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PAUL DUGDALE

Chair of the Australian Healthcare and Hospitals Association (AHHA)

Public hospital funding and the Budget

2016 Budget halves service improvement growth for public hospitals

Free, comprehensive public hospital care for all is one of the central planks of the Australian health system. The Commonwealth

Government has a vital role in ensuring such care remains sustainable, equitable and accessible for all. What does the 2016-17 Federal Budget mean for the funding of public hospitals, so close to a national election?

It needs to be understood in the context of the last five years of policies on funding public hospitals. In August 2011, the Commonwealth struck an agreement on the funding of public hospitals with all eight state and territory governments through the Council of Australian Governments (COAG). The key commitments were a shift to activity based funding to drive efficiency and access, and to the Commonwealth agreeing to meet 45% of 'efficient growth' funding until 2016-17, rising to 50% from 2017-18.

The actual dollar amount paid by the Commonwealth for efficient growth is over and above inflation, and includes amounts for growth in the size and age profile of the population (as older patients are more expensive on average). It also includes real growth for hospital service improvement, which mainly consists of new technologies, wider delivery of existing effective treatment to those who need it, improving safety and quality improvement.

In the 2014 Budget, the Commonwealth provided funding for its commitments under the 2011 Agreement until June 2017, but thereafter only provided funding increases to cover inflation, population growth and ageing, with zero funding for health services improvement. Over the eight years from

July 2017, this saved the Commonwealth \$57 billion in expected funding to public hospitals. That Budget also ended the Commonwealth's commitment to activity based funding.

Following an agreement on public hospital funding at the April 2016 COAG, the 2016 Budget to some degree reversed these cuts. It re-commits the Commonwealth to activity based funding, and provides for a maximum of \$2.9 billion in additional Commonwealth funding for public hospitals in the three year from July 2017. Both these initiatives are welcomed by the AHHA.

However, the Budget provides only 44% of the funding required from July 2017 to maintain the current rate of the Commonwealth's contribution to public hospital service improvement growth (based on the Commonwealth's share of growth being 45%), or only 40% of what was expected through the 2011 COAG agreement (based on the Commonwealth's share of growth rising to 50%).

In summary, we can say that this year's Budget halves Commonwealth funding for service improvement in public hospitals from July 2017 onwards.

It is easy to see this a bad thing. But there are always plenty of things for governments to spend money on so we need to think carefully about the implications of cutting growth in public hospital funding.

The first point is that health expenditure does grow in real terms – on average by 1% of GDP per decade. This is the way health systems improve.

The second point is that if adequate growth funding is not provided by government, it will occur through private expenditure. This may be a good thing in certain circumstances, and

a bad thing in other circumstances.

The third point is that if left unregulated, private expenditure on health is prone to moral hazards including unnecessary treatments and poorer health outcomes for patients with lower incomes, resulting in inefficient health expenditure growth.

Community rated private health insurance can in principle fill the gap in funding growth, but will not rise through private health insurance under current regulations. The industry would require extensive re-regulation in order to facilitate this. Perhaps we will see some action on this front after the election.

The likely alternative is that the expenditure growth will be pushed onto consumers as out-of-pocket costs. This places a greater burden on the more vulnerable members of society which would further entrench health inequalities and access difficulties. Australian health expenditure already involves higher out-of-pocket costs than comparable countries (the US excluded).

In short, if the Commonwealth does not continue providing its share of growth funding for public hospitals, health expenditure growth will likely need to be met through rising out-of-pocket costs, exacerbating the dysfunction already present in this area of the health system.

The 2016 budget allows for some improvement in services and for continuing momentum in the funding of public hospitals. Politically speaking, it may have neutralised public hospital funding as a negative issue for the Coalition in the coming election. However it begs the question on where appropriate and efficient growth is going to come from without hurting those who can ill afford to pay. **ha**



ALISON VERHOEVEN

Chief Executive
AHHA

Doing reform better

Commitment to collaboration rather than competitive politics required

In the seemingly endless focus on health reform and the continual debates about funding and roles and responsibilities, we often lose sight of the most important objective of all: improving health outcomes, particularly for those most in need in our community.

The work of the National Health and Hospitals Reform Commission during 2008-09 led to a broad range of structural and funding reforms under the Rudd/Gillard Labor Governments, some of which, such as activity-based funding for hospitals and the Closing the Gap initiatives, are still in place despite the policy changes which have occurred since 2013 and the election of a Coalition Government. Other reforms, such as the work led by agencies focused on prevention, workforce and information transparency, either ceased or were wound back substantially. The Abbott/Turnbull Governments introduced reforms such as regional commissioning of services by Primary Health Networks and the forthcoming health care homes, brought a tighter fiscal perspective to health, and instituted a series of review processes on matters such as private health insurance.

As we approach the 2 July 2016 election, what is in store for health, and how can we do reform better in the future? The AHHA considered this at a recent Think Tank attended by around 100 health leaders from across the country. We specifically looked at opportunities for delivering better

health outcomes with a focus on patients at the centre of the health system; and acknowledged that recent attempts at health reform have been unable to arrive at a shared understanding of what reform should deliver. One matter we all agreed on was that fragmented, short-term changes are unhelpful.


There was broad agreement that the health system needs to transition from:

- A provider-driven system to one where providers and consumers share decision-making
- A system with limited information transparency to a data-driven system where patient and system data is used to target care, ensure the best use of resources and achieve better patient outcomes
- Siloed, fragmented care to a collaborative system of joined-up care
- A system focused on managing chronic illness, including sometimes futile care at the end of life, to one focused on preventing chronic disease from the beginning of life

Strategies identified for prioritisation included:

- The need for 'system wranglers' who can support collaborative care – typically clinicians who have both a policy and funding base from which they can drive continuity of care, build relationships between providers, and promote structured change

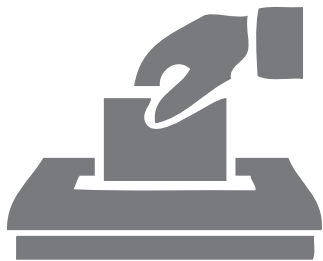
- Change management processes that embraced the varied perspectives of patients, providers, researchers, policy-makers and politicians
- Greater nimbleness, willingness to take informed risk, evaluations built into trials and used to inform policy implementation
- Better integration of key portfolios including health, aged care and disability
- Better connections between health education, research and service delivery
- Considering both high and low cost technologies as enablers of change
- Using data to reduce inefficiency, promote quality and increase consumer empowerment
- Acting on workforce challenges, including the ageing demographic, a perceived gap between professional expectations and appropriate remuneration, and unpredictable financing models
- Greater consumer participation, building on the democratisation of knowledge and shared decision-making models, but recognising that expectations must be managed pragmatically

Reimagining the health system will require health leaders to participate in an open dialogue that facilitates the recognition of priorities and motivations of different stakeholders. It will also require a commitment to collaboration, rather than competitive politics, in order to achieve better health outcomes for all, particularly our most vulnerable population groups. 

AHHA in the news

HAVE YOUR SAY...

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



2016 Election priority: Healthy Australia with best possible health system

The AHHA called for all candidates in the 2016 federal election to commit to working together for a healthy Australia supported by the best possible health system, after Prime Minister Malcolm Turnbull announced the election in early May.

"A priority for the incoming 45th Commonwealth Parliament must be to ensure that our health system provides affordable, accessible quality care to all Australians, both now and into the future" AHHA Chief Executive Alison Verhoeven said.

"The Commonwealth has a vital leadership role to play in supporting better integrated and coordinated patient-centred care across the primary, acute, aged and disability care sectors."

Australia's healthcare system consistently outperforms other OECD countries when comparing key health indicators and costs, but burdens such as an ageing population, increased rates of chronic and complex disease, and new medical technologies and treatments, are presenting new challenges and increasing the cost of care.

The AHHA calls on all candidates to commit to universal healthcare principles, long-term sustainable funding and an innovative patient-centred health system which is founded in well-resourced prevention and primary care, and integrated effectively with the hospital sector.



Budget 2016 all about savings: piecemeal health program support; cuts disguised as strategy

The AHHA labelled the 2016-17 Budget released on May 3 a disappointing result for the health sector. Nearly fifty measures, including some small investments and many cuts, were disguised as strategy.

"The confirmation of an additional \$2.9 billion over three years in public hospital funding is welcome, though this returns less than half of the expected funding that was initially removed by the Government in the 2014 Budget. The AHHA strongly supports the ongoing commitment to activity-based funding, particularly given the National Health Performance Authority's recent report has shown such funding improves hospital efficiency," AHHA Chief Executive Alison Verhoeven said. "However, the Government must continue to plan not just for the next electoral cycle, but with a strategic vision for the future of Australian health."

"Action is needed to align the interfaces between health, aged care and disability services to help coordinate patient care. The limited arrangements proposed for Health Care Homes will only partly serve to address this."

"Reform to the healthcare and related systems must be considered as part of a co-ordinated approach to the delivery of care across the primary, acute, aged and disability care sectors. What Australians have been delivered in this Budget is a hotch potch of spending and cuts, with no clear vision."

Activity-based funding improving hospital efficiency, work must continue

In late April, AHHA welcomed the release of the National Health Performance Authority's report, *Hospital Performance: Costs of acute admitted patients in public hospitals from 2011-12 to 2013-14*.

"This report shows the importance of national work undertaken since 2011 by the Independent Hospital Pricing Authority and by all state and territory Health Departments to implement activity-based funding and a national efficient price as a basis for funding public hospitals. This has been complemented by significant efforts to achieve efficiencies across the public hospital sector, which are now paying off, notwithstanding increases in service demand," Alison Verhoeven, AHHA Chief Executive said.

With three years of costs data now publicly available, the impact of this work is very clear: the average cost of care in Australia's major metropolitan hospitals has risen at less than the rate of inflation. In some hospitals, there have been marked improvements in efficiency, particularly in Victoria where activity-based funding has been implemented over a longer period.

Efficiency is also only one aspect of a high-performing public hospital system. Safety and quality, effectiveness of care, and accessibility are integral features to a strong public hospital system that meets the needs of all Australians, and should not be overlooked in the quest for budget savings.



NEAT not the answer to Emergency Department overload

A Deeble Institute for Health Policy Research Issues Brief published in April showed the pitfalls of using the National Emergency Access Target (NEAT) to reduce the length of stay in hospital Emergency Departments (EDs) and improve overall patient outcomes.

NEAT used a single, time-based target to incentivise patient flow and was adopted across Australia in 2011 with the aim of reducing 90% of all ED stays to four hours or less. This followed a 65% rise in presentations in the preceding decade.

The National Emergency Access Target: aiming for the target but what about the goal? by Deeble Scholar Katharine Silk, found that hospitals have been unable to achieve the targets, despite some improvement in NEAT attainment. NEAT was found to have increased hospital admissions, potentially reducing patient flow.

“Reform using a single, incentivised, process-based mechanism is unlikely to achieve broad changes to the effectiveness, safety, quality and equity of care provision, and risks producing unintended consequences,” Ms Silk wrote.

“It is for these reasons that the NEAT policy at present cannot be considered a complete success.”



