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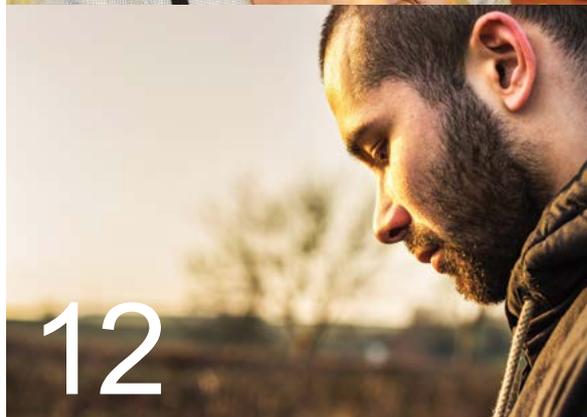
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**PAUL DUGDALE**  
Chair of the Australian Healthcare  
and Hospitals Association (AHHA)

# Innovation, integration, affordability

## Health reform to tackle chronic conditions

**H**ow Australia responds to the growing burden of chronic multimorbidities is a major challenge for our health system. Promisingly, there does seem to be a clear consensus that things need to change. For all its strengths, nobody is arguing that our current setup has optimised chronic care. We cannot think of our health system as part of a watchmaker state, where the mechanisms have been set in place and will tick along without significant adjustment.

Right from the mid-1980s when the main parts of our Medicare system had been established, successive governments have recognised the need for coherent, system-wide plans to deal with specific health problems such as HIV, drug abuse, and the various diseases given national health priority status.

Several of the national health priority strategies - those that shared common risk factors - were wrapped up into the 2005 National Chronic Disease Strategy. This was a useful document, but was never coupled with the funding and structural reforms needed to make a system-wide impact.

In 2010 the Rudd Government proposed bringing together responsibility for primary and community care by transferring publically funded community health programs from the states to the Commonwealth along with clawing back 30% of GST revenue. This somewhat improbable

proposal was dropped in the reform agreement the Gillard Government closed with the states in 2011, which focused on hospital funding and efficiencies.

The Turnbull Government's recent consultations on a Chronic Conditions Framework have raised expectations that reform momentum will build in this area. There is a lot to do. Here are a few priorities from my perspective.

We need to drive innovation in chronic conditions management. New approaches are emerging through the efforts of private health insurers, community health services, and health service researchers. It would be good to see a bit more funding, evaluative rigour, and international collaboration injected into this in order to create and capture the value this innovation can bring.

We need to improve integration between primary, community and tertiary care, between commonwealth and state systems, and between public and private sectors. Thankfully, the health policy debate seems to have moved on from inane discussion on whether the Commonwealth should (or even could) take over all state responsibilities for health, or that health financing is solely (or even largely) a problem for the states. Better integration requires an acknowledgement of the legitimacy of the many stakeholders and parts of the system, and an appetite for the hard and detailed work that needs to be done to enable them to work in harmony for the good of the patient.

We need to reduce the out-of-pocket costs for people with chronic disease. Commonwealth Fund research has highlighted how comparatively high these are in Australia. While they have their place, they need to be carefully structured in order to be useful price signals without impeding access to necessary care or worsening health and financial inequality.

Our health workforce needs to evolve to meet the challenge of multimorbidities. Greater responsibility for our nurses (who are virtually all tertiary educated now), stronger structures to support multidisciplinary teamwork, development of allied health, nursing and physician assistant roles, and a more astute focus on preventive care are all useful workforce reforms to aim for over the coming decade.

Finally, we need to support community development. Professional health services can only be one part of society's response to ageing and multimorbidities. Churches, charities, families, friendship circles and many other parts of our community all must respond to the challenge. Our policy and political leadership has to go wider than merely technical responses, and recognise and support cultural change.

There is much else to do besides the challenges above, and the articles in this edition of *The Health Advocate* show the breadth and depth of the AHHA's interests in this important topic. 

**ALISON VERHOEVEN**Chief Executive  
AHHA

# A chronic burden

## How to tackle the challenge of chronic disease

**C**hronic disease is one of the biggest challenges facing the Australian health sector and this burden is only set to increase in coming years. With the increasing prevalence of chronic health conditions and the associated demand for care being key drivers in the growth of health spending in Australia, a national plan for chronic disease management is urgently required.

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. A more integrated approach towards chronic disease is needed.

Australia's new approach to chronic health conditions must be centred on patients, rather than diseases, to deliver care tailored to those with multimorbidities. It must support regional-specific approaches that are more coordinated and easier for patients to navigate. The health sector needs to address the structural issues around funding models and the delivery of services, implementing arrangements that are patient centred and that support the right care in an appropriate environment. It is also essential to facilitate the sharing and use of data with reports from government-funded projects and research released in a timely manner.

Many of Australia's national chronic disease programs and initiatives have helped

provide direction for improving prevention and care for chronic diseases. However, these programs are disease-specific, meaning the needs of people with multimorbidities are less recognised. Research into care models to respond to these needs is relatively new, and there are comparatively few Australian studies that focus on comorbidity associated with chronic disease. However, what research does exist has indicated that communication among a patient's healthcare providers is vital.

Co-morbidities may also create barriers to acting on risk factors – for example, arthritis may reduce a patient's ability to exercise – as well as hinder the recognition of early symptoms of deterioration of other conditions, and reduce the patient's capacity to manage their medications. A patient-centred approach would better address these additional challenges.

The AHHA believes it is important to make explicit the problems of multimorbidities. At an individual level, this involves understanding and addressing the difference in treatment priorities between doctors and patients, and how the differing priorities of

multiple specialists or treatment providers are negotiated and coordinated. At a policy level, what is needed is more inter-agency dialogue to highlight research findings and identify policy gaps. More information and research is needed to support health practitioners managing patients with multimorbidities, while patients need to be clearly informed across their care journey.

**The health sector needs to address the structural issues around funding models and the delivery of services, implementing arrangements that are patient centred and that support the right care in an appropriate environment.**

Integration of care in the community is also vital in managing chronic conditions. The care of patients must be a joint effort by all healthcare providers, including hospital-based services, primary health care practitioners, home care teams and hospices. International models have shown patient-centred treatment yields the best results for treatment of chronic

conditions – as well as in other healthcare areas. It is particularly important in the treatment of people with multimorbidities.

There are important gains to be achieved through improving linkages between hospital and referral-based care, and primary and community based care. This will require a shift on both sides from episodic care to coordinated care. The drive toward patient-centred care must be supported by all levels of government. 

# 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](mailto:communications@ahha.asn.au)

### Commonwealth must take long-term view of health funding

In its pre-Budget submission in early February the AHHA called on the Commonwealth Government to take a long term view to health funding and reform and to better target and organise existing health infrastructure.

“The AHHA recognises the Government’s commitment to fiscal repair, but it is important that short-term measures do not have long reaching adverse consequences for the health of Australians,” AHHA Chief Executive Alison Verhoeven said.

“It is vital that health policy not be merely viewed through the prism of budgetary cycles. In the field of healthcare, imprudent savings made in the current budget cycle can manifest in poorer individual health outcomes and an increased burden on the healthcare system in the future.”

The AHHA’s submission recommended a number of key actions, among them that no further cuts to health expenditure should be made until current review processes are completed.

Most of the AHHA’s recommended budget measures and policy directions in its submission do not call for extra funding, but rather more efficient and better targeted use of current funding, along with better organisation of Australia’s existing healthcare system.



### A modernised pathology payment system is needed in a modern healthcare system

AHHA Acting Chief Executive Dr Linc Thurecht said in February the Grattan Institute’s report on the cost of pathology testing highlights the need for the Commonwealth to modernise Australia’s pathology payment system.

The report, *Blood Money: paying for pathology services*, found that the government could save at least \$175 million a year by changing the way it pays for pathology testing and negotiating a fairer share of efficiency savings with industry.

“The current fee-for-service payment system in pathology is outdated and does not take into account industry efficiencies realised through technological, market and regulatory changes,” said Dr Thurecht. “Nor does the current fee-for-service system pass on efficiency savings to health-consumers and taxpayers.”

The report further indicated that market based pricing of pathology services rather than government based pricing could lead to additional savings of up to \$160 million.

“The AHHA would support a pilot being conducted in Victoria to open the provision of pathology services to a competitive tendering process where the government would share some the benefits of improved economies of scale, with Primary Health Networks being closely involved to ensure care coordination at the local level,” said Dr Thurecht.

