The Health Advocate

Your voice in healthcare

Dental health
Why funding is important

Clinical care standards
Managing acute stroke

Addressing healthcare demand
Strategies for managing chronic disease

Improving care
Mental healthcare in the spotlight

Climate change
Reduce waste, increase efficiency

Challenges & opportunities

Funding and workforce sustainability

+MORE INSIDE

The official magazine of the Australian Healthcare and Hospitals Association

ISSUE 31 / August 2015

PRINT POST APPROVED PP :100009739

HESTA Primary Health Care Awards

2013 winners, left to right: John van Bockxmeer, Craig Maloney, Alison Gibson and Jodie Mackell representing MIA.

Know someone in primary health care who deserves an award?

Recognise a physiotherapist, dentist, GP, pharmacist, therapist or other primary health care professional for their outstanding contribution, by nominating them in one of three categories:

- **Young Leader**
- **Team Excellence**
- **Individual Distinction**

NOMINATE NOW!
Nominations close 31 August 2015

$30,000 in prizes to be won!*

Follow us:

@HESTAPHCawards

/HESTAPrimaryHealthCareAwards

*Proudly sponsored by:

me

Proudly presented by:

HESTA
An Industry SuperFund

hestaawards.com.au

Contents

The Health Advocate

Issue 31 / August 2015

In depth

Briefing

From the AHHA desk

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

Long-term vision needed if Australia wants to keep universal healthcare

In response to the COAG Leaders' Retreat in late July, the AHHA and Public Health Association of Australia (PHAA) urged political leaders to consider sustainable and durable long-term funding arrangements that support an efficient and holistic health system, rather than just short-term fixes.

"For too long the middle and lower income earners have been subsidising wealthier Australians," said PHAA Chief Executive Officer,Michael Moore.

"Any reforms considered by the First Ministers at the COAG Leaders' retreat this week must consider the impacts on funding for public hospitals and consumers' already significant out-of-pocket expenses, particularly for the most vulnerable low income Australians and those with chronic and complex conditions," said AHHA Chief Executive, Alison Verhoeven. Equally, Ms Verhoeven and Mr Moore argued, reforms must be patient-centred with a focus on safety and quality of care that is not only affordable for all Australians, but also effective, efficient and value-for-money.

Healthcare needs to be patient-centred and affordable.

Healthcare funding arrangements must be durable and have a long-term view.

Hospital funding: durable solutions are required

The AHHA welcomed the consensus reached at the COAG Leaders' Retreat in July on the imperative for healthcare funding reform.

While the AHHA supported the call for better coordination between primary healthcare and hospitals, it cautioned that the proposal to extend Medicare into our hospitals system must be approached with a view to developing sustainable and durable solutions.

"We have before us the opportunity for meaningful change in the way our healthcare system is operated and funded to meet the challenges of the future and the reasonable expectations of all Australians on their healthcare needs. Ongoing discussions on reform of health funding must be conducted in an open and consultative manner, recognising that a strong health system accessible to all citizens is fundamental to a healthy productive society," said AHHA Chief Executive, Alison Verhoeven.

Social Impact Bonds: options for primary care

Options for Finance in Primary Care in Australia is the latest issues brief released by Professor John Fitzgerald from the University of Melbourne and the AHHA's Deeble Institute for Health Policy Research. The brief explores financing options in healthcare and calls for a closer examination of funding that links objectives to outcomes, including social impact bonds.

Social impact bonds take an outcome-focused approach, encouraging private investors to take an interest in the health sector through incentives for performance while simultaneously allowing governments to mitigate their financial risk. They can promote innovation and broader social benefits.

With social impact bonds as one example, Professor Fitzgerald noted that Primary Health Networks (PHNs) now have an opportunity to rethink how healthcare is financed in this country; to explore options from around the world to improve the health of our community.

Organisations unite to fight Budget cuts to vital health services

A coalition of 16 peak organisations from the health and community sectors, including the AHHA, called on the Australian Government to scrap plans to cut nearly $800 million in funding to key health initiatives over the next four financial years. The foreshadowed cuts would drastically reduce the capacity of non-government organisations and peak bodies to deliver services across the country and to provide advice and support for reform in health.

"Cuts to flexible funding are a significant destabilising force in the health sector, both at organisational level where there will be an impact on the viability of many not-for-profit health services, as well as on the capacity of the new Primary Health Networks; and at individual level, particularly for many of our most vulnerable people," said AHHA Chief Executive, Alison Verhoeven.

AHHA's Deeble Institute for Health Policy Research welcomes a new Director

The AHHA has announced the appointment of Ms Susan Killion as Director of its Deeble Institute for Health Policy Research. The Deeble Institute brings together health researchers, practitioners and policymakers, both nationally and internationally, to explore opportunities for research collaboration in health systems.

"With health policy firmly at the centre of political debate, it is more important than ever for the Deeble Institute and its partners to collaborate on an evidence base for health policy that is built on sound research, taking into account the perspectives of health practitioners, while being cognisant of the political realities in which policy is made," said AHHA Chief Executive, Alison Verhoeven.

"Susan Killion has enjoyed an extensive career in health for over thirty years, both in Australia and the United States. Her experience includes holding a variety of health leadership roles including clinical, management, policy and strategic planning, performance, university lecturing, research and publishing," said Ms Verhoeven.

"Susan will play a key leadership role in working with our academic partners to extend and strengthen relationships with policymakers and practitioners. She is very well placed to understand their key issues, and to identify and share evidence to address these needs," said Ms Verhoeven.

Recent Deeble Institute publications include an Issues Brief on social impact bonds in primary healthcare financing and another on the evidence surrounding policy actions and interventions for addressing the growing problem of dementia.

In September 2015, the AHHA — in conjunction with the Deeble Institute — is hosting a *Think Tank on Sustainable Funding of Public Hospitals*. ha

Eat less and move more

In response to dementia being the second leading cause of death in Australia, affecting more than a quarter of a million Australians, a new issues brief authored by Australian National University PhD candidate and Deeble Institute Summer Scholar, Kimberly Ashby-Mitchell, examines the evidence surrounding dementia onset and the role diet and physical activity interventions might have in promoting brain health.

Six actions for intervention at various levels were outlined in the issues brief, including policy development, investment in research, multi-sectoral collaboration and education. All actions have as their foundation the Health in all Policies Initiative and social determinants of health approach.

The role of diet and physical activity in dementia onset is the subject of a new Deeble Institute issues brief.

PAUL DUGDALE
Chair of the Australian Healthcare and Hospitals Association (AHHA)

A new Constitution to strengthen AHHA

Helping us meet the broad interests of members

I am pleased to advise that at a Special General Meeting of the AHHA on 20 July 2015, members unanimously agreed to adopt a new Constitution to guide the organisation and our work into the future.

The adoption of the new Constitution follows a series of consultations and decisions aimed at positioning AHHA to better meet the broad interests of our members across the primary and acute health sectors, and to reflect the changed governance arrangements in the Australian health system.

In July 2014, AHHA members agreed to constitutional changes which provided for more direct representation on the AHHA Council, with less emphasis on jurisdictional quotas. This provided an opportunity for greater participation of members in development of AHHA policies to inform our work program. At that time the AHHA Board flagged its intention to review the Constitution in order to ensure the contemporary requirements of the Australian Charities and Not for Profit Commission (ACNC) were met; and to promote better governance of the organisation.

Specialist advisers, Board Matters, were engaged to lead this work. AHHA Council members discussed a first draft in March 2015; which was further refined to reflect input from this consultation. Good input was received through the consultations, and all issues were resolved through consensus.

The AHHA Board endorsed a final draft for consideration by members at the July 2015 Special General Meeting. They recommended the draft to members, noting that it:

- met ACNC requirements;
- ensured representation of all members in the strategic policy deliberations of the AHHA;
- provided opportunities for members to be nominated to Board positions;
- provided robust nomination and electoral processes;
- would ensure effective corporate governance of AHHA; and
- would ensure AHHA is able to maintain and build on its strengths as the voice of public healthcare in Australia.

AHHA members unanimously agreed the adoption of the new Constitution at the Special General Meeting, with my fellow Board member Gary Day endorsing the consultation process and the revised document as more robust and easier to use. AHHA Treasurer Deborah Cole commended the process undertaken and recommended the Constitution as a contemporary document meeting AHHA requirements. Immediate Past Chair Paul Scown noted that conflicting clauses in the existing Constitution had been addressed in the new Constitution, and that it provided AHHA a sound platform for good governance, positioning the organisation well to meet the challenges and demands of the future.

I would like to acknowledge the work of the AHHA Secretariat, and the expert advice of Board Matters and their efforts to ensure the input of AHHA members was addressed fully throughout the consultation process.

The AHHA's 2015 Annual General Meeting will be held in Brisbane on 15 September, at which time a new Board will be elected under the provisions outlined in the newly-adopted Constitution. I encourage members to consider participating actively in the work of the AHHA through their Council membership, and nominating for leadership roles in the AHHA. The organisation is only as strong as the combined contributions of its members. In a time where health is increasingly under public and fiscal scrutiny, for us to remain strong as the voice of public healthcare, I urge you ensure your voice is counted. ha

ALISON VERHOEVEN
Chief Executive
AHHA

Addressing demand in healthcare

Strategies for managing chronic disease

The third incarnation of regional primary health care organisations in Australia opened their doors on 1 July, and despite a difficult change process over the past 12 months, the new Primary Health Networks (PHNs) are well-positioned to meet the challenges of driving better integrated health at a regional level.

The Commonwealth Government's focus on ensuring a sustainable health budget can best be served by a health system where primary health providers and hospitals work together closely to identify and meet the needs of their communities. This approach places consumers at the centre of the health system, and seeks to promote better health outcomes for all Australians.

A key focus must be the burden of chronic disease, which threatens to overwhelm Australian health budgets, the capacity of health services and the health workforce.

Chronic diseases are a range of conditions that are long-lasting and negatively impact a person's health in a number of ways, including the presence of disease symptoms, functional impairment, disability, reduction in life expectancy and premature death.

The co-existence of multiple chronic diseases is increasingly common. Around 80% of Australians aged 65 years and older report having three or more chronic conditions. And rates of multi morbidity are increasing across the lifespan with recent estimates suggesting 10% of young people from infancy to young adulthood having two or more chronic diseases.

This high reported prevalence of patients with multi-morbidity highlights the need for integration and coordination of continuing care. Future policy initiatives need to move away from single illness orientation toward strategies that meet the needs of people with comorbid conditions and strengthen their capacity to self-manage.

The paradox of chronic disease is that better public healthcare, advances in acute care and investment in preventive health have resulted in more people living longer and experiencing a greater burden of chronic and non-communicable diseases.

The key challenge will be to transform our primary healthcare system away from a focus on episodic care to better direct engagement between primary care services and specialist consultant care providers, and better coordination between hospitals and community-based primary care. Our federated health arrangements in policy, funding and service delivery add to the challenge.

The former Medicare Locals worked to shift the balance in healthcare away from acute interventions toward prevention, early intervention and chronic disease management. Regional specific approaches to address the management of chronic and complex conditions through care coordination have been implemented, and it is expected that these might continue under the newly-established PHNs.

AHHA's submission to the Australian House of Representatives Standing Committee on Health Inquiry into Chronic Disease Prevention and Management in Primary Care noted that significant structural issues in the current system exist and prevent an integrated approach to managing chronic disease.

Furthermore, engagement and coordination between primary care, hospitals and specialised community-based services (including allied health services) needs examination, as do the impact of funding models and the delivery of services occurring through different levels of government. Together these create a "complex web" that gives rise to shifting responsibilities and an uncoordinated care.

AHHA advocated for a more integrated approach to managing chronic diseases that:

- is centred around patients, rather than diseases, to deliver care tailored to those with multimorbidity;
- supports regional-specific approaches that are more coordinated and easier for patients to navigate;
- addresses the structural issues around funding models and the delivery of services between different levels of government, implementing funding arrangements that are patient centred and support the right care in the most appropriate environment; and
- facilitates the sharing and use of data with open and transparent evaluation.

