to dental treatment. The AHHA looks forward to working with the Government on the further steps that need to be taken on the journey towards this goal. Other Budget highlights include:

- e-health: $233.7m for the continuation of funding for the roll-out of personally-controlled e-health records, ensuring people around Australia can register for an e-health record from 1 July this year. This will help promote more coordinated and integrated health care for consumers;
- Bowel cancer screening: $49.7m for the staged expansion of the National Bowel Cancer Screening Program. While biennial screening won't be fully implemented until 2017-18, when it is this program will prevent as many as 500 deaths from bowel cancer in Australia every year;
- Rural and regional health infrastructure: $475m for 76 health infrastructure projects in rural and regional areas – the final 'drawdown' from the Regional Round of the Health and Hospitals Fund (HHF);
- Aged care: $3.7 billion aged care package, focused on expanding aged care services and providing more options for older Australians to stay in their own homes longer through a big boost to the number of home and community care packages. The package also includes investment in the aged care workforce and dementia care.

Given the broader economic circumstances, it is noteworthy that the Health portfolio has by and large escaped the razor gang's scalpel. The Health Budget contains only modest and targeted savings proposals, such as further tightening of the Extended Medicare Safety Net and changes to the Private Health Insurance Rebate to remove benefits for some natural therapy services.

While large-scale savings have been avoided, it is worth noting though that some of the new spending measures are being partly funded by money being redirected from other areas – for example, funding that was earmarked for Multi-Purpose Services in the 2010 Budget ($120.7m) is being redirected to the aged care package.

The $1 billion start-up funding for the National Disability Insurance Scheme is a nation-building social reform. As the initial funding only covers five percent of Australia's disabled, this is only a first step in the introduction of a comprehensive scheme that will address inequities faced by people with disabilities, their families and their carers. It will be critical for the Government to maintain a long-term focus on this initiative.

Overall, the AHHA believes this is a prudent Budget given the current global financial environment. However, we point out that future budgets will need to build on this foundation to ensure that the measures announced today deliver long-term health gains to the Australian community. ha

At Fresenius Kabi, your priority really is our priority.

With a focus on the provision of high quality and best in class therapeutics, technology and service, Fresenius Kabi strives at all times to support healthcare professionals in their endeavours to address the needs of patients.

FRESENIUS KABI

caring for life

Fresenius Kabi Australia Pty Limited ABN 39 109 383 593 **Address:** 964 Pacific Highway PYMBLE NSW 2073
Tel: 02 9391 5555 **Fax:** 02 9391 5505 **Email:** info@fresenius-kabi.com.au **Web:** www.fresenius-kabi.com.au

PM2012.015

AHHA in the news

HAVE YOUR SAY...
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**

A solid base for a healthy future

AUSTRALIA'S DENTAL health crisis has finally been taken seriously by the Federal Government, which delivered a substantial package ($515.3m over four years) targeted at those most in need of dental care.

After seven long years of campaigning on this issue, the AHHA welcomed the Budget initiative, which will give thousands of low income Australians on waiting lists relief from the health, social and economic problems resulting from long-term dental disease. The AHHA also welcomed funding for dental health workforce and infrastructure initiatives, which will strengthen our public dental health system for the future. We look forward to working with the Government and other stakeholders in this area to ensure that the benefits of this funding measure are sustained over the long term.

The Budget delivered on other critical areas such as aged care ($3.7bn over five years), bowel cancer screening ($49.7m over four years), e-health ($233.7m over two years), Indigenous health ($713.5m over 10 years) and disability ($1bn over four years).

While the AHHA welcomed funding for the expansion of the National Bowel Cancer Screening program, testing will only occur every five years until 2017-18. With evidence demonstrating that testing is most effective when conducted every two years, it is disappointing that Australians in the at-risk age groups will have to wait until then to receive biennial tests.

The most concerning saving was the $120m cut from the Multi Purpose Services program, which will mean more than 200 sub-acute beds promised as part of the Council of Australian Governments health reform agreement will not be funded. The AHHA is concerned that this may affect the future availability of sub-acute beds within these facilities. This would significantly disadvantage rural communities where these beds are used to enable older people to receive sub-acute care close to their families and support networks.

The AHHA is also very concerned about the removal of the MBS item for Hyperbaric Oxygen Therapy for the treatment of non diabetic chronic wounds as a savings measure and will be following up on this issue.

And the Government continues its strong commitment to tobacco control, reducing the inbound duty free allowance for cigarettes and tobacco for international travellers (which will net a handy saving of $600m).

Public health the top of the list for new Queensland Government

FOLLOWING THE Queensland election, the AHHA welcomed the new Minister for Health Lawrence Springborg and Assistant Minister Dr Chris Davis.

"Queenslanders deserve a world-class public hospital system and AHHA calls on the incoming Minister to make public health care the top priority for his Ministry," Prue Power said.

The AHHA also called on the incoming government to focus on the safety and quality of health care throughout the health system through working collaboratively with clinicians, hospital managers and consumers. "By working together, we can deliver a first class public healthcare system for Queensland," Ms Power said.

Rural health reform opportunities need better communication and flexibility

IN APRIL, over 100 people concerned with healthcare services in rural, regional and remote areas came together from around Australia to discuss the implications of national health reform for rural health services and outcomes.

Participants expressed a sense of uncertainty about the shape of the reforms and their ultimate impact on rural and remote areas that have highly diverse communities and needs. In particular, the role of Medicare Locals and their relationships with Local Hospital Networks remain unclear. They called on governments to improve communications to ensure that the structure and intentions of the reforms are clear to both the healthcare sector and rural communities.

A flexible workforce is a key to maintaining necessary levels of service in rural and remote areas. Participants called for a greater focus on training generalists in medicine, nursing and allied health, and incorporating them appropriately into integrated health care teams.

Federal Budget: Dental D-Day

IN MARCH a number of key bodies, including the AHHA, reiterated their call on the Federal Government to invest in public dental care in the Budget. They said that Australia's public dental health services are at crisis point and the oral health status of many groups in the community is declining at an alarming rate. Untreated dental problems can impact upon people's ability to eat nutritious food, socialise and gain education and employment. If these issues are not addressed immediately, the long-term health, social and economic impact on our community will take generations to reverse.

Data shows more dental doom

THE AIHW report *Oral Health and use of dental services* provides stark evidence of the dental health crisis facing the Australian community. The report shows that one in three adults (34 percent) reported avoiding or delaying dental treatment because of cost.

In some groups, such as 25-44 concession holders, more than half (58 percent) reported cost barriers to accessing dental care. Even people on middle incomes of $40,000-$60,000 are experiencing difficulty with 42 percent avoiding or delaying treatment because of cost.

The AHHA called on the Australian Government to commit to dramatically improving access to affordable basic dental care in the Federal Budget, as a first step to a universal dental program that recognises that oral health is part of general health.

Federal Budget should focus on consumers

THE AHHA says a more efficient health system that works better for consumers should be the focus of the upcoming Federal Budget. This Budget offers the Federal Government the opportunity to reverse the worrying decline in Australia's oral health standards and to build a health system that is genuinely focussed around consumers' needs and priorities. Developments in information technology and current health systems research give us the opportunity to develop a world-class public health system. It also means we can address the unequal health status of some groups in the community, for example, Indigenous Australians and people in rural and remote areas.

"QUT was the only university I could find that would give me an integrated approach in my practice. When I looked into it as a pathway to registration as a psychologist, I really could see that the training is of such a high standard. The opportunity to study a range of therapies has been immensely important in working not only with other health professionals, but in being able to tailor treatment to specific patients."

Dr Rachael Bellair, QUT graduate

Are you passionate about making a real difference to people's lives through health care services and policy? Add value to your career and take it to the next level with a postgraduate qualification from QUT.

You'll learn from some of the most respected and influential practitioners, researchers and policy shapers in Australian health, welfare and biomedical and clinical science. Depending on your chosen course, you have the option of studying on campus or online to help you balance your study with other commitments.

Advance your skills and expand your career opportunities with postgraduate studies in:

- Nursing
- Health Management
- Occupational Health and Safety
- Psychology
- Counselling
- Public Health
- Social Work
- Environmental Health
- Biotechnology
- Ultrasound – Breast/Cardiac/Medical
- Research – undertake innovative research through a PhD

Apply now.

Learn more at **www.qut.edu.au/boost-your-health-career**.

a university for the **real** world®

QUT

Managing complex care

How can we achieve **a better balance** between **acute and home care** for our ageing population?

I REGULARLY TRY to join the emergency department team doing their morning round. This is partly a bed management strategy, partly to build relationships with one of the high-pressure parts of my organisation, and partly because I enjoy the clinical refresher this provides. A couple of patterns have struck me as a result of this practice. These are the increased proportion and increased complexity of older patients compared to when I worked regularly in acute general practice over a decade ago.

Doctors are taught to estimate the patient's age and then check their estimate against reality as a benchmark of that patient's wellbeing. Quite a number of older patients look surprisingly well for their years, aside from whatever acute reason has led them to

PATRICK BOLTON
Vice President of the Australian Healthcare and Hospitals Association

"Harmful errors are common in healthcare and both their frequency and severity increase with increased complexity of care"

the emergency department (ED). For others, I wonder whether ED and hospitalisation is what they and their families would really want if they had the opportunity to be properly informed and our healthcare system was better able to match care to need.

My hospital has a pretty active program of advance care directives and it is unusual for a patient who has requested less active care to be brought to our ED. However, on the odd occasion that they are, staff can be ignorant of the existence and content of the directive until after it has been breached. I have my doubts about the global value of the electronic health record, but expect that it would be reasonably simple to establish an electronic register of advance care directives which, with patient consent, could be accessed by registered health practitioners and institutions, thus allowing them to better tailor the care they provide to patients' wishes.

Even in the absence of an advance care directive, there is no sense in, or legal requirement to provide care that is futile. The futility of care needs to be judged against the patient's background condition and quality of life. This assessment is generally best made by the patient and family in consultation with a doctor who knows them well, like their GP, before the patient comes to hospital. Hospitals are designed to provide active care, so this is their default approach to patients.

Our system does not easily support GPs to work with patients and their families to provide more acute – but not necessarily more active – care at home. Patients are often found to have deteriorated overnight at the start of the new day. By the time the GP is contacted he or she is committed to their busy morning practice, making it difficult to visit the patient to assess and treat them. Getting an ambulance to take them to hospital is easier and may address anxieties on the part of patients or their carers around providing the best possible care.

Easier, but not necessarily better for the system as a whole. The episode cost for a patient to be transported to an ED by ambulance and assessed there is over $500. There is some evidence that some populations of older patients do less well when they receive hospital care compared with more conservative care in the community. It is possible to think of models that could be trialled which might be more in line with patient wishes, better for them and more efficient.

In the late 1990s I was involved in DiNQUM GP ('Dinkum GP'), a project seeking to improve the management of polypharmacy in the elderly. We defined 'polypharmacy' as taking five or more medications, in part on the basis of literature that suggested patients taking this many medications were almost certain to have at least one clinically important drug-drug interaction.

Fifteen years ago it took many of the participating GPs some effort to find 20 patients who met the criterion for polypharmacy. It would be difficult these days to find a patient in the ED over 70 who did not meet this definition. Many are on an anti-hypertensive, lipid lowering agent and aspirin as a baseline.

The increased complexity of older patients is illustrated by the extent of polypharmacy. It is commonplace that the ageing population has resulted in more people living with chronic illness, but this is compounded by an increased complexity of treatment. For example, lipid lowering agents with an acceptable side-effect profile were much less available in the past and an increased appreciation of the benefits of systematised care for chronic disease management has increased the rate of intervention.

The challenge of this complexity is the capacity of healthcare workers and patients to manage it. Harmful errors are common in healthcare and both their frequency and severity increase with increased complexity of care. We know that patients often struggle to comply with complex care regimes, such as taking multiple medications as prescribed, even with the help of tools such as Webster packs.

What is not yet clear from the evidence is how best to integrate complex care or whether some optimum level of care exists, beyond which the benefit from additional care declines. ha

Community care provided by a specialist can be **effective and cost-efficient**

Providing complex care in the community

MARK COCKAYNE
Director Hospice Care Service, Silver Chain

"If we want to tackle a problem that affects all of us, let's think big. If we want to transform health care, let's change the way we die"

THE RECENT TALK in government and media about the shortcomings of health care in Australia systematically under-rates a key plank of the solution: community models of care.

It's time now to make some decisions - some tough ones - and set a course towards building a more responsive and inclusive healthcare system here in Australia. One where the health consumer is firmly placed at its centre. Robust community models of health care should be key elements of achieving that outcome.

Silver Chain has particular experience and expertise in the end of life and palliative care needs of our communities. Silver Chain's community palliative care delivers a high quality, effective and person-centred model, which also significantly reduces the tax-payer cost burden.

While much has changed since the evolution of the modern palliative care movement in the 1960/70s, there is an expressed desire of our communities that requires further thought and action. Up to 75 percent of people want to be cared for and die at home, yet most will die in in-patient facilities across the country. Why?

In a recent Harvard Business Review article, Pulitzer Prize winning columnist Ellen Goodman wrote: "If we want to tackle a problem that affects all of us, let's think big. If we want to transform health care, let's change the way we die."

The way we die says much about our society and must be one mark of our humanity as a whole. Quality care at the end of life must be recognised as a basic human right. While the way we die in Australia has improved markedly through better pain management and understanding about the process of dying, we are not currently meeting all community expectations about the way we die, as evidenced by the majority of Australians dying in a hospital setting. So, what do we know about dying in Australia today?