### Private investment and outcome-focused improvements in public healthcare

The AHHA and its research arm, the Deeble Institute for Health Policy Research, on February 16 brought together a broad cross-section of interests associated with the funding and running of Australia’s public health system to discuss if private investors could drive outcome-focused improvements in public health care through social impact investing.

“Governments in Australia are actively looking at how social impact investing can help them to tackle significant societal challenges, and private investment is currently funding two NSW interventions in social service,” said AHHA Chief Executive Alison Verhoeven. “Health leaders at today’s roundtable unpacked the feasibility of social impact investing to drive outcome-focused improvements in the health sector.”

The attractiveness of social impact investing lies in risk mitigation to governments, cash flow management for government departments and the potential to promote innovation and increase accountability in service delivery through public-private partnerships.

“Using social impact investing to drive positive health outcomes for specific conditions or populations is very much in its infancy in Australia, and more work is needed to determine the applicability of social impact investing to the Australian primary and acute care environment,” said Ms Verhoeven.

## Public hospitals a national asset, require adequate investment

AHHA Chief Executive Alison Verhoeven said the Australian Medical Association's report on public hospitals released on January 28 raised important questions about the sustainability of public hospital funding.

"For the past three years, we've heard two successive health ministers talk about hospital funding growth, despite advice from the states that there will be a significant shortfall, with growth in demand for services outpacing growth in funding," Ms Verhoeven said.

"While governments play with alternative methods of counting dollars in the health budget, we will continue to see longer wait times, higher out of pocket costs, and poorer health outcomes, particularly for those who cannot afford private health insurance and private hospital services."

The federation reform process, and multiple health reviews currently under way, are looking at some options which might result in more effective distribution of health funding, but there is a very real risk of disjointed solutions, driven only by cost-saving goals.

Ms Verhoeven called for more public discussion of some of the options being canvassed by governments.



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## Reaching 2030 targets for Close the Gap must be a national priority

AHHA Chief Executive Alison Verhoeven urged health leaders and organisations around the country to pledge their commitment to work with community leaders to improve Aboriginal and Torres Strait Islander health, at the launch of the first *State of Reconciliation in Australia* report at Parliament House in February.

"Closing the gap needs to remain a national priority as we focus on ending the life expectancy inequity between Aboriginal and Torres Strait Islanders, and non-Indigenous Australians, by 2030," Ms Verhoeven said.

"To close the gap by 2030 is ambitious but it is achievable. With 200,000 people having signed the Close the Gap pledge as of last year, and the backing of Australia's peak Indigenous and non-Indigenous health bodies, NGOs and human rights organisations, it is clearly recognised as a priority for Australians."

There has been particular progress seen in areas such as improving infant mortality and cutting rates of smoking. However, the AHHA has called on governments to work with Aboriginal and Torres Strait Islander peoples and their representatives to build on these achievements as a matter of national urgency.

## Australia must do more for refugee and migrant health

The health sector must reflect on the ways our healthcare system could do more to help migrants and new arrivals, *Australian Health Review* (AHR) Editor-in-Chief Professor Gary Day said earlier this year.

"There has been much media attention and social commentary of late regarding refugees, asylum seekers, Australia's overall population 'cap', children in detention and migrant health," Professor Day said.

"This ongoing commentary often leads to vigorous and polarised debate about Australia's commitment to migrants and refugees, and raises the question of whether Australia is particularly welcoming to refugees and migrants when it comes to health service provision."

One area in need of critical attention is access barriers to appropriate maternity and paediatric services experienced by some migrants. Language barriers and social isolation can lead to migrants suffering a lack of support during pregnancy and post-natally, with similar barriers to access for child health service provision. ha



# The growing burden of chronic disease

The opportunities for reform from one of our biggest challenges  
**Federal Minister for Health Sussan Ley**

**C**hronic disease is one of the escalating pressures on our health system, however it equally presents one of the greatest opportunities for reform.

Along with our ageing population, rising consumer demands and the cost of highly-targeted new pharmaceuticals, an increasing rate of chronic disease is putting unprecedented strain on the nation's health budget.

While we generally can look forward to living longer, chronic diseases are occurring at an earlier age, affecting quality of life, productivity and health care costs – costs which are often borne by those who are suffering, as well as the taxpayer. The statistics are compelling. Medicare is now being billed more than one million times a day.

**“More than a third of all Australians now have a chronic condition, including issues such as asthma, heart disease, diabetes, respiratory or mental illness.”**

More than a third of all Australians now have a chronic condition, including issues such as asthma, heart disease, diabetes, respiratory or mental illness. Around 20% of us – one in five – have at least two chronic conditions. Currently, medical spending per person trebles between the ages of 50 and 80.

With the number of Australians aged 65 and over expecting to double in 40 years, you don't need to imagine the building pressure this will have on health costs. To this end, the Australian Government has a large programme of work under way – separate initiatives under expert groups but each closely connected – which will provide an effective and much-needed response to the escalating burden of chronic disease in this country.

Key to this is a National Strategic Framework for Chronic Conditions, being developed in partnership with the States and Territories. This Framework is looking at how we can prevent chronic conditions and how we can best provide coordinated, integrated and multidisciplinary care. The Framework will drive a stronger, more collaborative approach across local, state and federal levels, and be an important mechanism to more effectively prevent and manage chronic conditions.

This must – and will – include priority populations, such as Aboriginal and Torres Strait Islander communities, and critical life stages such as our ageing population.

One key area, often overlooked in a patient-centred health system, is that many chronic conditions are preventable, with effective disease management offering some impact in reducing the cost. Prevention initiatives can also significantly

reduce the volume and severity of these conditions, provide long term savings and optimise the quality of people's lives.

The Framework is being informed by our other expert groups running in tandem – the Primary Health Care Advisory Group and the Medicare Benefits Schedule Review Taskforce. The Primary Health Care Advisory Group headed by Dr Steve Hambleton has now presented its report to me, with a focus on new funding models for patients with chronic conditions, including mental health issues.

It has looked at the need to find alternative care and funding models for patients who need attention frequently, and from a range of health professionals.

It is also important that people with chronic and complex conditions should have ready access to health services, especially services which are affordable or at low cost.

They should be able to receive coordinated and multidisciplinary team care where different services and providers are all talking with each other, working on behalf of the patient.

It is here our new Primary Health Networks will play a central role for the integration of such care and improving access to the services that our communities demand.

The initiatives I have outlined will provide a better way for Australia to support its growing population to live healthier lives, as well as effectively delivering and funding care to those with chronic conditions, leaving lasting benefits for patients, health professionals, taxpayers and the health system itself. 



**WALTER KMET**  
WentWest CEO

# Integrating pharmacists into primary care teams

## WentWest CEO Walter Kmet on Western Sydney PHN's innovative pilot program

**W**ith over 26,000 pharmacists in Australia, well ahead of the next allied health professional category, it is hard to imagine an effective health system without a strong and capable pharmacy sector.

This is although the operational silos that exist in our health care system are also apparent for pharmacists. For community pharmacists, which is where most pharmacy professionals reside, the relationship to general practice is often reduced to an indirect retail transaction and interaction with the acute sector is rare. Where services and advice is provided at the community pharmacy level it is often in isolation, with the potential for duplication, confusion, and increased risk of adverse outcomes.

Models of high performing primary care based on medical home principles emphasise that primary care clinicians and other team members need a broad understanding of each patient's

health care needs to assist in coordinating all care, help the patient navigate the system, and ensure that the treatment plans and prescription medications of different specialists work together.

Pharmacists are ideally placed to support continuity of general practice based primary care for patients. Their contribution to improving health outcomes will only occur when they become well connected and integrated into high functioning primary care teams.

Separate surveys by the Australian Medical Association (AMA) and Pharmaceutical Society of Australia (PSA) identified the same major opportunities for integration of pharmacists in GP-led primary care teams:

1. Medication management reviews
2. Advising patients on medication
3. Patient education sessions

Functions such as these are consistently identified as improving the capability of general practice teams which is central to improving outcomes and reducing costs

at the hospital level and for medications. As a recent article in *Australian Family Physician* argued, to add value, pharmaceutical input needs to occur in the context of multidisciplinary teams, structured care, technology use and health systems redesign. I would add that these roles need to be "comprehensive", a term explored in depth by the Patient-Centered Primary Care Collaborative.

Progressing such initiatives has been difficult. The current fee-for-product pharmacy model is narrow, we generally lack the incentives to fund new models of care, and there is insufficient support for investment in primary care teams. However during 2015 a number of organisations, including the PSA, AMA and Pharmacy Guild, renewed calls for action.