AHHA will be advocating for a bipartisan national plan to improve the prevention and management of chronic disease and which is developed in genuine partnership with all levels of government, health service providers, health researchers, consumers and the broader health community.

AHHA's forum on options for bundled care in primary care is a natural next step. On 16 September in Brisbane, AHHA members will examine issues associated with introducing bundled care in Australia, including strategies to reach across the silos of healthcare services and better coordinate care to improve patient outcomes and efficiency within the healthcare system. Register for this event on the AHHA website at: www.ahha.asn.au/events ha

Sustainable funding of public hospitals

An invitation to join a national debate on healthcare

On 15 September 2015, the AHHA will be hosting a *Think Tank on Sustainable Funding of Public Hospitals*. This event has been organised in the context of the Australian Government's 2014-15 Budget decision to significantly change how the Commonwealth will contribute to the funding of public hospitals from 2017-18 onwards, in addition to the two White Paper processes currently underway on *Reform of the Federation and the Reform of Australia's Tax System*.

In the 2014-15 Budget, the Government announced that from 2017-18 the indexation of Commonwealth contributions to the funding of public hospitals will be changed to a combination of population growth and movements in the Consumer Price Index. This was coupled with the Government's decision to cease funding guarantees under the National Health Reform Agreement that had previously been negotiated between the Commonwealth and all state and territory governments. Over the eight year period from 2017-18, this represents an estimated $57 billion reduction by the Commonwealth for the funding of public hospital services.

'Teddy bear hospital' by Christiaan Triebert.
Image sourced from Flickr (CC BY 2.0: https://flic.kr/p/eKrcYT).

Against this policy backdrop, there are two other processes currently underway that could have a significant impact on the responsibilities that all levels of government have for the delivery and funding of health services.

The first is the *White Paper on Reform of the Federation* that is examining which level of government should be responsible for the delivery of healthcare in Australia (among other public services). This has the potential to significantly change the structure of the health system with an emphasis on states and territories being "sovereign within their own sphere". There is a need for clarification of roles and responsibilities for the delivery of healthcare services between levels of government.

The second is the *White Paper on Reform of Australia's Tax System*. This examines taxes and concessions with the stated aim to deliver lower taxes along with a simpler and fairer tax system. While the Goods and Services Tax has received much of the public attention in this process, proposals could also extend to the Australian Government handing income tax powers to individual jurisdictions. These options were discussed by First Minisiters at the July COAG Retreat.

These two white paper processes are proceeding in tandem to inform a system wide approach to the matching of service delivery responsibilities with funding capacities.

The AHHA *Think Tank on Sustainable Funding of Public Hospitals* will provide the opportunity for health leaders to discuss alternative ways that public hospitals could be sustainably funded given the challenges of the funding backdrop and the opportunities presented with these two potentially far reaching reform processes. ha

Join the debate on public hospital funding

In an environment of increasing pressure for the funding of public hospitals, coupled with reform of the tax system and in government responsibilities for the delivery of services, the Australian Healthcare and Hospitals Association will be holding a think tank to explore options to achieve sustainable funding of public hospitals.

The *Think Tank on Sustainable Funding of Public Hospitals* will examine topics such as:

- Should responsibility for the funding of public hospitals rest with only one level of government, and how might such an arrangement affect the setting of operational targets?
- How are alternative models of financing reflecting the evolving nature of coordinated care and the use of hospitals?
- How can the economic benefits of avoiding preventable hospitalisations and reducing delayed discharges be shared across sectors?

Throughout the day, delegates will be challenged with disruptive thinking, alternative models of care and funding, and innovative views.

Confirmed speakers include:

- **Professor Julie Byles,** Director, Research Centre for Gender, Health and Ageing, University of Newcastle
- **Professor Nicholas Graves,** Queensland University of Technology
- **Suzanne Greenwood,** Chief Executive Officer, Catholic Health Australia
- **Elizabeth Koff,** A/Deputy Secretary, Strategy and Resources, NSW Ministry of Health
- **Michael Pervan,** Acting Secretary, Department of Health and Human Services (Tasmania)
- **Professor Anthony Scott,** Melbourne Institute of Applied Economic and Social Research, University of Melbourne
- **Dr Tony Sherbon,** Ernst and Young

Event details

Date: 15 September 2015
Time: 9:00am - 3:00pm
Venue: Mercure Brisbane
Price: Members - $295
Non-Members - $590

To register, go to **https://ahha.asn.au/events**

HESTA
An Industry SuperFund

ahha
australian healthcare & hospitals association

SENATOR RICHARD DI NATALE
Australian Greens Leader and
Spokesperson for health

Medicare and the myth of unsustainability

Prioritising universal healthcare in Australia

Since taking office, the Abbott Government has argued that Medicare is unsustainable. But sustainability is a question of priorities, not merely accounting. Just as individuals invest more in their health as their income grows, it also makes sense for a society to prioritise a greater investment in health as its overall wealth grows. Not only is health a superior good, it also plays an important role in lifting productivity across the economy. Health spending is as much an investment as it is expenditure.

Whether health spending is growing, and whether our health spend is efficient, are two separate questions. According to the Australian Institute of Health and Welfare (AIHW) Health Expenditure Australia 2012-13 report, health expenditure is growing at its lowest level since the AIHW began keeping records 30 years ago. This past year, total spending on health goods and services in Australia increased by just 1.5%. This means that, when population growth is taken into account, average annual health spending of $6,430 per person was actually down in real terms.

Over the past decade, there has only been a small increase in Australia's health spend as a proportion of GDP (1.5%), a rate of growth in health spending that is well below the average for comparable countries. While Australia's health spend is projected to continue to increase marginally as a proportion of GDP over coming decades, the major driver of these increased costs is the development of new and improved health interventions, not the ageing population or the frequency of GP visits as the government would have us believe. Far from being a crisis, providing people with access to new lifesaving medicines, high-tech diagnostic procedures and minimally invasive surgery is a sign of an advanced and prosperous economy.

Australia has a relatively efficient health system by international standards. We know this because Australia spends less as a percentage of GDP on health than the OECD average yet we achieve significantly higher than average health outcomes and life expectancy. According to the OECD, health spending in Australia in 2011-12 was 9.1% of GDP, below the average of developed nations of 9.3% and just over half the 16.9% the USA spends. While health outcomes are not just the product of the health system but also of social determinants — such as education, housing and environment — analysis of health outcomes versus health expenditure points to a relatively efficient Australian health system.

We should be looking at ways of building up Medicare, not tearing it down. We should be bringing dental care into Medicare and looking for other ways to reduce people's out-of-pocket costs, not increase them.

Australia's health system is not in crisis but the Greens acknowledge that we do face some long-term challenges. It is possible to meet these challenges without slashing payments to doctors or shifting costs onto patients. The sensible and responsible pathway to reform is to follow evidence over ideology.

And the evidence tells us that the most important thing that Australia can do to keep the cost of healthcare under control is to protect Medicare. It may not be perfect, but for 30 years it has delivered healthcare fairly and efficiently. It keeps costs down because as a single universal insurer Medicare has the power to set prices which keep a lid on the cost of a visit to a doctor.

We should be looking at ways of building up Medicare, not tearing it down. We should be bringing dental care into Medicare and looking for other ways to reduce people's out-of-pocket costs, not increase them.

Fundamentally, this is not a debate about sustainability; it is a debate about what sort of country we want to be. The Greens stand for a society where everyone gets access to high quality healthcare, no matter what the size of their wallet or whether they are unlucky enough to be born with a chronic disease. There is no real question about whether we can afford it; the only question is whether we want to make it a priority. ha

Dr Richard Di Natale is the Australian Greens Leader and spokesperson on health. Before entering parliament he was a GP and public health specialist.

'Stryde at the ER' by Jim Larrison. Image sourced from Flickr (CC BY 2.0: https://flic.kr/p/edzdS8).

Knowledge translation and exchange

A round up of the **Deeble Institute's** July short course, presented with the University of Western Australia's School of Population Health in Perth

Every year, there are countless research projects completed with little to no tangible effect on policymaking. This waste of brainpower is what the Deeble Institute's short course on knowledge translation and exchange is hoping to address.

Following the successful inaugural short course held at the Australian National University in 2014, this year the course was hosted by the University of Western Australia's (UWA) School of Population Health. Over three days, 17 academic researchers joined together at the Harry Perkins Institute of Medical Research to learn how to get policymakers to take more notice of their research.

Professor David Preen from the School of Population Health at UWA said that the short course was "a must for any serious health researcher wanting to learn the skills, techniques and 'tricks of the trade' for working with healthcare decision-makers to effect change in policy and practice from research evidence."

High profile speakers including Professor Gary Geelhoed and Dr. Tarun Weeramanthri from WA Health, Alan Singh from the National Health and Medical Research Council, Professor Mike Daube from Public Health Advocacy Institute Western Australia, and Dr. Paul Nicolarakis from Lorica Health, each provided the participants with a wide variety of insights into the competing pressures facing government policymakers and the politics of policy implementation. Some of the topics covered included:

- why knowledge exchange and research translation is becoming more important for academic researchers and how it can tailored for different audiences;
- the realities of the policy making process and the environment in which policymakers work;
- understanding how research is used by health service providers, consumers and political advisors; and
- engaging effectively with the media and non-academic audiences.

Course participants working through training exercises together.

Practical exercises included developing media releases, describing each other's research following a short pitch, and presenting information to a minister, complete with interruptions from the parliamentary bells and ministerial staff. The final exercise of the course saw each researcher interviewed on camera by a journalist, an experience which most people found terrifying at first. However, the successful interviews demonstrated just how far each participant had come as they were all able to explain their research in layman's terms and a 'TV-ready' sound bite.

Helen Myers, a PhD student at School of Population Health UWA, said of the course: "I always felt that the end point of a research project was to get an article published. This course helped me to see that if you want your research to change things, you need to do a lot more than that. The insight into how policy is made helped me to appreciate what happens to your research if that's all you do. I really liked the practical focus and learnt a lot of skills to enable me to communicate my research findings more broadly and effectively." ha

The Deeble Institute Knowledge Translation and Exchange Short Course will be again in 2016, at a date and venue which is yet to be announced.

Life in recovery: beyond the individual

Claire Barber, General Manager at South Pacific Private, discusses how recovery can help to reduce the burden of alcohol and drug use on the health sector

The impact of drug and alcohol addiction is substantial, extending far beyond the individual to healthcare professionals, hospitals and emergency wards. While there have been numerous studies into the burden and impact of drug and alcohol addiction, very few tell the story of recovery from addiction and the associated positive benefits.

The *Australian Life in Recovery Survey* (2015), conducted by South Pacific Private and Turning Point, was the first survey of its kind that has evidenced these benefits. It compared a life in active addiction with a life in recovery from that addiction and has confirmed many things anecdotally assumed about the crippling effects of addiction — for instance, the resource pressure it places on the health and legal systems, the breakdown of communities and relationships impacted by addiction, and the positive transformative impact of recovery from addiction.

It has been argued that alcohol is the world's third largest risk factor for disease and correspondingly, a burden on the health sector globally. The *Australian Life in Recovery Survey* supported this claim, with 35.3% of participants indicating that alcohol was their primary addiction, 53.6% stating that they had an addiction to both drugs and alcohol, and a further 11.1% saying that drug addiction was their primary addiction.

Recent studies into the dangers of the excessive consumption of alcohol and other drugs show a gap in both knowledge and evidence around the outcomes of treatment for addiction and the ongoing recovery management journey that ensues. Previous studies have not provided insight into the treatment options available for people active in this excessive consumption, and until very recently in Australia, this was the norm. There was relatively little empirical evidence that could clearly indicate the benefits of recovery — financially, physically, relationally or mentally.