- 75 percent of all deaths can be anticipated
- Patterns of death have changed radically in the past 100 years
- 61 percent of residents admitted as high care into residential aged care will die within 12 months
- By 2056 the death rate will be more than double that of today
- It is estimated that five percent of people accessing the Australian healthcare system consume almost 25 percent of its entire funding in the last 12 months of their life
- It is about five times less expensive to care for a person with a life threatening illness at home than it is to care for them in hospital
- In-patient settings are typically poorly placed to address the social determinants of health and the complex family and social dynamics that complicate a terminal illness
- Inequitable funding of community palliative care service provision across the country provided at a whole of population level can vary from $1 to $10 per person/annum – a 1000 percent differential.

Clearly, if the community's expectation is to be cared for and die at home, then this requires a significant shift in the way in which we conceptualise and resource community services. Creating more hospital beds will not in the main lead to more people being cared for and dying at home – we need to utilise the beds we currently have in the system better. We need to reconsider health care in an entirely new paradigm, one that is viewed through the eyes of the individual and one where the individual is situated in a community setting.

Complex care in the community is not a casual undertaking and must be the core business of the provider. Such care provision can be patchy and inefficient when delivered as an isolated outreach program from a hospital setting. Best practice community care needs to be a systemic approach that supports a whole population. It requires investment in sophisticated and community-tailored (not expensive) approaches in technology, logistics, HR systems, quality systems and organisational and clinical governance.

A vision that every Australian receives high quality, coordinated and robust health care over which they retain control, choice and dignity requires significant reform and modernisation of palliative care in Australia. This has to start with a re-think of community models of care. ha

Silver Chain has a rich history of more than 100 years of service provision in Western Australia. It is a not-for-profit organisation that provides care to people living in metropolitan, rural and remote areas. Today, Silver Chain is one of the largest providers of community, clinical and healthcare services to the Western Australian and South Australian communities and has a growing presence in Queensland.

We need to talk about death

DR PETER SAUL, an intensivist at the John Hunter Hospital in Newcastle, recently said in a Tedx talk that he toyed with the idea of suggesting that the 'occupy' movement should focus on death rather than on Wall Street![1]

As he pointed out on that occasion, sudden death is now rare and even death after a 'terminal illness' happens mostly to young people. Most of us will die at an old age, after gradual organ failure or as a result of the gradual dwindling of our capacities.

Medical successes of the last half century mean that, for many of us, death will come after we have lost the capacity to talk to our doctors and to those who care for us about what we would want provided to us by way of medical treatment. And in an affluent country like Australia, where virtually everyone has access to advanced medical treatment, this will be a problem for most of us.

In fact, those of us who die in hospital will do so after a decision has been made not to do something. That decision-making imposes great burdens, not only on the healthcare professionals (trained to save lives), but also on the relatives who are consulted. Increasing numbers of us have no relatives to contribute to that decision making process and because the decision making process is so stressful, families are often unable to agree among themselves as to what it is best to do.

So we need to reclaim death and to initiate conversations in our families about what we would want done for us as we approach death. The most valuable thing we can do is identify the person we'd like to speak for us should we become unable to speak for ourselves.

I recently heard of an elderly woman who

We all have a **responsibility to talk** about what we would want done for us as we **approach death**

BERNADETTE TOBIN
Director of the Plunkett Centre for Ethics, a joint centre of St Vincents and Mater Health Sydney and Australian Catholic University

had chosen her adult son rather than her elderly husband. "Mum knew that you would not be able to let her go," the son gently told his father when the time came.

We also need to talk to the person we choose to speak on our behalf so that he or she is strengthened for the task. For it often comes as an onerous responsibility, especially today when people often think doing everything possible to prolong the life of their loved one is the most effective way they can show their fidelity to that person.

As death approaches, indeed as frailty and disability set in, caregivers need to be confident that they are neither over-treating nor under-treating the people in their care. So they need to be able to talk to the person for whom they are caring or, more often, someone who can speak on behalf of that person. Prof Jane Ingham, of the Cunningham Centre for Palliative Care at Sacred Heart Hospice in Sydney, says "I need to be able to talk to someone I know the patient trusted".

So identifying the person we'd like to speak for us, and talking to that person about what matters to us and what our priorities and anxieties are, is something that we all need to do. In fact, I think we have a responsibility to have those conversations, a responsibility to the members of our family and to the community that makes such an array of treatments and forms of care available to us.

What about writing so-called living wills? This is an alternative and better than nothing. But it's now nearly 10 years since the publication of a paper in the US which proved (conclusively, in my view) that written instructions simply don't work. Few people have them; few people can predict their actual preferences accurately; few people can articulate their preferences clearly; and 'living wills' are often not available when they are needed.[2]

In addition, written instructions are not self explanatory; they need interpretation. The course of illness is unpredictable and a doctor needs to be free to provide good care in the actual circumstances of a patient's illness as well as when unanticipated circumstances arise. Written instructions can tie a doctor's hands, privileging past wishes over the provision of reasonable care. So I say let's not go for the bureaucratic solution of filling out yet more little bits of paper. Let's go for the human and humane solution: reclaiming death and talk of death. The better we become at this, the more confident we can be about approaching death, both our own and that of our relatives. ha

References

1. www.ted.com/talks/peter_saul_let_s_talk_about_dying
2. Angela Fagerlin and Carl Schneider. Enough: the failure of the living will. Hastings Center Report, March-April 2004

Join the fight against dementia

Making **dementia a national health priority** is at last within reach

ON 20 APRIL the Prime Minister, Julia Gillard and the Minister for Mental Health and Ageing, Mark Butler announced that the government will take a proposal to the next meeting of Commonwealth, State and Territory Health Ministers that dementia be designated as a National Health Priority.

It is almost ten years since the Access Economics report *The Dementia Epidemic: Economic and Social Impact and Positive Solutions for Australia* recommended that dementia be made a National Health Priority.[1]

This report documented the spiralling prevalence of dementia, the economic cost of over $5 billion and predicted dementia would become the most disabling of all conditions.

In response, the Coalition Government made the landmark decision in 2005 to implement the Dementia Initiative – making dementia a national health priority, which provided $320 million over five years. The funding was used to support high care dementia community packages, expand dementia training, fund dementia care and research and to provide additional funding for Alzheimer's Australia.

An independent evaluation of the initiative found it to be effective and recommended its continuation. However, the evaluation made it clear the initiative had fallen short of the action needed to combat dementia in key areas, including the lack of a communication strategy or action on primary care.

The Dementia Initiative was terminated in the 2011 Federal Budget as part of changed funding arrangements.

The Federal Government's aged care reform package Living Longer, Living Better has not come a moment too soon in recognising the need for a comprehensive plan to tackle dementia. It is a red letter day for people with dementia and their family carers in their advocacy for dementia to be addressed within a public health framework.

The urgency is self evident. There are 280,000 Australians with dementia, a number that will grow by close to 50 percent within 10 years to over 400,000.[2] In 2012 there will be 1,600 new cases of dementia every week. By 2050 that number will grow to 7,400 new cases each week.[3] And by 2030 dementia is projected to be the third largest area of health and residential aged care expenditure.[3]

The Alzheimer's Australia report *Consumer Engagement in the Aged Care Reform Process*, released on 9 April, showed that the overwhelming view of people with dementia and their families who were consulted was that the aged care system is not working well for people with dementia, and even less so for people from diverse communities.

The report found consumers have no clear pathway to access services and once consumers do find some support, it is often inflexible and cannot cope with the special needs that people with dementia and their carers require.

It is not just the aged care system that has failed people with dementia. Arguably the health system fails the person with dementia and their family carer from the start.

Alzheimer's Disease International (ADI) released a report last year that found in high income countries, only 20-50 percent of people with dementia are recognised and documented as having dementia in primary care.[4]

GLENN REES
CEO, Alzheimer's Australia

The findings are consistent with Alzheimer's Australia's own report *Timely diagnosis of dementia: Can we do better?*, which found there is an average of three years before a diagnosis is made from when the first symptoms show. These are three lost years in the lives of people struggling with the uncertainty of knowing what is happening to them.[5]

In acute care there is good evidence from both Australia and overseas that hospital services for people with cognitive impairment are generally poor and that hospitals are dangerous and confusing places for people with dementia.[6] This results in part from failure to identify patients with cognitive impairment and lack of staff training in how to communicate with this population. As a result individuals with dementia have a longer stay in hospitals which leads to added costs to the hospital system.

In Australia there has been an assortment of small projects focussing on improving the quality of dementia care in hospitals. However, it is clear that without coordinated action by the Commonwealth and states, hospitals will continue to be dangerous places for people with dementia.

Despite the evidence, those responsible for preventive health have shown scant interest in dementia risk reduction through environmental and lifestyle changes. As a consequence, there is no recognition in preventive health programs of the links between dementia and other chronic diseases.

And Australia has put our health futures at risk by failing to invest adequately in dementia research. Dementia research is grossly underfunded in relation to health and care costs, disability burden and prevalence compared to other chronic diseases. In the 2011-2012 financial year the National Health and Medical Research Council's research funding for chronic diseases was $159.2 million for cancer, $92.4 million for cardiovascular disease, $71.2 million for diabetes and $53.6 million for mental health. Alzheimer's disease and other types of dementias received only $24 million.

Living Longer, Living Better goes a considerable way to addressing the concerns of people living with dementia in two ways.

The first is to ensure that the aged care reforms have a focus on dementia given it is core business in aged care. Over 50 percent of facility residents have dementia. The reforms address this in three ways:

- There will be a new dementia supplement to provide additional financial assistance for dementia care in recognition of the costs involved in community care packages and residential care. There is a recognition of those with severe behavioural and psychological symptoms of dementia in residential care.
- Respite care will be more flexible to give family carers greater choice in how they use their entitlement. The design will need to ensure not only a break for carers but activities and social engagement for the person with dementia.
- There is funding to provide improved support for people with younger onset dementia. Currently there are few age appropriate services for the 16,000 people aged under 65 who have dementia.

The second strategic element is the recognition of dementia as a chronic condition. Over the last 10 years, successive health ministers and policy makers have not responded to consumer concerns about the diagnosis of dementia, making hospitals safer places for people with dementia, dementia risk reduction or investment in research.

Living Longer, Living Better breaks new ground in health policy. There will be support for better access to timely diagnosis of dementia. GPs and practice nurses will receive much needed training and improved support to help them better diagnose dementia.

Considerable work is already in hand. Minister Butler's Ministerial Dementia Advisory Group is organising a stakeholder forum on primary care for people with dementia, the House of Representatives Standing Committee on Health and Ageing has an Inquiry into early diagnosis and intervention of dementia and Alzheimer's Australia and the Australian General Practice Network have put a proposal to government for GP training in diagnosis and management of dementia.

There is also funding to improve acute care services for people with dementia. Staff will be trained to identify early signs of dementia, particularly at point of admission. Alzheimer's Australia is working with the Australian Institute of Health and Welfare on the economic impact of dementia on hospitals and strategies to better coordinate dementia care in that setting.

Living Longer, Living Better is a significant step forward in addressing the dementia epidemic but it falls short of the $500 million over five years sought in the Alzheimer's Australia Fight Dementia Campaign. There is no additional funding for dementia research. Nor is there any funding to promote awareness of how Australians may reduce their risk of dementia by making changes in their lifestyle.

And there is still no communication strategy to promote a better understanding of dementia in the wider community. Market research in Australia suggests there is limited understanding of the symptoms of dementia beyond memory loss, that it can affect younger people, that it is a terminal disease, that the symptoms develop decades before diagnosis or that lifestyle may offer some risk reduction.

So the battle is won but the war is not over. Australia has again shown that it is capable of leading the world in recognising the need to tackle dementia. And in August, Health Ministers will have the opportunity to make a historic decision by including dementia as a National Health Priority alongside other major chronic diseases.

To support the campaign, sign up as a Dementia Champion at **www.campaign.fightdementia.org.au**

References

1. *The Dementia Epidemic: Economic and Social Impact and Positive Solutions for Australia*, Access Economics, 2003.
2. *Dementia Across Australia: 2011-2050*, Deloitte Access Economics, 2011.
3. *Keeping Dementia Front of Mind: Incidence and prevalence 2009-2050*, Access Economics, 2009.
4. *World Alzheimer's Report 2011: The benefits of early diagnosis and intervention*, Alzheimer's Disease International, 2011.
5. *Timely Diagnosis of Dementia: Can we do better?* A report for Alzheimer's Australia, Paper 24, Dr J. Phillips, Prof. D. Pond, Ms S. M. Goode, 2011.
6. *Counting the Cost* , Alzheimer's Society UK, 2009.

An age-old **problem**

Addressing oral health in residential aged care

AS OLDER PEOPLE living in the community become functionally dependent, their oral health deteriorates. This accelerates when they move into residential aged care. Maintaining reasonable oral health among older people is made more difficult by medical comorbidities, polypharmacy, cognitive impairment, dependence on carers and their limited ability to access timely dental care. As more older people are retaining their natural teeth, the impact of these factors is magnified, as is their increased need for good oral health care.

Poor oral health affects an older person's ability to age positively. Basic qualities of life such as eating and talking comfortably, being pain free and maintaining self-esteem are compromised. Deteriorating oral health is linked to significant general health problems such as cardiovascular disease, stroke, aspiration pneumonia, diabetes and nutritional deficiencies. Older people with oral pain or infection are also far more difficult for aged care staff to manage.

People in residential care need support in four key areas to maintain their oral health:

- oral health assessment
- the development of an oral health care plan
- assistance with oral hygiene
- timely dental treatment.