Bipartisan support for dental care welcome, but devil is in the detail

The April announcement by Health Minister Sussan Ley of a Public Dental Scheme for children and adults was a welcome shift to bipartisan Commonwealth support for dental care as an important part of the Australian health system, said Alison Verhoeven, AHHA Chief Executive. However the funding is neither as generous as suggested in the announcement, nor will it underpin equitable access to care.

“All Australians should have access to affordable dental care — good oral health is important for our health and wellbeing, but affordability challenges mean many people miss out,” Ms Verhoeven said.

“Whether the scheme announced today assists in addressing these challenges will be highly dependent on the detail: many of the people who will be eligible for the new program are already eligible for public dental services but face long waits for care. This funding stream from the Commonwealth may contribute to easing waiting times, but it will be dependent on the calculation methodology for the efficient price the Commonwealth has indicated it will pay, and the capacity of the states and territories to meet co-funding requirements. This creates a real risk of variation across Australia in the availability of care.”

Cultural change, shared vision needed alongside data, technology to meet health challenges


Cultural change and shared vision amongst health system stakeholders is needed if we are to move beyond fragmented, short-term changes in health, according to participants in AHHA’s April *Think Tank: Looking Over the Horizon — Where to next for the Australian health system?*

“Reimagining the Australian health system will require centering the health system around patients, redesigning workforce and professional roles, reducing silos and exploring strategic partnerships,” AHHA Chief Executive Alison Verhoeven said.

“The Think Tank’s communique notes agreement that a whole of system approach is needed, based on culture change and increased use of technology and data.”

“The Think Tank challenged stakeholders to look beyond funding models as drivers of reform, and consider the opportunities presented by shared decision-making between providers and consumers, use of data to target care and achieve better patient outcomes, greater continuity of care across the health system and complementary sectors, investment in prevention and a focus on reducing futile care.”

While technology and data were acknowledged as enablers of change, participants identified a need to urgently address workforce challenges including the ageing workforce demographic, increased professional expectations and unpredictable and decreasing funding.

A full report on the Think Tank can be found on page 10. 



A close-up portrait of Catherine King, a woman with shoulder-length brown hair, smiling warmly. She is wearing a grey blazer and pearl earrings. The background is a plain, light-colored wall.

Embedding healthcare reform

Shadow Minister for Health Catherine King
on the need to reform the health system

This federal election must draw a line in the sand on the politically inspired cycles of boom and bust that characterise Australia's recent healthcare reform journey.

Too often we have taken two steps forward, only to take one or two back. While there are huge differences between Labor and the Coalition on health policy, especially in areas such as primary care and hospital funding, ultimately, Labor believes that there should be a long-term commitment to healthcare reform in Australia, and that reform should be embedded in our healthcare system.

Healthcare reform shouldn't be something the last Labor Government did. And healthcare reform requires much more than an announcement and some funding. It should be an ongoing process that ensures our healthcare system continues to meet the changing needs of all Australians. This requires a continuing process of policy and program development, implementation, monitoring, evaluation, communication and feedback.

That is why, when last in Government Labor committed with the states and territories to a new long term agreement to fund 50 per cent of the growth in the National Efficient Price of hospital-based activity.

This agreement came out of years of discussions, and years of work to ensure we could meet increasing demand, but at the same time ensure this funding was used to drive real reforms that improved patient care.

“Health systems with strong primary health care are more efficient, have lower rates of hospitalisation, fewer health inequalities and better health outcomes including lower mortality, than those that do not”.

The Coalition went to the 2013 election promising to continue with that funding agreement. Instead, they tore it up, and with it years of reform to build a decent hospital system, returning to funding hospitals on a formula based only on population growth and the Consumer Price Index.

But the changes went much further than just ripping out the funding, because at the same time the Government also tore up a series of agreements, years in the making and agreed by governments — state and federal, Labor and Liberal — to not only place hospital funding on a secure basis, but use that funding to drive some real reforms that would not only improve patient care, but do so in a way that made hospitals much more efficient.

The agreement delivered better quality care in primary care, hospitals and prevention while putting in place a secure funding base for the health system and hospitals well into the future.

They were in short, the most significant reform to the health system since the introduction of Medicare.

Two years later, the government has acknowledged just how disastrous this decision was, by now declaring that it supports both activity based funding and a national efficient price.

While this is a welcome development, it's distressing to think just how much has been lost in those two years — two years of going backwards on making hospitals more efficient and of cutting waiting lists.

I believe that governments — federal and state — can do more to embed reform in our health care system.

But governments and politicians can't do it alone — and in fact, we shouldn't try. Reform should be driven by the people who know our system best — consumers, practitioners and experts.

That is why one of the most disappointing aspects of Malcolm Turnbull's election manifesto is its continuing attack on primary care.

After being devalued in the Coalition's first two budgets by the GP Tax and then the four year Medicare Benefits Schedule indexation freeze, the profession could have been forgiven for hoping a change of leader marked a change in approach to general practice.

Sadly, as we now know, this was not the case, and the shock decision to extend the freeze out to six years effectively signals that under the Coalition, Medicare rebates are

now effectively locked at their current rates.

This is despite the fact that all of the evidence internationally is that the stronger a country's primary healthcare system, the better its health outcomes are.

We know from a number of studies that health systems with strong primary health care are more efficient, have lower rates of hospitalisation, fewer health inequalities and better health outcomes including lower mortality, than those that do not.

Just as important is preventive health. Trust for America's Health, with whom I was pleased to meet last year — estimates every \$1 spent on increasing physical activity, improving nutrition and reducing smoking lowers health care spending by \$5.60.

This is why, as part of our historic health reforms, Labor established the National Preventative Health Taskforce, which recommended a 10 year roadmap for action on obesity, tobacco and alcohol.

Much of that work remains relevant today, and could help guide a future Labor Government. Labor also established the Australian National Preventive Health Agency, so that governments would receive ongoing expert advice on promoting health and preventing disease.

Of course, we also put our money where our mouth was. Under our National Partnership Agreement with the states, we committed \$872 million to help children, adults and communities stay healthy.

Investing in primary care and preventive health, negotiating long term agreements with state and territory governments, and at all times working with the health sector are smart, sensible and sustainable health reforms that can break the boom bust cycle.

This is the path Labor will take in Government because Labor understands health reforms can only be achieved in co-operation with the health sector, and that co-operation can never succeed if the sector is constantly blindsided by Budget night surprise raids and politically inspired attacks on the integrity of doctors. **ha**

The AHHA seeks to ensure balanced representation of political views. Health Minister Sussan Ley's article on health reform was published in the April edition of The Health Advocate. An article to be provided by the Prime Minister's office on innovation was not received in time for publication in this edition.

Looking over the horizon

Where to next for the Australian health system?
Connor Rochford

Reforming the Australian health system is not a new concept. However, *reform* can mean different things to different people. Recent attempts at health system reform have been unable to arrive at a shared understanding of what reform should deliver. There is a need for a shared vision from all stakeholders to deliver a future-oriented health system. A policy process that leads only to fragmented, short-term change to the health system is not enough for the Australian public. Instead, stakeholders must look beyond the immediate funding and reform debates which dominate the policy debate and consider what lies over the horizon for the Australian health system. These were some of the key messages from the *Think Tank: Looking Over the Horizon – Where to next for the Australian health system?* recently convened by the Australian Healthcare and Hospitals Association (AHHA).

The Think Tank brought together around 100 health system leaders to debate the future of the Australian health system. With the Federal election underway, concerns regarding the long-term financial sustainability of the health system are well known. While other industries

have reinvented their delivery models, technological base and value chain, healthcare has remained fundamentally unchanged. The existing supply models have been unable to match the economy's efficiency gains and face a major productivity gap. Meanwhile, demand for service is being driven by the burden of disease, rising consumer expectations and increased utilisation. This clash in supply and demand increases the imperative for a shared vision that aligns the competing and conflicting interests of all stakeholders.

Although specifics remain disputed, there was broad agreement amongst participants at the Think Tank that realising the vision of a fit-for-purpose health system will require transitioning from:

- A provider-driven system predominately driven by information asymmetries and fee-for-service financing to a system where providers undertake shared decision-making with consumers.
- A system with limited accessibility and transparency of information to a data-driven system where patient and system data is utilised to target care, ensure the best use of resources and achieve better patient outcomes.



- A lack of continuity of care across different healthcare providers and complementary sectors to a collaborative system where connectivity facilitates integration with different parts of the health sector and other relevant sectors such as aged care, disability and education.
- A system focused on responding to chronic health conditions at the end of life, including sometimes futile care, to one focusing on preventing chronic disease from the beginning of life with consumers using increasing information and technologies to achieve self-monitoring and healthier lifestyles.

Achieving these transitions requires a policy process that recognises the diverse priorities and motivations of stakeholders. The need for ‘system wranglers’ to reimagine the health system through a whole-of-system approach was a common theme throughout the Think Tank. Each of these factors is described below.

Reimagine the health system

To solve some profoundly entrenched problems within the health system there is a need to think differently.

Some participants offered the provocative premise that the notion of an Australian health care *system* is a fallacy. Instead, we have a web of services; ‘a loose connection of dysfunctional entities’. In addition, there was broad consensus that the Australian health system’s ‘Business As Usual’ cannot continue; there is a need for a demonstrable shift in approach to public policy which respects ‘the drivers of change’ and ‘reflects international best practice’. Changing ‘Business As Usual’ will deliver health, social and economic benefits to all stakeholders within the system. A more efficient and effective healthcare system will decrease system cost, increase individual wealth and create a healthier, more prosperous Australia.

The need for ‘culture change’ was repeatedly identified as a fundamental component of a reimagined health system. As an example, stakeholders suggested the perceived lack of urgency and nimbleness around innovation must shift to a steady

pace of change and an increased tolerance for taking informed risks. There was an underlying sentiment that the persistent change of political leadership, and consequential churn of government policy, is exhausting. This inhibits any ‘appetite for risk’ within the system, as the aspirations and behaviour of stakeholders is persistently confined by short-term incentives, typically financial. This would suggest there is a currently a disconnect between prevailing political rhetoric and day-to-day system mechanics.

Take a whole-of-system approach

A whole-of-system approach that reduces silos and explores strategic partnerships should be a high priority for system reformers.

Looking top-down, this approach would better integrate key portfolios and Ministers, including aged care, disability and health. Further, health system stakeholders need to build relationships with stakeholders outside the system. For example, Think Tank participants felt working closely with central agencies such as Treasury and Finance to better align funding with health policies would improve patient care and achieve system efficiencies.

Taking a bottom-up view, there is a need to connect service delivery, education institutions and research institutes. There exists a unique opportunity to better connect health care professionals with ‘the bigger picture’; just as sensible health policy promotes the integration of research, service delivery and funding, it must be informed by an integrated vision for the system.

System actors must drive change

Achieving structural change within large systems is notoriously difficult, with health being no exception; a reality understood by all who attended the Think Tank.

Change must be a dynamic process informed by the narrative of all stakeholders, including patients, providers, researchers, policy-makers and politicians. Simultaneous change must be delivered at all levels of the system; government policy, service delivery and individual patient-provider interactions.

This again illustrates the need for stakeholders to create a shared understanding of health system reform.