The *Australian Life in Recovery Survey* has delivered much-needed knowledge into this area. It has provided clarity around what life in recovery from addiction really looks like; the differences, the benefits, and journeys that people take when they decide to get help for their addiction and begin to get well.

The survey looked at various aspects of life and wellbeing including finance, family and social life, health, legal issues and work. It clearly indicated that recovery from addiction, after exposure to appropriate treatment, can enhance outcomes and reduce healthcare costs. For instance, those in recovery are:

- 48% less likely to experience untreated mental health problems;
- 24% less likely to frequently attend emergency departments;
- 22% less likely to frequently use healthcare services;
- 29% less likely to use tobacco products;
- 75% less likely to drive under the influence of alcohol or other drugs; and
- 40% less likely to experience domestic violence.

These and other results from the survey support the suggestion that there are clear improvements that happen over time in recovery. Those in recovery for the longest term report markedly higher levels of psychological wellbeing and quality of life and much lower levels of need for professional support for emotional or mental health issues.

It is important to remember, though, that this story is only just starting to be told. The survey shows that stigma around mental health concerns are still pervasive and that many people do not access treatment for their addiction until they have been using for an average of 18.6 years, and at an average age of 34.8 years.

It is more beneficial and cost-effective to treat addiction than it is to punish it.

While addiction is a chronic, relapsing condition, this report provides much needed hope that recovery and a better life is possible for the many people suffering from addiction. It also shows that it is more beneficial and cost-effective to treat addiction than it is to punish it. Such an approach not only helps individuals, it has far-reaching benefits for society at large. ha

South Pacific Private is a mental health and addiction treatment facility located in New South Wales. For more information, go to: www.southpacificprivate.com.au

Turning Point Alcohol and Drug Centre is a specialist treatment centre located in Victoria. For more information, go to: www.turningpoint.org.au

'Poise' by Conor Lawless. Image sourced from Flickr (CC BY 2.0: https://flic.kr/p/3oWcyi).

DEBORAH COLE
Chief Executive Officer
Dental Health Services Victoria

Viewing the mouth as part of the body

Why dental health funding is important

Unless the Federal Government provides continued and adequate funding for public dental care, Australia's dental health will continue to suffer, The gap between the "haves" and the "have nots" is getting greater and is obvious every time we smile.

For too long, dental care has been viewed as an optional add-on to medical care. Dentistry is not an extra. More people are avoiding care because of cost with the majority of dental care being delivered in the private sector and paid out-of-pocket.

The formation of the National Partnership Agreement (NPA) on dental services was intended to improve the situation by delivering $1.3 billion over four years, starting from 1 July last year. So far, the Coalition's pledge has amounted to a 12 month delay, a nearly 25% cut to the 2015-16 allocation from $200 million to $155 million, and the wiping of the remaining $1.15 billion from the forward estimates. This means fewer people will be treated and they will wait longer for the opportunity of dental care.

Affecting more than half of all Australian children, and almost all adults, tooth decay is now the second most costly diet-related disease in the nation. Clearly, there has never been a more crucial time to ensure greater access to dental care.

The Federal Government's announcement that it will spend $155 million in 2015-16 on dental health across Australia has rightfully been received with mixed feelings by those in the public oral healthcare sector: relief that there is some funding and trepidation about what will happen next. While access to the Child Dental Benefit Schedule has been rolled over to another year, the uncertainty of its future, along with the further NPAs, makes future planning difficult. This on-off funding cycle does not make for a sustainable system, as it is difficult to put resources into producing good models of care with preventive components if there is only a one year time scale. It also means that money is used less efficiently in efforts to meet "drilling and filling" targets rather than in designing a system that reaches more people, over a sustained time period, to improve oral health outcomes.

Health Minister Sussan Ley pointed to a "once- in-a-lifetime opportunity for constructive reform… to achieve a better integrated system with services working in co-operation." Stripping over $1 billion funding from dental services providing care to the most vulnerable in our society and in under serviced areas is not a good way to start. This less than ideal commitment raises significant issues about how serious the Federal Government is about dental healthcare — especially as a long-term investment.

It is also disappointing that the Federal Government decided to cease funding for the Voluntary Dental Graduate Year Program and the Voluntary Oral Health Therapist Program, both of which target workforce shortages in rural and remote areas. The comment was made that the scheme resulted in less than 5% of participants undertaking placements in rural and remote regions. This remark appears to have been made with little real evaluation of the scheme — which is still only in its infancy. Clearly, the remark is aimed at justifying an expenditure cut to areas of need. One thing the evaluation could have noted was that there may have been a decrease in available jobs in the rural and remote areas because the NPA funding was cut just as many were completing their graduate year.

Such changes to the dental budget are effectively helping to remove funding for prevention from the Commonwealth Budget, following on from cancellation of the NPA on Preventative Health last year. At a time when more people are presenting with chronic illnesses, obesity rates are rising, and cardiovascular disease is the leading cause of death, it is crucial that preventative and primary healthcare are prioritised, not just to rein in acute health spending but for the individual wellbeing of all Australians. Dental health is one clear avenue for prevention that is integral to good overall health and requires a strong partnership between the Commonwealth and all states and territories.

Budget reform discussions must take dental health seriously, with dental conditions underlying approximately 18% of preventable hospitalisations for acute conditions (and around 8% of preventable hospital admissions overall). Reform discussions must also include consumers who incur significant out-of-pocket costs, being responsible for nearly 60% of the $8.7 billion spent on dental care every year.

The compartmentalisation involved in viewing the mouth separately from the rest of the body must stop. Peoples' ability to work, eat, play and socialise — their quality of life and wellbeing — are all affected by their oral health.

It is disappointing the 2015-16 Federal Budget has not delivered for the dental health of people in Australia, particularly those that need it the most. While hope is not a strategy, we look forward to the constructive reform process suggested by Minister Ley so that together we can design a system that does improve the oral health and hence, general health, of all Australians. ha

Improving health from the outside

Data informatics specialist and tech entrepreneur **Marcus Dawe** explains why we need a global health innovation marketplace for today and tomorrow

As an entrepreneur and technology specialist, I have spent the last two decades convincing government departments and health bodies that they need new ways to manage and share their information: in a citizen-centric way. In health, this means patient centred care.

From moving the Federal Government onto the internet in the 1990s with the Australian Government Homepage to putting two Prime Ministers online, building a virtual tallyroom for the Australian Electoral Commission, putting the National Health and Medical Research Council and the Australian Institute of Health and Welfare online and, recently, building a Chronic Disease Management register for ACT Health: I've experienced great personal reward in creating innovation systems that improve our lives.

Now, in the age of smartphones and clouds, we have health practitioners who are also in business as innovators. They're developing health improvements through apps, devices, pathways or treatment approaches, and taking them to market. Globally, 30% of new startups are in the health sector. Health and healthcare innovation is booming.

Sitting on a health commercialisation board for seven years, I became very frustrated with the difficulty in getting good technology and breakthrough research translated. According to the World Bank, only around 20% of innovations in health make it to translation and adoption. This is because, outside of the pharmaceutical industry, there's no clear path for either commercialisation or collaboration.

30% of new startups are in the health sector. Health and healthcare innovation is booming.

In 2013, I knew the answer was to take a "top down" and data based view: using data mining and machine learning techniques to research the health innovation market, and classify it. In doing so, our team assembled the world's largest database of health innovations.

This database is the foundation of the website www.health-innovate.com: an online marketplace that lets you showcase your innovation, collaborate, find investors, or seek interest in progressing the innovation to market.

Now in 2015, just like Uber owns no cars, and Facebook creates no content, Health-Innovate owns no innovations. It's an online platform which was built on two core assets: the largest global data collection of health innovations, and a novel taxonomy which bridges natural language and medical terminologies, like SNOMED and ICD10.

We have identified over 30 categories of innovations, with many novel types in the mix. For example, if you have done a review of the best apps for managing heart disease, we will include that as an innovation. We've also included pathways, treatment plans, quality systems and health promotion campaigns.

Hospitals, researchers, investors, consumers and anyone with an interest in health can search Health-Innovate by the type of innovation, by disease group or by purpose, and also by the stage an innovation has reached on its commercialisation journey: idea, proof of concept, trials, seeking investment, ready for market and so on.

For the first time, people will be able to like or follow an innovation and keep up with its progress as it moves from an idea, to the laboratory, to the point where it is improving lives.

Simply put: If you have an innovation in health and you want to progress its development, find an investor, seek collaborators or find early adopters, list it on Health-Innovate and you have an immediate world-wide audience. Students and practitioners will be able to keep across the latest innovations in their field in a new way.

While we will offer news and a daily digest to those who want it, our model is built less as a linear stream and more on building blocks of quality information, an evidence rating and on two way collaboration.

The global consumer community has also matured in their desire for authoritative health information online. This is most evident in the emergence of mHealth (mobile) and pHealth (personalised) innovations, or apps and wearables. We will be an evidence based resource where the broader community can find emerging innovations and follow breakthroughs in medical, health and wellbeing science.

After two years of development, we're excited to launch Health-Innovate on 8 October 2015 at the International Hospital Federation World Hospital Congress in Chicago. We'll feature over 50,000 innovations from 20,000 organisations: with a large collection of Australian innovations from our universities, hospital networks and health startups.

If you have an innovation you can join us and benefit from a free listing before the end of the year: visit www.health-innovate.com ha

‘Electric Spark’ by Watcha Macallit. Image sourced from Flickr (CC BY 2.0: https://flic.kr/p/r1WB61).

Working together to reduce waste and increase efficiencies

New global campaign calls for health sector to step up on climate, writes **Fiona Armstrong,** Executive Director of the Climate and Health Alliance

Back in 2012, the Australia arm of a new global network of green and healthy hospitals was established in Australia. Environmental health expert Dr Peter Orris, senior advisor to Health Care Without Harm, was in Sydney to launch the initiative at the inaugural Think Tank on Greening the Health Care Sector — a now annual event co-hosted by Climate and Health Alliance (CAHA) and the AHHA.

There were around 4,000 members of Global Green and Healthy Hospitals then; now, with the commencement of an online platform to support this virtual community, the global network has grown to over 15,000 members. This dynamic community of people and institutions is working together in a global collaboration to share knowledge, skills, tools, as well as resources to build up global best practice in sustainability in healthcare, and accelerate the transition of health care to low carbon operations.

Starting from just a handful of members a few years ago, the Pacific region now has more than 150 hospitals and health services from across Australia and New Zealand as part of the network. We hope to dramatically grow the participation of Australian and New Zealand hospitals and health services in coming years, and see the lessons from this region as potentially cutting edge sustainable healthcare practices.

Our innovative workforce, coupled with the growing realisation among health service leaders and managers regarding cost savings and reputational benefits, is likely to see greater investment in efforts to realise these gains, offering Australia and New Zealand the chance to be world leaders in this field.

We already have amazing work being done: Austin Health in Victoria has implemented a comprehensive environmental management strategy, with initiatives underway across several facilities to help improve energy efficiency, limit waste, reduce water use, and create green outdoor healing spaces, among other things. Specific gains include the introduction of additional recycling streams, leading to further diversion of waste from landfill with almost 20% of all waste now being recycled. Mater Health in Queensland has saved almost $1 million and around 400 tonnes of carbon emissions in one year with smarter electricity contracts. St Vincent's Health Australia is investing heavily in energy efficiency and expects to reduce energy consumption by 30-40%.

Across the Tasman, Counties Manukau District Health Board (DHB) are recycling paper, glass and electronic waste, cutting carbon emissions and organising car-pooling for staff. Counties Manukau DHB have reduced their carbon footprint by 4% every year since 2012, and are the first Australasian participant in the 2020 Health Care Climate Challenge — a new campaign launched in May to encourage hospitals across the world to set their own emissions reduction targets

'Recycling Troopers' by Alan Levine. Image sourced from Flickr (CC BY 2.0: https://flic.kr/p/dMYJAB).