In 2007, a three-state consortium led by the South Australian Dental Service was funded by the Australian Government under the Encouraging Best Practice in Residential Aged Care (EBPRAC) Program to test a 'Better Oral Health in Residential Care' model based on these four key processes. With the assistance of a resource portfolio, general practitioners and registered nurses undertook simple oral health assessments and developed oral health care plans for residents as part of their wider care plans. Care workers were given training in the techniques of daily oral hygiene for residents. Referral pathways were established to ensure appropriate dental treatment was available and provided.

Evaluation of the program showed residents' oral health status rapidly improved, as did their wider quality of life.

In December 2009, the Australian Government funded the roll out of the Better Oral Health in Residential Care training program to all of Australia's residential aged care facilities under the banner of the first national Nursing Home Oral and Dental Health Plan. During this time 89 percent of the country's residential aged care facilities attended the training. As part of this program residents had an oral health assessment, which was used to inform their care plan, with care workers providing the important daily support for residents' oral hygiene.

The introduction of the national Nursing Home Oral and Dental Health Plan is an important first step in ensuring that older people in residential aged care are able to achieve and maintain reasonable oral health. However, to make the model sustainable, it is important that there is ongoing leadership and investment. This includes the development of strategies that support the training of the aged care workforce (with its relatively high turnover) and the need to provide links to safety, quality and accreditation standards.

Furthermore, if these highly dependent older people are to have a reasonable quality of life, timely dental treatment needs to be more accessible than is currently the case.

Providing dental treatment for people in residential care is a challenge. Someone needs to pay for the treatment and most residents are financially reliant on pensions.

However, there are other barriers that need to be, and can be overcome. For example, residents cannot always be moved to a dental surgery and much of the dental treatment must be provided in the facility. Therefore the dentist will often need access to portable dental equipment. Many residents have complex medical conditions and the aged care staff will need to assist in the interaction between the dentist, medical practitioners and families to manage these issues.

Building oral health into the systems already in place to support the wider general health of people in residential aged care is a highly cost-effective approach. This integration includes making use of the full team of health professionals and carers. However, the four key components of assessment, care planning, maintenance of oral hygiene and referral for treatment must all be addressed in a sustainable way. The next steps involve making affordable and accessible dental treatment available to these highly dependent members of the Australian community. ha

ADRIENNE LEWIS
Project Manager, Aged Care SA Dental Service

"Building oral health into the systems already in place to support the wider general health of people in residential aged care is a highly cost-effective approach"

Living longer, **living better**

The **National Aged Care Alliance** examines the Government's blueprint for **aged care reform**

THROUGH ITS well-coordinated Age Well campaign to bring together a uniform call for reform from the aged care industry, the National Aged Care Alliance (NACA) was instrumental in bringing to fruition the Federal Government announcement on 20 April 2012 of its much anticipated and very significant aged care reform package, Living Longer Living Better. NACA is the representative body of 28 peak national organisations in aged care including consumer groups, providers, unions and professionals. The AHHA is a member.

The Federal Government's reform package is its response to the independent Productivity Commission report, *Caring for Older Australians*, released last year, which recommended comprehensive reform to the aged care sector to provide a system which is simpler, fairer, more affordable and equitable for all Australians. Some of the key elements of the reform package include:

- additional government funding through Home Care Packages and increased accommodation payments for concessional residents
- accommodation payments to be negotiated between providers and residents who can afford to pay, within boundaries set by the new Aged Care Financing Authority, acting as the industry's funding and pricing watch-dog
- removal of the distinctions between high care, low care and extra services places and inclusion of incentives for consumers to pay periodic rent-style payments or a combination of both periodic and lump sum payments for residential aged care accommodation instead of lump sum accommodation bonds
- increased opportunity for providers to obtain recurrent contributions to funding from consumers (user-pays revenue), resulting from changes to means testing
- funding towards achieving parity in wages with the acute sector - also intended to begin to address long-term workforce issues
- establishment of a number of new government bodies, with associated new regulation for providers
- guidance by an independent Aged Care Reform Implementation Council.

While we await the detail, which is anticipated to be released through continued consultation between government and industry stakeholders, NACA supported the package for providing "a firm foundation for ongoing reform of aged care... it provides: far greater support for older people to be able to age at home; a plan to tackle dementia; and a 'Compact' to improve pay and conditions for aged care workers, which were key elements of our Blueprint".

The Productivity Commission emphasised that, without reform of the sector, the system would increasingly fail to meet community needs and expectations and would compromise the quality of care provided to older Australians. Reform had to start now to avoid expensive intervention in years to come.

In heeding the call for reform, NACA developed the Blueprint for Aged Care Reform (available at www.naca.asn.au) which outlined how major reforms could commence as part of this year's Federal Budget and be rolled out in a responsible way over forthcoming years. NACA particularly welcomed the following elements of the announced reform package:

- improved access through a single Gateway, including the My Aged Care website
- giving older people more choice and options for how they pay for their accommodation
- the introduction of fairer and more equitable user contributions
- the establishment of an independently advised Aged Care Financing Authority
- better palliative care and support in aged care
- more support for consumer advocacy and the community visitor program.

However, in the midst of a resounding welcome from the industry, as the detail emerges and further analysis is undertaken, varied opinions of the implications of the reform package are coming to the fore. The most recent of these commentaries is the *Review of the Government's Aged Care Reform Package April 2012*, by Grant Thornton.[1]

"The report is critical of the $1.6 billion clawback from nursing home operational funding to finance other changes and describes the proposed aged care costs watchdog "as another layer of bureaucracy" that was unlikely to work." (The Age, 30 April 2012)

The report casts doubt over whether proposed changes will address the demand for a more consumer-friendly and financially sound industry. In not implementing key recommendations of the Productivity Commission to transform aged care into an 'entitlement' system where funding is allocated to individuals rather than providers, "the cornerstone of a dynamic system" that empowers consumers would not eventuate.

NACA noted that the reform package offers $115 million of new funding per year on average for five years, plus significant redirected funding from the Aged Care Funding Index (ACFI). This latter element is a cause of concern for providers as it would mean the reallocation of $1.6 billion from recurrent funding, mainly because of suspected over-claiming of subsidies. Although much of that money would go to boost wage rates, that would not offset the reduction in funding.

In addition, the Grant Thornton report highlights that reductions in revenue might improve providers' access to the capital required to build new facilities, "only to find they cannot be operated viably. Without certainty around care revenue, it would be inappropriate for providers to progress their extension plans."

The report also raises doubts about the extent to which people will be able to stay in their own homes even with expanded home care support services. It would not be practical or safe for many to remain in their own homes, as they required the ongoing support of spouse, children or friends. Given the composition of the baby boomer population, access to such support would decline.

NACA recognises that priority-setting is essential in the current budgetary climate but that delaying aged care reform is not an option – it's well past time for older people's needs to be given priority. The immediate priority must be preparing for the future now by developing and implementing those reforms that will lay the foundations for real and sustainable long-term change, while also responding to the more immediate pressures in the system.

The Government's proposed reform of aged care puts Australia on the road to ageing well, but there is more work to be done. NACA has committed to work with Government to ensure the package is delivered and has already expressed concern that the entitlement had not been firmly established and some Blueprint recommendations were only partly adopted.

NACA and its sponsors are developing an analysis of the package against the Blueprint, which will include questions for clarification and an issues list for discussion with the Department of Health and Ageing and the Ministers Office.

The AHHA supports NACA in this important detailed assessment of the reform package. As many of the details are unlikely to be known at this stage, NACA is well placed to influence how and what happens. ha

Reference

1. Grant Thornton International is an independently owned and managed accounting and consulting firm.

The National Aged Care Alliance is the representative body of peak national organisations in aged care including consumer groups, providers, unions and professionals. The AHHA is proud to be a member of NACA.

New dimensions in telemedicine

By the Department of Broadband, Communications and the Digital Economy

THE UNIVERSITY of Ballarat is leading the field in Australia in trialling a number of world-first high-definition three-dimensional (HD 3D) telemedicine applications. The HD 3D telemedicine project is led by Associate Professor Andrew Stranieri, from the School of Science, Information Technology and Engineering at the university's Centre for Informatics and Applied Optimisation.

The work is being carried out in collaboration with the Victorian eResearch Strategic Initiative (VeRSI), the Institute for a Broadband-Enabled Society (IBES), the Melbourne Dental School, Information Technology Services (ITS) Research Services (co-located with Melbourne eResearch Group, University of Melbourne), the Department of Psychiatry at the University of Melbourne, Ballarat Health Services and Northern Health in Melbourne, as well as with many healthcare groups in Melbourne and Western Victoria.

The full project comprises four proof-of-concept projects to test and trial innovative ICT hardware/software to be used for the tele-assessment, diagnosis and follow-up of patients located at a distance from the relatively small number of highly-trained clinical specialists in oral health, oncology, psychiatry, wound management and aged care/geriatric services. Sub-projects are:

- Homecare: to trial the use of HD 3D cameras in patients' homes
- Mind-care: to trial the use of HD 3D units to provide better access to specialised neuropsychiatric assessments
- Aged-care: to trial and model general and specialist healthcare support to Heritage Lakes Aged Care centre

Exploring **high-definition three-dimensional** telemedicine applications

- Bushcare: to trial provision of specialist cancer care to patients at the Nhill and Horsham Hospitals.

The program's primary funding through the Victorian Government's Broadband Enabled Innovation Program was made possible when the National Broadband Network (NBN) turned a set of good ideas about a suite of telemedicine operations into a potential reality.

Tele-dentistry

Delivery of oral healthcare services in aged care facilities is, according to many reports, at really low levels. It's a huge problem. It's very difficult and expensive for nursing homes to get a dentist to visit, so many nursing home residents end up with few or no dental assessments. There is such a shortage of dentists that those who are available simply do not have the time to travel to nursing homes.

The tele-dentistry trial is at two locations; the dentist is stationed at the Melbourne Dental School, University of Melbourne and patients at an aged care centre in the Melbourne suburb of South Morang. The aged care centre is in an early NBN rollout site, which is exciting for the project, as it means that it can fast-track the real-time version of the trial.

A nurse at the aged care centre uses a camera (resembling an electric toothbrush) for dental scanning, from which a dentist makes an assessment at a distance from visuals on a very high definition screen with high resolution video streaming. With the NBN's speed of transmission, the dentist will be able to interact both with the patient and the nurse in real time.

From these assessments, the dentist identifies and prioritises residents' care and generates treatment plans, including advice, which is particularly important as epidemiological and clinical data suggest that many dental infections end up as a severe threat to overall health of these older patients. Many conditions, including pneumonia (a big killer among the elderly), start off as minor oral infections. It is hoped that the tele-dentistry trial will nip these infections in the bud.

Tele-oncology

Ballarat has only three oncologists serving the cancer patients in that city as well as the western districts right up to the South Australian border. Currently, the oncologists have to make a six-hour return drive – a big outlay in time – to these regional areas once a week.

Sometimes patients have to travel to Ballarat, not only to see an oncologist, but a radiologist, radiotherapist or other clinician. It's difficult enough for someone who is healthy to make such a journey, but if you're not so well it's a major and costly burden, often ending up as an overnight stay.

The tele-oncology trial involves consultations between an oncologist in Ballarat and cancer patients in Nhil and in Horsham, some 300km and 400km from Ballarat. The trial is assessing how HD 3D can be made to work more efficiently over the internet using a broadband enabled network at NBN speeds.

It involves an oncologist in Ballarat and cancer patients who visit the chemotherapy unit at Horsham Hospital. The oncologists will work either from consulting suites using the NBN's high-speed broadband, or from Ballarat Hospital, which uses the inter-hospital broadband network. A nurse-practitioner, with readier access to the oncologist as a result of HD 3D at the Horsham end, can work closely with the patients in tele-consultation.

HD 3D brings realism and clarity, particularly important in oncology for the assessment of medical conditions resulting from chemotherapy or radiotherapy as well as seeing musculature in three dimensions. Such realism extends to improve measurement not only of physical dimensions but in terms of muscular suppleness used in the assessment of degradation, enhancing the treatment plan.

This can also involve assessment of MRI scans at a distance, when the specialist has simultaneous vision of the patient and the scans. Then, at the flick of a switch, the patient is also given the opportunity to see the scan so that specialist and patient can discuss it.

All of these trials, bench-tested to refine productivity gain measures, have commenced implementation from May this year. After the installations have been built, trials involving real installations and real patients will take place over the next eight months.

Tele-psychiatry

The tele-psychiatry trials involve the Ballarat Psychiatric Unit at Ballarat Base Hospital and the Horsham Hospital, connecting to a specialist in neurological assessments from the University of Melbourne's Department of Psychiatry.

Psychiatric patients who live in the western districts often have episodes resulting in their admission to the Ballarat Psychiatric Unit. The project aims to link them with psychiatrists and social workers back home using the realism of HD 3D, which allows full neurological assessment capable of visualisation of very fine motor movements such as pupil dilation.

Until the advent of the NBN, this had to be done face-to-face, but in this study, the patient will be at home in Ballarat (an NBN rollout area) while the psychiatrist is in Melbourne.

Under trial is the extent to which HD 3D enhances the accuracy of assessments. As with tele-oncology, this can also involve evaluation at a distance of MRI scans, when the specialist has vision of both the patient and the scans, with the ability for the patient also see the scan and discuss it with the specialist.

"At last the establishment of the NBN is beginning to make a difference to the health and wellbeing of those who live in regional and rural areas"

Tele-wound management

A high proportion of admissions to hospitals are elderly people with wounds that begin as small scratches or bedsores. In the elderly, these wounds deteriorate rather than heal. A nurse has to make difficult decisions, often requiring wound management specialisation, about the best way to treat these wounds.

An example of difficulty in such cases is a wound that appears to be healing from day-to-day because improvement is taking place at the top of the wound, but not beneath it. Only a wound specialist nurse can recognise that this type of healing is occurring.