Some Primary Health Networks (PHN) have engaged in this area with their primary care teams and have begun pilot projects as a prelude to more fully implementing integrated roles for pharmacist with general practice. They could be useful and practical steps in the right direction. Both Western Sydney PHN and ACT PHN have currently funded projects which seek to leverage off existing general practice capability and capability building, integrated care projects and their role in commissioning services to meet regional needs.

In Western Sydney the PHN has

**“Pharmacists are ideally placed to support continuity of general practice based primary care for patients. Their contribution to improving health outcomes will only occur when they become well connected and integrated into high functioning primary care teams.”**



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commissioned two local GP associations to engage clinical pharmacists amongst an initial group of general practices in Mt Druitt and Blacktown. A model for team-based care based on a pilot undertaken by a practice in Mt Druitt is ready to be implemented.

The pharmacists involved will be integrated into general practice teams to improve the use of medicine, reduce adverse drug events and support better coordination of patient care. This will be particularly relevant to the patients transferring from hospital episodes and those with multiple chronic diseases. Another important element will be to improve patient education and monitoring of medication adherence through both telephone and face to face interactions.

Key indicators will be tracked in the project using the PEN Clinical Audit Tool and with support from University of Technology Sydney. Results are expected to be released later in the year and hopefully support further investment in such projects across Western Sydney and beyond.

Clearly PHN flexible funding is not sufficient to make a comprehensive impact on this area but a PHN role is sensible for the ability to align with other PHN regional system building activities noted above, and also for the following reasons:

1. Applying a commissioning-based approach to the use of flexible funding and supporting sharing of resources across individual general practice (network)
  2. Using current data collection and quality improvement activities to demonstrate improvement outcomes
  3. Networking clinical pharmacy resources and ensuring these are provided in a consistent way
  4. Linking pharmacists into eHealth-enabled shared care planning approaches
- Areas of funding that could sustain a comprehensive approach are:

1. More efficiently and appropriately utilising NPS funding through PHNs rather than in isolation to them
2. Looking at shared savings models for

general practice, where quality of medication use is rewarded and reinvested in general practice

3. Funding clinical pharmacy as a core component of primary care teams as the system moves away from largely fee for service payments with its inherent limitations

Training is a critical enabler for better system outcomes in the future. Training needs to emphasise not only clinical and technical aspects of roles but also the skills to operate effectively in multidisciplinary teams. Colleges, training providers, PHNs, Local Health Districts (LHDs), and service providers should all work together to achieve this. [na](#)

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# Breaking a toxic relationship

The role nursing can play in helping patients with co-occurring mental illness and chronic disease  
**Australian College of Mental Health Nursing  
 Professional Development Manager Peta Marks**

**T**he mental health burden in Australia is significant and it is growing. The National Mental Health Commission's 2014 report *Contributing lives, thriving communities*<sup>1</sup>, clearly sets out the burden associated with mental ill health, in terms of health outcome, quality of life, co-occurring illness, death and disability. Mental ill-health impacts on individuals, families and communities; and poses significant economic and social cost to the nation, with estimates in the vicinity of \$40 billion a year or approximately 2% of GDP. These costs are projected to increase significantly, particularly as the population ages.

There is a well-documented but complex reciprocal relationship between chronic disease and mental health, which can represent challenges for nurses in terms of recognition and management. Many physical health conditions increase the risk of mental illness and poor mental health is known to increase the risk of diseases such as heart disease, diabetes, stroke and cancer (for example, depression as a risk factor for the development of heart disease is of a similar magnitude as smoking). Co-morbidity of

physical illness and mental health issues impacts on whether people seek help, their diagnosis and their treatment. It also impacts on their physical and mental recovery<sup>2</sup>, because it can reduce a person's capacity to optimally self manage chronic disease, increase the burden of symptoms of the disease, and create additional functional impairment. Co-occurring mental illness and chronic disease also affects longer term health outcomes, morbidity and mortality e.g. patterns of depression predict mortality in people who have had a cardiac event up to 12 years after that event.

People with cancer who are depressed and/or anxious have a poorer quality of life, are less committed to treatment and have a diminished will to live. Half of all patients with terminal or advanced cancer suffer poor mental health and death rates are as much as 25% higher in cancer patients who are experiencing depressed moods and 39% higher in cancer patients who

receive a diagnosis of clinical depression. Despite the fact that treatment for depression could improve a person's quality of life and prolong life, less than half of cancer patients receive treatment for depression.

Conversely, people with mental illness experience poorer physical health and higher morbidity and mortality as a result of their poor physical health than people in the general population. This is evidenced by the fact that they die much earlier than the rest of the population – around 15 years earlier for women and around 20 years earlier for men<sup>34</sup> – and for some groups of people, for example those diagnosed with of schizophrenia and cardiovascular disease, death rates are two to three times higher than in the general population<sup>5</sup>.

The practice of nursing is frequently described as 'holistic' – in theory, this means we are addressing the mind, body and spirit. However, it is clear that the physical health needs of people with mental illness are

**“People with cancer who are depressed and/or anxious have a poorer quality of life, are less committed to treatment and have a diminished will to live.”**



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often neglected<sup>6</sup> and that the mental health needs of people with physical illness are also frequently ignored. This is an issue that the profession of nursing needs to address.

Every nurse will be working with clients who are at risk of developing, are developing, or are having early signs and symptoms, of mental health issue.<sup>7</sup> As such, *all nurses*, regardless of clinical practice area need to identify those at risk of developing mental health issues and provide emotional support for people experiencing physical illness. For example, nurses working in cardiac care need to be able to identify the 'Cardiac Blues' (shock, denial, worry, guilt, anger, sadness and grief) which are common and normal in people who have experienced a cardiac event (see the Heart Research Centre) and differentiate this from depression, which is not. Similarly, nurses working with people who have mental illness need to ensure that clients are receiving the same level of physical health care (including health promotion, screening and early intervention) as all other Australians.

People with chronic disease want nurses to ask about their emotional wellbeing and to listen to what they are saying. People with mental illness want nurses to ask about

their physical health and to take them seriously when they are experiencing physical symptoms. Regardless of whether the mental illness or the chronic disease is the primary diagnosis, physical health outcomes are better when a person's mental health needs are addressed and worse when they are not, and it is our role as nurses to ensure our practice is truly holistic and to address both the physical and mental health domains for improved client wellbeing.

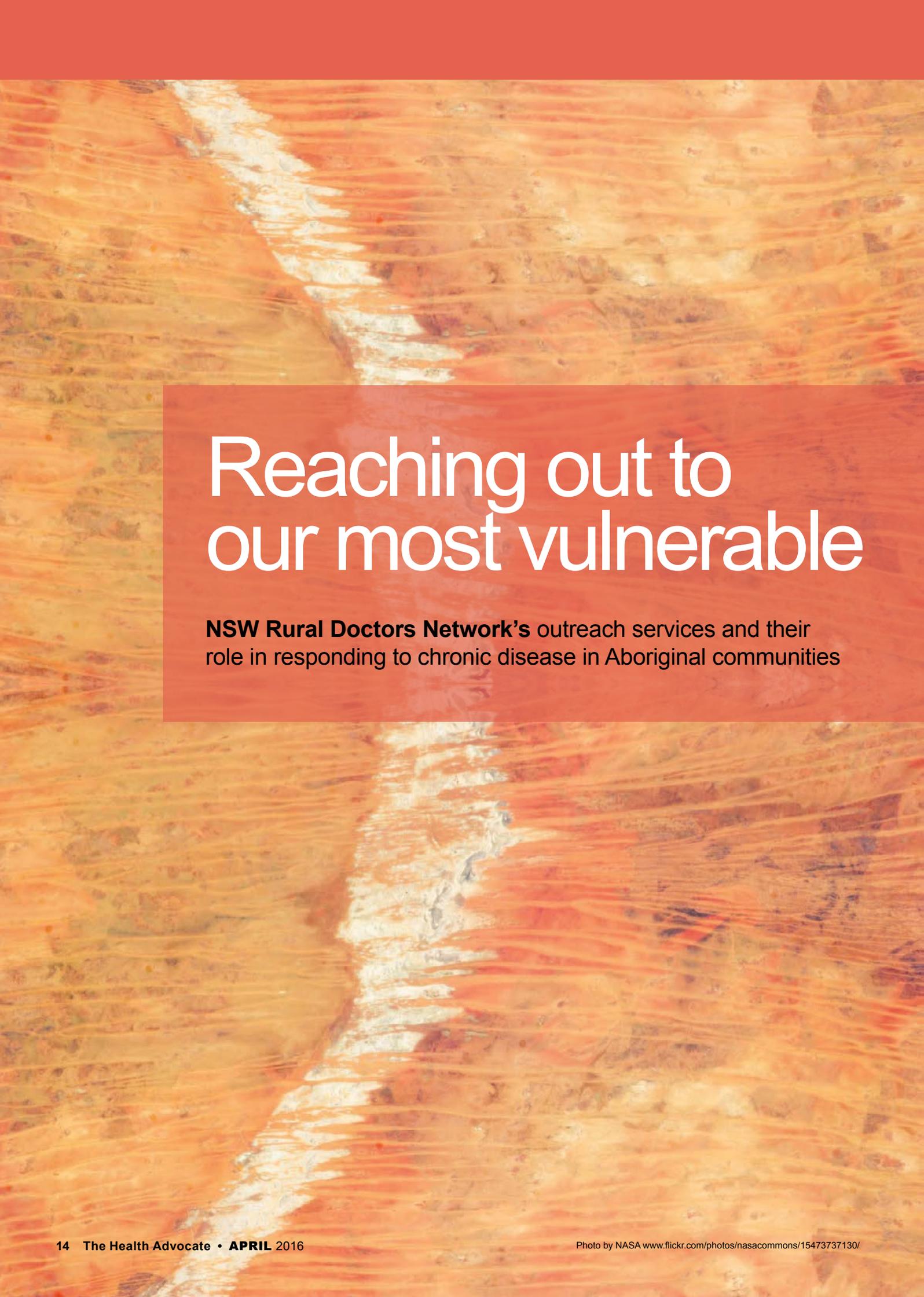
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**Nurses who are interested in undertaking free eLearning modules addressing mental health as it presents in chronic illness are invited to visit the Australian College of Mental Health Nurses professional development portal. See [www.acmhn.org/credentialing/continuing-professional-development/134-cpd/424-elearning](http://www.acmhn.org/credentialing/continuing-professional-development/134-cpd/424-elearning)**