– to reduce their carbon footprint and protect public health from climate change.

Other participants in the 2020 Challenge include Gundersen Health System (USA), Hospital Albert Einstein and Hospital Sirio Libanes (Brazil), Kaiser Permanente (USA), National Health Service (NHS) Sustainable Development Unit (United Kingdom), Virginia Mason Health System (USA), Western Cape Government Health (South Africa), and Yonsei University Health System (South Korea). Several of the initial participants, such as Kaiser Permanente, Yonsei University Health and the NHS have already committed to reduce their greenhouse gas emissions by 30% or more by 2020. All have also pledged to encourage public policy, economic development, and investment strategies that move their societies away from fossil fuel dependency and toward healthy energy alternatives.

It is an inspiring demonstration of an emerging global trend towards cooperation, rather than competition; of sharing, rather than secrecy; with an emphasis on community, rather than individuals.

While the 2020 Challenge provides incentives through the spirit of competition and recognition of achievements through awards, the ethic of the Global Green and Healthy Hospitals network is really all about collaboration. It is an inspiring demonstration of an emerging global trend towards cooperation, rather than competition; of sharing, rather than secrecy; with an emphasis on community, rather than individuals.

As we wrestle with the challenges of a resource-constrained, climate changed world, this kind of cooperation can enable us to build on our strengths, support others, and in doing so build trust, resilience, respect, understanding, and power, while boosting quality of care, realising financial savings and ensuring public health and environmental protections.

It is also the case that cooperation is fun, and personally rewarding. Through my own involvement I've seen people inspired, friendships develop, ambitions realised and then renewed through this relentlessly positive and supportive network. When people of shared passion (and for many, concern about our future is a deep and profound passion) come together, change is not only possible, but from my observation of the network, it becomes exponential and, we hope, unstoppable. ha

Immunisation success

Angela Newbound discusses the contribution of Medicare Local vaccination initatives

A high vaccination rate in Australia has reduced the incidence of many preventable diseases such as polio, diphtheria, measles and tetanus. Since 1999, a range of strategies has increased immunisation coverage rates in Australia by 4.54% to the current rate of 91% for children aged 12 to <15 months, 17.6% to the current rate of 90.08% for children aged 24 to <27 months, and 17.66% to the current rate of 92.16% for children aged 60 to <63 months. The Immunisation Program Coordinators within the previous Divisions of General Practice and more recently, Medicare Locals enhanced these strategies by providing valuable support and educational opportunities to immunisation providers, keeping the community informed of the importance of timely immunisation and developing resources to meet local needs.

Not only did these programs address changing geographical and organisational landscapes over time, they were also instrumental in rolling out a multitude of immunisation program changes, delivered education around new vaccines, policies, procedures and recommendations to providers, and attended community events to disseminate immunisation messages.

Resources developed for providers and community have been in a range of styles. Darling Downs-South West Queensland Medicare Local (DDSWQML) developed colourful plastic bath ducks for immunisation promotion to the 12-18 month age range and small brightly coloured dinosaur drink bottles for the 4-year-olds. By implementing initiatives such as these, DDSWQML maintained immunisation coverage rates of above 90% in all age cohorts.

Through a local primary school competition, the Goldfields-Midwest Medicare Local (GMML) superhero mascot Neddy Needle promoted immunisation coverage within the Aboriginal community. Neddy was designed to appeal to children of all ages and cultural backgrounds, and to help distribute the *Immunisations are for Everybody* activity book to families.

A poster displaying the recommended injection sites was developed by the Lower Murray Medicare Local (LMML), with a second poster identifying the immunisation scheduling points throughout life developed by the Gippsland Medicare Local (GML). A third poster was developed for providers of hepatitis A and pneumococcal vaccination for Aboriginal children by Perth Central and East Metro Medicare Local (PCEMML).

A strong holistic approach was a key factor behind increasing adolescent immunisation coverage rates within the Great South Coast Medicare Local (GSCML) region. Through the establishment of a local government networking group and working closely with general practices, the HPV vaccination rate increased to over 90%. A simple administrative approach was adopted by primary care providers whereby the HPV reporting form was attached to the vaccine box with an elastic band to prompt the provider to report the administered doses to the HPV Register. GCML successfully initiated a direct mail out strategy removing the reliance on

'Needles this morning, smiles this afternoon' by David D. Image sourced from Flickr (CC BY 2.0: https://flic.kr/p/mrgGrJ)

students and teachers to deliver consent forms to parents. This initiative enhanced consent form return rates and has increased immunisation rates in one school by 11.15%.

The aptly titled *Has your Tot had their Shots?* campaign was instrumental in achieving high immunisation coverage in the Far North Queensland Medicare Local (FNQML) region. A suite of resources including fridge magnets, recall postcards, bravery certificates, bookmarks and posters were developed as part of this campaign to promote immunisation.

The Central Adelaide and Hills Medicare Local (CAHML) developed immunisation reminder fridge magnets and conducted an Immunisation Blitz involving 19 child care centres situated in areas of low coverage. Consequently, 1,017 Australian Childhood Immunisation Register (ACIR) history checks were undertaken, with two immunisation clinics provided at a child care centre with a specifically Aboriginal focus. All parents were contacted and advised of their child's immunisation status. Incorrect or missing data was updated and parents were advised of the 3½-4-year-old scheduling point change and how to update incorrect address details where required. CAHML also developed an online pneumococcal algorithm tool to assist providers in managing the complexity of pneumococcal vaccination for those with medical risk factors. The tool is hosted on the Influenza Specialist Group (ISG) website.

Together, we remain hopeful that much of what has been initiated and developed by the Medicare Locals will be embraced by the Primary Health Networks.

Lulu's Good Day immunisation story book and suite of other resources to help promote 4-year-old immunisations, and undertaking a total of 613 ACIR checks at primary schools in the region, were successful initiatives of the Country South (South Australia) Medicare Local (CSSAML). In addition to providing face-to-face educational opportunities, the CSSAML also funded and supported 32 Registered Nurses to complete the SA Health Understanding Vaccines and the National Immunisation Program online course. An increase to adult immunisation coverage in the Aboriginal community was another key focus and resulted in immunisation days targeting pertussis booster and MMR vaccinations.

In reflecting back on these Medicare Local achievements, I would like to thank all of the Immunisation Program Coordinators who submitted information for this article. Together, we remain hopeful that much of what has been initiated and developed by the Medicare Locals will be embraced by the Primary Health Networks (PHNs). As there will be fewer PHNs, hopefully there will be many opportunities for them to collaborate and share resource initiatives with one another to minimise workforce time and preserve valuable health dollars. ha

RON DE JONGH
Chief Executive Officer
Grand Pacific Health

Life after the Medicare Local

Continuing the efforts of coordinated care

On 1 July 2015, I commenced as the new CEO of Grand Pacific Health ltd which, up until one day before, had been trading as Illawarra Shoalhaven Medicare Local (ISML). I had been appointed to an executive role with ISML in November 2013 and as a result have a 'lived experience' of the end of the Medicare Local era. Rather than reflecting on the past and recounting its substantial achievements I would prefer to share my own personal views on "life after the Medicare Local".

Grand Pacific Health (GPH) tendered successfully for the Southern New South Wales Primary Health Network (PHN) through a special purpose company now known as Coordinare. In the aftermath of the announcement, we were privileged to be given the opportunity to merge into our structure all the clinical services previously delivered by Southern NSW Medicare Local (SNSWML). Although we are still finalising both the outbound spinning off of the PHN activities and the inbound integration of a large clinical service delivery capacity in Southern NSW, our future as a service delivery entity looks bright.

One of the great gains achieved by the segregation of service delivery from core PHN objectives is clarity of purpose. As a not for profit health services provider our patients, clients, consumers and carers are front and centre. The delivering of health services is no longer just a peripheral activity only tolerated in situations of market failure; it is proudly and unapologetically core business. This is particularly liberating to our frontline staff. Our 180 staff working across our *headspace* centres, integrated primary care centres, Partners In Recovery programs, Aboriginal health programs and chronic disease and preventative health programs all now know and feel that it is them who are delivering our mission and vision.

As many of our services originated from a response to some notion of market failure, they are by design tailored to local needs. Every service delivery type, without exception, is characterised by strong local collaboration, integration and consultation. I am certain that this is true for many "ex ML" service entities. Our very strong community ties have the ability to set us apart from more specialised state-wide or national providers. These connections are particularly critical where we seek to facilitate and coordinate clinical and other supports and services around a person's needs. So even though we now operate across a reasonably large geographical area, throughout our corporate structure, "localisation" is prolific.

Our community connectedness and partnerships will continue to be a defining advantage...

With the successful incorporation of the Southern New South Wales clinical services, our organisation has a healthy mix of funding bodies. Our funding is no longer dominated by one particular Deed for Funding. The service mix also includes a substantial self-funded and sustainable fee-for-service component.

Brand awareness and recognition will take some time to take hold, both for us and the PHNs. It seems amazing to me how sticky a label that nobody really wanted can become in a very short period. It will take time and effort to explain to our stakeholders who we are, who the PHN is and where the MLs went; and all this needs to be achieved before their eyes glaze over, they get bored with the acronyms, and they secretly think they might just let this one go and pick up the thread when a government changes everything next time around.

Our sector is subject to regular change. The current scope and timing is certainly unsettling but it provides new opportunities for successful organisations. I am encouraged by the recommendations of the Mental Health Review. I am convinced that our various mental health service delivery models can have a strong place in an appropriate policy response to these recommendations. I am sure I express the views of many in our sector in urging the government to embed these responses in long term funding arrangements and the continued effort to make a difference and provide an important mainstream choice for Indigenous people.

So yes, I think our future looks bright. The roots of our services will serve us well. Our community connectedness and partnerships will continue to be a defining advantage and will deliver better outcomes for those we assist in their quest for optimal health and wellbeing.

There absolutely is life after the Medicare Local, and we are lucky to employ 180 passionate staff who demonstrate this every day! ha

LISA MCINTYRE
Chair
HCF Research Foundation

Investing in health services research

Informing the future of Australian healthcare

International research ranks Australia's healthcare system as one of the best in the world, and yet more must be done in order to face the challenges ahead. Delivery of health services is one area for improvement that is often overlooked.

The HCF Research Foundation was established 15 years ago to fund health and medical research for the benefit of all Australians. Since inception, the Foundation has committed more than $13 million to universities, research institutes and hospitals across the country. Investment so far has covered a diverse range of health situations; diabetes, osteoporosis, knee and hip replacements, appendicitis, and breast cancer to name a few.

Quality health services research, when funded appropriately, can be invaluable to healthcare delivery at all levels. With an ageing population, increasing hospital admissions and rising healthcare costs, it's important for us to take a more proactive role in ensuring the quality and efficiency of health services in the future. By taking this approach we can also hope to alleviate growing pressure on the health system.

Most recently, the HCF Research Foundation helped fund a clinical study focused on dementia patient care that was conducted by the NSW Clinical Excellence Commission. Considering that by 2020 the number of Australians suffering from dementia will reach almost 400,000, the results of this research have the potential to touch a large portion of Australians — both sufferers and their carers — by shaping the delivery of hospital care.

The study analysed the impact of introducing the TOP 5 program, which involves a patient's primary carer sharing five tips about the patient with clinicians on admission to hospital. The tips are then used by the hospital team to develop a strategy to better manage patient care. It's a simple program, taking about 20 minutes to implement for each patient, and yet it has produced encouraging outcomes. Results indicate less anxious patients and happier carers, while showing a significant decrease in falls and in the use of medications. The reduction in medications and falls alone could have a significant impact on the cost of care and this is a fantastic example of how seemingly simple research can deliver great gains. In light of these successes, the TOP 5 program is now being implemented in a variety of care settings such as transition between different hospitals, aged care facilities, ambulance and the community.