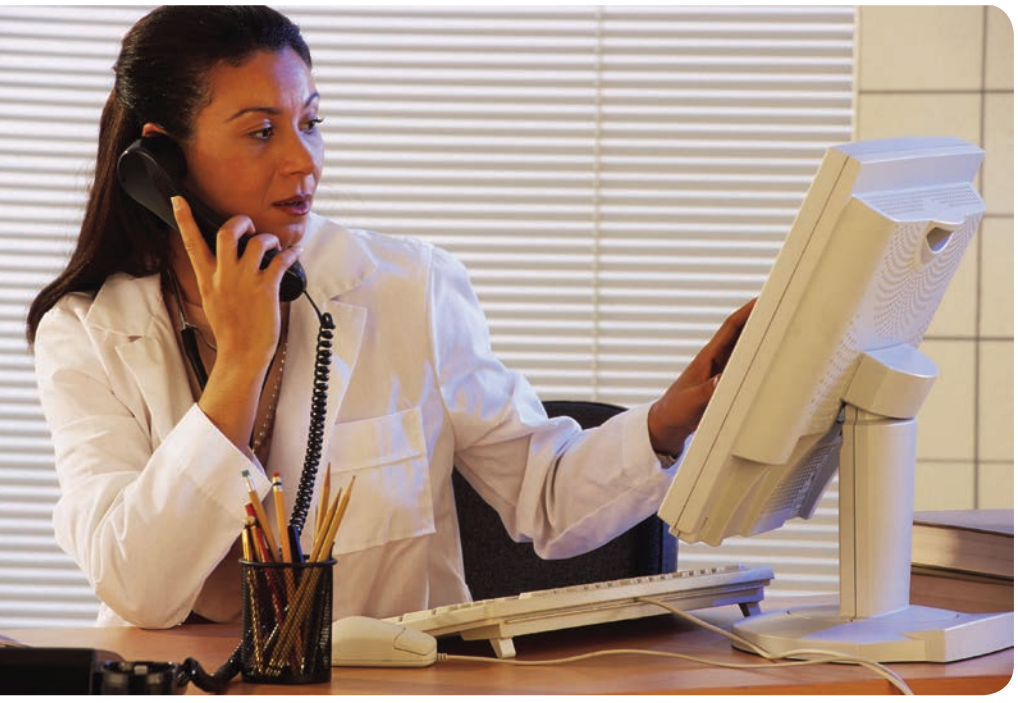
In Ballarat there are very few wound management specialist nurses with skills necessary to make those sorts of assessments. They are also too busy to have enough time to travel to patients' homes.

Once the NBN rollout is complete in Ballarat, a nurse visiting a patient in the home armed with a 3D video camera will be able to link into the NBN and take images of the wound. A wound specialist will then be able to make an assessment and advise on the best course of treatment. Currently, these situations require the wound specialist to travel to the patient's home or for the patient to travel to the wound specialist.

A spin-off research process is to use computational intelligence to develop a program that can automatically detect the depth of a wound, an important indicator of healing, using 3D images.

Tele-geriatrics

The HD 3D tele-geriatric trial runs between an aged care centre and geriatricians at Melbourne's Northern Hospital. What is different about this trial is that more peripherals are needed, such as patient monitoring devices, including a digital stethoscope and equipment to register vital signs such as ECG, blood pressure and oxygen levels.



The NBN has a bandwidth capable of efficiently connecting the aged care centre back to the hospital and for these measurements to be transmitted in real time across the internet. As with other telemedicine applications it is also possible to use NBN broadband for communication involving patients with other interested parties such as specialists at a distance, including experts from overseas, consulting physicians and family, while simultaneously transmitting complex visual and textual data.

Associate Professor Stanieri said the trials, as with many other NBN-assisted applications "are of extraordinary value to the health of people who live in Australia's far-flung regions or nursing home residents who, while not being remotely located, are unable to travel to see specialists due to their age or condition".

In addition to its cost-effectiveness and productivity gains, the tele-consultations under trial will create records leading to improved practice models and play an important part in solving many problems besetting Australia's health system. The high-definition medicine being implemented by his team for specific kinds of consultations will save patients and clinicians time, energy and money. This work will result in better care for many thousands of patients, no matter where they may live in Australia. There is an air of excitement about the projects – doing new things in new ways. It's impossible to put a dollar value on that.

Congratulating Associate Professor Stranieri and his team on their work, Broadband Champion, Nan Bosler, President of the Australian Seniors Computer Clubs Association, said: "The HD 3D telemedicine project enabled

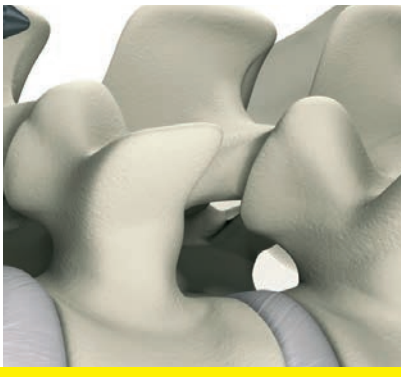
by the rollout of the NBN shows Australia as a world leader. These identified important health issues impact severely on those who live at a distance from expert medical attention. It has long been essential that these needs should be addressed. At last the establishment of the NBN is beginning to make a difference to the health and wellbeing of those who live in regional and rural areas."

A specialist in the use of communication technology as a mechanism for community development, Broadband Champion Dr Helen Thompson, Director of the Centre for eCommerce and Communications, University of Ballarat, said significant innovation in service delivery was being demonstrated through the 3D telemedicine projects.

"A whole new era of healthcare will be ushered in as a result of the rollout of the NBN across regional Australia."

Another Broadband Champion, Dr Mukesh Haikerwal AO, Chair, World Medical Association and former National President of the AMA, said the use of new health technologies brings care to where it is preferred – closer to where the patient lives.

"Telehealth consultations by web-enabled video-conferencing is another string to the clinician's bow. It increases therapeutic options, patient access, patient choice and convenience – all better deployed using high-speed broadband at each end of the care episode." ha



Health – Made in Germany

Work world-class – with German medical technology

Innovative products set international mark for quality and reliability

Reliability is a health care imperative. Providers need equipment they can count on to be equal to patient trust. German medical technology meets that obligation – the sector has delivered dependability for decades. What is more, the country's medical technology suppliers tailor their products to suit customer needs.

A step ahead

Innovation, research and development are cornerstones of German med-tech. Manufacturers have repeatedly developed innovations that set industry standards. It's a tradition that has made Germany into one of the world's leaders in terms of registering patents. In addition, a third of the sector's sales revenues come from products that are less than three years old.

Just a click away

Medical technology from Germany is at home all over the world. German suppliers are only as far away as your computer or phone. Health professionals who buy German medical technology are getting more than a product. Delivery of first-hand knowledge in the form of local training programs and seminars and are part of the package as well.

Step up to a step ahead

- → Highly specialized product range for all types of health care
- → Thousands of patents
- → Exports account for >60 percent of sales
- → More than 11 thousand companies
- → Years of local support

Find suppliers and exporters

Learn more about what German medical technology can do for you.

www.health-made-in-germany.com

Health
made in Germany

HIP members benefit from great insurance

Health Industry Plan

HIP works hard to offer members better income protection and death cover.

Improved policy benefits include:

- increased death cover up to a total of $618,240* without the need to supply a medical report
- a 20% increase in the benefit of each unit of death cover
- $6,000** per month of income protection for four units of cover.

HIP is a national industry superannuation fund for health and associated industries, offering low fees, no commissions, great insurance, super pensions, plus much more – run for the benefit of members.

How good is your super?
Find out more about HIP today

Industry Super Fund + Low fees + Personal service + History of strong returns

Contact HIP **1300 654 099** hipsuper.com.au

This information from Health Industry Plan contains general advice only. It is not specific to your personal financial situation, objectives or needs. Get the facts (including a Product Disclosure Statement) from www.hipsuper.com.au or talk to a financial advisor before making any super decisions. The Trustee of HIP ABN 50 030 598 247 is Private Hospitals Superannuation Pty Ltd ABN 59 006 792 749, AFSL 247063.
* This calculation is based on members aged between 16-36 at four units of cover, and only if members apply for an additional three units of cover within 60 days of joining the Fund. Insurance benefit is reduced each subsequent year. Please refer to the HIP Insurance Booklet or PDS for full details.
** Subject to a maximum monthly benefit of 75% of the member's monthly income. Please refer to the HIP Insurance Booklet or PDS for full details.

HIP.32238_V2

Super benefits

The **added extras** a super fund offers can be a **very real benefit** to your employees now

SUPERANNUATION is one of those things that people can pay a lot of attention to, or very little. Many people think of super only as savings for retirement and don't take advantage of the member benefits they can tap into now.

Individual employees generally have the option to choose their own superannuation fund. However, many don't and rely on their employer's choice of default fund. Choosing the right fund can give your employees access to benefits that are of very real value to them.

When choosing a default super fund for your organisation, the investment performance and level of fees should be your main considerations. But there can be very little difference between funds based on these criteria. The added member benefits is what really differentiates funds today. And there are some very interesting benefits out there.

Many super funds have arrangements with a financial institution to give members access to discounted banking products, including credit cards, home loans and personal loans with lower interest rates. Members may also be able to take advantage of saving and term deposit accounts with higher interest rates

Many super funds also have arrangements to provide discounted insurance products, including health insurance and in some instances, insurance for home and contents, cars and travel. Then there are the unique benefits, which range from free access to the Best Doctors program to discounted flowers.

There are benefits for employers as well, including free seminars for employees provided in the workplace.

The Nurses Award 2010 and the Health Professionals and Support Services Award 2010 specify the funds that employers must make contributions to if an employee fails to choose a fund. We've done a round-up of the member benefits some of these funds offer so you can compare what your fund provides for employees compared to the others.

Eligible super funds:

- Care Super
- Catholic Super
- First State Super
- Health Industry Plan (HIP)
- Health Employees Superannuation Trust of Australia (HESTA)
- Health Super
- Mercy Super
- NGS Super

>

Fund	Annual admin fee	Fee to join, exit, rollover, contributions, withdrawal	Income protection insurance	Death and disability insurance	Discounted health insurance	Discounted banking products	Access to financial advice
caresuper	$78 admin	$35 withdrawal	Yes	Yes	Yes. Through NIB and SMHP	Yes. Through ME Bank	Yes. Provided by Industry Fund Financial Planning
CATHOLIC Super	$78 admin	No	Yes	Yes	Yes. Through Medibank Private	Yes. Through ME Bank	Yes. Provided by Catholic Financial Services
FIRST STATE SUPER FSS Trustee Corporation	$52 admin	$36 withdrawal	Yes	Yes	No	No	Yes. Provided by FSS Financial Planning
hip Health Industry Plan	$72.80 admin	No	Yes	Yes	Yes. Through HCF	Competitive financial products available through My Credit Union	Yes. Provided by Bridges Financial Services
HESTA An Industry SuperFund	$65 admin plus trustee operating cost of 0.01% p.a. (ie $1 per $1000)	No	Yes	Yes	Yes. Through Super Members Health Plan (More information on page 30)	Yes. Through ME Bank (More information on page 30)	Yes. HESTA members have access to a comprehensive scaled advice service. (More information on page 30)
healthsuper	$91 admin	No	Yes	Yes	Yes. Through Australian Unity	Yes. Through SGE Credit Union	Yes. Provided by Health Super Financial Planning
mercy super	$57.20 admin	$55 withdrawal	Yes	Yes	No	Yes. Through ME Bank	Yes. Provided by Industry Fund Financial Planning
ngs super The educated choice	$65 admin	$30 withdrawal	Yes	Yes	No	Yes. Through ME Bank	Yes. Provided by NGS Financial Planning

Extra member benefits	Benefits for employers	Contact details and hours of operation	Special awards in the previous two years
Free information sessions	Dedicated Client Partnership Manager. Superannuation education seminars can be provided in the workplace	1300 360 149; 8am to 8pm AEST weekdays	SuperRatings Platinum Super 2012; SuperRatings 7-Year Platinum Performance 2005-2012; SelectingSuper AAA rating; Chant West Five Apples; Heron partnership 6 stars top rated fund; Money magazine's 2012 Best Growth Super Fund; Your Money magazine Super Fund of the Year silver medallist
Free information sessions. Discounted newspaper and magazine subscriptions through iSubscribe	Superannuation education seminars can be provided in the workplace	1300 655 002; 8am to 5.30pm AEST weekdays	SuperRatings Platinum Super 2012; SuperRatings 5-Year Platinum Performance 2007-2012; SuperRatings Super of the Year Finalist 2012; SelectingSuper AAA rating; Roy Morgan Industry Superannuation Fund of the Year 2011
Free information sessions about super and retirement. Free financial advice from 1 July 2012 for pension members.	Nil	1300 650 873; 8.30am to 5.30pm AEST weekdays	SuperRatings Platinum Super 2011 and 2012. SelectingSuper Innovation Award 2011; Chant West Five Apples; Money magazine Best of the Best 2012 Lowest-Cost Super Fund (awarded five years in a row)
Free access to the Best Doctors service for members and their family. Discount (15%) on flowers purchased online through Petals Network. Discounted Car, Home and Contents and Travel insurance through QBE	Face-to-face visits to answer questions. Superannuation education seminars can be provided in the workplace	1300 654 099; 8am to 7pm AEST weekdays	SuperRatings Gold Super 2012; SelectingSuper AAA rating
National workplace education and advice service; Default income protection cover and benefits to the proposed pension age of 67; Life events option: HESTA members can apply to increase their insurance following key life events, without having to provide evidence of their health (More information on page 30)	Face-to-face visits to answer questions. Superannuation education seminars can be provided in the workplace (More information on page 30)	HESTA: Free call 1800 813 327 from any Australian landline, 8.30am to 5pm HESTA Income Stream: 1300 734 479, 8.30am to 5.30pm	HESTA continues to maintain the highest rating from all ratings agencies including SelectingSuper and SuperRatings 7-year platinum performance 2005-2012. Our retirement product – HESTA Income Stream – also received high industry ratings including SuperRatings' Platinum Pension 2011; Winner of Victorian Funds Management Corporation (VFMC) 2012 Investment Stewardship Award for Superannuation Funds
Access to the Financial Fitness Program. Automatic insurance cover for eligible members	Face-to-face visits to answer questions. Superannuation education seminars can be provided in the workplace	Members:1800 331 719; Employers: 1800 133 050; 8.30am to 6pm AEST weekdays	SuperRatings Platinum Super 2011; SuperRatings 7-Year Platinum Performance 2005-2012; Long-Term Growth option ranked 1 out of 105 funds by SuperRatings; Chant West Five Apples
Free information sessions. Client service office onsite at key employer (Mater Health Services)	Superannuation education seminars can be provided in the workplace	1300 368 891; 8.30am to 5pm AEST Mon-Thurs, 8.30am-4.30pm Fri	SuperRatings Gold Super 2012
Free information sessions	Face-to-face visits to answer questions	1300 133 177	SuperRatings Platinum Rating 2012; SuperRatings 7-Year Platinum Performance 2005-2012; SuperRatings Super of the Year Finalist 2012; Chant West Five Apples

Information provided by listed superannuation funds or taken from product disclosure statements available online. Annual management fees may also apply and vary depending on investment option selected. Though Globe Publishing makes every effort to ensure information is correct at the time of print, please refer to individual superannuation fund Product Disclosure Statements before making any decisions.