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# Reaching out to our most vulnerable

**NSW Rural Doctors Network's** outreach services and their  
role in responding to chronic disease in Aboriginal communities

It is well documented that rates of chronic disease are increasing and are exacerbated in Aboriginal communities. This is not a recently observed trend: in 2006, the Australian Government's Aboriginal and Torres Strait Islander Health Performance Framework<sup>1</sup> identified rising and disproportionate rates of kidney disease, diabetes and cardiovascular

**“The knowledge of communities and health services that these local organisations contribute to the outreach program is integral to outreach service planning, delivery and ongoing quality improvement.”**

risk factors. Since then, there have been significant investments from both federal and state governments to improve health outcomes for Aboriginal people. Perhaps the most notable was the \$1.6 billion committed by the Coalition of Australian Governments (COAG) in 2008 to closing the gap in Aboriginal and Torres Strait Islander health outcomes that spawned a range of initiatives and programs – including many designed to tackle chronic disease.

The NSW Rural Doctors Network (RDN) currently delivers a number of Commonwealth-funded outreach programs in New South Wales including the Medical Outreach Indigenous Chronic Disease Program (MOICDP) that originated from the COAG commitment, and supports visiting multidisciplinary chronic disease teams of medical specialists, allied health practitioners and nurses to provide clinics where there are access barriers. The most significant barriers to access include large distances and disruption to family that many rural Aboriginal people must overcome before accessing services in state capitals or regional

centres; the economic hurdles associated with travel, accommodation or fees charged by private services; and cultural barriers that are experienced by many Aboriginal patients who are more likely to access services that are specifically designed to meet their cultural needs.

RDN partners with local health organisations that include Aboriginal Community Controlled Health Services (ACCHSs) to identify priority service gaps, manage the implementation of services, collect activity data and evaluate outcomes. The knowledge of communities and health services that these local organisations contribute to the outreach program is integral to outreach service planning, delivery and ongoing quality improvement.

Outreach programs that were originally restricted to medical specialists have been expanded by programs like MOICDP to provide a more comprehensive range of services that respond to gaps in prevention, detection, treatment and ongoing management. For example, a team comprising a visiting endocrinologist and diabetes educator will work alongside a locally-based GP, exercise physiologist and Aboriginal health practitioner to provide fortnightly diabetes clinics. Such a multidisciplinary diabetes team will work with patients to develop and implement management plans which include lifestyle modification and ongoing medication management that are delivered on Country and through a culturally-fitting model.

The MOICDP has grown significantly in recent years and now supports over 700 outreach services that provided more than 80,000 patient consultations to NSW Aboriginal communities in 2015. This rapid response by outreach to workforce gaps has precipitated other Aboriginal-specific outreach programs such as the Healthy Ears, Better Hearing, Better Listening program designed to address the high prevalence of chronic otitis-media in Aboriginal children. Another is the recent expansion of the Visiting Optometrist Scheme to enhance Aboriginal patient access to eye health services.

What impact are outreach programs having on Aboriginal health outcomes? Outreach services represent a relatively small portion of the wider health system they are designed to supplement. In addition to service access, there are many other factors such as genetics, the environment, employment and education

that influence our health and make it difficult to empirically isolate and measure the impact made by outreach. Despite the challenges of measuring outcomes, evaluations of individual outreach services are promising. Two examples in NSW include: a nurse-led colposcopy service<sup>2</sup> that has enhanced health outcomes through the early detection and treatment of potentially life-threatening cervical carcinomas in Aboriginal women who were less likely to have accessed alternative gynaecology services; and a chronic kidney disease (CKD) service<sup>3</sup> that has multiplied manyfold the identification of patients living with or at risk of CKD, their staging, the implementation of management plans and measured improvement in some patients. Both of these services are managed by and delivered in ACCHSs.

Outreach is an important contributor to comprehensive chronic disease management in Aboriginal communities and rural locations that do not have or cannot sustain a fulltime health workforce, and RDN will continue to work with local organisations to respond to health service gaps and pursue outreach opportunities. [ha](#)

**More information about the outreach program is available on RDN's website at [www.nswrdn.com.au](http://www.nswrdn.com.au) or by contacting the RDN Outreach team on [outreach@nswrdn.com.au](mailto:outreach@nswrdn.com.au) or 02 8337 8100.**

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# Making them welcome

## West Wimmera Health Service's cultural responsiveness framework

It is acknowledged that Australia is a melting pot of many cultures, a multi-cultural populace defines our modern nation.

Since 2012 some 180 members of the Karen refugee community have resettled in Nhill in western Victoria and now comprise 10% of the population. In 2007 Karen refugees were accepted into Australia, resettling first in Werribee and from there relocated to Nhill to work for a poultry manufacturer.

The successful integration of the Karen community has meant that family migration to Nhill directly from the refugee camp in Thailand is now a reality with another 50 families expected to relocate in the next 18 months. This will bring the Karen population in our region to around 350, or close to 20% of the population.

This change in our population has made us think about how we reconfigure, advertise and deliver our services to the community.

### Our effectiveness

- Our policies direct and guide our staff if translators are required.
- A Diversity Group meets bi-monthly with membership from the Karen community and also representatives of our international staff to consider areas for improvement.
- Inclusion of the HACC and Disability Programs ensure West Wimmera Health Service has one Diversity Plan which is all encompassing.
- Senior management representatives on the Diversity Committee ensures service leadership for cultural responsiveness.
- Training this year by the State Wide Facilitator Refugee Health Program included the Shire, local schools, Community and Allied Health staff and

members of the local Karen population.

- Training for staff took place in 2015 to provide awareness of the reality of resettling into a new country as a refugee or asylum seeker. Specific training will assist to identify and meet specific needs.

### Communication – the biggest hurdle

Communication appears to be the biggest hurdle as we seek to engage with members of the Karen community. In conjunction with local Karen representatives brochures detailing services and how to access them have been produced.

Tours of the Nhill Hospital were conducted in conjunction with the Hindmarsh Shire specifically for migrant community members including those from the Karen community and the Philippines. Explanations were given about all aspects of the Health Service,



**“The successful integration of the Karen community has meant that family migration to Nhill directly from the refugee camp in Thailand is now a reality with another 50 families expected to relocate in the next 18 months.”**

including what happens when a patient is admitted to hospital, going to theatre for an operation, attending the Dental Clinic and what the different Allied Health departments can do to assist patients remain healthy.

These tours will continue so all new arrivals will feel at ease when coming to our Health Service for the first time.