All of these projects have the potential to produce substantial economic benefit to both hospitals and patients alike. But it's not enough to simply fund the research. We need to take that next step to ensure it goes beyond the pages of a medical journal.

Other projects include one from the University of Newcastle and Hunter Medical Centre, which aims to reduce the ordering of unnecessary pathology tests when treating inpatients; and another by the Macquarie University Hospital, which is investigating ways to improve pre-admission assessment processes at hospitals.

All of these projects have the potential to produce substantial economic benefit to both hospitals and patients alike. But it's not enough to simply fund the research. We need to take that next step to ensure it goes beyond the pages of a medical journal. That's where the HCF Research Foundation's Commissioned Research comes in, as it is specifically designed to assist researchers with the translation of findings into practical outcomes. One of our major partnerships is with The Australian Prevention Partnership Centre; an initiative designed to ensure health policymakers can access the best research evidence about what works to address lifestyle-related chronic disease. This is all part and parcel of an ongoing commitment to health services research for the benefit of the whole community.

While striving towards overall long-term objectives, we must continue to prioritise projects that can deliver results and be implemented in the short-term. Support for research that brings about tangible change in "the now" ensures that Australia maintains a global reputation for healthcare for many years to come. ha

Clinical Care Standards

STROKE

Stroke occurs when the supply of blood to the brain is interrupted either because of a blockage (ischaemic stroke) or a bleed (haemorrhagic stroke) in an artery.

OVER 1/3

of Australians who have had a stroke have a resulting disability.*

Strokes affect thousands of Australians

In 2011-12, an estimated 36,800 Australians had an acute stroke.*

Despite well-developed treatment guidelines, not all people who have a stroke receive appropriate treatment.

Right care, right time, right place

The **Acute Stroke Clinical Care Standard** relates to the care that patients with a suspected stroke should receive from the onset of their symptoms to the start of their rehabilitation.

F.A.S.T

F.A.S.T. (face, arms, speech, time test) test or other validated tool, is used immediately to assess symptoms.

Timely reperfusion is offered to patients with ischaemic stroke if appropriate.

Treatment in a stroke unit is preferred if available.

Rehabilitation is started as soon as possible depending on the patient's condition and preferences.

A care plan outlining ongoing treatment is provided to patients before they leave hospital.

Dial 000 if you or someone you know shows symptoms of a stroke

*Australia's Health 2014

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

strokefoundation

www.safetyandquality.gov.au/ccs

ROSIO CORDOVA
Program Director, Clinical Care Standards, Australian Commission on Safety and Quality in Health Care

Recognising and managing acute stroke

New evidence-based clinical care standards for clinicians and patients

Stroke affects thousands of Australians each year and is a major cause of death and disability. According to the Australian Institute of Health and Welfare's report *Australia's Health 2014*, stroke was the underlying cause of 8,800 deaths in 2011, which is 6% of all deaths for the year. Moreover, more than a third of Australians who have experienced a stroke have a resulting disability.

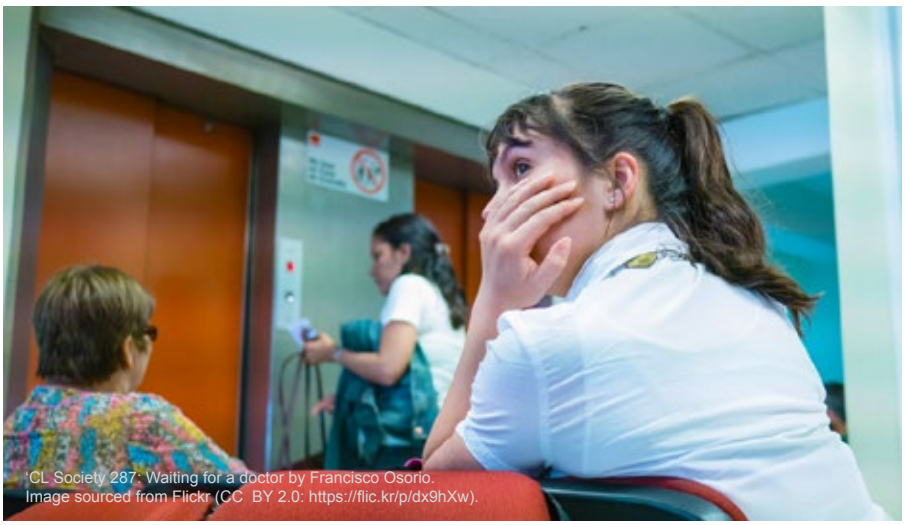
Despite well-developed guidelines for treating stroke, not all patients receive appropriate treatment. Ensuring consumers, clinicians and health services have the same understanding of care that should be offered is one way of improving appropriateness of care and health outcomes.

The Australian Commission on Safety and Quality in Health Care (the Commission) has been working with consumers, clinicians, researchers and health organisations to develop a Clinical Care Standard for acute stroke.

The goal of the Acute Stroke Clinical Care Standard is to improve the early assessment and management of patients with a stroke so as to increase their chance of survival, maximise their recovery, and reduce their risk of another stroke.

This Clinical Care Standard focuses on the key components of care a patient should be offered during the acute phase of a stroke. These key components are:

- recognising stroke symptoms straight away by using a validated screening tool, such as the F.A.S.T. (Face, Speech, Arms, Time) test;
- offering reperfusion treatment, such as a clot-dissolving medicine, to patients with ischaemic stroke, if the treatment would be of benefit to them and the patient agrees to it;
- offering care in a stroke unit and starting the rehabilitation process as soon as possible, depending on the patient's condition and preferences;
- educating the patient and carers, while the patient is in hospital, about how to minimise the risk of another stroke;
- providing carers with specific training and support on how to better care for the patient with stroke; and
- developing a care plan that outlines the ongoing care the patient will need after they leave hospital.



'CL Society 287: Waiting for a doctor by Francisco Osorio. Image sourced from Flickr (CC BY 2.0: https://flic.kr/p/dx9hXw).

Clinical Care Standards are developed in a user-friendly format to support clinicians in delivering best practice, and to provide guidance for health services on the systems that need to be in place to support best practice.

There is also another separate consumer information leaflet to encourage discussions between clinicians and consumers on various treatment options.

Following a broad public consultation process, the Commission launched the Acute Stroke Clinical Care Standard in June 2015. Clinical Care Standards to improve care in the areas of antimicrobial stewardship and acute coronary syndromes are also available.

The Commission is currently developing Clinical Care Standards to address gaps in care in the areas of delirium and hip fracture care.

For more on the Clinical Care Standards, see: www.safetyandquality.gov.au/ccs

Reform and partnerships on show in Brisbane

Gathering some of the brightest minds in health, aged and community care

Reform. Ready. Set. Go. Image courtesy of Metro North Brisbane Medicare Local.

The second annual Metro North Health Forum, set around the theme: *Reform. Ready. Set. Go*, addressed recent national health reforms in aged care, mental health and disabilities, explained what they meant for the sector, and provided vision for the future.

The forum was a joint initiative of Metro North Brisbane Medicare Local and the Metro North Hospital and Health Service (HHS), whose executive consultant Terry Mehan delivered the day's opening presentation. Mr Mehan explained that the HHS knew it was a "big" participant in the local health system, but also recognised it was just one part of the system and depended on partnerships to achieve reform. "We now accept that being big is important, but we are big in something that is bigger," he said, underscoring the organisation's commitment to consultation and cooperation.

Among the keynote speakers was Telstra Health managing director Shane Solomon, who described the rationale behind the company's venture into eHealth. Mr Solomon discussed overseas examples of successful eHealth systems and noted that "doctors will not go to two or three screens" to access patient medical information. Despite this, he declared: "There will never be one electronic health record — there will be many," emphasising that these records need to be integrated, not siloed, and should be linked to monitoring systems and analytical research tools.

Council on the Ageing (COTA) Chief Executive Ian Yates provided a consumer perspective about the reforms in aged and community care. "From our point of view this is an exciting time to be involved in aged care," Mr Yates said. He discussed the National Aged Care Alliance and its "blueprint" for aged care reform and called for a much stronger interface between the health and aged care sectors. "Some people have commented that moving aged care out of health hasn't helped that process," Mr Yates said. "I'd have to observe, that in the time aged care was in health, there wasn't much integration or seamlessness across those systems."

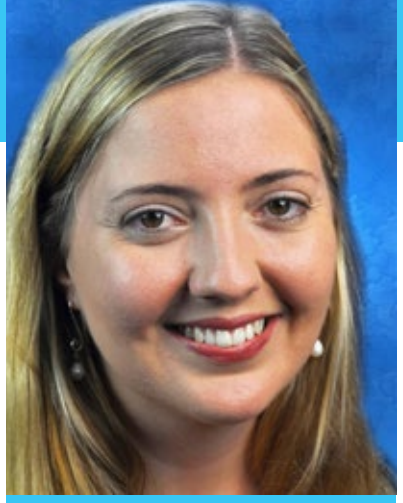
During a concurrent session, Mental Health Australia CEO Frank Quinlan spoke about reform across the mental health sector, including the impact of the National Disability Insurance Scheme and the recommendations to come from the National Mental Health Review. Mr Quinlan said the sector also needed to keep abreast of the McClure Review into welfare and Andrew Forrest's review of Indigenous employment, as well as negotiations on housing agreements and the Federation White Paper between the Commonwealth and states and territory governments. Mr Quinlan also stressed that the sector needs to stay current in debates around the Australian Government's reviews into Medicare and primary healthcare. "The picture I'm trying to create for you is of a really complex web of Commonwealth Government reviews and processes that are all underway, that are all likely to have really significant impacts on mental health, and for whom the outcomes of which are largely unknown," Mr Quinlan said.

"The diverse agenda covered primary and acute care, aged and community care, mental health and the National Disability Insurance Scheme. Cross-sector collaboration is key to successful reform and I am confident this event has shown very clearly what we can achieve by working together."

Among the other presenters were Fiona Anderson from the National Disability Insurance Agency, as well as Dan Minchin from the Silver Chain Group, and the Executive Director of Metro North Mental Health Associate Professor Brett Emmerson. To close the forum, Medicare Local CEO Abbe Anderson delivered a presentation on the Australian Government's primary healthcare reforms and the transition to the new Brisbane North PHN. She told forum attendees that the Department of Health's two key objectives for PHN's were increasing efficiency and effectiveness of medical services and the coordination of care. "One of the reasons that we were successful in our application [was] the Department… already liked what we were doing and the approach and engagement that we've had," Ms Anderson said. "In our case, we've been engaging with the community for a long time and with clinicians to help understand the healthcare needs of the community, to document that each year, [and] to undertake a process where we identify those gaps together. And we set those priorities and in our case, through collective impact, we try and get everybody working toward the same goals and we will continue to do that."

Ms Anderson thanked the 22 presenters who shared their expert knowledge and helped make the event a success. "Around 230 health professionals and consumers attended the Metro North Health Forum, representing corporate and non-profit health providers, peak organisations and government agencies," Ms Anderson said. "The diverse agenda covered primary and acute care, aged and community care, mental health and the National Disability Insurance Scheme. Cross-sector collaboration is key to successful reform and I am confident this event has shown very clearly what we can achieve by working together." ha

This article was prepared by Metro North Brisbane Medicare Local's Simon Brooks. As of 1 July 2015, MNBML now operates as Brisbane North Primary Health Network.



BONNIE CLOUGH
PhD Candidate, School of Applied Psychology, Griffith University

LEANNE CASEY
Lecturer, School of Applied Psychology, Griffith University

Facing the fear

A new approach to treating anxiety

A recently developed program at Griffith University is aiming to improve the treatment of anxiety disorders among adult sufferers. The Facing the Fear program is in its fourth year and is based on a transdiagnostic, cognitive behavioural approach developed in the United States. This approach to therapy has the potential to increase dissemination of treatments and reduce unmet need, particularly given that anxiety disorders are among the most prevalent mental disorders in Australia.