The Think Tank discussed the importance of celebrating and supporting change agents, or ‘system wranglers’. These individuals will typically be clinicians who have ‘the ability to form relationships with people in other sectors’ and capacity to drive change in a structured and planned way. Enabling this process will require a mandate from a Ministerial level, given the silos that are in play.

As part of discussions on how we might transition to a future oriented health system there were a number of specific policy issues debated at the Think Tank, including technology, health workforce, and the role of the consumer.

Role of technology and data

Technology is not necessarily a saviour of the system, but instead, an enabler of change.

The Think Tank heard how the use of emergent technology is already playing an increasing role in the health system. This is unlikely to reverse. As such, both high and low cost technologies have a role to play in the future of the health system, providing they are evidence-based and individualised. Concerns remain regarding what funding mechanisms will best actualise the opportunity provided with the rapid advances in health technology.

There was also consensus for the need to move beyond the myth that technology is intrinsically complicated, as simple self-monitoring can be as effective as more complex systems. However, evidence is often lacking. Regardless, there was broad recognition that the future health system must be designed to integrate self-monitoring into the system. This integration will necessitate linking up existing IT infrastructure with health professionals and patients, both within and between jurisdictions. Effective use of technology has the potential to increase the quality and safety of care, transition delivery closer to patients in their homes and reduce health system costs.

There is also significant potential for the role of data to reduce inefficiency and increase consumer empowerment. This will only be realised by increased accessibility and transparency of information. In order for this to be achieved the Think Tank acknowledged much work is needed to address data ownership, access and privacy concerns. This includes balancing both public and private interests in how data is shared and used. In addition, there was a strong view that the collection of any new information must provide a clear benefit and should not involve excessive administrative burden. It will also require information technology capacity building amongst clinicians, and augmentation of technology and data use between researchers, academics and clinicians; yet another example of the need for a better integrated system. This social and cultural change will not be successful unless supported by funding and capacity investment.

Workforce: the elephant in the room

Immediately addressing workforce challenges is a prerequisite to future-proofing the Australian health system.

Multiple speakers and participants suggested there has been a failure to firstly recognise, and then act on, the enormity of the workforce challenge facing the health system. The Think Tank heard that within the context of constant review the scale of the problem is constantly diluted. It would seem this creates an inertia to action, at political, policy and organisational levels.

It is reasonable to consider workforce challenges in three broad categories;

1. An ageing workforce demographic
2. Increased professional expectations that are not commensurate with support for professional development or appropriate remuneration
3. Unpredictable financing models and

decreased funding of jobs (including research positions) are 'eroding' the workforce

Ensuring a future oriented health system requires a productive workforce; the system's intellectual capital is an inherently valuable asset. There was acceptance that there is a need for the workforce to evolve. Health professionals need a new approach to problem solving and thinking critically as improving health service delivery and workflow will require staff to 'solve non-routine problems creatively'. There was broad agreement that for this evolution to occur, health services management will

need to shift leadership 'to the front line'. This may also require changes to funding models to facilitate a culture change. Again, we might consider how technology can be used as an enabler to support solutions to workforce challenges.

Role of the consumer

Future reforms that both harness the opportunities and mitigate the risks presented by increased consumer empowerment was a consistent theme throughout the Think Tank.

Consumers are already taking steps to manage their own health and better navigate the health system. Increases in health literacy are facilitating a 'democratisation of knowledge', which is enabling patients to participate in shared decision making. Importantly, shared decision making is not equivalent with the foundational ethical principles of informed consent and patient autonomy. Whilst these ethical principles were considered necessary, they are not sufficient to increase patient participation to the level that translates to new models of care and better health outcomes.

Obviously, a lower level of literacy will inhibit an individual's ability to participate in shared decision making. Health inequity was an area of considerable concern amongst Think Tank attendees. In fact, a recent OECD report found that 'at age 30, those with the


lowest levels of education are expected to live roughly six years less than well-educated counterparts'. A focus on increasing health literacy is not only an imperative for the health sector, but requires a whole-of-government response. There is a role for technology here too, with increasing access to decision support tools giving patients the confidence to ask questions and be involved in their health care decisions.

Enthusiasm for increasing consumer empowerment was linked with a degree of caution with many at the Think Tank concerned with the influence of 'Dr Google'. In particular, participants were alarmed at the increasing demand for inappropriate health services based on online advice. There must be a renewed focus on educating both patient and clinician on the benefits and risks of online platforms. More too can be done to bring evidence and decision-tools to the fingertips of clinicians. This will harness the full potential of digital technologies to better enable self-management and remote monitoring.

Conclusion

Reimagining the Australian health system will require re-centering the health system around patients; redesigning workforce and professional roles; reducing silos and exploring strategic partnerships. This will require a whole-of-system approach inspired by a culture change and increased use of technology and data.

Too often stakeholders within the health care sector have a narrow view of the future of the Australian health system. The Think Tank encouraged participants to consider the bigger picture and participate in an open dialogue that facilitates the recognition of priorities and motivations of different stakeholders.

If all parties come to this challenge with a commitment to collaboration we can develop a pathway to ensure Australia's health system continues to deliver effective and efficient health care, improve outcomes for disadvantaged groups, support the effort of health professionals and be future-oriented to continue providing for future generations. 

"The Think Tank brought together around 100 health system leaders to debate the future of the Australian health system."

Kicking goals for oral health

Innovative engagement approaches are helping to improve oral health Metro North Oral Health Services

Poor oral health is one of many challenges faced by homeless people in Australia. Engagement with mainstream health services can be difficult for a range of reasons and even more so for those who are living on the streets or who don't have a stable housing situation.

To support better access for homeless people in Brisbane, Metro North Oral Health Services has partnered with the Big Issue's Community Street Soccer program. The Community Street Soccer program operates in all states and territories. Street Soccer is an innovative approach to engaging with people who may not be accessing traditional support systems. Launched in 2007 the program has engaged with over 7000 homeless, marginalised and disadvantaged people.

Research undertaken by La Trobe University in 2009 found a range of positive benefits for participants including: increased self-esteem, greater ability to obtain and retain employment, reduced smoking rates, improved health awareness, relief of mental illness symptoms and improved housing situation. Further research found that as a result of individual behaviour change and reduction in high-risk activities, there was an estimated a saving of \$4.30 to the Australian community for every \$1 invested in Street Soccer.

Following an approach from The Big Issue staff, Metro North Oral Health Services staff have attended the weekly soccer games held in a Brisbane park to provide information and advice about oral health and access to services. To help break the ice, the dentists and oral health therapist from Metro North have put down their dental instruments, donned their boots and



joined the other players on the soccer field. Actively participating in the soccer program has encouraged a more social and relaxed engagement with the program participants. An initial survey found that around three quarters of the soccer program participants felt they needed some form of oral health treatment. Participants have been provided with information about eligibility and service locations, oral hygiene advice and general health information. Where appropriate assistance has been provided to access priority care for those most in need.

One of the participants who was provided with a new full denture through the Metro North program has also been selected to represent Australia in the next Homeless World Cup. Ronnie will be heading to Glasgow, Scotland in July as part of the Australian team to compete against 47 other national teams. Sixteen women's teams will also participate in the tournament.

Applications to participate in the tournament are invited from the 73 National Partner programs across the world. Applying countries undergo a lengthy evaluation process with the evaluation including assessment of capacity, development and growth, local partnerships, participation within the Homeless World Cup network, and communication, among other factors.

At the presentation of the team jerseys at Parliament House in February Minister for Health and Sport Sussan Ley said "(The program gives players) better nutrition, increased physical fitness and decreased rates of smoking and substance abuse are changing players' lives for the better. The benefits of the program extend beyond the physical, with many players also improving their psychological wellbeing."

The Big Issue CEO Steven Persson said "The Homeless World Cup is an opportunity for our Street Soccerroos to connect with homeless and disadvantaged men and women from around the world in the spirit of friendship, social inclusion and fair play".

It will be the eighth time Australia has participated in the Homeless World Cup. In 2001 and 2009 the team was awarded the Fair Play Award for sportsmanship and positive attitude. ha

For more information on the Street Soccer program visit the Big Issue website at www.thebigissue.org.au/community-street-soccer/about/ and to follow the Street Soccerroo's progress: www.homelessworldcup.org

Supporting contraceptive choice

Unplanned pregnancy a key health issue



“200,000 unplanned pregnancies are estimated to occur annually in Australia, with the majority of women using at least one form of contraception at the time of their pregnancy”

A new report has called for an overhaul of medical services offered to women seeking contraception,¹ as researchers reveal that half of all pregnancies are unplanned and half of all unplanned pregnancies are terminated.²

The report by the AHHA, which was funded by MSD in Australia, states that inadequate Medicare rebates are a key reason women are not offered more effective and less user-dependent methods of contraception.¹

A Health System that Supports Contraception Choice identifies unplanned pregnancy as “a key health issue for women in Australia”.¹ It calls for increased Medicare funding for contraception services, including the extension of Medicare items to include nurses working in GP clinics who insert and remove long-acting reversible contraceptive implants and devices.¹

“The current Medicare Benefits Schedule review process is an opportunity to address this, ensuring that MBS items reflect best contemporary practice,” said CEO of the Australian Healthcare and Hospitals Association, Alison Verhoeven.

Dr Deborah Bateson, Medical Director at Family Planning NSW, speaking at the Women’s Health Summit held in Sydney in May, said “while the pill remains a useful contraceptive option, it is important for women to be informed about long-acting reversible contraceptive methods, including the implant and intrauterine devices, and be able to easily have one inserted if this is their choice”.

“Use of the pill is high in Australia, however oral contraceptives rely entirely on the woman

remembering to take a pill each day which can make them less effective in the real-world than most people assume,” she said.

“In countries like Sweden, one-in-four women use a long-acting contraceptive.³ This compares to one-in-ten in Australia.⁴ There appear to be several reasons for this difference, including a lack of awareness, as well as misinformation about these effective methods of contraception which can be used by most women with a low chance of side-effects and high rates of satisfaction and continuation.”

Dr Philip Goldstone, Medical Director for Marie Stopes International, Australia’s largest provider of pregnancy termination services, says that long-acting reversible contraceptive methods have the potential to significantly reduce unintended pregnancy compared with the more commonly used contraceptive pills.⁵

“Despite this, our experience is that currently only a quarter of women chose a long-acting contraceptive after a termination.⁵ A lack of awareness and education is a major barrier to changing contraceptive methods,” he said. “However, in lower socio-economic areas the uptake of long-acting reversible contraceptives by women following termination is less than that in more affluent areas, suggesting cost barriers to reliable contraception may also contribute to this lower uptake.”⁵

In addition to increased Medicare funding, the Australian Healthcare and Hospitals Association report calls for:¹

- Greater education of Australian women on contraception choice, including materials adapted for those with low literacy, or addressed to specific population groups.
- A single ‘gold standard’ guideline across all health professions and practice environments to support use of appropriate contraception methods.
- Increased training and involvement of nurses in the provision of contraception services, including the insertion and removal of long-acting reversible contraceptive devices.
- An increased role for pharmacists in providing counselling on contraceptive options, most notably when dispensing emergency contraception (i.e. the morning-after pill).