More about HESTA member benefits

Discounted Health Insurance

HESTA members have access to discount private health insurance through the Super Members Health Plan, which offers:

- competitive pricing and discounts
- hospital, extras, and combined health cover options
- no or low waiting periods when you transfer from another health insurance provider
- a great rewards program that includes weight-loss programs, swimming lessons, remedial massage and more
- award-winning customer service.

Discounted Banking Products

HESTA members can access discount banking products from ME Bank. ME Bank was established to provide Australians with a complete and fairer financial solution and is owned by some of Australia's biggest industry super funds, including HESTA. HESTA does not receive any commissions as a result of members using ME Bank. ME Bank brings members:

- EveryDay Transaction Account
- Online Savings Account
- Super Members Home Loan - a discount home loan
- Super Members Term Deposit Account
- InterestME Savings Account
- First Home Saver Account
- Low-rate personal loans
- Low-rate credit cards.

Financial Advisor Assistance

- Member seminars: Our member education and advice seminars are held across the country, all year round – during work hours and in the evening. We also make special workplace visits to HESTA employers at no cost to members or employers.
- General advice: HESTA Superannuation Advice Officers provide general telephone advice to members on aspects of HESTA super. This service can be accessed by HESTA members at no extra cost.
- Personal superannuation advice: Our team of Superannuation Advisers (SAs) specialise in the delivery of personalised super advice and can travel to worksites on request. All SAs have a minimum qualification of an Advanced Diploma in Financial Services – qualifying them to provide financial advice to members. This service is offered to members as part of our service delivery at no extra cost.
- Personal advice on transition to retirement and retirement strategies: HESTA SAs provide personal advice to members on creating a transition to retirement or retirement strategy. For a fixed fee, deducted from their HESTA super account, members can speak with a qualified HESTA SA about: transition to retirement and retirement planning, pensions and income streams, and investment options in retirement.
- Financial planning: HESTA members can access affordable, commission-free financial planning. HESTA financial planners are licensed to give advice on all financial matters, including investments in addition to HESTA super. This service is offered in conjunction with Industry Fund Financial Planning on a fee-for-service basis.

Unique Member Benefits

- National workplace education and advice service.
- Default income protection cover and benefits to the proposed pension age of 67 – HESTA is the first to do this.
- Life events option: HESTA members can apply to increase their insurance following key life events without providing evidence of their health.
- An environmentally responsible investment option, HESTA Eco Pool – the first environmentally responsible investment option by a major fund.
- Professional recognition for the health and community services industry through our five national awards programs, including HESTA Australian Nursing Awards, HESTA and ACSA Aged Care Awards, HESTA Primary Health Care Awards, and HESTA Community Sector Awards. ME Bank sponsors the awards in partnership with HESTA.
- Online annual member statements issued every September. HESTA members can choose to receive their annual member statement pack electronically instead of by post.
- Online super consolidation tool. Our tool allows members to find and combine lost super using the ATO's SuperSeeker database.
- 24/7 online account access.

Unique Employer Benefits

- Online super induction module for new (and existing) employees.
- A range of online contribution payment options to suit employers of all sizes.
- Truly national presence: local offices for every state and territory to support HESTA employers.
- Professional recognition for the health and community services industry through our five national HESTA awards programs.
- National workplace education and advice service – to assist your employees with their super.

This material is issued by H.E.S.T. Australia Ltd ABN 66 006 818 695 AFSL 235249, Trustee of Health Employees Superannuation Trust Australia ABN 64 971 749 321, and is current as at 1 May 2012. It is of a general nature. It does not take into account your objectives, financial situation or specific needs so you should look at your own financial position and requirements before making a decision. You may wish to consult an adviser when doing this. Third-party services are provided by parties other than H.E.S.T. Australia Ltd and terms and conditions apply. H.E.S.T. Australia Ltd does not recommend, endorse or accept any responsibility for the products and services offered by third parties or any liability for any loss or damage incurred as a result of services provided by third parties. You should exercise your own judgment about the products and services being offered. For more information fee call 1800 813 327 or visit hesta.com.au for a copy of a product disclosure statement which should be considered when making a decision about HESTA products.

HESTA
An Industry SuperFund

Models of **Palliative care**

YVONNE LUXFORD
Chief Executive Officer,
Palliative Care Australia
Incorporated

Helping people die well, and live well until the end, is **essential**

WHEN THE Productivity Commission argued in its report *Caring for Older Australians* that palliative and end of life care should be core business for aged care services, this brought no surprises for the sector. With a third of people in residential aged care dying annually, it is obvious that ensuring that these residents die well, and are supported to live well until the end, forms an essential component of aged care services. Unfortunately, this is not always the case.

The majority of aged care workers receive only minimal training in palliative care and the term is often confused with terminal care. Nurses who could greatly assist in ensuring good end of life care are often burdened with administrative and management tasks; GPs who visit the facilities may also lack confidence in palliative care and are not financially supported to coordinate the multidisciplinary care that is required. Connections with the local specialist palliative care service are often not maintained.

Circumstances can be further confused by a lack of advance care plans or appointment of substitute decision makers; lack of understanding of cultural requirements and expectations; and a poor understanding of disease progression, such as with dementia.

With surveys indicating that Australians (like the rest of the world) would prefer to stay at home as they age, and die, the provision of real choice and support for such a choice is vital. Access to services can be limited and frustrating to negotiate and funding is frequently determined by the luck of geographic location.

Despite this litany of barriers, aged care services do their best to try to meet the needs of ageing Australians as they die. Some have introduced successful models of care aimed to ensure that people die with dignity, respect and with their pain and other symptoms well managed.

The Gold Standards Framework is embedded in the British health system to utilise generalist health professionals to ensure that the right patients have the right care at the right time. This innovative system of care has been adapted and adopted on Tasmania's Cradle Coast to promote care with dignity for the 500 residents across the region's aged care facilities.

This project uses a variety of mechanisms to enhance person-centred care that closely involves the resident in the decision making process and in determining goals of care. This is a program that is clearly empowering to residents and their loved ones, but also to the nursing and associated staff. Nurses are enabled to focus on care and GPs are involved on a case-by-case basis. It is intended that all eHealth records will be online by mid-2012, which will connect residential aged care facilities (RACFs), general practices, after hours GP services, acute hospitals and allied services such as pharmacists.

Silver Chain in Western Australia provides community based palliative care services to the entire Perth metropolitan region, admitting around 3000 people every year. Primarily funded by the WA Department of Health and the Department of Veterans' Affairs, the service aims to provide comprehensive multidisciplinary palliative care services that support people to remain at home. The success of the program can be witnessed in the average of around 60 percent of patients who are supported to die at home – more than double the national average.

The service relies on an interdisciplinary care model with 24/7 service that is both person-centred and evidence based. Each team serves a specific geographic area and can draw upon the support of Clinical Nurse Consultant Managers and on call Hospice Care Service doctors. All staff use hand held devices such as smart phones and purpose designed IT software which integrates care and connections across residential and community based care.

There are numerous such exemplary programs across the country, but the real problem is a lack of uniformity of high quality care that truly meets the needs of aged and dying Australians, their carers, and loved ones.

It is estimated that there are approximately 2700 RACFs and 1500 community services in Australia. While every service does its best to meet the needs of dying patients, not enough is done to share learnings of models of care that work, to educate all aged care professionals in palliative care, or to focus on person-centred rather than system-centred care.

To provide care that ensures that the needs of the person and their loved ones are integral in the decision making process, that people's cultural and other needs are respected, along with their pain and other symptoms being well managed requires a paradigm shift in aged care. Until we can achieve this shift, ageing Australians will not be protected from dying with a lack of dignity and respect, and potentially in preventable pain. ha

MARGRET MEAGHER
Executive Director of
Arts and Health Australia

Creative ageing

Could **ageing creatively** be the key to **ageing well**?

AS HEALTH SERVICES grapple with the challenges of a rapidly ageing population, identifying models of aged care is an increasing imperative.

The critical importance of encouraging older people to adopt healthy lifestyles and identifying ways to assist people to manage chronic conditions, such as dementia, while also providing support for their carers, has brought attention to the emerging field of creative ageing as a model of care. Best of all, creative ageing ticks all three boxes.

Creative ageing is the use of professionally designed arts and creative programs to foster and support healthy, positive ageing. The simplicity of this practice is such that creative ageing often flies under the radar. Yet there is mounting quantitative and qualitative evidence that demonstrates the efficacy of arts and health programs for older people.

There are a myriad of creative ageing programs that revolve around singing and music, dance, art and craft, theatre, creative writing, circus and clowning, to foster preventative health and health promotion as well as being used as an intervention in the treatment of debilitating illness.

Programs encompass singing to maintain and improve cardiovascular condition and lung function or to restore voice facility for stroke victims; dance to improve mobility or combat obesity; clay modelling for people with arthritis; visual art and music to support people with dementia or Parkinson's disease; creative and narrative writing to facilitate reminiscence and foster self esteem.

Between 2001 and 2005, the late American psychiatrist and geriatrician, Dr Gene Cohen led the first multi-site longitudinal study on the impact of professionally conducted, participatory cultural programs on older adults, supported by National Endowment for the Arts in the US. At the time, Dr Cohen was Director, Center on Aging, Health and Humanities, Professor of Health Care Sciences and Professor of Psychiatry and Behavioral Sciences, George Washington University, Washington DC.

This landmark study, *Creativity and Aging Study: The Impact of Professionally Conducted Cultural Programs on Older Adults* was conducted across three sites in Washington DC, New York City and San Francisco with 300 participants. The average age of participants was 80, with an age range of 65-103 years. Compared to the control group, the intervention group maintained greater independence, enjoyed higher morale, experienced less loneliness, used less medication, suffered fewer falls, had reduced hospital stays, had expanded their outlook with increased interests and activities and demonstrated a greater sense of control and higher social engagement.

In addition to tracking the physical and psychosocial benefits for older people who engage in the participatory arts, Dr Cohen extrapolated a compelling business case.

In the US in 2007, Medicare, the national health insurance program for those aged 65 and older, expended $48.6 billion on medication reimbursement. To illustrate the potential magnitude of savings due to less medication taken by older adults in arts programs, Dr Cohen looked at an estimated saving of just 8 cents a day for people entitled to reimbursement of medical prescriptions. The result? Over a billion dollars a year in savings for Medicare in the US.

Dr Cohen's study, along with the growing body of international scientific research into the benefits of creative ageing, demonstrates that engaging in the arts and creative activities is not just good for people's health and wellbeing but it also makes sound economic sense. Creative ageing is a model of care that should be music to the ears of those who manage and deliver health services in Australia. ha

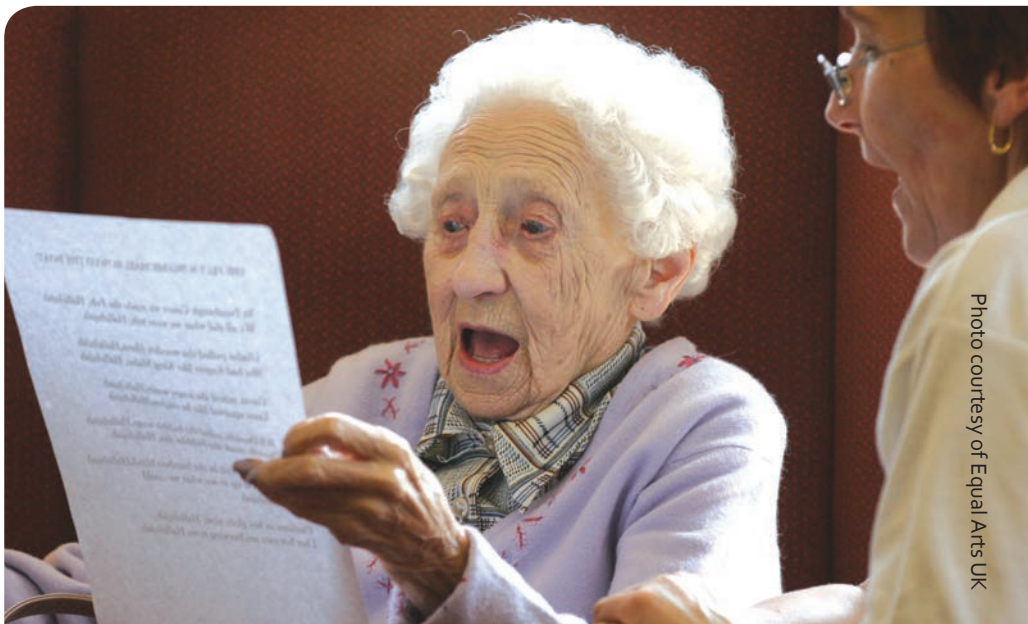


Photo courtesy of Equal Arts UK

Models of care: what's not to love?