According to the Australian Bureau of Statistics, each year approximately 14% of Australians aged between 16-85 years will experience an anxiety disorder. The overall annual cost of mental illness in Australia is estimated at $20 billion. However, it is the personal costs of anxiety that are most significant for sufferers.

Anxiety can present as excessive or seemingly uncontrollable worry. For others, it may be more related to panic attacks, social situations or traumatic events. Numerous manuals and psychological treatments exist for each of the different anxiety disorders. Indeed, much research to date has focused on developing "gold standard" disorder specific treatment approaches. However, although these types of anxiety may appear distinctive on the surface, recent research from the United States has emphasized commonalities among the anxiety disorders suggesting there may be more effective ways to treat this problem.

Research conducted by David Barlow and colleagues indicates that anxiety disorders likely develop through common etiological pathways. In support of this notion, Barlow highlights evidence that suggests it is common for sufferers to not just experience one type of anxiety, but to experience symptoms from other anxiety disorders as well. An individual may suffer from a number of anxiety disorders at any one time, or it may be that their anxiety changes over time from one disorder to another. The overlap among the disorders is also supported by research demonstrating differential treatment effects. That is, by treating one anxiety disorder other comorbid disorders also improve.

Barlow and his team argue that anxiety should be viewed as resulting from underlying difficulties with emotion regulation rather than as having distinct etiologies. High rates of comorbidity between the anxiety disorders and unipolar mood disorders (such as depression and dysthymia) are also used to support the theory of underlying emotion dysregulation across the group of disorders. This is the premise that underlies a recently developed treatment approach, known as the "Unified Protocol for Transdiagnostic Treatment of Emotional Disorders".

The Unified Protocol is a therapy based on cognitive behavioural principles, with the addition of newer techniques such as mindfulness and emotion focused strategies. It is designed for the treatment of all anxiety disorders and depression, and is particularly useful when an individual experiences more than one disorder. Initial research using this approach has been promising, with trials demonstrating positive treatment effects for patients. There are also other advantages to the use of a transdiagnostic approach to treatment, including ease of dissemination both to patients and in training clinicians.

This transdiagnostic approach to treatment is currently being offered at the Mt Gravatt Campus at Griffith University in Brisbane. Facing the Fear is a nine-session group therapy program designed for the treatment of anxiety disorders in adults. It is open to adults suffering any type of anxiety disorder, including with concurrent depressive symptoms.

Over 100 adults have already participated in the program. Initial results are promising, with positive treatment effects observed over the course of the program. However, the researchers are currently seeking more adults to take part in the program. It is estimated that another 40 adults are required for the trial before final results can be analysed.

To find out more about the Facing the Fear program or participating in the trial, go to www.facingthefear.net or contact project staff at facingthefear@griffith.edu.au. More information regarding the Unified Protocol as treatment approach for anxiety disorders can be obtained at www.unifiedprotocol.com ha

'_MG_879[illegible]' by Sprout Creative. Image sourced from Flickr (CC BY 2.0: https://flic.kr/p/aEasmB).

LUIS SALVADOR-CARULLA
Mental Health Policy Unit
Brain and Mind Research Institute

The Integrated Atlas of Mental Health

A new visual tool for evidence-informed planning

During the last 30 years, considerable structural changes have been made in the Australian mental health system, including the closure or downsizing of many large psychiatric hospitals and the development of community mental healthcare. However, this journey has not been completed and application of reform has been patchy. For example, the Australian mental health system still has high rates of readmission to acute care,[1] high rates of compulsory community treatment orders,[2] and high rates of seclusion.[3] These features are associated with a system characterised by fragmented, hospital-based, inefficient provision of care. It has been argued that we lack a clear service model, that reform has not been adequately informed by evidence, and that there are marked inequities in the geographical accessibility to care.[4]

In this context, it is crucial to provide policy and service decision-makers with every tool and opportunity to make better, more intelligent choices about future investments in mental healthcare, including which services are needed and where, as well as how they can be most effectively delivered. Integrated Atlases of Mental Health include maps and graphics as a main visual form of presenting the data and are ideal tools to help planners in this process. They allow policy planners and decision-makers to understand the landscape in which they work (including areas of gap or over-supply), make bridges between the different sectors and to better allocate services. This is particularly important as mental health services become more person-centred (placing the person and their needs at the centre of their care) and public investment focuses on care coordination programs such as Partners in Recovery (PIR) or the National Disability Insurance Scheme (NDIS).

The need for a better knowledge of the local area motivated Western Sydney Partners in Recovery to fund the development of the Integrated Mental Health Atlas of Western Sydney, developed by a consortium of experts from the University of Sydney, University of Wollongong, Western Sydney University and the local public agencies in Western Sydney. The Atlas uses a standard classification system, the Description and Evaluation of Services and Directories in Europe for long-term care (DESDE-LTC) model, to map the services.[5] The use of an internationally agreed common language has allowed us to compare the pattern of mental healthcare provided in Western Sydney with regions in Europe and, eventually, with other regions in Australia. These comparisons are not intended to replicate service delivery models implemented elsewhere but to provide relevant contextual information to better understand the local pattern of care delivery.

The Integrated Atlas of Western Sydney indicates that there is a structural problem in the construction of the public mental health system, as basic components of the community care model. If these core components are not available, the system may not show significant improvement regardless of the resources devoted to increase coordination and to the implementation of care programs for specific groups (e.g. suicide prevention in youth and adolescents, perinatal depression, early psychosis, and so on). The critical areas to be developed for system improvement which have been identified by the Atlas are:

- alternatives to hospitalisation including residential facilities in the community (e.g. crisis housing) as well as high-intensity acute day care (e.g. Day Hospitals).
- health-related non-acute day care centres staffed with highly skilled mental health professionals that can focus on recovery oriented rehabilitation. These centres promote social inclusion by providing the opportunity to socialise, while also offering training in skills related to the development of strategies both to manage their condition (e.g. stress management) and day to day activities of living.
- scope and amount of specific services related to employment for people with a lived experience of mental ill-health. Other alternatives, such as 'social firms' or 'social enterprises', should also be implemented.
- improve the information on public and community housing for those experiencing mental health problems to allow better planning.

These core components should be combined with a change in the culture of care at local level. This change should include a move from a reactive to a proactive system, with an increase of the overall robustness of the system which implies the provision of long-term funding mainly for the NGO sector, which could stabilise operations and allow for long-term planning. It should also incorporate systems thinking into policy and planning to encourage the development of an integrated mental health model of care.

The Integrated Atlas of Mental Health in Western Sydney fills an information gap in the current analysis of mental healthcare in Australia. The National Review of Mental

'Macro crayons' by Chris Dlugosz. Image sourced from Flickr (CC BY 2.0: https://flic.kr/p/6jeSc1).

Health Programmes and Services called for "comprehensive mapping of mental health services, programmes and supports available in regional, rural and remote areas through Commonwealth, state and territory and local governments, private and not-for-profit sectors."[6] It recommended: 1) *to develop more community-based psychosocial, primary and community mental health services, as alternatives to acute hospital care;* and 2) *to boost the role and capacity of NGOs and other service providers to provide more comprehensive, integrated and higher-level mental health services.*

The atlases of mental healthcare may harness local evidence to change the mental health system, for the benefit of all of our fellow community members experiencing mental ill-health. ha

For more information on the Integrated Atlas of Mental Health Care in Western Sydney, go to: http://www.wentwest.com.au/component/k2/item/473-mental-health-atlas-of-western-sydney

References

1. Zhang, J.Y.; Harvey, C. and Andrew C. (2011). Factors associated with length of stay and the risk of readmission in an acute psychiatric inpatient facility: a retrospective study. *Australian & New Zealand Journal of Psychiatry* 45(7): 578-85.
2. Light, E.; Kerridge,I.; Ryan, C. and Robertson, M. (2012). Community treatment orders in Australia: rates and patterns of use. *Australasian Psychiatry* 20(6): 478-82.
3. Australian Institute of Health and Welfare (2014). *Mental health services—in brief 2013*. Canberra: AIHW, 2014.
4. Mendoza, J. et al (2013). Obsessive Hope Disorder: Reflections on 30 years of mental health reform in Australia and visions for the future. Caloundra, QLD: ConNectica.
5. Salvador-Carulla, L. et al (2013). Evaluation of an integrated system for classification, assessment and comparison of services for long-term care in Europe: the eDESDE-LTC study. *BMC Health Services Research* 13(218): http://www.biomedcentral.com/1472-6963/13/218
6. National Mental Health Commission (2014). *Report of the National Review of Mental Health Programmes and Services.* Canberra: Australian Government.

'Soaring thoughts' by Elade Manu. Image sourced from Flickr (CC BY 2.0: https://flic.kr/p/d1v7C3).

A recent tweet by @UberFacts suggested that condom vending machines could be found in nearly 96% of high schools in France. This statistic from the French Ministry of National Education is the result of a 2006 government directive, which urged schools to install the condom vending machines. Some regions in the United States have similarly recommended ease of availability of condoms in schools from as early as 1992, however the awareness and implementation of such policies were not widespread.

More recently, protesters at St Peter's Square in Rome showed public support for the one high school (Keplero High School) that had installed a condom machine for student use. The installation had drawn the ire of the Vatican, as well as of the pharmacy collective, with claims that the school's availability of condoms was like "giving sugar to a diabetic". The emotive difficulty in this situation is in the coupling of two benign entities: a sheath of latex that is evidenced as the best method — when used correctly — of prevention of pregnancy and sexually transmitted infections (STIs); and young people, aged 11-19.

On the other side of the world in Gippsland — a giant of the Victorian countryside encompassing 41,000 square kilometres of land and a fast-growing population, currently at around 270,000 residents — the Gippsland Sexual and Reproductive Health (GSRH) Strategy Reference Group has recently sought to map condom availability. This has been done in conjunction with Department of Health funding for four condom vending machines (CVMs) for a public place, and one CVM for a sporting facility, (five in total) in each Local Government Area. Funding included the initial year of restocking and maintenance and was established in response to high rates of STIs and adolescent pregnancy in Gippsland, and also based on the success of a similar CVM project carried out in north-eastern Victoria.[1]

Of particular interest to *headspace* — a youth mental health early intervention service — is the notion that private access of condoms via CVMs represents a boon for young people, who value the anonymity that the CVM offers. In the process of mapping, larger towns were found to have good condom availability in supermarkets, chemists and public areas. Often, however, the cost of condoms was high and out-of-hours availability limited. In the smaller towns, convenient access was often non-existent or not youth-friendly.

While the Gippsland condom availability program is a seemingly simple one, the practical application of sexuality in a public health setting is not without difficulties. If making condoms available to young people equips them with the means to participate in sexual interaction, does this then mean that sexual activity has been condoned, even encouraged? Responses from local government representatives have not, in

Condoms: they're not on

Rebecca Vandyk from *headspace* Gippsland and **Selena Gilham** from Gippsland Women's Health discuss the need for greater access to condoms for young people in rural and regional areas

most cases, been enthusiastic. But given a voice, young people have plenty to say on the matter. A recent large survey of the sexual health needs of regional and rural young people by Women's Health Goulburn North East resulted in a clear message: they need easy and private access to contraception and sexual health advice, and more of it.

Another message was not so clear: young people want freedom from their community's and health professional's negative attitudes regarding their sexual involvement. The role of *headspace* in this instance is to talk more with young people about how they feel about the availability of both condoms and sexual health advice, and if they feel able to discuss their understanding of themselves as sexual beings, especially in the contexts of the relationships they seek and participate in. A 2007 study carried out during a radio talk-back show, found that of the 212 callers aged 15-24 years, only 30% of their questions regarding sexuality and sexual health were about the "standard discourse" of sexual reproductive health; that is, questions regarding STIs, contraception, and pregnancy.[2] Instead, they wanted to know about normalcy and they wanted to be reassured; because all kinds of new questions come up when sexual interaction is begun. And in a lot of cases, the questions referred to the relationship they were in *at the time*. Hence the sexual interaction is in the context of the romantic relationship. The difficulties faced are less to do with biological function and more to do with human interaction.