The Women’s Health Summit, which was attended by doctors, nurses and health policy experts with an interest in reducing the rate

of unintended pregnancies, was told that:

- 200,000 unplanned pregnancies are estimated to occur annually in Australia,⁶ with the majority of women using at least one form of contraception at the time of their pregnancy;⁷
- More than 80,000 terminations are estimated to occur annually in Australia.² This equates to a quarter of all known pregnancies.
- Emergency contraception was dispensed by pharmacists on more than 700,000 occasions last year alone.⁸

Both the Australian Healthcare and Hospitals Association report and the Women’s Health Summit were supported through educational grants provided by MSD in Australia. 

This article was prepared by Ethical Strategies. For more information, contact: John Morton (0416 184 044) or Rebecca Anable (0404 019 323)

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Innovation that keeps the patient central

Health providers are often challenged by the task of delivering person-centred treatment and care. Despite the best efforts of staff and policy makers, understanding the full picture of somebody's health conditions or concerns can prove difficult in the health sector's time-pressured and crisis-driven environment.

It is also common for people with ongoing or chronic health conditions to receive support from multiple health and human service organisations. In many cases, people who experience social disadvantages, such as poverty, addiction, homelessness and domestic violence, also experience injury, health conditions, disability and mental illness. Poor communication across support services can diminish the quality of care received and ultimately increase an individual's dependency on both the health and welfare systems.

In NSW, Patchwork aims to offer a potential solution to these challenges. Patchwork is a web-application for better collaboration around patients. It enables health practitioners to quickly find and contact the other services that are working with a patient in order to develop the most effective support for an individual. It has the potential to change the way some of the most vulnerable people interact with human services.

Patchwork aims to foster collaboration across services while protecting a client's

Redesigning the way health professionals in NSW think about the needs of their patients

Department of Family & Community Services

privacy. It is not a case management system. Rather, it encourages coordinated case management by providing the names and work contact details of practitioners that work with a client. When engaging on Patchwork, practitioners are required to follow their organisation's best practice and privacy guidelines. Patchwork is intuitive to use, does not require formal training and can integrate seamlessly with the current systems and policies in human service organisations.


To better support vulnerable people in NSW, frontline practitioners across both sectors need to work together to produce holistic wraparound support. When a practitioner communicates across services, support becomes coordinated, seamless and person-centric. By joining Patchwork, health practitioners optimise their ability to work in a team to break the cycle of disadvantage for vulnerable patients. This may be as simple as notifying a patient's support or social worker of certain health needs, so appropriate wraparound support can be provided.

Joanne, an NGO support worker uses Patchwork to learn about her clients' health needs. Reflecting on one experience, she said: "I was able to gain an understanding of another service's involvement with (my) client's mental health diagnosis. As a result, I was able to change my style and get the client off to a really good start." Having a comprehensive understanding of her client's needs allowed Joanne to make a positive impression, gain her client's trust and modify her practice.

Patchwork can also assist when a

practitioner needs to notify other support services about a client's health conditions and needs. Helen, an autism specialist, said "continuity of care is really important to (her)" and Patchwork is the tool she uses to "help other practitioners understand more about how to support people with autism". Patchwork lets health practitioners quickly and easily inform support workers how they can best address a patient's health needs.

Patchwork is about changing human services to be more collaborative, coordinated and person-centred. Experience shows that clients benefit when human service organisations connect and collaborate. Patchwork helps frontline workers better understand the factors that contribute to an individual's health and support needs. It can help redesign how practitioners and clients interact within the health and welfare system and improve experience.

By collaborating together, health professionals can be a part of real change that improves an individual's quality of life, reduces their dependency on health and welfare, and possibly even breaks the cycle of their disadvantage. It is a practical solution to the age old challenge of providing person-centred care and support across the human services. 

To find out more, or join the Patchwork NSW network please visit www.patchworknsw.net.au or email patchwork@facs.nsw.gov.au.

Innovation Alliances: a new approach

It began from an idea that was hardly radical. And yet it's been an idea that has been resisted by health system managers since the beginning of time.

Maybe management don't hold all the answers to the problems our organisations face? Maybe our efforts at reform frequently fail because we do not truly understand the nature of performance challenges on the ground?

Maybe solutions to the big performance challenges are generated without the right information and minds involved?

Which leads to the inevitable conclusion: maybe as managers and executives we should ensure the right information and minds are involved from the start. To solve big performance problems, perhaps the people delivering the solution should be at the centre of generating the solution?

These notions formed the basis of the development of Innovation Alliances, a new approach to organisational problem solving in Metro North Hospital and Health Service

(MNHHS).

In 2015, incoming Chief Executive Ken Whelan and his executive team created the environment for such an approach to succeed through their Putting People First strategy. The strategy supports a culture of consultation, partnership and engagement to deliver high-quality networked public health services to the population of northern Brisbane and surrounds, as well as designated specialist services across Queensland and beyond.

The starting point for Innovation Alliances was something we could all agree on: that when we are busy and the stress is on, the flow of patients through the health system suffers.

Open forums were held across MNHHS to get a sense of how our staff perceived the challenge of maintaining patient flow, particularly during peak periods such as winter. We encouraged staff to send us


details of patient flow projects already completed or underway, and were astonished to receive information on several hundred projects.

The volume of projects received was evidence that MNHHS staff are innovative and dedicated to improving the way we do business. But how effective were we at harnessing

this innovative culture to drive change throughout the organisation?

From that project list we developed a conceptual model of the typical patient journey through the health system. In doing so we noticed that many of projects related

“To solve big performance problems, perhaps the people delivering the solution should be at the centre of generating the solution?”



What happens when management puts clinicians front and centre of defining and solving the biggest organisational challenges?

to improving handover points between places of treatment, such as admission or discharge processes, rather than to the treatment itself.

That's where Innovation Alliances come in. We identified seven key handover points in the patient journey, for example Primary / Community Care to Emergency Care, and formed Alliances around each of them.

Alliances were comprised of participants from all relevant facilities and professional streams, and from a variety of backgrounds including some of the most influential clinicians in the system. Each Alliance had a facilitator from a clinical background to emphasise the clinical ownership of the process from start to finish.

The Alliances were tasked with identifying the greatest challenges to patient flow around their handover point, agreeing on solutions, and nominating how best to measure and monitor success in addressing them.

Alliances are not simply working groups of


committees. They work to a tight formula, based on theory and research, that seeks to move through the big barriers to solutions in large organisations. These barriers may be social, cultural, structural or individual in nature.

Achieving organisational change is never easy. Research and anecdotes show that merely sitting people down to solve problems is often not enough. A technical, evidence-based framework is often needed to get results from groups of people.

The results of this approach have been impressive. Barriers to timely patient handover that have long been considered intractable have been freely discussed in a non-adversarial environment. Administrative support staff have sat around a table with some of the most eminent clinicians in Queensland and spoken the same language of process improvement. Participants from our healthcare partners such as the Queensland Ambulance Service, Brisbane North Primary Health Network and the

residential aged care sector have been working collaboratively with MNHHS on our shared challenges.

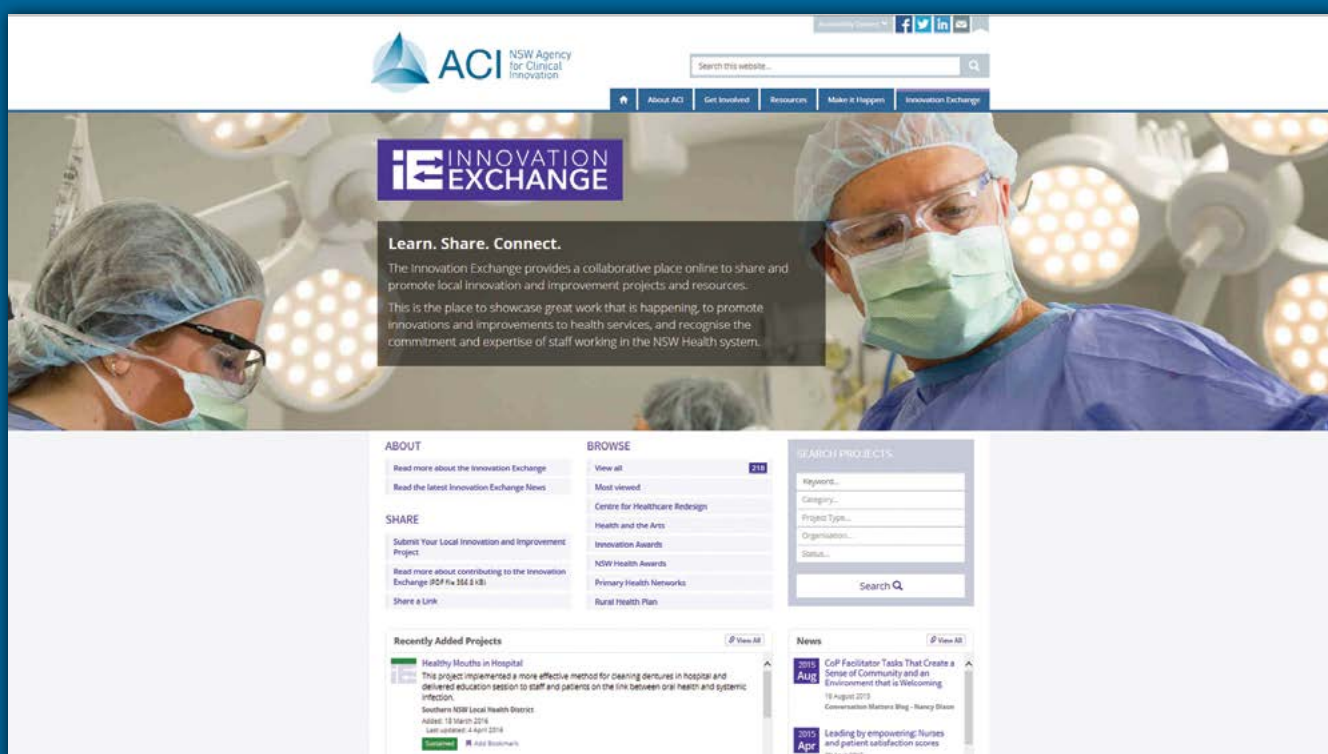
It is a powerful lesson. When we all sit down together to discuss what we can do to improve the flow of patients throughout the health system, and we do it in a structured environment in the spirit of cooperation, it is remarkable how much that we can agree on.

And when our staff agree on the challenges, the solutions and the parameters for measurement and monitoring, implementation becomes a whole lot easier. Management becomes less about coercion and demand for change, and more about creating a culture that equips staff with the tools and environment they need to drive change themselves. 

**Luke Worth, Executive Director,
Organisational Development, Strategy and
Implementation, Metro North Hospital
and Health Service**

Local innovation bettering the sector

Introducing a collaborative online space to share innovative, adaptable solutions and promote better healthcare
NSW Agency for Clinical Innovation



The ACI Innovation Exchange Website: www.aci.health.nsw.gov.au/ie

The Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better

healthcare for NSW. The agency provides expertise to NSW healthcare providers on service redesign and evaluation; specialist advice on healthcare

innovation and service improvement; improvement initiatives including guidelines and models of care; local implementation support; knowledge sharing; and continuous capability building.

The ACI promotes and facilitates the sharing of best practice through the Innovation Exchange

page on the ACI website (www.aci.health.nsw.gov.au/ie). The Innovation Exchange website provides a freely accessible collaborative online space to share local innovation and improvement projects and resources from healthcare organisations in NSW, Australia and beyond.