We have a telephone interpreter service, however, this process can be difficult with clients preferring face-to-face interpreting. As a result interpreting services are often provided by family and friends which creates some challenges with regard to privacy, a problem we are endeavouring to solve.

In recognition of the need to ensure excellent communication between clients and health professionals in 2015-16 the Service will investigate employing a health professional with fluent Karen language skills

to work specifically as an interpreter within the Nhill Hospital, Outpatients and also assisting in the Tristar Medical Clinic. We are also investigating employing a Community Health Nurse with Karen language skills to undertake health promotion and health and wellbeing within the Karen community.

### **Consumer participation**

We have a multidisciplinary, Consumer and Community Diversity Committee bringing together people from various organisations and professional disciplines who have a common interest in the growing cultural diversity of our community. Examples of issues discussed include language differences, job opportunities and Maternal and Child Health matters.

Opportunities to develop consistent understanding of concerns and strategies

for migrants to live in, participate in and contribute to our society are developing.

### **Strengthening the workforce**

We have participated in education as it is available but acknowledge this is an area requiring more involvement in the future. Training was held in Nhill in late 2015 which did much to address this gap. 

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West Wimmera Health Service is a community health centre, a disability service and a residential aged care provider in western Victoria committed to the delivery of services which are compassionate, responsive, accessible and accountable to individual and community needs. For more information contact the service on (03) 5391 4222 or visit [www.wwhs.net.au](http://www.wwhs.net.au).



Some of the Karen and Philippine families on a tour of the Nhill Hospital Complex with West Wimmera Health Service Community Liaison Officer Meredith Taylor (centre) and Hindmarsh Shire Council interpreter Tha Hser Bleh Dah (far left).

# Financial incentives and the patient experience

Are we ready for one standard measure of patient experience across Australian health?  
**Dr Avnesh Ratnesan, CEO of Energesse**



**T**here is a growing body of evidence starting to influence thinking on linking financial incentives to patient experience measurement and improvement in Australia. One of the major challenges in making a difference in Australia (compared to the UK) is that we still do not have a single, clear national standardised metric for measuring improvement of patient experience.

Within the NHS there has been implementation of a standard measure of patient experience called the 'Friends and Family Test'. Whilst there has been much debate about the measure over the past five years of its implementation, the one thing it has done is raise the bar on the conversations and investments on how healthcare services should be measured and delivered in a truly patient-centred way, with input from patients.

Australian public hospitals are required to improve quality metrics around patient experience based on Standard 2, one of the

standards set by the Australian Commission for Safety and Quality in Healthcare. This standard calls for effective partnerships between consumers, healthcare providers and healthcare organisations which are deemed essential for safe and high quality care in national health policy in Australia.<sup>1-3</sup>

This standard aims to guide health services to become responsive to patient, carer and consumer needs and partner with consumers in the implementation of all other NSQHS Standards. However, according to the Commission reports, some health services have found the implementation of systems to meet the requirements of Standard 2 challenging<sup>4</sup>.

Australian health services and hospitals are in their infancy in terms of executing the latest strategies to collect, analyse, measure and improve patient experience. The lack of a standard national metric and the complexity of survey questions and aggregated data sources can further confuse management decision-making and budget allocation in this space.

Guidance from organisations such as the Picker Institute and Beryl Institute are helpful, yet implementation of these questions do require tailoring to local needs, such as in translation of survey questions to local ethnic languages. There also needs to be electronic mechanisms in place to complement paper-based collection in order to improve response rates and engagement and obtain meaningful insights in real-time.

Most important is the need to close the feedback loop and take action from patient experience data. While some staff and executives may see this process as a 'box-ticking' exercise, patient experience data collection can be a driver for organisational strategy and a source for targeting innovation initiatives with real financial outcomes.

Why? Because an organisation that is close to its 'customer', is the most financially viable over the long term. A hospital that is sensitive to understanding the needs and wants of its patients,

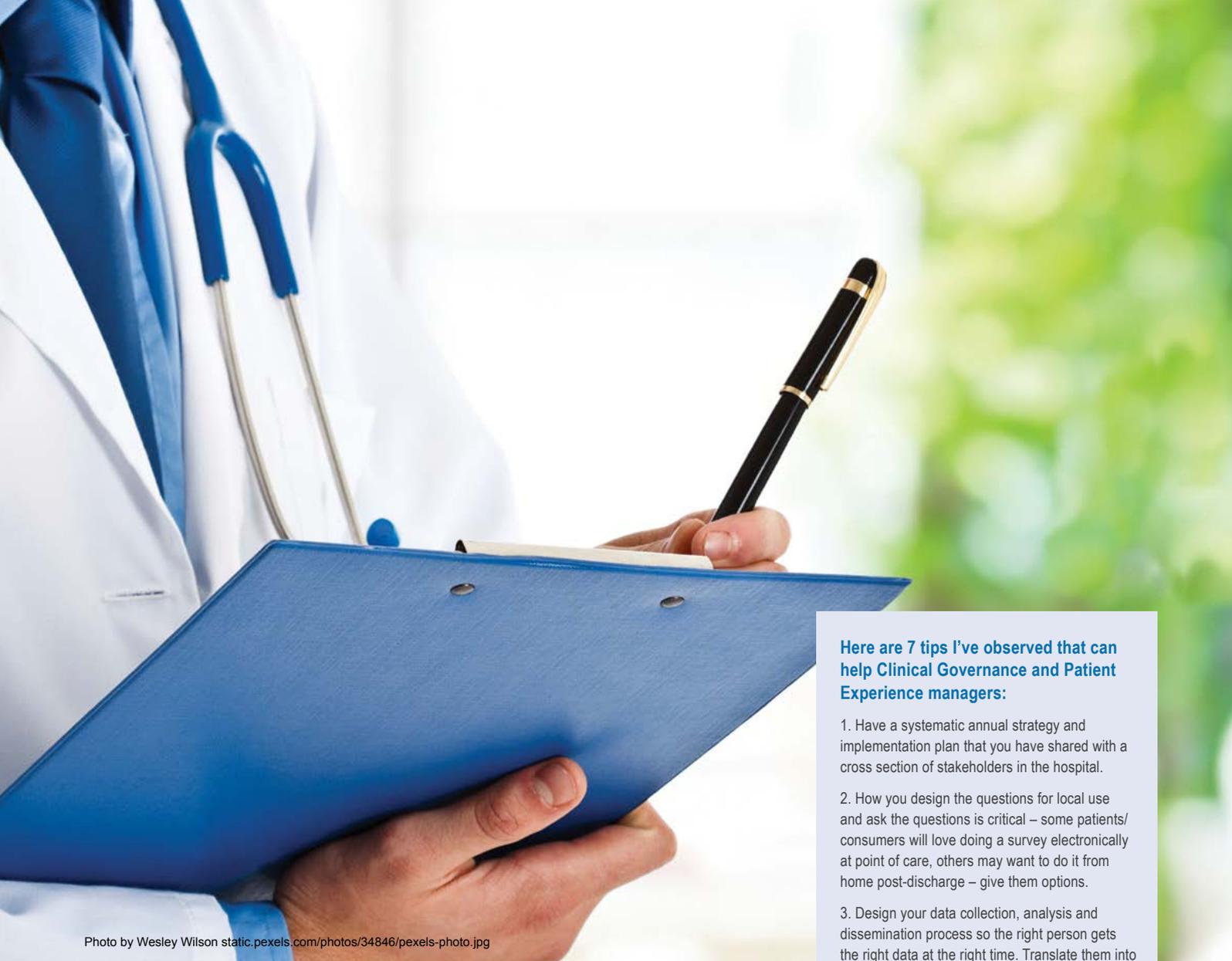


Photo by Wesley Wilson static.pexels.com/photos/34846/pexels-photo.jpg

### Here are 7 tips I've observed that can help Clinical Governance and Patient Experience managers:

1. Have a systematic annual strategy and implementation plan that you have shared with a cross section of stakeholders in the hospital.
2. How you design the questions for local use and ask the questions is critical – some patients/consumers will love doing a survey electronically at point of care, others may want to do it from home post-discharge – give them options.
3. Design your data collection, analysis and dissemination process so the right person gets the right data at the right time. Translate them into actionable insights. Many 'big data' technologies that can save managers time, and perform these tasks more objectively and effectively than humans.
4. Implement changes through a prioritisation process involving a multi-disciplinary team (that ideally involves two consumer representatives).
5. Visibly demonstrate the results of feedback and management actions to drive culture change, motivation and results over the long term. Frontline clinical staff want to know that their daily hard work is appreciated. It also helps them improve the quality of their care and communication if they understand that these aspects can actually be measured via patient feedback.
6. Monitor experience with a ward's performance metrics to ensure that interventions are effective and are continuously aligned with patient needs – many wards now have visibly transparent performance dashboards on the ward. The right way to do this is to have 3-4 main high priority metrics visible (not 20 metrics that cannot be easily seen by busy staff)
7. Finally, have the discipline to iterate the process to achieve continuous improvements to outcomes. Repetition is key to behaviour change. For any person, in any industry.

will be the best performing over the long term. Analysing patient complaints and frustrations may seem like a dreary task, however, these 'warning signs' are particularly useful when coming directly from patients or frontline staff. Alleviation of patient concerns in the early stages acts as an 'early warning system' that can reduce systemic errors and multi-million dollar lawsuits. There are also often positive stories that can be effectively shared in the organisation to lift morale and staff engagement.