The need for sexual education that includes more than just anatomy, disease and pregnancy prevention has being echoed by young people during recent discussions. Following ethics approval by the West Gippsland Healthcare Group's Human Research Ethics Committee, recorded individual interviews will be carried out by *headspace* as part of a qualitative research project seeking the opinions of young people on such matters. So far, some young people have suggested that providing easy access to condoms *may* be seen as "encouraging" sexual interaction, but most agree that they are needed regardless — and in as many places as possible. Preliminary data analysis also suggests that young people's sex education during their school years tends to be rather more miss than hit, and that their sexual health fact-finding is mostly done via Google. Hopefully, the collated views of young people, combined with the promotional work of the GSRH Strategy Reference Group, will place sexual health squarely on the agendas of at least some of the local government councils in Gippsland. ha

References:

1. Tomnay, J. & Hatch, B. (2013). Council-supported condom vending machines: are they acceptable to rural communities?, *Sexual Health Journal* 10(5): 465-466.

2. Kang, M. & Quine, S. (2007). Young people's concerns about sex: unsolicited questions to a teenage radio talkback programme over three years, *Sex Education* 7(4): 407-420.

Millennial medicos and the #FOMO phenomenon

Greg Mundy, CEO of Rural Health Workforce Australia, discusses the advantages of rural medicine for our next-generation doctors

Two Millennial Medicos. Image courtesy of Tony Wells, Rural Health Workforce Australia.

Fear of missing out, or FOMO, is one of the great undercurrents tugging at the feet of Millennials these days. The term crops up regularly as a hashtag in the social media stream, where opportunities lost or gained are variously mourned or celebrated by that well-connected generation of people born between 1980 and 2000. The need to constantly check in on mobile devices is one of the symptoms of this "condition".

It appears that FOMO is also a key driver of medical students and junior doctors as they strive to get an edge over their peers in a highly competitive career environment.

These "Millennial Medicos" are competing with twice as many of their peers as a decade ago for hospital placements, preferred rotations and specialist training places.

For some, going rural is deemed a bit of a backward step in this career race. The FOMO perception at play here is that by going rural you may miss out on more prestigious city placements, with better facilities and exposure to the latest technology.

Yet students who think in this way may actually be missing out on more compelling advantages of rural training, as well as opportunities to be greater than average.

Recently, Rural Health Workforce Australia commissioned the University of Queensland to do some research on this subject. The study was based on in-depth interviews with 41 junior doctors and 25 medical students from Adelaide, Brisbane and Melbourne.

If that sample is anything to go by, the Millennial Medicos are looking for quality training experiences that will develop their skills and boost their professional prospects.

The research showed they prize:

- working in smaller teams, with more attention from supervisors;
- more responsibility, with opportunities for hands-on learning;
- broader scope of practice; and
- greater continuity of care.

These are the very benefits offered in rural medicine. As one student told us recently: "Rural placements are NOT career limiting. They are an opportunity to excel in practical and theoretical components of clinical medicine, make connections, smash your exams and advance your future career."

When asked what else contributed to successful rural placements, the Medico Millennials wanted strong professional and social support. Not surprisingly, good internet access was deemed very important to stay in touch with friends as well as for study, research and remote clinical support. A preference for flexibility in relation to part-time training was also expressed by some of the junior doctors we spoke with.

We decided to explore a little further and asked 1,000 university health students about their attitudes towards clinical placements. These students belong to Rural Health Clubs, which we help support through the National Rural Health Students' Network. This broadened the sample by giving us a good mix of medical, nursing and allied health students. They reiterated the benefits of rural training described above. In fact, the number one answer across medicine, nursing and allied health students to the question of what factors they considered important when deciding to undertake a clinical placement was "opportunities for hands-on learning". Financial costs associated with placements, such as accommodation, were important for nursing and allied health students who clearly need more assistance in this area.

For some, going rural is deemed a bit of a backward step... Yet students who think in this way may actually be missing out on more compelling advantages of rural training, as well as opportunities to be greater than average.

So what does all this mean for rural and remote health?

Our investigations have uncovered some key characteristics about the new Millennial generation of health professionals. They:

- are tech savvy (therefore rural infrastructure and technology is critical);
- value life balance (therefore old-school rostering needs to be more flexible);
- thrive on social connection (therefore team-based care fits into their world construct);
- question the status quo (therefore are likely to adapt more readily to new workforce models); and
- are competitive and are prepared to shop around (therefore the rural health sector needs to "sell" itself more effectively).

These characteristics mean that the future workforce will be different to the past, as will future health service models and the workers they need.

Meanwhile, Australia continues to invest heavily in health care undergraduate and vocational training in the hope of developing a home-grown rural health workforce. Matching culture to that workforce is going to be critical as these Millennial Medicos, nurses and allied health workers explore the various roads to rural.

The greatest FOMO is felt in Australian rural communities who will miss out if policymakers and health services fail to connect with the up-and-coming generation of health professionals. ha

Growing your own

Diana Carli-Seebohm of the Health Network Northern Territory on how to successfully cultivate your local health workforce

Medical Student Melanie Kahl returns to her own high school in Katherine in 2015 to connect, engage and inspire young Territorians to pursue a career in health. Image courtesy of Health Network Northern Territory.

The Northern Territory (NT) is a unique place with beautiful landscapes, towns and people. It's a place of diversity; overcoming shortages in the rural and remote health workforce requires diverse strategies.

The Health Network Northern Territory operates a Rural Workforce Agency function that focuses heavily on cultivating a local health workforce through the Future Workforce Initiatives program. The program's ultimate goal: a workforce born from the NT that understands the need to cater for diversity, can demonstrate creative problem solving, can be an advocate for rural and remote health, and can work intra-professionally.

Encouraging high school students to consider pursuing a health discipline at a tertiary level is one of the strategies employed by the Rural High School Visits (RHSV) program. Research has shown that once they finish their studies, rural students are more likely to return to rural communities to live and work. The RHSV program aims to help NT high school students to identify pathways to a fulfilling career in health.

Through the NT RHSV program, 12 undergraduate or postgraduate medical, nursing and allied health students from across Australia are selected to visit high schools across the NT to promote further education and health career opportunities. Through a series of workshops, the university students are able to demonstrate the challenges and rewards of pursuing a career in healthcare, drawing on their own experiences. Workshops include hands-on activities such as plastering, oral hygiene and basic life-saving; these can vary depending on the health disciplines represented by the cohort of university students. The strength of this program is that rural students are provided with an insight into the transition from high school to university study, as well as a supportive environment to ask questions about academic life while living away from home.

Emerging from the program are young Territorians who are keen to take up careers as health professionals and potentially delivering health services in rural and remote locations.

The NT RHSV program is closely aligned with the National Rural Health Student Network (NRHSN), a body that facilitates similar events. In 2014, through the NRHSN, 300 rural health club members visited 117 rural high schools and presented to more than 5,000 country students across Australia on health careers and healthy living.

One of the markers of success of the NT RHSV program is seen through students who have grown up in the NT return to participate in the program and inspire their younger peers. This year's program saw medical students Natalie Kew, originally from Darwin, and Melanie Kahl, from Katherine, along with nursing student Jorja Hutton, from Alice Springs, return to the NT to help influence and mentor the next cohort of high school students to become health professionals.

Emerging from the program are young Territorians keen to take up careers as health professionals and potentially delivering health services in rural and remote locations.

Another positive outcome of the RHSV program is that, through their visit to the NT, the interest of participating university students is piqued by the experiences and opportunities offered by the program. Hospital visits, clinic tours and one-on-one clinical "speed dates" provide these university students with the chance to see, first-hand, the types of medical and clinical experience gained through working in the NT.

Sometimes, it's enough to entice them to return to the NT to pursue their careers in health.

Dr Sam Goodwin was one such participant. In 2006, he came to the NT as a medical student to take part in the NT RHSV program. Dr Goodwin's NT journey didn't stop there: he then undertook registrar training across rural and remote parts of the NT. Since fellowship, Dr Goodwin has become the Director of Medical Services of Alice Springs and Tennant Creek Hospitals. Dr Goodwin continues his involvement in the NT RHSV program through providing opportunities for medical students to meet with him and discuss the career opportunities that may be available to them should they return.

Sarah Falconbridge is a qualified occupational therapist currently working as a specialist mental health worker at the Top End Mental Health Service in Darwin. Sarah trained as an occupational therapist with the University of Western Sydney and was introduced to the NT through the RHSV program in 2011 and 2012.

The RHSV program took Sarah to health services across the NT, where she met passionate practitioners and people in communities that cared about the work they did. She was on a placement in Darwin during her last semester in 2014 and, following this, was successful in securing employment with Top End Mental Health Service.

Sarah understands the rewarding nature of the RHSV program and she is committed to helping provide similar experiences to others, sharing her rural and remote clinical experiences with other young health professionals who may be considering health careers in rural and remote Australia.

The challenges remain great but the rewards reaped by the Future Workforce Initiatives program are high as the Health Network Northern Territory continues to "grow its own". ha

Using music and play to help diversify child health services

Insight from **Merri Community Health Services'** Northern Outreach Project

Merri Community Health Services (MCHS) is a large multidisciplinary community health organisation operating across the northern metropolitan area of Melbourne. Providing an extensive range of primary healthcare services across 10 sites, MCHS aspires to make a positive difference in people's lives as an innovative and integrated health, community and advocacy service provider.

In January 2015, MCHS set out to better streamline their Child Health Team service delivery practices in an effort to reduce wait times for child speech pathology and enhance multidisciplinary service options. The Team established the Northern Outreach Project (NOP), a six-month project introducing innovative practices, with funding from the Victorian Government Department of Health and Human Services (DHHS).

Seeking to diversify child health services through additional speech pathology and audiology hours and the introduction of social work and music therapy services, NOP would build partnerships between MCHS staff, families and childcare centres to facilitate a collaborative process in addressing children's complex needs.

Providing a comprehensive and localised model of care, NOP set out to achieve:

1. A reduction in wait times to their Child Health Team speech pathology therapy services by four months.
2. A multidisciplinary service option for complex and vulnerable families.
3. The development and execution of a pilot music and play program, Merri Music, for educators and parents at Belle Vue Kindergarten, Glenroy and Joybelle Childcare Centre, Fawkner.

Objectives 1 and 2 sought to deliver a holistic service within a multidisciplinary model of care through the provision of:

- locally-based multidisciplinary assessments and timely referral onto other appropriate support services;
- Streamlined screening and therapy processes;
- outreach-based therapeutic services (home and community settings);
- short-term play based therapy groups jointly facilitated by a social worker and speech pathologist in the two childcare settings; and
- prioritisation of audiology consultations and screenings for those children in the target areas.

Objective 3 focused on facilitating four music and play groups at each centre with a professional development session with

Merri Music in action. Image courtesy of MCHS.

educators. The place-based music and play program would provide educators with the resources to support enriched learning environments for children with developmental concerns. By designing a "train the trainer" pedagogy, *Merri Music* worked with educators from both childcare centres to increase their understanding of the elements of music and play and how these can be used to enhance the participation of children at their centres.

Educators and children were key in the development of the resource, providing feedback such as song and lyric suggestions, potential changes and how the resource may be relevant in different situations. Upon finalisation, the CD was distributed to participating educators and parents at both centres.