The site promotes the great work happening across health service providers, promotes innovations and improvements to health services, and recognises the commitment and expertise of staff working in the health sphere. It is designed to share and spread solutions identified by staff working on the frontline, that can be adapted to suit other local health challenges without the need to duplicate work that has already been undertaken.

The Innovation Exchange website offers resources to assist and encourage health professionals to make improvements and foster innovation in their own healthcare setting. It acts as a platform for health professionals to learn new ways of

improving and innovating for their local needs, and as a space to share their experiences and lessons learned.

The Innovation Exchange website also connects health professionals with others who share similar clinical interests to improve healthcare.

Both small and large scale innovations and improvements generated across the local services are recognised and shared to benefit the broader health system. Currently more than 220 innovative local initiatives are showcased on the site.

Examples of initiatives on the Innovation Exchange include:

- **A Public-Private Rural**

Physiotherapy Service

Murrumbidgee Local Health District and Murrumbidgee Primary Health Network

This project established a partnership between the local health district, Primary Health Network and private physiotherapists, to pool resources and deliver physiotherapy services in rural communities.

- **Improving Clinical Communication at the Aged Care Emergency Service**
Hunter New England Local Health District and Hunter New England and Central Coast Primary Health Network

This project trained residential aged care facility and emergency department staff in the Identify, Situation, Background, Assessment and Recommendation (ISBAR) clinical handover tool to enhance the effectiveness of the Aged Care Emergency (ACE) service.

- **After Hours Program**
(former) Western NSW Medicare Local

The After Hours Program developed emergency guidelines and online


training modules for the most common aged care presentations to emergency departments, including chest pain, stroke, abdominal pain, confusion and tubes. The online training program was created to train residential aged care facility staff in the implementation of these guidelines.

- **CommunicatingCARE, incorporating ISBAR and 'Stop and Watch'**
(former) Central Coast NSW Medicare Local

CommunicatingCARE is an aged care education package incorporating ISBAR methodology and 'Stop and Watch' early warning tools. The package was developed in consultation with local aged care providers, to help staff identify when a resident's condition changes and allow them to communicate these changes to other health professionals.

- **Aged Care After Hours Program**
(former) Southern NSW Medicare Local

This program aimed to improve the quality of care in residential aged care facilities after hours, through the development of an Emergency Decision Guidelines Tool and staff training package.

If you have an initiative of benefit to other healthcare providers, and would like to share this on the ACI Innovation Exchange*, please get in contact using the details below. 

For more information contact:

Hediyeh Vahdat

A/Knowledge Manager, ACI

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hediyeh.vahdat@health.nsw.gov.au

**Some charges may apply for organisations not based in NSW*

“The Innovation Exchange website offers resources to assist and encourage health professionals to make improvements and foster innovation in their own healthcare setting.”

The next 70 years

AHHA celebrates 70th birthday with gala dinner

The Australian Healthcare and Hospitals Association celebrated its 70th anniversary in Melbourne with a gala dinner attended by Shadow Minister for Health Catherine King.

The dinner followed the AHHA's Think Tank *Looking over the horizon: Where to next for the Australian health system?*, which brought together health leaders from across the country to discuss how the health sector could overcome the challenges of the near future.

"70 years is an amazing length of time for an organisation to have been advocating for high quality healthcare in Australia," Ms King said in her speech on the night.

"It's essential that we continue to have organisations like the Australian Healthcare and Hospitals Association putting forward high quality, respected and representative advocacy for universally accessible, high quality healthcare in Australia. This is especially true at a time when so many voices in the health sector are under so much pressure."

The celebratory dinner was attended by members of the AHHA Board, Council and staff, as well as guests including National Aboriginal Community Controlled Health Organisation Chair Matthew Cooke.

"It was a pleasure to welcome all guests to the dinner, which was a wonderful celebration of AHHA's 70 years as a leading voice for public healthcare in Australia,"

AHHA Chief Executive Alison Verhoeven said.

"Rather than look to the past, however, we have our eyes set firmly on the future and the challenges the health system will face in the coming years. AHHA will remain vigorous in our advocacy for a healthy Australia, supported by the best possible health system.

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

During its 70th year, the AHHA will be undertaking advocacy and research on these and other challenges facing the health sector. AHHA will continue its role as a leading voice for public healthcare to ensure an effective contemporary healthcare system supporting a healthy Australia.

"The need for a health system that can meet and overcome the challenges of the

future is a national priority, which must be reflected in the priorities of our elected representatives," Ms Verhoeven said.

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


Senior health consultant Amanda

Croker said the Association should be "congratulated" on 70 years of shaping health policy and increasing the quality of health services in Australia.

"The recent forum and dinner reinforced the policy priority of

investing across the health continuum, with a vibrant primary health sector essential to improving outcomes and controlling costs," she said.

Merri Health Chief Executive Officer and AHHA Board member Nigel Fidgeon also congratulated the Association on reaching its 70th anniversary.

"It's important to celebrate the vital role (AHHA has) as a voice for health equity, access and advocacy, (and) striving to improve the health system for all Australians. Here's to the next 70 years!" he said. 

"70 years is an amazing length of time for an organisation to have been advocating for high quality healthcare in Australia."

NACCHO Chair Matthew Cooke, Shadow Minister for Health Catherine King, and AHHA Chief Executive Alison Verhoeven.



A framework for success

How PHN-led consortia can transform the aged care landscape
Brisbane North Primary Health Network

Primarily Health Networks (PHNs) have a lead role to play in delivering high quality community aged care services to their region, as Brisbane North PHN has found.

Having already organised and implemented two consortia to achieve that aim, the PHN and its partners are eager to share their experiences with other like-minded organisations, and will do so when they present a workshop at the International Federation on Ageing's (IFA) 13th Global Conference on Ageing in Brisbane from 21-23 June.

Michele Smith, who manages Brisbane North PHN's community care team, said consortia can deliver efficiency gains and cost savings while continuing to meet client service expectations.

"An independent evaluation of our Commonwealth Home Support Program-funded consortium reported efficiency gains

of close to 30%, following the transition of services from an earlier governance structure," Ms Smith said.

The Commonwealth Home Support Program (CHSP) provides community-based care services to people aged 65 years and over (or aged 50 years and over for Aboriginal and Torres Strait Islander peoples), to enhance their independence and avoid or delay premature entry into residential aged care.

"Our Healthy@Home consortium now comprises 19 organisations, all fully committed to providing high quality community aged care services in our region."

"The Australian Centre for Health Services Innovation (AusHSI) at the Queensland University of Technology evaluated our consortium over a period of two years," Ms Smith said.

"AusHSI found not only that the transition had dramatically reduced costs to the Commonwealth, but also that clients remained satisfied with their services throughout the process."

The evaluation also noted that providers reported numerous benefits from joining the consortium, which is now operating under

the name Healthy@Home.

These benefits included networking and professional development opportunities with other providers (facilitated by the consortium), expansion of their client base, greater service flexibility, and enhancement of their individual business models through collaboration.

"Our Healthy@Home consortium now comprises 19 organisations, all fully committed to providing high quality community aged care services in our region," Ms Smith said.

"Each of the provider and peak organisation members are represented on a management committee, which oversees consortium activities, along with carer and consumer representatives and our local Hospital and Health Service."

CHSP service utilisation is another key indicator used to measure the consortium's effectiveness.





Assistant Minister for Health and Aged Care, the Hon Ken Wyatt AM, MP (centre) met with Brisbane North PHN's Michele Smith (fourth from left) and representatives of the PHN's aged care consortia when he visited in March 2016.

Photo: Belinda Wright

"In both the 2013/14 and the 2014/15 financial years the consortium easily exceeded Australian Government targets across all of the four main service groups," Ms Smith said.

"That pretty much never happens but has been achieved in our region largely due to a commitment to collaboration, rather than competition."

Collaborative Framework

Ms Smith said Brisbane North PHN had adopted a Lead Partner/Supply Chain model within a collective impact framework to manage Healthy@Home and another consortium contracted to deliver a Regional Assessment Service across all of Brisbane and the Moreton Bay region.

"This model involves more than just the sub-contracting of services. It has a strong focus on collaboration to achieve service and system improvement," Ms Smith said.

"The workshop we're running at this

year's IFA conference will show participants how they can implement this model within a Collaborative Framework."

Ms Smith said that when a consortium is built around such a framework and has a highly-effective "backbone" organisation (e.g. a PHN or similar body), it can alleviate pressure on service delivery organisations in areas such as tendering, performance monitoring, management, and reporting.

"Under this model, the backbone organisation is primarily focused on quality services, contract management and policy advocacy," Ms Smith said.

"Funding bodies may also perceive this model to be less risky if the backbone organisation has established a good reputation."

Ms Smith said consortia can advantage small to medium organisations in particular, because they have the support and backing of larger members.

"Consortia provide an infrastructure for mutual support and development and, in this way, can increase opportunities to share expertise, skills, knowledge, resources and training, or to pursue opportunities for business development and expansion," Ms Smith said.

"One of the key ways we support sector development is through our annual and quarterly aged care forums. These events regularly attract large turnouts, with more than 200 aged care and community care workers attending last year's annual forum." ^{ha}

To view a video about the Healthy@Home consortium, visit: <https://youtu.be/1byeWbXeYec>. To register for the 13th Global Conference on Ageing (21-23 June), go to: www.ifa-fiv.org/.



Professor Emily Banks is the Scientific Director of the 45 and Up Study.

Australia's biggest health study, the Sax Institute's 45 and Up Study, is tackling new frontiers, including helping to create the world's largest public genome database and contributing to a \$6.5 million world-first trial into modifiable risk factors for dementia.

The Study is the largest ongoing study of healthy ageing in the Southern Hemisphere involving a quarter of a million people — one in every 10 men and women aged 45 and over in NSW.

While the Study has been going for over a decade, Scientific Director Professor Emily Banks said it was far from standing still, with a number of innovative new projects underway.

She said the Study was linked to a growing number of datasets including 42 million Medicare (MBS) and Pharmaceutical Benefits Schedule (PBS) records, making it an incredibly rich resource.

"Researchers already have a huge data resource available to them in the 45 and Up

Study and its quarter of a million participants, but new enrichments mean we now have a research advantage that people in other parts of the world will envy," she told the Study's annual meeting late last year.

Sequencing the genome of the 'wellderly'

A new collaborative project with the Garvan Institute of Medical Research will see the Study data used to investigate what the genome of a healthy older Australian looks like - dubbed sequencing the genome of the "wellderly".

Blood samples from about 2000 Study participants will form part of the NSW Government-funded Medical Genome Reference Bank (MRGB), the largest public genome database in the world. It will sequence a total of 4000-4500 genomes of individuals aged over 75 years, who are free of chronic diseases like cancer, cardiac and neurological diseases.

Head of the Garvan Institute's Kinghorn Centre for Clinical Genomics, Associate

Professor Marcel Dinger, told the Study meeting last year that the data would be used as a "filter" to distinguish between normal genetic variation and variation caused by disease, helping to identify genetic variants linked to disease.