Fortunately, many technologies now exist that can perform automated free text analysis of patient narratives in high volumes, particularly rich, long form ones to extract deeper actionable insights from this type of data to guide management decisions. Among them are tools like MES Experience, PanSensic, InVivo and SAS. Some of these tools are also able to analyse compassion, staff attitude and quality of communication. **ha**

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# A united voice

## The national agreement between the AHHA and the PHAA



**T**he Australian Healthcare and Hospitals Association (AHHA) and the Public Health Association of Australia (PHAA) will draw on an effective and well-established partnership to continue to advocate for and support the primary health care sector.

The AHHA and the PHAA entered into a national agreement of mutual support in 2014 and have since then joined forces a number of times, including to protest the Federal Government's \$800 million cuts to health funding last year.

The PHAA is the principle non-government organisation for public health in Australia and works to promote the health and wellbeing of all Australians. It seeks better population health outcomes based on prevention, the social determinants of health and equity principles.

PHAA CEO Michael Moore said the agreement was a powerful instrument in ensuring the best care was available for all Australians.

"AHHA and PHAA have shared goals and we are now working together to maximise the impact we have on the public health and primary health sectors. Both our organisations are passionate about seeing significant improvement in primary health care so everyone can have access to the best care available," he said.

Mr Moore said joining forces ensured a better outcome.

"By working together, we will be able to achieve so much more in advocating for better public health in Australia," he said.

"This partnership will allow both organisations to grow and have a stronger voice to advocate for better services. Having access to more resources is essential when working to improve the primary health care sector."

"I look forward to the new initiatives and networks this collaboration provide. This joint collaboration will strengthen the voice of public health particularly in the delivery of primary health care."

AHHA Chief Executive Alison Verhoeven said improvements in the primary care sector were vital for reducing the burden on the health sector and improving community and individual health across Australia.

"Through this agreement we have become a more effective united voice in speaking out together to improve the primary care system in Australia," she said.

"This agreement strives for a whole of sector approach to better integrate primary with community, aged and acute care to deliver better health outcomes for patients."

"We have also explored and will continue to explore new opportunities for collaboration through our research arm the Deeble Institute for Health Policy Research," Ms Verhoeven said.

"This partnership remains an important pillar supporting our mutual work to improve the primary care sector and thus reduce the burden on other areas of the health sector."

The partnership allows AHHA and PHAA to maximise resources and value-add for members through a collaborative approach to identified areas of service delivery relating to the primary care sector.

"Improving primary care and increasing integration with other sectors is vital if Australia is to confront current and future health issues, including the increasing burden of chronic disease, our ageing population, the rising costs of acute care and the poorer health experienced by disadvantaged population groups such as migrants, refugees and Aboriginal and Torres Strait Islander peoples," Ms Verhoeven said.

AHHA and PHAA will in the future collaborate on projects from policy development and advocacy, to national and state forums and submissions to governments, including parliamentary and other inquiries. 



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

Australian Health Practitioner Regulation Agency

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- ▶ Have you ever wondered if you should **report that practitioner** who might be putting the public at risk of harm?
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# The challenges of 2016

**AHHA** looks at the issues confronting the health sector in its 70th year

In its 70th year the AHHA is focused on a broad range of issues facing the health sector. Many of these issues, such as those relating to funding and the need for system integration, have been with the health sector long-term. However, the AHHA agrees with the widely-held sector view that the time for reform is now.

There are also new challenges facing the Australian healthcare system as the country moves further into the 21st century. Australia's ageing population, the increasing burden of chronic and complex diseases, and the health inequalities faced by different groups in the community such as Aboriginal and Torres Strait Islanders and humanitarian immigrants, are just some of these challenges.

While there are many important issues facing the Australian health sector, the AHHA believes that considered reform can address many of these challenges we now face.

## CHRONIC DISEASE

The AHHA has long called for the urgent development of a national plan for chronic disease management. A growing burden of chronic disease in Australia has highlighted the significant structural issues in the current health system that prevent a coordinated response from primary care, hospitals and specialised community-based services.

The AHHA made a submission to the Commonwealth Government last year which put forward a number of guidelines for a new national plan. The AHHA believes chronic disease management should be centred on patients, not diseases, so patients with multiple chronic conditions can be better treated. The plan should also support regional-specific approaches that are more coordinated and easier for patients to navigate.

The AHHA has also called for the government to address the structural issues surrounding funding models, establishing arrangements that are patient-centred and supportive of the right care in the most appropriate environment. The AHHA also believes it is crucial for the data gathered by government projects and research into chronic disease management to be shared openly.

## REFORM OF THE FEDERATION

The Commonwealth Government's ongoing Reform of the Federation process presents an opportunity for the health sector to address many challenges. The chance to address accountability gaps, waste, confusion amongst both consumers and providers, and a system that does not fully meet the health needs of large sections of our population, must be seized with this reform process.

The AHHA believes the reform process should make it a priority to establish a sustainable funding partnership between the Commonwealth and the states and territories to ensure Australians have access to an equitable health system delivering quality outcomes in both the short and long term.

Any change should take into account the very real health needs that are not being adequately met within our current institutional and funding arrangements. Consideration should also be given to better ways of planning and delivering health care, not just a passing of responsibilities from one level of government to another.

**“A growing burden of chronic disease in Australia has highlighted the significant structural issues in the current health system that prevent a coordinated response from primary care, hospitals and specialised community-based services.”**

## AGEING

Every older person should be able to live well, with dignity and independence, as part of their community and in a place of their choosing. They deserve a choice of appropriate and affordable support and care services when they need them. Particular attention must be given to ensuring availability of appropriate services to vulnerable groups including Aboriginal and Torres Strait Islander peoples.

The AHHA believes there must be close coordination between the primary, acute and aged care sectors, and better collection and use of data, including connection of the My Health Record and the My Aged Care Gateway. Services should be easy to navigate so older Australians know what care and support is available and how to access these services.

The Commonwealth must also commit adequate funding to ensure older Australians have sufficient support to live at home. To this end, a long-term aged care workforce strategy is required, with a focus on skills, training and appropriate remuneration. The formal aged care sector is also complemented by a significant informal care sector. Adequate services and financial assistance must also be made available to support informal carers.

## ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

As the Close the Gap campaign reaches its 10-year anniversary, AHHA has taken an active role in promoting and encouraging support to reduce health inequalities between Aboriginal and Torres Strait Islander people and other Australians.

In its recent pre-budget submission, the AHHA called for government funding for Phase Three of The Lighthouse Project, which seeks to improve the care that Aboriginal and Torres Strait Islander people receive when being treated for acute coronary conditions such as those with heart attacks symptoms. This project is being jointly conducted by the Heart Foundation and AHHA.

Better planning for the healthcare needs and challenges facing Aboriginal and Torres Strait Islander people is also required. Planning and delivering more appropriate care, including health promotion and prevention measures, will serve to lower the disease burden and contribute to Closing the Gap goals.

## LOOKING AHEAD

During its 70th year, the AHHA will be undertaking advocacy and research on these and other challenges facing the health sector. The need for an accessible, equitable, sustainable health system delivering quality outcomes is a national priority. AHHA will continue its role as a leading voice for public healthcare to ensure an effective contemporary healthcare system supporting a healthy Australia. 

# Driving positive change

Chronic disease among Aboriginal and Torres Strait Islander peoples  
 Michael de Looper and Ros Seselja

**C**hronic diseases currently cause an estimated nine out of ten deaths in Australia, and has extensive personal, social and economic impacts. The burden of chronic disease has elsewhere been characterised by the Australian Institute of Health and Welfare (AIHW) as the biggest health challenge that Australia currently faces.