Merri Music is unique in that the CD teaches modelling of behaviour through music therapy. Musical lyrics are especially useful for children with early developmental concerns and those with English as a second language, as music creates rhythm and melody for a child to follow (see raisingchildren.net.au). Promoting children's social and communication skills, singing, playing instruments, improvising, song writing and listening to music help children and educators communicate with one another. It provides a tool for educators to utilise musical cues to teach children new skills by pairing a music cue with a new skill or specific behaviour.

A significant decline in speech pathology therapy waiting times by five and a half months has been achieved since the commencement of this project.

MCHS staff reported that the outreach and multidisciplinary model of this project provided holistic and easy access for parents and families, particularly physical access. It was easy for staff to streamline referrals and for the social worker to be present when setting a child's weekly goals, which resulted in productive parallel assessments. Parents also provided positive feedback regarding service access and the enhanced multi-disciplinary approach.

Merri Music has great potential to address complex family needs by building the capacity of educators in childcare settings through a "train the trainer" framework, providing enriched mainstream learning environments for children. "We were surprised by the children's capacity to change over a short period of time," reflected one educator.

NOP has received further funding from DHHS to continue to strengthen the outcomes of the pilot project in 2015 and 2016. ha



LEI GROUP AUSTRALIA

BE PART OF THE LEAN REVOLUTION

LEAN TRAINING

INTERNATIONALLY CERTIFIED ONLINE COURSES IN LEAN HEALTHCARE

FAST TRACK YOUR CAREER with a Lean Healthcare qualification that is recognised across Australia, Europe and North America from LEI Group Australia, a foremost global provider of Lean training, education and consultation since 1995.

Sign up today for **LEAN ON-LINE COURSES** on our world-class **MOODLE LEARNING MANAGEMENT SYSTEM**

JOIN the on-line Lean student forum and benefit from our mentoring team of highly experienced Lean experts.

LEAN HEALTHCARE YELLOW BELT

An overview of the basic principles of Lean thinking outlining the essential Lean tools and practices that can be applied within a healthcare organisation.

LEAN HEALTHCARE GREEN BELT

A detailed understanding of the theory and effective application of Lean Healthcare concepts, tools and practices, This involves the implementation of a work-place project to develop quantitative improvements.

LEAN HEALTHCARE BLACK BELT

A practical application of advanced Lean Healthcare tools and techniques, appropriate process improvement, leadership and programme management skills to drive and sustain changes necessary for successful Lean transformation.

CERTIFICATION BODY

ahha
australian healthcare & hospitals association

The Australian Healthcare and Hospitals Association (AHHA), is the independent membership body and advocate for the Australian healthcare system and a national voice for high quality healthcare in Australia.

LEI Group Australia is proud to partner with the Australian Healthcare and Hospitals Association to prepare healthcare professionals and organizations to increase efficiencies and improve organisational performance through the delivery of a series of Lean Healthcare educational programmess at Yellow, Green and Black Belt levels.

For more information on pricing and registration please contact: 02 6162 0780
email: admin@ahha.asn.au

HTTP://AHHA.ASN.AU/LEAN-TRAINING

Who's moving

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

Nadia Rosenthal, Director of the Australian Regenerative Medicine Institute at Monash University, is moving to Maine in the United States to take up the role of Scientific Director of The Jackson Laboratory.

Shane Kelly, who is currently the Chief Executive Officer for North Metropolitan Area Health Service in Western Australia, has recently been appointed as the new Chief Executive Officer for Mater Health Services in Brisbane.

Lindsay Gillan, previously the General Manager Operations at Genea, is now the Chief Executive Officer at Westmead IVF.

Ken Whelan, the former Deputy Secretary Systems Purchasing and Performance for the New South Wales Ministry of Health, has moved back to Queensland to take up position of Chief Executive Officer Metro North Hospital and Health Service.

Christopher Snowden will be leaving the University of Surrey, where he is the President and Vice Chancellor, to go to the University of Southampton as Vice Chancellor.

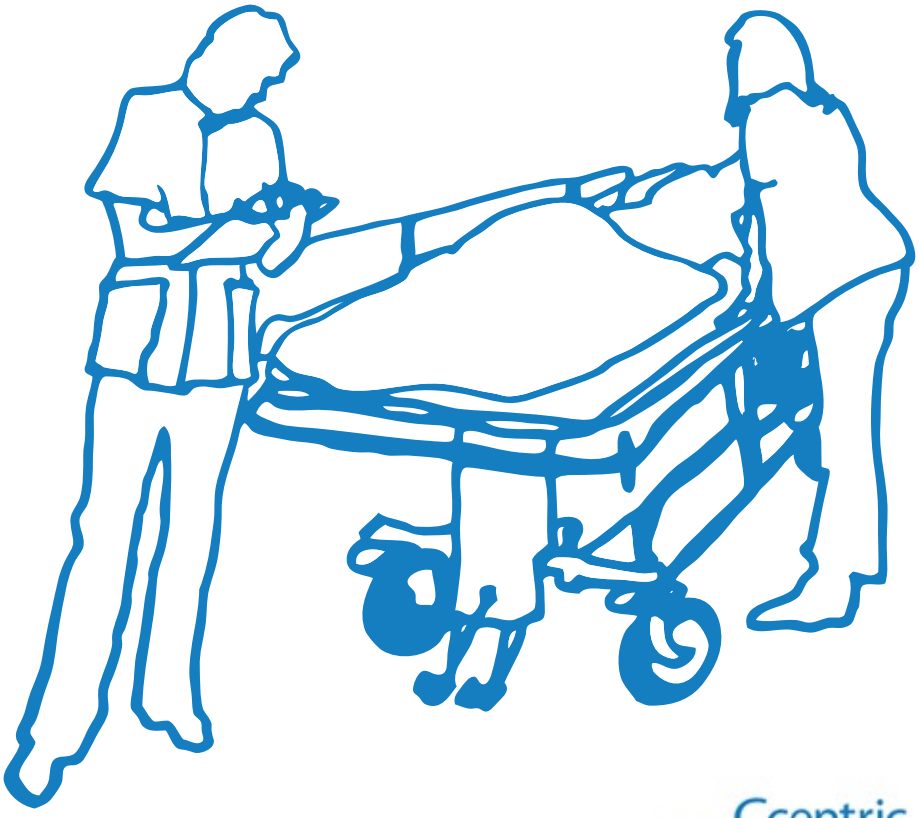
Jason Thomas has been appointed as the new Director of Nursing at the Metropolitan Rehabilitation Private Hospital. He was previously Deputy Director of Nursing at Hunter Valley Private Hospital.

John Cordery is moving over to Curtin University as Provost and Senior Deputy Vice Chancellor, leaving the University of Western Australia where he has been Chair of the university's Academic Board and Head of Management and Operations in the university's Business School.

Julie Lahey, the Nursing Director of Redcliffe Hospital, is moving to work at the Caboolture Hospital as the new Director of Nursing.

Tobi Wilson is relocating to Adelaide to take up the role of Chief Operating Officer at the Southern Adelaide Local Health Network, leaving his role as Chief Operating Officer of Royal Melbourne Hospital.

Luke Tanks, previously the Manager of Anglicare Southern Queensland, has moved to Darling Downs Hospital and Health Service as the new Director of Aged Care. ha



Ccentric Executive Search

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

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

By becoming a member of the AHHA, you will gain access to AHHA's knowledge and expertise through a range of research and business services.

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

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

In partnership with the LEI Group, the AHHA also provides training in "Lean" healthcare which delivers direct savings to the service provider and better outcomes for customers and patients.

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

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

AHHA Council and supporters

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 2014-2015 Board is:

Dr Paul Dugdale
Chair
Ms Elizabeth Koff
Deputy Chair
Dr Deborah Cole
Treasurer
Dr Paul Scown
Immediate Past Chair
Prof Kathy Eagar
Academic Member
Prof Gary Day
Member
Mr Philip Davies
Member
Mr Walter Kmet
Member

AHHA National Council

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

Dr Michael Brydon
Dr Deborah Cole
Ms Gaylene Coulton
Ms Jill Davidson
Mr Philip Davies
Prof Gary Day
Dr Martin Dooland AM
Dr Paul Dugdale
Ms Learne Durrington
Prof Kathy Eagar
Mr Nigel Fidgeon
Mr Andrew Harvey
Ms Siobhan Harpur
A/Prof Noel Hayman
Mr Matt Jones
Mr Lewis Kaplan
Mr Walter Kmet
Ms Elizabeth Koff
Mr Ben Leigh
Mr Robert Mackway-Jones
Ms Sue McKee
Ms Jean McRuvie
Mr Ross O'Donoghue
Mr Michael Pervan
Ms Prue Power AM
Ms Lizz Reay
Ms Barbara Reid
Mr Anthony Schembri
Dr Paul Scown
Ms Annette Schmiede
Mr Lyndon Seys
Mr John Smith
Mr Tom Symondson
Ms Sandy Thomson

Secretariat

Ms Alison Verhoeven
Chief Executive
Mr Murray Mansell
Business & Finance Director
Dr Linc Thurecht
Director, Research Director
Mr Krister Partel
Advocacy Director
Ms Susan Killion
Deeble Institute Director
Ms Yasmin Birchall
JustHealth Project Manager
Ms Lisa Robey
Marketing & Engagement Manager
Ms Kylie Woolcock
Policy Manager
Ms Emily Longstaff
Editor, *The Health Advocate*
Ms Sue Wright
Office Manager
Mr Daniel Holloway
Web/Project Officer
Mr Matthew Tabur
Administration Officer, Deeble Institute
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
Dr Linc Thurecht
Associate Editor, Financing and Utilisation
Dr Lucio Naccarella
Associate Editor, Workforce
Ms Danielle Zigomanis
Production Editor (CSIRO Publishing)

AHHA Sponsors

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

- HESTA Super Fund
- Good Health Care

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

Contact details

AHHA Office
Unit 8, 2 Phipps Close
Deakin ACT 2600

Postal address
PO Box 78
Deakin West ACT 2600

Membership enquiries
T: 02 6162 0780
F: 02 6162 0779
E: admin@ahha.asn.au
W: www.ahha.asn.au

Editorial enquiries
Emily Longstaff
T: 02 6180 2808
E: elongstaff@ahha.asn.au

Advertising enquiries
Lisa Robey
T: 02 6180 2808
E: lrobey@ahha.asn.au

General media enquiries
E: communications@ahha.asn.au

The Health Advocate

ISSN 2200-8632

FREE

Palliative Care online training

www.palliativecareonline.com.au

Do you want to make a real difference in end-of-life care?

Wherever you are located, you can do our free online palliative training course and develop the skills and confidence to care for someone with a life-limiting illness.

Whether you work in aged care, acute or primary care, or the community sector, the training will help you to better support people approaching the end of their life.

The training can be completed at a time and place that suits you, and will help ensure that the next person you care for at the end of their life will benefit from your experience.

New portal, new modules

Launching in July 2015, the new online portal builds on the success of the original award-winning online training modules based on the COMPAC Guidelines for community based palliative aged care, which have already been used by over 20,000 people across Australia and internationally. In response to stakeholder feedback, two new training modules on pain management and recognising deteriorating clients have been developed for the portal.

Continuing professional development

All of the modules are accredited and will enable participants to accrue Continuing Professional Development (CPD) points. Recognition of Prior Learning (RPL) from relevant accredited training organisations is also available.

What does the training cover?

The six online modules have been developed in accordance with best-practice guidelines to help participants:

- Reflect on the needs of people and their families as they approach the end of life
- Build screening and assessment skills
- Develop confidence in having end-of-life conversations, especially around advance care planning
- Invest in self-care and build resilience
- Connect to a wider network of experts who can support and assist you
- Extend knowledge of assessing, treating and managing pain
- Develop skills in recognising and managing the deteriorating client.

The palliative care online training portal has been developed by the AHHA's business arm, JustHealth Consultants, in partnership with Silver Chain Training. The project is funded by the Department of Health.

ahha australian healthcare & hospitals association

justhealth consultants

Training Silver Chain