JUDITH DWYER
Professor of Health Care Management at Flinders University

Judith Dwyer questions whether a single model of care can be effective in all circumstances

THE IDEA OF models of care is so 21st century. They seem to incorporate all good things; as WA Health says, it's about ensuring people get the right care at the right time, by the right team and in the right place. What's not to love?

The health and aged care industry is finely attuned to the rhetoric of new policies and management approaches, and this applies even to those among us who merely fume and spit when they hear a new one. This one brings together not only evidence-based practice, quality improvement, project and change management methods, but also interdisciplinary practice, consumer engagement and efficiency.

As always, even defining the concept is hard. A 'model' in this context is an abstraction (as in a diagram) that makes the structure and relationships among the elements of something clear. Models of care encode and make explicit what is to be done by whom, when and where. They are worth paying attention to for three reasons.

First, the very idea is based on the premise that we can change the way things are done, even sacred practices and working rules that seem to be part of the natural order. The benefit is in making the submerged operating assumptions that underlie business as usual explicit and discussable.

Second, things do often need to change, so it's useful to have an explicit framework and standards that provide an agreed starting platform on which changes can be designed.

Finally, models of care in use can improve safety and quality (through reliable use of proven methods and desirable standards) and equity of access to good care (by making it harder to justify variations).

However, there are a few problems in the application. The first is the problem of scale. Some people think that an entire health system can be described as having a model of care; others think about a model of care for a single clinical condition. Sometimes it's about health care for an individual in a single setting; sometimes a model of care covers the whole spectrum from prevention to palliation. In other words, it ranges all the way from system design to clinical guidelines. This isn't necessarily a problem, but you can see the bandwagon effect – people being seized with enthusiasm and expanding the definition until it risks becoming meaningless.

You've got to worry about bandwagons. This one has a whiff of world domination about it. That is, there seems to be an idea that everything can be prescribed (in a clinician-led and patient-friendly way of course) within models of care, and then the great mystery of how to make health and aged care more predictable, efficient and manageable will be solved.

It's not that this would be a bad thing, rather it just seems unlikely. A team I lead has just completed a research project that asks 'how might city hospitals do a better job for country Aboriginal patients?' We have concluded that there are many good things happening; lots that clinical units and hospitals can learn from each other; and some useful elements of a good model of care. But we have also been impressed by the glorious specificity of the circumstances, resources, priorities and needs of each clinical unit we studied.

In this situation, models of care can help, but it's all about levels. There is a correct level of specification that can usefully be done from the centre; and then there is the urge to world domination in the form of detailed instruction from central authorities to operating units. On the delivery side, there is the necessary level of 'decision space' for effective operations; and then there is the wasteful indulgence of persisting with poor approaches to care because change is inconvenient or controversial.

Models of care need to be carefully negotiated to get the levels right, seeking as they do to bring system-wide principles and standards to bear on operational care delivery. The implementation of models of care will fail to the extent that their proponents get these levels wrong. ha

MICHAEL PERVAN
Executive Director
Health Service
Commissioning Tasmania

Planet of **the apps**

Will the **Personally Controlled Electronic Health Record** improve efficiency and quality of care?

AS HEALTH service executives we are inundated with glossy brochures promoting "essential", "must attend" conferences and equally glossy software and information systems that promise "solutions" to all our problems, whether we have them or not.

We are told that a comprehensive electronic health record will revolutionise health care in the same way penicillin did in the 1930s. By placing all the patient's information at the fingertips of those treating them, health records will organically integrate the patient's journey and naturally and seamlessly deliver truly holistic health care. While this looks great on a glossy, it is nonsense.

Given the technology we have and the claimed benefits to patients of eHealth initiatives, why is it taking so long and costing so much more than expected to roll out any major initiatives in this space? Is it the what or the how? Or perhaps it is the why?

Information doesn't deliver care - people do. The answers to all our supposed questions are not in the technology but in the people who we hope will use it.

This may sound like heresy but it isn't. Health services that have successfully moved to electronic health records and those that have gone the extra evolutionary step to paperless services have done so through rigorous implementation processes that focus on the user and patient – not the software developer.

Developing an application is very different to a group of people coming together around a patient, identifying an information problem and fixing it using technology. Remember, information is a tool - like a spanner. A spanner doesn't fix your car. It has to be wielded by someone who understands the problem and has the skill to fix the problem.

There is now a considerable body of work addressing the question of why change falters and fails. Writers such as Heifetz and Linsky from the Kennedy School[1] attribute a great deal of change failure at mistaking technical problems for what are in essence adaptive challenges.

We are struggling to deliver an eHealth record because we approach the issues as though they are technical problems with access, content and security and we have largely overlooked the adaptive issues.

Until we (or more accurately our staff delivering services) can answer the question: "why", we will not know what we are adapting to or the reason adaptation is required beyond the existence of the gizmo and its siren promises. We have spent too long assuming eHealth records will revolutionise health care but we have not engaged with those who we assume will use this wonderful product to ascertain what they need and want it to do.

How will access to this information change treatments or pathways? How will the eHealth record support integration of care unless the staff involved have already collaborated on integrating the patient's pathway and just need some common information to enable that pathway?

Will the new PCEHR make a difference? Yes, but only if people use it and they only will if it is useful. ha

References

1. Leadership on the Line: Staying Alive Through the Dangers of Leading, by Ronald A. Heifetz and Marty Linsky (Cambridge Mass, HBS, 2004)

This year's model

PHILIP DARBYSHIRE
Director Philip Darbyshire Consulting and Professor, Monash University

Philip Darbyshire presents his model for big-picture thinking

THE IDEA OF a 'model of care' or 'model of nursing' remains seductive to some. Little wonder. Imagine a cute diagram or flowchart, or all-embracing theoretical construct that would not only look and sound incredibly clever but that clinicians would actually use as a template for their practice. Such a model would somehow explain or 'represent' nursing or health care or the world (limited ambition was never a failing of such models), and it would also determine the focus, (its own of course) of clinical practice, professional education, workforce development and anything else that fell under its spell.

Back in the 1980s and 1990s 'models of nursing' were all the rage, veering from trendy to tyranny as a UK nursing regulator even considered withholding approval from schools that did not use a recognised model of nursing. Models logic was clumsily compelling. Practice without a 'theoretical framework' must be haphazard, foundationless and directionless.

Times change though and fashion moves on. Your 'loon pants' or padded shoulders may have a longer shelf-life than many of these models that in their heyday demanded such allegiance. A models of nursing conference today could be held in a Brighton Beach Hut with space at the back for the voluminous documentation.

I'm a reasonable person though and there is undoubtedly a place for 'big picture' thinking in health care. So here is my contribution: 'Philip's Four Horsemen of the Apocalypse'™. Four killer questions that cut to the chase of today's ultra-demanding healthcare world. Four questions that you should ask your staff and yourself. Four questions that we had better be able to answer, from bedside to boardroom. Pin them at the nurses' station, hang them in the executive meeting room, use them in every appraisal.

Horseman 1: What do you do all day?

This sounds simple or even insulting until you hear how many people answer it by only listing tasks or procedures. Changing IVs, doing dressings, giving baths, is NOT what nurses do, these are means to an end. Nurses change lives. Going to meetings is not what managers do, these are conduits through which they enable staff to be stellar. We need to articulate our practices by stating their outcomes and effects.

Horseman 2: Why do you do it (that way)?

The evidence based practice juggernaut is no passing fad. Being able to justify and explain your practices, decisions and services using research and evidence is no longer a luxury for the academically minded. Heaven help any health professional or manager who thinks that 'because that's what we do here' or 'because I'm the boss', constitutes such a justification.

Horseman 3: How could you do it better?

Welcome to the new world of health care where we will never be able to rest on our laurels, where there will be no let-up in demands for improvement and where last year's greatness is simply this year's norm. Sounds tough? That's because it is, but this is no less an improvement imperative than we ourselves expect from everything else in our world, from our technology to the services we receive.

Horseman 4: How do you know you are making a positive difference to people's lives?

The $64,000 question. The question that many of us in health care assume has been answered by our commitment, qualifications, hard work, education, shiny new facility or whatever. Sorry. This horseman won't back off until we start talking about metrics and measures (no, not just numbers), about how we genuinely know that we make this positive difference and what that difference looks like.

A health setting where the respective responses to my 'Four Horsemen' was along the lines of 1: "I'm just a nurse", 2: "I only do what I'm told", 3: "Don't you know how fully committed/busy/world-class we are?" and 4: 'Sorry I don't understand the question", is in serious strife.

Contrast that with an organisation whose staff can clearly and confidently articulate their practices and services while highlighting their benefits and outcomes; where research awareness and activity in support of practices and services is hardwired throughout; where the drive to be better is professionally and organisationally pervasive and not sloughed off to some backwoods QA or HR department; and where regular internal and external evaluations and reviews keep a laser focus on identifying shortcomings and demonstrating positive impact.

Loose these Four Horsemen in your organisation. Who knows, we may have found this year's model. ha

Update on Adv
Care Direct

ALISON CHOY FLANNIGAN
Partner Health, Aged Care and Life Sciences, Holman Webb

ADVANCE CARE Directives (also living wills or advance care planning) enable a person over the age of 18, who is mentally competent, to express their wishes in relation to future medical care. The common law in Australia recognises two relevant but in some cases conflicting interests:

1. a competent adult's right of autonomy or self-determination – the right to control his or her own body
2. the interest of the state in protecting and preserving the lives and health of its citizens.[1]

Legislation and guidelines

Legislation dealing with Advance Care Directives is not uniform in Australia. It is necessary to have regard to the relevant legislation in each jurisdiction, including:

- ACT - *The Medical Treatment (Health Directions) Act 2006 (ACT); Powers of Attorney Act 2006 (ACT)*
- NSW - NSW Health has published a *Guideline on Using Advance Care Directives* (GL2005_056)
- NT - *The Natural Death Act 1988 (NT)*
- Qld - *Guardianship and Administration Act 2000 (Qld), Powers of Attorney Act 1998 (Qld)*
- SA - *Consent to Medical Treatment and Palliative Care Act 1995 (SA); Guardianship and Administration Act 1993*
- Vic - *Medical Treatment Act 1998 (Vic); Guardianship and Administration Act 1986 (Vic)*
- *WA - Guardianship and Administration Act 1990 (WA)*[2]
- Tas – *Guardianship and Administration Act 1995 (Tas).*

In September 2011, the Clinical, Technical and Ethical Principal Committee of the Australian Health Ministers' Advisory Council released a Report called A National Framework for Advance Care Directives. This Framework includes a Code for Ethical Practice and a set of Best Practice Standards.

Cases

In addition to the legislation, there have been a number of recent key cases, including:

- *Hunter and New England Area Health Service v A* (by his Tutor) (2009) 74 NSWLR 88; and
- *Brightwater Care Group (Inc) v Rossiter* (2009) 40 WAR 84.

The Hunter and New England case involved a patient, Mr A, who was a Jehovah's Witness. He attended a solicitor, Mr N, and appointed an enduring guardian. In relation to dialysis, Mr A ticked "I refuse".

His Honour, McDougall J, concluded that the direction represented a considered decision made by Mr A, and that when Mr A made that decision (and when he was admitted to hospital), Mr A was in law capable of making the decision to refuse dialysis. The hospital was entitled to the declaration sought; that is, that the document was a valid Advance Care Directive given by Mr A, and that the hospital would be justified in complying with his wishes as expressed in that directive.

In that case, His Honour gave a summary of the relevant principles with emergency care decisions (while acknowledging that they will not apply in every conceivable circumstance).

1. Except in the case of emergency, where it is not practicable to obtain consent (see para 5 below), it is at common law a battery to administer medical treatment to a person without the person's consent. There may be a qualification if the treatment is necessary to save the life of a viable unborn child.
2. Consent may be express, or in some cases, implied; and whether a person consents to medical treatment is a question of fact in each case.
3. Consent to medical treatment may be given by the person concerned, if that person is a capable adult; by the person's guardian (under an instrument of appointment of an enduring guardian, if in effect; or by a guardian appointed by the Guardianship Tribunal or a court); by the spouse of the person, if the relationship between the person and the spouse is close and continuing and the spouse is not under guardianship; by a person who has the care of the person; or by a close friend or relative of the person.
4. At common law, next of kin cannot give consent on behalf of the person. However, if they fall into one or other of the categories just listed (and of course they would fall into at least the last) they may do so under the Guardianship Act.
5. Emergency medical treatment that is reasonably necessary in the particular case may be administered to a person without the person's consent if the person's condition is such that it is not possible to obtain his or her consent, if it is not practicable to obtain the consent of someone else authorised to give it, and if the person has not signified that he or she does not wish the treatment, or treatment of that kind, to be carried out.
6. A person may make an Advance Care Directive: a statement that the person does not wish to receive medical treatment, or medical treatment of specified kinds. If an Advance Care Directive is made by a capable adult, and is clear and unambiguous, and extends to the situation at hand, it must be respected.

ance ives

Two cases that help clarify complicated **Advance Care Directives** legislation

It would be a battery to administer medical treatment to the person of a kind prohibited by the Advance Care Directive. Again, there may be a qualification if the treatment is necessary to save the life of a viable unborn child.