"The data contained in the Medical Genome Reference Bank will be an unparalleled resource that will vastly improve our understanding of healthy ageing and catalyse genomics studies seeking to identify the genetic basis of rare, inherited and more common diseases such as heart disease, diabetes, cancer and developmental disorders," he said.

World-first dementia research

Data from the study is also set to be used in a \$6.5 million trial into modifiable risk factors for dementia that will investigate whether an internet coaching tool can reduce the risk of the condition.

The "Maintain Your Brain" trial, led by University of New South Wales Scientia



Innovative future of Australia's biggest health study

The Sax Institute's 45 and Up Study is contributing to a growing body of research on healthy ageing, including a cutting-edge project to sequence the genome of the 'welllderly'

Professor Henry Brodaty, Co-Director of the Centre for Healthy Brain Ageing, was announced as the recipient of the five-year \$6.5 million NHMRC grant last year.

The study team comprises 20 specialists from institutions around Australia, including Sax Institute CEO Professor Sally Redman.

Professor Brodaty told the Sax Institute that the trial would be the largest in the world to address modifiable risk factors for dementia in general and Alzheimer's disease in particular, including physical inactivity, cognitive inactivity, depression, overweight and obesity, diabetes, high blood pressure and smoking.

A total of 18,000 people aged 55-75 years who have at least one risk factor for dementia and access to the internet will be invited to take part in the study.

Half the trial participants will be given information on managing dementia risk factors, while the rest will be given support through


online tools focusing on elements including diet, exercise, cognitive training and online therapy for depression.

Use in predictive modelling

In another new collaboration with the Cancer Council NSW, the 45 and Up Study data will also be used to build predictive models on the risk of disease that will help determine where to intervene for prevention and early detection of diseases such as lung and prostate cancer.

Director of Cancer Council NSW Cancer Research Division Professor Karen Canfell said Cancer Council NSW would use information already collected from participants in the Study to create computer simulated 'virtual populations'.

The information from these computer models could then be used to predict outcomes like lung cancer and the health and economic impacts of prevention strategies.

"Predictive modelling has the power to tell us what types of patients we should target to get the most benefit from health services we might offer," she told last year's meeting. "This type of work really is the next frontier in using research to help us answer important policy questions such as how can we screen for diseases like lung cancer in a way that maximises the benefits and cost effectiveness?" 

The 45 and Up Study is managed by the Sax Institute in collaboration with major partner Cancer Council NSW; and partners: the National Heart Foundation of Australia (NSW Division); NSW Ministry of Health; NSW Government Family & Community Services – Carers, Ageing and Disability Inclusion; and the Australian Red Cross Blood Service.

Tackling a big problem with small data

The potential of mobile technology to support those living with chronic disease

Diabetes is the sixth leading cause of death amongst Australians and a major burden on our health system¹. According to the 2014-15 National Health Survey, the number of diabetes patients in Australia has increased by 100% in the last 15 years (from 624,500 in 2001, to 1.2 million in 2015)². These figures represent 5.1% of the population and this rate is tipped to continue to rise.

However a patient's quality of life and the cost to our health system can be significantly improved with effective disease management. Self-management and lifestyle modification are crucial to maintaining good health, yet patients are often challenged in controlling food intake, exercising and engaging with other

interventional activities. Effective self-management not only requires sufficient knowledge about the illness, but also considerable self-discipline when away from the watchful gaze of the consulting room.

This is where mobile devices such as smartphones and tablets, equipped with the right apps, have the potential to help people manage their day-to-day routine of self-care. The Australian Communications and Media Authority reports that 92% of Australians use the internet and 70% do so with their mobile phones³, suggesting the penetration of technology is sufficiently wide spread. For some, however, adapting to a new digital device is not an easy task and unless it is well integrated into a user's

every day habits, it is hard to keep up with required routines.

International estimates indicate that more than one-fifth of the population lack basic digital skills, and this deficiency increases with age⁴. The prevalence of diabetes increases with age and the proportion of people at high risk of diabetes is the highest among those aged 75 and over⁵. Digital literacy requires training, and effective mobile health (mHealth) intervention requires users to understand the technology and to embed it into their daily lives.

With that in mind, an mHealth project aimed at developing evidence-based strategies to support wider adoption of mobile tablet devices in healthcare, focusing on type 2 diabetes patients was undertaken by a multi-disciplinary team of researchers from the University of Canberra, NICTA, ANU Medical School and Canberra Hospital. It was conducted at the ACT GP Super Clinic (Bruce) in collaboration with Ochre Health.

Using a co-design workshop with the practitioners at Ochre Health Medical Centre Bruce, the research team developed a pilot program where iPads were distributed to 28 type 2 diabetes patients, providing them with on-demand digital training support for 10 months in 2014-2015. Various apps were installed to improve knowledge of diabetes, record and track blood glucose levels, help with dietary decisions, encourage exercise, and share experiences with other patients.

The majority (60.7%) experienced improvement in their diabetic condition after 9 months. Participants reported improved self-management, increased confidence, and overall satisfaction with their health indicators. About 75% of the participants reported more confidence with food choices, 32.1% of the participants

experienced an increase in satisfaction with exercise plans, and 21.4% were more satisfied with their prescribed medication.

Digital training improved the effectiveness of mHealth. A total of 19 participants attended the on-demand training sessions. Most of those who attended digital training sessions (89.5%) felt that their iPad helped in the self-management of diabetes.

In contrast, only 44.4% of non-trainees said that the iPad helped them. Trainees perceived that the iPad was useful for


recording, tracking and reminding activities to a greater extent than those who did not participate in digital training.

At the end of the study, the main uses of the iPad for diabetes management were to regularly monitor themselves, acquire knowledge and resources, and to use as an aid to

change lifestyles. At the time of sign-up, only 46.4% of participants searched for information online but at the end of the study, 82.1% used the internet to obtain information about diabetes management.

When asked if they were confident to use the iPad at the end of the pilot program, every participant answered yes. More than half replied that they gained confidence through their participation in the mHealth study. The results demonstrated that not only did the pilot program increase the confidence of self-managing diabetes, but enhanced broader digital skills and connectivity. Mobile tablet devices provide a new era of accessibility, portability and useability. They may fill a need that desktop technologies have not successfully served.

Digital devices have a huge potential to engage users in managing their chronic conditions and overall health. However, the widespread adoption of such tools requires training and ongoing support programs linked to healthcare delivery systems that

educate and encourage effective use among patients. While training and support can require additional resources, doing so can improve digital literacy, self-management and health outcomes. There is potential to reduce the need for more acute and costly interventions. 

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More information about the “Mobile digital communication and health management: A mHealth pilot program at the ACT GP Super Clinic” is available on N&MRC's website at www.canberra.edu.au/research/faculty-research-centres/nmrc/research/mobile-digital-communication-and-health-management or by contacting the Chief Investigator Associate Professor Sora Park at sora.park@canberra.edu.au.

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Innovation in dementia care requires re-thinking

The new approach needed to
caring for people with dementia

Sue Pieters-Hawke

It's time to go back to the cognitive drawing board.

In order to construct innovative approaches to how we deal with dementia, we have to unravel most of what we think we know about the disease and about people diagnosed with it. Much of what we think we know about impairment of the mind is actually a relic of history, and is profoundly outmoded - scientifically, practically and in terms of human rights. Traditionally, when the human mind was thought 'defective', the person in question was in various ways considered sub-human, sometimes even dangerous, and at the very least, hugely inconvenient to society.

As well as the artefacts of historical misunderstanding, our societal and personal response to dementia is also often fear based: we fear the threat to 'who we are' and the loss of those who are integral to our own sense of self, such as parents and partners. We fear (wrongly) that the syndrome is an inevitable part of aging.

The idea that somebody with brain-impairment is somehow "less human" than

they were previously, has carried into how we view dementia and people with it. Once diagnosis has been made, their social identity is instantly eroded, the validity of their thoughts and feelings undermined in the minds of those around them.

Yet all of us experience our own reality subjectively, and express ourselves uniquely, through a myriad of filters. One of the filters of a person with dementia will be *their* particular brain impairment caused by the disease causing their dementia.

What is felt and understood by a person with dementia is as real and valid to them as is anyone else's experience. Yet rather than responding with compassion, insight and support, our response to changing capacities and behaviour tends to be to control and limit, to deny rather

than to empower agency. This 'limiting and containment' appears at every level – interpersonal, family, medical and community. With physical disability, and other issues of 'brain difference' such as the Autistic spectrum, we are learning

and appreciating that isolation from society is a form of prejudice, and far more onerous and deleterious to both parties than meaningful participation. Yet the response to dementia is invalidation, isolation and often institutionalisation. Bluntly stated, our current models of care

derive mostly from the historical models of the asylum.

However, when we start to relate to people with dementia respectfully, by validating their experiences, supporting and responding thoughtfully rather than being dismissive ('it's the dementia'),

“We need to forget dismissive ideas about people with dementia and see ourselves as “doers-with” not “doers-for” those with the diagnosis.”



a new panorama of relationships and possibilities open up. Like any change, some initial effort is required to see and do things differently, but it is likely to be far more constructive and rewarding for all parties than the frustrating and degrading experiences that are now sadly all too common.

We need to forget dismissive ideas about people with dementia and see ourselves as “doers-with” not “doers-for” those with the diagnosis.

One of the most important things to any human being is a life that allows for a sense of meaning and opportunities for participation. Yet we mostly deny this basic right and need to people with dementia, even though a life of meaning, engagement and connection, albeit altered, is still absolutely possible and even more vital.


Person-centred care can only really be achieved within person-centred models. Throwing all the money in the world at an institutional model that has merely been rebranded ‘person centred’ is virtually pointless, as people are still

fundamentally invalidated, over-medicalised and institutionalised. All attempts at ‘person centred’ care, although they have ameliorated some of the worst aspects of institutional ‘care’, will eventually butt up against the constraints of systems that are not person centred. This frustrates those already working within the system attempting to deliver better care as decisions are made, protocols followed, and funding allocated according to the current thinking and structures. Billions are already spent on dementia each year¹ an amount that will certainly increase, but this is not matched with any real systematic changes.

The failure of system change is glaringly evident at the hospital level. Research shows that about 30% of hospital patients have some form of cognitive impairment due to dementia, delirium or other issues. They tend to have longer stays and generally worse outcomes than non-impaired patients with patients, doctors and families struggling with communication and understanding.² Without protocols and training to counter this, hospitals remain

dangerous places for people with dementia, within an already stressed hospital system.

‘Non-institutional’ models such as the Montessori and Eden and other innovations are nothing new. Crucially, they need cost no more than current approaches.

Achieving innovative approaches to dementia is partly a challenge of ‘reconceiving’ what dementia is, and what a person with it may want and need; of changed models of care and relationships, and the change management processes to achieve, ultimately, a vastly altered landscape. 

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The Kooweerup Regional Health Service Community Garden.

Climate change and health – who cares?

A small rural health service response to the impact of climate change on health
Kooweerup Regional Health Service
CEO Terrona Ramsay

Kooweerup Regional Health Service (KRHS) is a public hospital located within the Shire of Cardinia in Victoria. KRHS has been providing a broad range of health services to the local community since 1921. KRHS is passionate about health, climate change and environmental sustainability for their patients, staff and the community.