Chronic disease, however, is not uniformly distributed in the population. A new report by the Australian Institute of Health and Welfare, *Cardiovascular disease, diabetes and chronic kidney disease – Australian facts: Aboriginal and Torres Strait Islander people*, underlines the extent to which Aboriginal and Torres Strait Islander peoples are disproportionately affected by these three largely preventable diseases.

The report highlights that cardiovascular disease (CVD) (including coronary heart disease and stroke), diabetes and chronic kidney disease (CKD) tend to appear earlier, progress faster, present alongside other chronic diseases and result in higher death rates in Indigenous people than in non-Indigenous people.

Using the latest available survey and administrative data, the report shows:

## Higher levels of important underlying risk factors

Aboriginal and Torres Strait Islander peoples experience higher rates of selected behavioural and biomedical risk

factors which influence the development and progression of chronic disease. In 2011-13, Aboriginal and Torres Strait Islander adults were 2.6 times as likely as non-Indigenous adults to smoke daily (42% and 16%, respectively), 1.2 times as likely to be overweight or obese (72% and 63%), and 1.2 times as likely to have high blood pressure (25% and 21%).

## Disease rates are greater, and are higher at younger ages

Higher rates of risk factors contribute to earlier onset and higher disease rates among Aboriginal and Torres Strait Islander peoples. An estimated 27% of Aboriginal and Torres Strait Islander adults had CVD compared to 21% of non-Indigenous adults. The rate of acute coronary events (heart attacks and unstable angina) was 2.5 times as high.

The difference between Aboriginal and Torres Strait Islander and non-Indigenous Australians was even greater for diabetes and chronic kidney disease. While 5% of non-Indigenous adults had diabetes, 18% of Aboriginal and Torres Strait Islander adults had the condition. They were also twice as likely to have biomedical signs of CKD (22% and 10%).

These conditions occur at much younger ages in Aboriginal and Torres Strait Islander peoples. For example, at age 18-34, 9% of Aboriginal and Torres Strait Islander peoples had CVD compared to 4% of non-Indigenous people of the same age. Rates

of both diabetes and CKD in Aboriginal and Torres Strait Islander peoples aged 35-44 were four times those of non-Indigenous people of the same age.

## Hospitalisation rates are greater

Aboriginal and Torres Strait Islander adults were almost twice as likely as non-Indigenous adults to be hospitalised for CVD in 2013-14. Just over half (52%) of all Aboriginal and Torres Strait Islander hospitalisations for CVD were for people aged under 55, compared to 17% for the non-Indigenous population.

Rates of hospitalisation where dialysis was the principal diagnosis were 10 times as high as for the non-Indigenous population.

## Death rates are greater, and are higher at younger ages

Higher rates of risk factors, and of disease, translate into higher mortality rates.

In 2010-12, the Aboriginal and Torres Strait Islander CVD mortality rate was 1.5 times as high as the non-Indigenous rate, and Aboriginal and Torres Strait Islander peoples were 4 times and 3 times, respectively, as likely to have diabetes and CKD listed as an underlying or associated cause of death. Premature and potentially preventable CVD deaths contributed almost one-quarter (24%) to the mortality gap between Aboriginal and Torres Strait Islander and non-Indigenous people.

The gap in death rates between Aboriginal and Torres Strait Islander and



# Cardiovascular disease, diabetes and chronic kidney disease

## Australian facts

### Aboriginal and Torres Strait Islander people

non-Indigenous people was widest among younger age groups—the CVD death rate for Aboriginal and Torres Strait Islander peoples aged 35-44, for example, was 8 times as high, falling to 4 times as high for the 55-64 year old age group. For diabetes and CKD death rates at age 55-64 were 10 times as high for Aboriginal and Torres Strait Islander peoples as for non-Indigenous people.

#### Comorbidity is also more frequent

Shared risk factors mean that CVD, diabetes and CKD often occur concurrently, and this happens more frequently in the Aboriginal and Torres Strait Islander population. In 2011-13, 38% of Aboriginal and Torres Strait Islander adults with CVD, diabetes or CKD had 2 or more of the conditions, compared to 26% of non-Indigenous adults. More than one in 10 (11%) Aboriginal and Torres Strait Islander deaths had all three conditions listed as causes of death, compared with 3% of non-Indigenous deaths.

Comorbidity, often associated with worse health outcomes, increased with age for both populations, but was greater at each age in the Aboriginal and Torres Strait Islander population.

#### Changes over time

When comparable data were available over time, time trends were analysed. These show mixed results. There was a 40% fall in CVD deaths between 1998 and 2012, and a subsequent narrowing of the gap between

Aboriginal and Torres Strait Islander and non-Indigenous people. Minimal change was observed in the gap in diabetes and CKD death rates.

The number of Aboriginal and Torres Strait Islander people treated for end-stage kidney disease more than doubled between 2000 and 2013—a 58% increase compared to a 35% increase for non-Indigenous people. There was little change in the disparity between Aboriginal and Torres Strait Islander and non-Indigenous people in the use of diagnostic and revascularisation procedures in CHD hospitalisations.

#### The importance of monitoring

As the Australian Government develops a new National Strategic Framework for Chronic Conditions, these data provide supporting evidence on the magnitude of inequalities in chronic disease within the Australian population.

risk factors  
chronic kidney disease  
cardiovascular disease  
diabetes

Ongoing monitoring of chronic disease in the Aboriginal and Torres Strait Islander population will help drive positive change by informing the policy frameworks and programmes which bring together chronic disease and Aboriginal and Torres Strait Islander health, including the Close the Gap initiative, the National Aboriginal and Torres Strait Islander Health Plan and the Better Cardiac Care for Aboriginal and Torres Strait Islander People project. [lia](#)

#### Where do I go for more information?

The report is available for free download on the AIHW website at [www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129553626](http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129553626)

# Chronic conditions and allied health

The untapped potential in the Australian healthcare system  
**Professor Kathryn Refshauge, Dr Sarah Dennis and Amy Vassallo**  
 are from the Faculty of Health Sciences at the University of Sydney

**T**he impact of chronic illness is increasingly being felt throughout the Australian community. Chronic illnesses can affect every aspect of a person's life including their ability to work, go to school, live independently, care for children and family, engage in physical activity and maintain social connections. They are the leading cause of illness, disability and death in Australia accounting for approximately 85% of the total burden of disease and 90% of all deaths<sup>1</sup>. The economic burden of these illnesses is far higher than for catastrophic injury due to the combined effects of health care costs and lost productivity, as well as the social burden.

Due to advances in medical research and innovations in health care, people with chronic conditions are living in the community for longer, presenting an unprecedented challenge to Australia's health and social care system. The most expensive component of this health care expenditure is admission to in-patient hospital services. Therefore, the greatest potential for change

**“Currently only a limited number of visits (usually five) with allied health practitioners are funded, regardless of the complexity of the diagnosis or presence of more than one chronic illness.”**

towards more effective and more efficient health care provision, is for chronic diseases to be managed in community settings, thus effectively reducing hospitalisations.

Allied health practitioners play a critical role in improving the health and wellbeing of Australian's living with chronic conditions in primary health care. We know that allied health interventions prevent deterioration and improve and maintain function and wellness<sup>2</sup>, with the overall aim of reducing acute episodes requiring hospitalisation or more costly interventions<sup>3</sup>. There is also evidence that the most effective interventions for community based chronic disease management

are self-management support, multidisciplinary team care and decision support<sup>4</sup>. These are all recognised areas of allied health expertise.

Despite the evidence, there are significant barriers to best practice use of the allied health care workforce for chronic disease management in primary health care.

First and foremost is the inequitable funding arrangement for allied health through the Medicare Benefits Schedule. Currently only a limited number of visits

(usually five) with allied health practitioners are funded, regardless of the complexity of the diagnosis or presence of more than one chronic illness. This limited number of sessions is shared between the allied health specialities and is unlikely to be adequate to improve health outcomes because of an insufficient dose of treatment. As chronic illness disproportionately affects those from lower socioeconomic backgrounds and without private health insurance, many people are also unlikely to be able to cover the full cost of additional treatment sessions themselves.

A restructure of the current funding arrangement by the Medicare Benefits Schedule is desperately needed to ensure better provision of evidence based effective allied health services in primary health care.