7. There is a presumption that an adult is capable of deciding whether to consent to or to refuse medical treatment, however, the presumption is rebuttable. In considering the question of capacity, it is necessary to take into account both the importance of the decision and the ability of the individual to receive, retain and process information given to him or her that bears on the decision.
8. If there is a genuine and reasonable doubt as to the validity of an Advance Care Directive, or as to whether it applies in the situation at hand, a hospital or medical practitioner should apply promptly to the court for its aid. The hospital or medical practitioner is justified in acting in accordance with the court's determination as to the validity and operation of the Advance Care Directive.
9. Where there is a genuine and reasonable doubt as to the validity or operation of an Advance Care Directive, and the hospital or medical practitioner applies promptly to the court for relief, the hospital or practitioner is justified, by the emergency principle, in administering the treatment in question until the court gives its decision.
10. It is not necessary, if there is a valid Advance Care Directive, that the person giving it should have been informed of the consequences of deciding, in advance, to refuse specified kinds of medical treatment. Nor does it matter that the person's decision is based on religious, social or moral grounds rather than upon (for example) some balancing act of risk and benefit. Indeed, it does not matter if the decision seems to be unsupported by a discernible reason, as long as it was made voluntarily, and in the absence of any vitiating factor such as misrepresentation, by a capable adult.
11. What appears to be a valid consent given by a capable adult may be ineffective if it does not represent the independent exercise of the person's volition: if, by some means, the person's will has been overborne or the decision is the result of undue influence, or of some other vitiating circumstances.

In *Brightwater Care Group (Inc) v Rossiter* (2009) WASC 229, the Brightwater Care Group operated a residential aged care facility in Perth for people with disabilities.

Mr Rossiter was a quadriplegic who was mentally competent. He was unable to move and only able to talk through a tracheotomy. He directed his medical service provider to discontinue the provision of nutrition and general hydration, the consequence of which he could die from starvation. He also requested the prescription of analgesics for the purposes of sedation and pain relief as he approached death.

Mr Rossiter was not terminally ill, nor was he dying. However, he had been advised that there was no prospect that his condition would improve, and in some respects, for example his eyesight, his condition was deteriorating.

Western Australia has specific provisions in its Criminal Code that impose a duty to provide the necessaries of life; however, His Honour Martin CJ concluded that the Criminal Code did not impose upon Brightwater a duty to provide the necessaries of life to Mr Rossiter against his wishes. His Honour held that it is clear that Mr Rossiter had been provided with full information with respect to the consequences of any decision he might make and has the right to determine and direct the

extent of the continuing treatment in the sense that treatment cannot and should not be administered against his wishes. If, after the provision of full advice, he repeats his direction to Brightwater that they discontinue the provision of nutrition and hydration to him, Brightwater is under a legal obligation to comply with that direction.

Such a direction is not irrevocable and while the patient retains his capacities, can be revoked by him at any time. ha

References

1. Hunter and New England Area Health Service v A (by his Tutor T) (2009) 74 NSWLR 88, McDougall J
2. Note also legislation enabling Enduring Powers of Guardianship

For more information, please contact:
Alison Choy Flannigan
Partner, Health, aged care & life sciences
Holman Webb, Lawyers
alison.choyflannigan@holmanwebb.com.au

Activities from AHHA's **member organisations**

Seizing opportunities with both hands: **ageing in rural Australia**

PEOPLE LIVING in rural and remote areas have as much right to a wide range of healthy ageing choices as city dwellers do. This is what the National Rural Health Alliance (NRHA) believes. This belief encompasses the entitlement to matters such as older people who are living at home feeling able to stay there safely and to get down the street or into town, through to help with cleaning the bathroom, doing the shopping and maintaining the garden. It also includes help with more personal care such as dressing and medicines, through to residential aged care as close to home as possible.

This might not sound like a 'big ask'. But a variety of factors make it more challenging than it first appears. Health and aged care services in rural areas, whether they are helping with community care, supporting people to live at home or running a residential aged care facility, must cope with higher costs for basic things such as food and maintenance services. Due to large distances from major centres, it costs more to provide goods and services and to travel to a regional centre to see a specialist. Staff costs can be a lot higher too, especially when someone is sick or needs to take their annual leave. On top of the higher rates for agency staff, it can be very expensive to get relief staff to a rural town, and costs might include the need to locate and pay for accommodation as well. And it's not usually practical to ask someone to provide that sort of cover for a day or two.

Even with viability supplements from the government it simply isn't be possible to provide residential aged care in every small town. And we do need to recognise that some people will end up in, or want to move to, residential care in the regional centre or even in the city, perhaps to be close to family, friends or a major hospital.

There are already a number of Multi-Purpose Services in small rural towns, where the local hospital funding is pooled with the aged care funding. This enables retention of hospital beds in the district together with residential aged care places, and perhaps some temporary or respite care for an older person who is convalescing before going home out of town. Maybe there will be some

consulting rooms for the local GP, a physician or other medical specialist who comes out once a month and a visiting physiotherapist who might run some falls prevention, incontinence and healthy activity programs. There might also be a community nurse there.

Flexible service models that are available locally are critical for rural towns. It does need to be done in consultation with the local community and service providers though, so that it will work for them rather than send them out of town. (The Alliance also supports further development of the Aboriginal and Torres Strait Islander Flexible Aged Care program).

While it's really important that the local aged care service or Multi-Purpose Service provides good quality care, it's also important that the accreditation requirements and administration necessary is practical in the smaller rural settings.

We need to remember that aged care, even in residential aged care facilities, is as much about heart and home as it is about paperwork and standards. One woman who cared for her ailing mother during her last years spelt out the distressing details of high staff turnover in the regional hospital where she eventually took her mother and the massive burden of paperwork and administration they had.

This resulted in bells being left unanswered and "[a] proud woman reduced to tears, frustration and pain. ... the system ... takes the power out of our hands and reduces our capacity to function well in a stressful situation".

There are many stages of ageing, and according to some very persuasive studies, people at all stages can be helped by the integration of arts into health. The NRHA, along with the Arts and Health Foundation and Regional Arts Australia, is developing a national arts policy because of the documented benefits of the arts on individual and community health. For some powerful demonstrations of this, and particularly on ageing community members, see the Art of Good Health and Well-Being conference November 2011 (www.artsandhealth.org and click on the Creative Ageing section for video presentations). There is further information about aged care, for example Fact Sheets 3, 22 and 29, Public seminars, and Submissions on NRHA's website www.ruralhealth.org.au

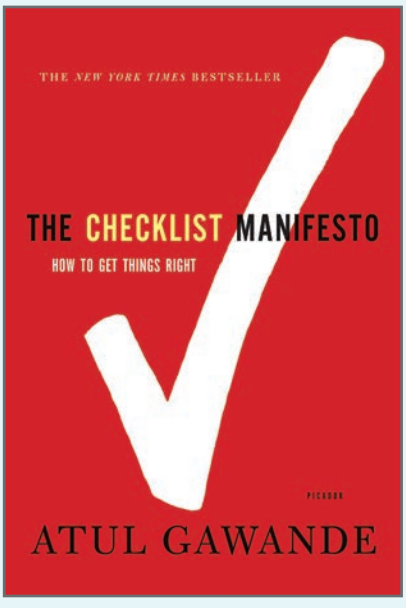
The carer in the case study above ended her account with the fervent belief that "the system has to work to meet the needs. And it can – even in remote areas. I think we have our opportunity. We should seize it with both hands." ha

References

1. Health professional and carer case study, NRHA Submission in response to the Productivity Commission's *Draft Report on Caring for Older Australians*, April 2011.

Book reviews

This issue we review ***The Checklist Manifesto:*** *How to get things right* by Atul Gawande



The Checklist Manifesto: How to get things right

Atul Gawande
Metropolitan Books
RRP $24.99

One of my brothers, Joe – now known as Job for reasons that will soon become obvious – had a hip replacement in 2005 because of an old motorbike injury. Soon after, he became very ill. He quickly lost 25 kilos and he could not have been described as fat before.

After many tests, the doctor finally diagnosed golden staph infection. Two more operations on that hip and the same number on the other and six years later, his life could not be described as very wonderful. Luckily he has a black sense of humour inherited from the Irish side of our family. Between episodes of rabid fever and festering pustules he does a lot of laughing.

He also has chronic pain, insomnia and is a recovering alcoholic. When I read Atul Gawande's The Checklist Manifesto (2010) I knew Job would like it. Gawande leads the World Health Organisation's Safe Surgery Saves Lives program and teaches at Harvard. Medicine has dazzling successes but also failures. Gawande points out that there is tremendous know-how in medicine but it is often unmanageable because of burgeoning medical complexity. In The Checklist Manifesto the author outlines the lessons he learned from industries like building and flying and applies them to his own field.

A checklist for pilots is simple, brief and to the point. It fits on an index card, with step-by-step checks for take-off, flight, landing and taxiing. A checklist is a 'cognitive net' and in complex environments it can provide the solution to two problems: the fallibility of human memory and attention and the temptation to skip a step even when people do remember it. It won't always matter, after all – until one day, it does.

According to the author, nurses have used checklists since about 1960. Doctors have been more resistant to them. Gawande received permission to experiment with them. In a year-long trial using a checklist for line infections at Johns Hopkins Hospital in 2001, the rate went from 11 per cent to zero. This success proved not to be an isolated case. After many subsequent trials and tests, within a shortish amount of time, hospitals in many countries were using checklists.

In India the usual procedure was to give patients a pre-surgery antibiotic in the waiting area before wheeling them in for surgery. The checklist enabled the Indian clinicians to realise that frequent delays in the operating schedule meant that the antibiotic had often worn off before the operation. So the staff changed the routine to give the patient the antibiotic in the operating room.

Job remembered that on the day of his first hip replacement there were many patients in the waiting area. The room was very cold and nurses put blankets on the patients. He recalls waiting at least two hours, enough for them to change his blanket twice. When he read The Checklist Manifesto he was able to put the procedure of the medical staff into context. He could now see the essential step they left out: they should have given him the antibiotic not when he arrived in the waiting room but when he was in the operating theatre.

Job and I were talking about this on the phone and I reminded him that since the results of the World Health Organisation Safe Surgery checklist were made public, more than twelve countries, including Australia, have committed to implementing it in hospitals nationwide.

Such a mistake is unlikely to happen again. So, I said, as Franz Kafka told his mate Max Brok, when they were corresponding about the depressing state of things at that time, "There is hope, but not for us." Job burst out laughing.

Reviewed by Penny Hanley ha

Note this date in your diary: 24–27 September, 2012
Sofitel Sydney Wentworth

THE QUANTUM LEAP

Measurement: redefining Health's boundaries?

Proudly sponsored by

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSW GOVERNMENT Health

Following the success of **The Great Healthcare Challenge** in 2011, the Australian Council on Healthcare Standards (ACHS) and the Australian Healthcare and Hospitals Association (AHHA) will join forces with the Women's and Children's Hospitals Australasia in 2012 to bring you – **The Quantum Leap. *Measurement: redefining Health's boundaries?***

Whether you work in a healthcare facility or department as a clinician, a clinical leader, a manager or executive, a finance officer or an information officer you are required to measure and assess your outcome. The National Health Reform is set to put this part of your job under scrutiny. This Conference will be exceedingly beneficial and stimulating.

How do we measure individual patient outcomes or population health status? How do we relate financial performance to both utilisation and quality? Do we collect and link our data efficiently to reduce the red tape burden? How will the National Standards, mandatory from 1st January 2013, influence our administrative and clinical priorities? How will the national entities such as the National Health Performance Authority (NHPA), the Australian Institute of Health and Welfare (AIHW) and the Independent Hospital Pricing Authority (IHPA) plus their state counterparts rationalise their roles? How will they incentivise good performance?

This conference will discuss these questions and highlight the views of key stakeholders.

ahha australian healthcare & hospitals association

THE AUSTRALIAN COUNCIL ON HEALTHCARE STANDARDS ACHS

WOMEN'S HOSPITALS AUSTRALASIA | CHILDREN'S HOSPITALS AUSTRALASIA

A collaboration of the Australian Council on Healthcare Standards (ACHS), the Australian Healthcare and Hospitals Association (AHHA) and the Women's and Children's Hospitals Australasia (WCHA)

WHO SHOULD ATTEND?

This conference will appeal to a wide cross-section of the public and private healthcare sectors across rural, regional and metro areas.

REGISTER NOW
www.thequantumleap.com.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.

GLEN POWER moved from his position as Deputy CEO of Joondalup Health Campus to become CEO of the South West Aboriginal Medical Service.

Maree Feery has been promoted within Epworth HealthCare to be Executive Director Human Resources, succeeding **Chris England** who has retired. Best wishes Chris.

John Amery has transferred within Healthscope from Ringwood Private Hospital in Victoria to Hobart Private Hospital as the new CEO.

Former CEO of Hobart Private Hospital **Kathryn Berry** has moved across town to be the new CEO with Calvary Healthcare Tasmania.

Kemsley Fairhurst has also moved on – from Commercial Manager Victoria and Tasmania with Healthecare to Director Performance and Reporting with Southern Health.

Chief Financial Officer at Medibank Private **Michael Sammells** is now the CFO at Healthscope.