In 2007, the organisation adopted a proactive approach to health which includes the protection of our natural environment, conservation of resources and increased community connectedness and is reflected in the values of the organisation, as seen at www.kooweeruphospital.net.au.

Our goal is to ensure we support our community to become resilient to the health, social and environmental changes ahead.

Cardinia Shire is an area which is vulnerable to climate change and has experienced the impacts of severe weather through floods and bushfire.

KRHS was one of the first health services in Victoria to integrate health promotion which has enabled climate change to be recognised as a priority issue. We believe we are one of the leading health services in Victoria in working towards addressing this significant global health issue.

Health services are one of the largest service industries and as such have a significant environmental footprint. They are large consumers of energy, water, clinical and chemical products and large producers of waste. Sustainability in healthcare must address a wide variety of activities while ensuring a high quality of care.

Where does sustainability fit in our organisation?

KRHS has a commitment to deliver high quality, safe health care, and be environmentally sustainable by applying a sustainability lens across the organisation as we work towards reducing our environmental impact through our everyday operations.

Health impacts from climate change will be major challenges for health services in the future and in particular relating to the most vulnerable in our community such as people with disabilities, low socioeconomic populations, young children and elderly.

There are significant co-benefits to be found for health by responding in a positive manner to climate change.

As a health-promoting health service, integrating sustainability principles is a priority across the service. This has enabled dedicated time to progress initiatives across the health service.

Contact with nature can improve human health

Evidence shows that exposure to natural environments helps us cope with and recover from stress, illness and injury, gives us a more positive outlook and greater life satisfaction. Interaction with natural settings can improve concentration and productivity. Nature-based therapies can support improved quality of life for residents, patients and clients. The gardens within the health service are used as a key environmental determinant in enabling patients and the community to achieve positive life satisfaction and health goals.

Environmental awareness is integrated into the core business of the health service. This includes a wide range of eco-policies and has been achieved by integrating the following processes:

- Environmental Management Strategy developed and validated by the CEO and Board.
- Climate change/environmental sustainability established as a priority area for health promotion team.
- Capacity building – increased knowledge and skills within Senior Leadership Group, recruitment of staff with backgrounds in sustainability. Establishment of Environment committee. Green Champions have been identified across the organisation.
- The Multidisciplinary Environmental Committee meets regularly to review current projects and action new initiatives.
- Specific initiatives enabled staff to get involved by the environment being added as an agenda item to relevant committees including board meetings, and Heads of Department meetings.
- New staff induction to our Environmental Philosophy.

Key people and partners

Strong leadership from the senior executive and the Board has embedded health promotion, enabling us to address the future health needs in a community challenged by climate change.

This has been achieved by:

- An executive champion who advocates for sustainability to important stakeholders and drives change at executive level and throughout the organisation.
- Health promotion team members including the Health Promotion Manager who links sustainability to various health promotion initiatives and to strategic plan and a project officer with sustainability background who supports innovative projects. Education placements are delivered to students from Environmental Engineering and Public Health – Deakin University Sustainable Futures Unit.
- Inter sectoral partnerships have been formed, for example with other health and environmental agencies.


Innovation

KRHS engages with its staff to look for

innovation in their daily practice and take these ideas to their managers to discuss the feasibility of their innovative ideas.

Examples of innovative practice include:

- The Meals Makeover project which commenced with the identification of ongoing food waste. The audit identified 60 kilograms of waste per day. Discussions with staff and residents followed about the meals and food waste. This has resulted in a review of the menu to be more enhanced, with nutritional value and reduced waste. This is a great result for both patients, residents and the environment.
- In health promotion and community engagement, KRHS actively encourages the wider community to participate in a range of environmental sustainability activities. Our Community Garden and Eco House are considered key enablers for fostering positive human-environmental relationships. The Community Garden is completely organic – with no pesticides or herbicides used – and predominantly utilises harvested water. The garden is managed by a number of our volunteer groups and program participants including the Gardening Group, Men's Shed, School Mentoring Youth Groups and Ladies Auxiliary. The Garden is designed for all residents, as is demonstrated by our twice weekly community gardening mornings and a monthly Nature Play program for children. In addition to helping foster positive human-environmental relationships, the Community Garden produce is used to promote healthy eating within the community by our community kitchen and by our Preserving for Life Programs. Older people have taken on the responsibility of environmental stewardship as demonstrated in supporting tree planting and protection of the habitat for the Southern Brown Bandicoot. Currently we are collaborating with Landcare to install interpretive signage throughout the hospital grounds to educate our staff, the community, patients and residents.

These initiatives are unique and innovative as they have been led from within the Health Service. 



DAVID CAMILLERI
Executive General Manager
of mi-Clinic

Innovation, integration, affordability

Health reform to tackle chronic conditions

Technology is transforming many aspects of healthcare delivery, however, it need not come at the cost of personal care – it can actually improve it.

There are some really inspiring examples of technology combining with creativity to deliver amazing outcomes.

Take the Pain Squad app, a mobile 'game' designed in Canada to replace pain diaries for children suffering cancer that rewards users for tracking their pain each day by advancing them through the game's ranks. It provided researchers with better data and helped excite and distract children.

In another example, researchers who had been trying to decipher a crystal structure in a virus for 15 years found a solution within 10 days when they created FoldIt, an online puzzle game about protein folding.

Advances in medical technologies have also connected patients and doctors who are geographically thousands of kilometres apart, through telecommunications. Patients can now hold video conferences with physicians to save themselves the time and money associated with travelling to a physical appointment.

We live in exciting times with robotic surgery, pills that report back on whether they've been taken, exoskeletons enabling people with spinal damage to walk, surgical simulators, wearable devices, nanotechnology, and other advances.

However, many of the most useful aspects of healthcare technology are not

revolutionary headline grabbers, just the sorts of things that make life easier or more efficient. Think electronic medical records, telehealth services, remotely monitored devices, quick access to information on medical research or drugs, and solutions delivered through cloud-based computing.

Like every other industry, healthcare is employing technology to improve its products and services. For healthcare specifically, technology can help create better patient outcomes through automating critical processes, improving record keeping, reducing medical errors, e-health initiatives, decreasing documentation time and improving cost efficiencies, allowing for investment in other areas.

The key is to ensure organisational outcomes are considered first, with the technology itself being a secondary consideration. To put it another way, the result is the most important thing, rather than the tools used to achieve that result. If e-health records are quicker, more accurate and easier to use, then go with them. If paper charts provide a superior hospital bedside solution, then stick with them.

As another example, cloud computing offers scalability, security (when used correctly), speed and flexibility. Using the cloud, healthcare professionals and organisations can outsource medical transcriptions (and offer medical practitioners a range of other services).



Technology has the potential to offer great improvements in healthcare.

Essentially, technology in healthcare is not something to be afraid of. When employed for a clear purpose, and as a means of reaching a desired and defined result, technology has boundless potential to improve patient outcomes. **ha**

David Camilleri is the Executive General Manager of mi-Clinic, a quadruple ISO-certified business which offers services including medical transcriptions, patient bookings and pay-per-use rooms for medical specialists.



Aboriginal and Torres Strait
Islander health practice
Chinese medicine
Chiropractic
Dental
Medical
Medical radiation practice
Nursing and Midwifery
Occupational therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Australian Health Practitioner Regulation Agency

Know your obligations when employing health practitioners

There are **three important steps** to making sure you meet your obligations.

1

Before employing a registered health practitioner, always check the online register

2

Once they are employed, you need to stay up to date with any changes to their registration

3

During their employment you must make sure you meet your mandatory notification obligations

The national register is the only accurate and up-to-date source of information on the registration status of all registered health practitioners in Australia.

Visit www.knowyouobligations.com/advocate for more information and to download your free tool kit to help you meet your obligations or call **1300 419 495** to find out more.

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**YOU CAN
CLOSE THE GAP**

Support health equality for Alyssa,

support Indigenous health equality

We all deserve the chance to be healthy; and you can help make this happen.

Ten years into the campaign for Indigenous health equality, Aboriginal and Torres Strait Islander health outcomes are improving. The support of people like you is helping make that difference. But we still have a long way to go to close the gap entirely by 2030.

It is critical that we keep pressure on our governments to create the long term changes required to close the gap on health inequality.

Closing the gap will require improvements to Indigenous health that go above and beyond those of the general community. This will take serious commitment and long-term resourcing to achieve.

We need your help: join the 220,000 Australians who have already pledged their support to the Close the Gap campaign. Send a strong message that ours must be the generation that closes the gap!

oxfam.org.au/closethegap

CLOSE THE GAP



The Gathering of Kindness sought to examine how a greater emphasis on kindness might change the health sector.

Creating a kind and respectful culture

The Gathering of Kindness looks at how to change the healthcare sector

More than a hundred people committed earlier this year to spending a few days together to re-imagine a healthcare system that has kindness, trust and respect as core components. Our group stretched from a Yorta Yorta Elder to medical officers, patients, patient advocates, thinkers, allied health professionals, surgeons, nurses, younger and older practitioners, health managers, quality officers, musicians, actors, lawyers, politicians, students, philosophers, designers and more.

Story Starters opened conversations that went on to flourish in Creative Clusters. The large marquee in the beautiful grounds of Duneira Estate at Mt Macedon thrummed with the buzz of conversations and fell silent to listen to single voices. Piano notes picked up the story in the music room as our brainwaves steadied and sang to new rhythms.

By the end of the two days we had agreed that this work is important. We teased out some fundamentally flawed assumptions that we may hold about our healthcare system and our capacity to bring about change within it.

We agreed that there are many definitions of what kindness is and forms it might take, along with many views about how to nurture innate understanding, avoid 'fake kindnesses', develop our own courage and skills, and support others in developing theirs.

It might be that a 'Coalition of Kindness' will emerge with a peer to peer network of committed 'conversation groups' across healthcare aimed at challenging, building awareness, nurturing and expanding pockets of brilliant practices.

We know for sure that building a culture of kindness is not a top-down exercise. Kindness starts within all of us, and so becomes us

inside and out. It is generic to human nature and the efficacy of kindness in healthcare is increasingly supported by scientific research.

So many things have come out of our time together, including an entire radio program dedicated to the Gathering of Kindness. We would like to thank Dr. Rachael Kohn from The Spirit of Things on ABC Radio National for coming along to share our story. You can listen to this program at radio.abc.net.au/programitem/pgOLGmbPE6?play=true.