Daryl Pedler departs from his position as the Director, Gippsland Regional Clinical School, Monash University to Professor of Rural Health, Deakin University School of Medicine.

Ian Wilson is no longer the Professor of Medical Education at the University of Western Sydney School of Medicine. He is now Associate Dean, Teaching and Learning at University of Wollongong Graduate School of Medicine.

At Allergon, **Catherine McMahon**, formerly Director Human Resources ANZ, has been promoted to be Director, Talent Acquisition and HRIS, Asia Pacific.

Steve Rubic, previously CEO of St Vincents and Mater Health Service in Sydney, is set for a change of image as he becomes the CEO of the I-Med Network.

Doug McRae, Finance and Administration Manager at Baringa Private Hospital in Coffs Harbour has headed south for the winter to become CEO of Albury Wodonga and Murray Valley Private Hospitals in Albury.

In the opposite direction, **Connie Porter**, previously Director of Clinical Services at

Figtree Private Hospital has moved north to be the Director of Clinical Services at Port Macquarie Private Hospital.

Mike Gray was Finance Manager across Ramsay's three mental health facilities in Adelaide but has moved with Ramsay to Coffs Harbour to fill the vacant position above as Finance and Administration Manager at Baringa Private Hospital.

From across the Tasman, **Michael Quirke**, formerly Business Manager at Southern Cross Hospitals, New Zealand is now with Healthscope as State Manager, NSW Medical Centres. ha

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

Ccentric Group
Executive Search Specialists

philip darbyshire consulting pty ltd

When 'it's time' to make that decisive improvement to your organisation or services, here are what clients and colleagues say about the value and return on investment that Professor Philip Darbyshire brings:

As a Consultant:

"We knew who would be the perfect person to help us, Professor Philip Darbyshire. The "Darbyshire Report" has been an invaluable investment for our organisation, giving us a vital , 'fresh eyes', perspective almost impossible to obtain 'internally'. Thanks to Philip's insightful findings and ongoing involvement, we are taking Rainbow Place to the next level. **Without a 'Philip Darbyshire Review', you may never know just how great your service could become**." Elizabeth Bang, CEO, Hospice Waikato & Rainbow Place Children & Young People's Service (Winner: National 'Every Child Counts' Award 2011)

"Professor Darbyshire's review has been critical to identifying a coherent and well articulated strategy to strengthen the research performance of the School. I know of few other consultants with the experience and ability to complete a hard edged review of this kind while engaging with concerns and developing real enthusiasm amongst staff about the challenges and opportunities for research development in the School. **The review represents a real turning point for the School and we thank Philip for his extraordinary contribution.**" Professor Paul Arbon, Dean, School of Nursing & Midwifery, Flinders University

As a Thought Leader in Nursing and Health Care:

"Philip is the 'go-to person' for hospitals and health care organizations across the world who want research and evidence-based practice demystified and moved out of the 'too-hard basket' and into the hearts and minds of clinicians who will use it make a real difference". *ACHSM*

"Nurse leaders and health organisations everywhere would benefit immensely from Philip's insightful and practical approaches to improving our services". *Association for Leaders in Nursing, UK*

"Your work on the possibilities of nursing, and the advances in the design of care taken together represent the basis for a more confident and humane approach to policy development and service design which must result in people receiving a standard of care which recognises their inherent humanity and dignity"
Professor June Andrews, former Head of Modernisation at NHS Scotland

"Your work at Princess Alexandra Hospital was the pivotal point in creating a research culture in nursing."
Prof. Joy Vickerstaff, former Chief Nursing and Midwifery Officer, ACT

As a Speaker:

"Philip Darbyshire needs to present and share his wisdom with every student nurse, every professional nurse, every nurse educator and anyone associated with health care. So much has entered my brain; but much more has been imprinted on my heart."
"Awesome speaker"
"Dynamite speaker! Find a way to bring him back to visit each OHSU campus."
"Best speaker ever - most useful info… what a breath of fresh air he was in all this academia!"
- Nurse Education Conference, Oregon, USA

"Absolutely brilliant. Witty, informative, a really inspiring presentation"
"Outstanding look at human spirit - honesty, bravery, essence - an extraordinary human being"
"So good I can't put into words"
"After listening to PD I believe in cloning!"
"Fantastic! Very moving & informative"
"His depth of understanding is outstanding - his words will stay with me forever."
"Inspiring. Enthusiastic. Outstanding."
"Absolutely magnificent - inspirational and so powerful"
- Ronald MacDonald House Charities, International Conference, Adelaide

"Your overall contribution far exceeded our expectations. We have now collated our participant evaluations and found that their responses echo ours. Your overall feedback score out of a possible total of 5 was a remarkable 4.75! We look forward to any opportunities for working with you in the future."
- Child & Family Health Nurses Conference, Adelaide

"Inspiring and passionate"
"What an inspiration"
"Wonderful speaker enjoyed the presentation so much. Very relevant."
"Phillip once again brilliantly entertaining, cuts to the chase and reminds us about our role in positive health care experiences"
"Mesmerizing. A truly fascinating and inspiring session"
"Empowering presentation"
"Inspiring and entertaining at the same time."
- 'Passionate about Practice' 2010 Conference, Brisbane

Let's talk about how we can join forces to bring this kind of value to your Hospital, School, Health Service or NGO. The best time to begin an improvement process is always right now. Prof. Philip Darbyshire

philip darbyshire consulting pty ltd

p: PO Box 144, Highbury, SA 5089
e: philip@philipdarbyshire.com.au
m: 0430 079 597

skype: philipdskype
linkedIn: Philip Darbyshire
twitter: pdarbyshire

Become an AHHA member

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

THE 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.

Network and learn

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 better service integration; enhanced information management systems; efficient financing models; targeted performance measures and benchmarking; and a sustainable, 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

For more information:
W: www.ahha.asn.au
E: admin@ahha.asn.au
T: 02 6162 0780
F: 02 6162 0779
A: PO Box 78
Deakin West, ACT 2600

Trade news

Information from suppliers in the healthcare industry

To advertise in The Health Advocate please contact:
Adam Cosgrove
Globe Publishing
T: 02 8218 3412
E: adam.cosgrove@globepublishing.com.au

Made in Germany – a win-win initiative

GERMAN medical technology sets global standards in innovation, quality and reliability. Now, the initiative "Health – Made in Germany" is bringing Australian and German partners together to promote further, sustainable advances in Australian health care.

The European leader in med-tech turnover, Germany has a great deal to offer. Among the industry's strengths are a drive to innovate, excellent R&D infrastructure and proven ability to produce state-of-the-art, reliable, quality med-tech products, time after time.

Recent statistics show a thriving med-tech industry that generates EUR 20 billion, with more than two-thirds of sales going abroad. A third of all sales are also of products that are less than three years old, and Germany led the world in registering new patents for surgery and surgical navigation in 2010.

Like Australia, the German healthcare system faces an ageing population and increasing costs. Despite government-implemented reforms to curb expenditure, Germany's healthcare system is working well for the people it serves, at home and abroad.

The drive to innovate in response to health care challenges, particularly in the fields of medical technology, biotechnology and pharmaceuticals development, has left Germany well-positioned to contribute the latest in products and equipment to medical providers the world over.

The purpose of the initiative, "Health – Made in Germany" is to bring the advantages of German healthcare products and systems to more places around the globe. Ultimately, the point is to create alliances that are win-win situations for all partners.

Contact
www.health-made-in-germany.com
info@health-made-in-germany.com

Health
made in Germany

HIP teams up with Best Doctors

Health Industry Plan has announced a partnership with Best Doctors through MLC Group Insurance to provide members with specialist medical advice from around the world – a first in the Australian industry superannuation fund.

Best Doctors enables HIP members and their immediate family to connect with leading specialists from around the world to obtain independent and confidential medical advice. It provides peace of mind in an otherwise stressful situation, with the service provision not confined to life threatening events, but also day-to-day health advice to support best possible health outcomes.

The service does not replace a member's relationship with their current doctors; rather, they work side-by-side to offer an opportunity to access expert second opinion, which may otherwise be difficult to attain.

HIP members will automatically be able to access this service immediately at no additional cost. For more information visit **www.hipsuper.com.au**

hip Health Industry Plan
Quality super for the health industry

MLC

Best Doctors

BD AutoShield™ Duo Safety Pen Needle

Injection pens have been shown to improve the quality of treatment for patients as they provide simple, more convenient and more accurate dosing[1]. However, without the use of a safety engineered device, injection pens may be associated with needlestick injuries six times more often than syringes[1].

BD AutoShield™ Duo is BD's next generation, safety-engineered pen needle, designed to protect healthcare workers from needlestick injuries and blood exposure. This new product design offers an additional level of safety with both front and back end needle protection. Benefits of 5 or 8mm length options and a thinner needle gauge* can be experienced by the patient, while providing the clinician with user confidence as there is no change of injection technique compared to a non-safety pen needle.

For more information or to view a BD AutoShieldTM Duo product sample, please contact your local BD Diabetes Care Account Manager or the BD Customer Service Team on **1800 656 100.**

* Compared to BD regular wall needles

1. Pellissier G, Migueres B, Tarantola A, et al. J Hosp Infect. 2006; 63:60-64

BD, BD logo and BD AutoShield™ are property of Becton, Dickinson and Company. ©BD 2012 ANZMED162 (12/11)
Australia: Becton Dickinson Pty Ltd. 4 Research Park Drive, Macquarie University Research Park, North Ryde, NSW 2113.
New Zealand: Becton Dickinson Ltd. 8 Pacific Rise, Mt Wellington, Auckland.

BD

Snippets

The last word

What's been happening since we last met?

HEALTH MINISTER Tanya Plibersek welcomed the passage of legislation through the Parliament to means test the private health insurance rebate, saying the legislation will save taxpayers $2.4 billion over the next three years.

A new national body was established to review alcohol advertising. The Alcohol Advertising Review Board will consider and adjudicate complaints from the community about alcohol advertising, providing an independent alternative to the ineffective advertising self-regulation system.

Aboriginal Australians in the Northern Territory will continue to have better primary health care and improved access to dental and allied health services, with a $719 million funding investment as part of the Australian Government's Stronger Futures package.

The world's largest tobacco companies have taken the Federal Government to the High Court in a bid to overturn the Commonwealth's plain packaging laws, which will require cigarettes to be sold in plain olive green packs.

Following a nine-month campaign, Victorian nurses and midwives stopped the Victorian Government replacing nurses with health assistants, saved the state's unique nurse/midwife patient ratios, achieved some improvements to ratios and secured increased money between 14 and 21 percent.

COAG agreed help improve the care and support provided to people living with severe and persistent mental illness and complex care needs through a new National Partnership Agreement. The Australian Government will provide $200 million to help address gaps in state and territory mental health systems.

The first government initiated national website to provide comprehensive and reliable information on eating disorders was launched at **www.nedc.com.au**.

Government reforms reduced the price of more than 1000 different generic drugs, dropping by as much as $15 per packet for patients. Under the reforms to the PBS, generic versions of 60 different types of medicine will be cheaper for general patients.

Under landmark changes to the aged care system, more people will get to keep their home and will get to stay in their home as they receive aged care. The Federal Government announced the 10-year, $3.7 billion Living Longer, Living Better plan to reshape aged care.

Health Workforce Australia's report Health Workforce 2025 conservatively reported a potential shortage of nearly 110,000 nurses by 2025, however if we can keep nurses in the workforce, the shortage is predicted to be less than 25,000.

The AIHW report, *Australian hospital statistics 2010–11*, showed hospital admissions increased from 8.5 million to 8.9 million in a year. For the first time in five years, the demand for public hospitals is increasing faster than for private hospitals.

The Prime Minister announced that the Federal Government will fund part of the National Disability Insurance Scheme (NDIS), which will start from July next year. Ms Gillard outlined funding of $1 billion over 10 years in the Federal Budget as the Government "does its part" to get the scheme started a year earlier than expected. ha

Whose scrub suit will you be wearing tomorrow?

Single-use medical devices are widely recognised as essential to controlling infection. But in many hospitals, a lot of different people will still end up using the same reusable scrub suit.

BARRIER® scrub suits are used once by you and you alone to support the effectiveness of your infection control routines. They are comfortable, professional-looking and available in a wide range of sizes.

Visit **www.molnlycke.com.au** to learn more about the full range of BARRIER single-use scrub suits. And discover the benefits of starting every shift with a scrub suit you can truly call your own.

www.molnlycke.com.au

BARRIER®
NO COMPROMISE IN SECURITY

MÖLNLYCKE HEALTH CARE

Mölnlycke Health Care Pty. Ltd., 14 Aquatic Drive, Frenchs Forest NSW 2086 T 02 9453 1144. F 02 9453 1155. www.molnlycke.com.au
The Mölnlycke Health Care name and logo and BARRIER® are registered trademarks of Mölnlycke Health Care AB
(Copyright 2010)

BD AutoShield™ Duo

Safety Pen Needle

Because Pen Needle Safety Really Matters

- Automatic Double Protection
- Audible and visible safety indicators
- Thinner and transparent base for more precision
- Thin Wall Technology for an improved flow rate*
- 30G x 5mm & 8mm
- Designed to fit all pens†

Automatic Double Protection

BD

†at January 2012 *Compared to BD regular wall pen needles

Australia: Becton Dickinson Pty Ltd. 4 Research Park Drive, Macquarie University Research Park, North Ryde, NSW. 2113. Toll free telephone: 1800 656 100.
New Zealand: Becton Dickinson Ltd. 8 Pacific Rise, Mt Wellington, Auckland. Toll free telephone: 0800 572 468.
BD, BD Logo and all other trademarks are the property of Becton, Dickinson and Company. © BD 2012 ANZMED181 (01/12)