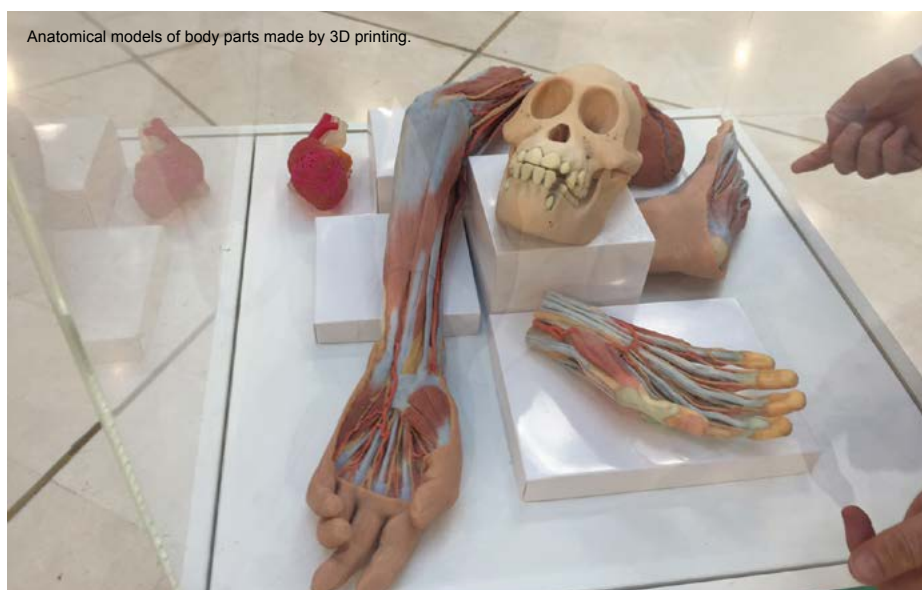
We will be releasing a summary of the actions and ideas that were offered over the two days. If you would like to receive that summary and a link to our soon-to-be-released video, please join the mailing list at gatheringofkindness.com and we will keep in touch. **ha**

Mary Freer is the CEO of Change Day Australia and a social innovator with Freerthinking

The future is now

3D manufacturing in the health sector

Neil Sharwood, A3DMA Operations Manager



Anatomical models of body parts made by 3D printing.

Another industrial revolution is underway due to advances in 3D printing, biotechnology, nanotechnology and the development of new materials. This latest tech boom brings greater access to manufacturing capability to all of us.

For the health sector, it has already delivered:

- a facility to produce tailor-made prosthetics cheaply
- the ability to fabricate body parts using living cells
- production of models from 3D scans that allow for better planning of operations, and
- tablets that provide a custom dose and/or controlled release time

Australia is one of the leaders in the 3D manufacturing boom. Last year, the University of Wollongong, in conjunction with Queensland University of Technology, launched a Masters course in Bio-fabrication. Professor Paul McMenamin at Monash University is transforming the teaching of

anatomy by utilising 3D printing.

Late last year, an Australian company, Anatomics, produced the first 3D-printed ribcage and sternum. Thoracic surgeons usually use flat and plate implants in the chest, but they can become loose over time. The 3D-printed titanium implant provided the complex customised geometry to identically match the patient.

Another Australian company, OMX Solutions, produces customised prosthetic jaw components. They are moulded to a patient's anatomy and deliver a perfect fit and a less arduous surgical procedure. This results in reduced patient discomfort and improves recovery time.

Change is happening rapidly. In the US, the entire hearing aid manufacturing industry converted to 100% 3D manufacturing in less than 500 days. It was reported that no hearing aid manufacturing company that stuck with traditional manufacturing methods survived.

In Russia, a five day-old baby boy was rushed to hospital with a life-threatening

congenital heart defect. He suffered from a rare and complex condition, Taussig-Bing malformation, which required specialised patient information to plan the surgery. Standard CT scans were not detailed enough to allow the surgeons to confidently plan and operate. They used 3D printing technology to create a model of the heart. This 3D-printed heart served as a pre-operational guide in two separate surgeries. The model also gave the baby's parents an easy way to understand their child's condition. The surgeries were a success and the child recovered.

The use of 3D-printed medical models may result in shorter surgical procedures and faster patient recovery. 3D-printed prosthetics not only allow for less expensive, custom-designed items, but can allow the recipient to be involved in the design. Special purpose items that address a problem can be made quickly.

UK company Open Bionics has invented and 3D printed low-cost robotic hands. Typically, robotic limbs cost from \$5,000 to \$100,000, making them too expensive for many people. However, using 3D printing an entire hand can be printed and assembled in approximately 40 hours for under \$2,000. These hands are able to perform the same tasks as the more expensive prosthetics, including allowing individual finger movement. They utilise electromyographical sensors attached to the patient's skin.

The cases mentioned here are only a small sample of the myriad of uses of 3D manufacturing to achieve better medical outcomes. 3D manufacturing will keep on providing better solutions and allow many more minds to work on the problems. I urge you all to consider how you might utilise this technology now. **ha**

**EVELYN EDWARDS**

North and West Remote Health
Chief Executive Officer

A truthful dialogue

The benefits **Parliamentary Friendship Groups** bring to health

As a member of the Australian Healthcare and Hospitals Association and in my capacity as Chief Executive Officer of North and West Remote Health (NWRH) I recently had the pleasure of attending and presenting to the Parliamentary Friendship Group for Rural and Remote Allied Health at Parliament House, Canberra.

As a vibrant, not-for-profit company employing multidisciplinary teams to provide health, support, aged care and wellbeing services to over 39 communities spanning from Queensland's East Coast to the Northern Territory border the focus of my presentations were to inform Members of Parliament, Senators and their advisors about two of the challenges that we face as a health service provider in remote communities.

1. the inability for our organisation to provide care through the Medicare Benefits Scheme and record health service activity data on a national level, and

2. advocating for appropriate capital infrastructure funding to be allocated for accommodation and service delivery purposes in remote communities

On the first matter my presentation addressed the issue of NWRH and other not-for-profit organisations delivering primary health care services to remote communities, who are excluded from the Medicare Benefits Scheme due to being funded either directly or indirectly by

health grant funding. Such exclusions result in data from ourselves and similar health services not being captured adequately to reflect the true health needs and conditions of remote communities. NWRH advocates for a change in Commonwealth policy to ensure this area of need is addressed.

Secondly I addressed the issue of organisations delivering health services in remote communities continually draining local accommodation and office space stocks to house employees. NWRH has a sound commitment to employ locally where possible however, it takes time

to build career capacity of community members to undertake roles and it is sometimes necessary for employees to be contracted from outside the communities to fulfil specialist roles. These positions require safe and well maintained housing to support them in their roles. This housing predominantly comes from local supply, and can place a strain on small remote communities with limited infrastructure.

I believe advocacy for these two very important issues by informing the attendees of the Parliamentary Friendship Group will assist them in decision making for budget allocations and during consultations with community representatives.

All in all I found the experience thoroughly rewarding and would like to thank the attendees for their obvious engagement and questions on the matters presented. I recommend this experience to others who are passionate about rural and remote health issues. **ha**

The AHHA encourages its members to actively participate in its advocacy program. The voices of our members play a vital role in guiding leaders and policymakers.

Fairer super for all

HESTA is at the forefront of the current political debate, examining why women retire with less than men. **HESTA**

We are strongly advocating on behalf of our members at the Senate inquiry into the economic security of women in retirement. This inquiry is examining why women retire with significantly less super than men and what changes could be made to improve the system.

HESTA's submission stresses that the wage gap between men and women remains the biggest factor in women retiring with less than men.

"The gap in super savings that women experience is not due to the choices they make - the main causes are the gender pay gap that sees women earning less than their male counterparts and unpaid time out of the workforce," says HESTA CEO, Debby Blakey.

The vast majority of HESTA's 800,000-plus members are women working in health and community services, where the gender pay gap is 27.7%, according to figures from the

Workplace Gender Equality Agency.

"Super is there for every Australian and the conversation needs to start including low-income earners and women," Ms Blakey said.

Closing the pay gap is clearly vital and must be tackled through structural and societal changes. In the meantime, the super system can also evolve.

Here are three important recommendations that underpin HESTA's Senate inquiry submission:

Remove the \$450 monthly super threshold

The successful introduction of *SuperStream*, which simplifies and removes the administrative burden on businesses, means employers can now make contributions more easily.

That barrier is removed, so all employees should be eligible for guaranteed super contributions, including those who earn less than \$450 a month.

This is particularly vital for nurses or other people in care-giving professions, who may work shift work across multiple employers.

For instance, consider a nurse who returns to work following the birth of a child and takes irregular shift work across three health providers.

In one month she earns:

- \$360 from a pathology lab drawing blood samples
 - \$420 from a casual night shift at a hospital
 - \$445 teaching first aid at a GP practice
- Gross pay (monthly) = \$1,225
Mandated super guarantee contribution = \$0
SuperStream makes it easy for employers to make contributions, so there is no reason why anyone working, no matter what they earn, shouldn't be eligible for super.

The low income super contribution

We are continuing our campaign of pressuring the government to abolish plans to discontinue





the low income superannuation contribution (LISC) in 2017.

If it's removed, 3.6 million Australians, including more than 2.1 million women, will pay the same, or in some cases, a higher tax rate on their super contributions than they pay on their wages.


HESTA believes the LISC must remain in place in its current form. Since 2014, HESTA has been a leader in the campaign to retain the LISC, in cooperation with the wider super industry.

Value unpaid caring roles

We think Australia can learn from the many overseas examples where unpaid caring roles are recognised and remunerated.

Many European and South American countries have systems that ensure women receive a pension voucher or benefit for time taken off work to raise children or care for the elderly.

HESTA's submission to the inquiry points to the success of Chile and we believe a similar system could be adopted here in Australia.

These recommendations would help ensure all Australians can afford a dignified retirement. 

Want to learn more?

To read more visit hesta.com.au

With more than 25 years of experience and \$33 billion in assets, more people in health and community services choose HESTA for their super.

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With more than 25 years of experience and \$33 billion in assets, more people in health and community services choose HESTA for their super.



Become an AHHA member

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

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

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

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

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

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

policy makers, researchers and practitioners connect when they need expert advice.

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

In partnership with the LEI Group, the AHHA also provides

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

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

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



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More about the AHHA

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

AHHA Board

The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation, the protection of its assets and the quality of its services. The 2015-2016 Board is:

Dr Paul Dugdale
ACT Health (Chair)

Dr Deborah Cole
Dental Health Services Victoria

Mr Walter Kmet
WentWest, NSW

Mr Adrian Pennington
Wide Bay Health and Hospital Service, Qld

Mr Nigel Fidgeon
Merri Community Services, Vic

AHHA National Council

The AHHA National Council oversees our policy development program. It includes the AHHA Board as well as a range of members. The full list of Council members can be found at:

ahha.asn.au/governance

Secretariat

Ms Alison Verhoeven
Chief Executive

Mr Murray Mansell
Chief Operating Officer

Dr Linc Thurecht
Research Director

Mr Krister Partel
Advocacy Director

Ms Susan Killion
Deeble Institute Director

Ms Lisa Robey
Engagement and Business Director

Ms Yasmin Birchall
Research Manager

Ms Kylie Woolcock
Policy Manager

Ms Kate Silk
Policy Adviser

Ms Sue Wright
Office Manager

Ms Freda Lu
Assistant Accountant

Mr Daniel Holloway
Web/Project Officer

Mr Matthew Tabur
Executive Officer

Ms Cassandra Hill
Administration Officer, AHHA

Mr Adam Vidler
Communications Officer

Australian Health Review

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

Prof Gary Day
Editor in Chief

Dr Simon Barraclough
Associate Editor, Policy

Prof Christian Gericke
Associate Editor, Models of Care

Prof Sonj Hall
Associate Editor, Health Systems

Dr Lucio Naccarella
Associate Editor, Workforce

Dr Linc Thurecht
Associate Editor, Financing and Utilisation

Ms Danielle Zigomanis
Production Editor (CSIRO Publishing)

AHHA Sponsors

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- HESTA Super Fund
- Good Health Care

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

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