There is an inverse care law in relation to access to allied health professionals by people with chronic conditions. Data from the National Health Performance Authority showed that the proportion of people surveyed who



Photo by Clint Adair

had access to an allied health professional or nurse in the last 12 months was lower (17%) in outer metropolitan areas with lower socioeconomic status and higher prevalence of chronic disease than in more affluent metropolitan areas (26%)<sup>5</sup>. The situation is even worse for people living in rural and remote areas of Australia. The innovative use of technology may be a solution to address this inequity of access to allied health, for example through telehealth interventions. However, at this time payment for eHealth interventions by allied health professionals is excluded from the Medicare Benefits Schedule, acting as a disincentive to its adoption.

The Australian health system was developed as a highly medical model which focussed on acute and episodic care provided in hospitals by doctors and nurses<sup>2</sup>. While appropriate for a time when infectious diseases were the most prevalent cause of ill health, this structure needs to be updated to reflect the current

needs of the community. A more efficient use of resources would be to allocate them to the innovative and evidence based primary care strategies required for those with chronic conditions, thus preventing the much more expensive hospital care needed for acute exacerbations.

Allied health provides an “untapped potential” in the Australian health care system<sup>2</sup> particularly for chronic disease management. There is a growing body of evidence demonstrating that better utilisation of the allied health workforce can improve health outcomes and reduce overall health costs. Therefore increasing access to allied health in primary health care is likely to be a much more cost-effective way to manage chronic conditions in the community and reduce the overall burden of disease.

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# A hidden problem

## The issue of diagnosing coeliac disease in Australia

Coeliac disease is one of Australia's most common autoimmune illnesses, affecting 1 in 70 of the population, and its prevalence is increasing. However, lack of awareness and its broad clinical presentation means that detection is poor, with only 20% of affected Australians diagnosed.

Coeliac Australia estimates more than 270,000 Australians are unaware they are living with coeliac disease, risking long-term health complications. The not-for-profit organisation has launched a campaign to raise the profile of coeliac disease with health professionals and promote awareness of symptoms and best practice screening and management.

Typical problems associated with coeliac disease include gastrointestinal complaints, anaemia and nutrient deficiencies, chronic fatigue and headaches. For people with coeliac disease, a strict gluten free diet can heal the damage caused by gluten and reduce long-term morbidity and mortality.

Delayed diagnosis is concerning, as the immune-mediated inflammatory response to gluten is associated with nutrient deficiencies and a range of systemic complications including osteoporosis, other autoimmune disease (3-fold higher), and elevated mortality (2-4-fold higher), often due to sepsis or malignancies such as lymphoma.

The negative impact on quality of life, education and work performance often goes unappreciated. A mean of 11–13 years from first presentation to diagnosis signifies

missed opportunities to break the cycle of chronic symptoms that can generate health care costs comparable to those incurred by patients with diabetes.

Diagnosing coeliac disease is the first critical step towards combating its burden on health, quality of life and resources. While population screening has its proponents, current guidelines recommend an active-case finding strategy – seeking those at higher-risk for screening serology.

With case-finding applied in primary care 1:50–1:30 tests typically return a positive case of coeliac disease. Here the most frequent presentations are bloating, thyroid disease, 'irritable bowel syndrome', diarrhoea, chronic fatigue and constipation. Screening people with high-risk features such as 1st-degree relatives of patients with coeliac disease, type 1 diabetes and irritable bowel syndrome is important and cost-effective.

Coeliac Australia has developed new online resources to support health professionals in the diagnosis of coeliac disease, including a video *Diagnosing Coeliac Disease – A Brief Guide for GPs* and GP Fact Sheet, which are available on its website [coeliac.org.au/resources](http://coeliac.org.au/resources). 

For more information:

Visit Coeliac Australia online at [www.coeliac.org.au](http://www.coeliac.org.au)

Or contact us on:

1300 GLUTEN (1300 458 836)

### COELIAC DISEASE QUICK FACTS:

> Coeliac disease is an immune-based illness caused by gluten, a dietary protein from wheat, rye, barley and oats. Treatment involves a strict and lifelong gluten free diet.

> People with coeliac disease may experience a variety of symptoms, including abdominal pain, bloating, flatulence, diarrhoea or constipation, nausea or vomiting, fatigue or rashes. However, an absence of these symptoms is also possible.

> Associated conditions seen with coeliac disease are not always considered as related — such as dental enamel defects, mouth ulcers, alopecia, osteoporosis, unexplained weight loss, abnormal liver function results, ataxia, pregnancy complications and neurological symptoms.

> Coeliac disease remains one of the most underdiagnosed conditions in this country — affecting 1 in 80 men and 1 in 60 women.

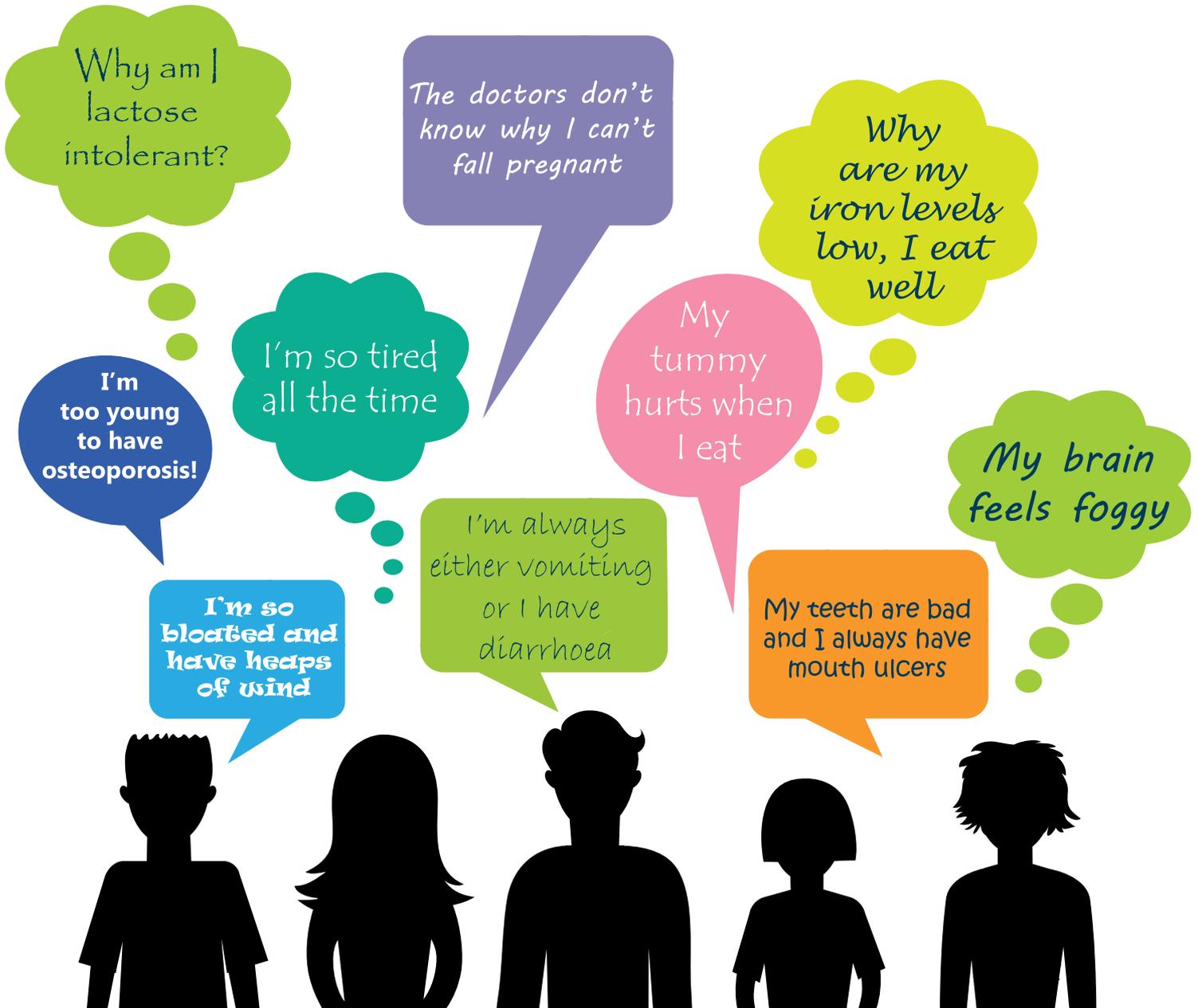
> Testing rates are particularly low among men — representing only a 1/3 of those who are tested for coeliac disease.

> For many people with coeliac disease, even those exhibiting symptoms, it can take 10 or more years before they are tested.

> In the long term, if left untreated, this condition can create issues with fertility, osteoporosis and even some cancers.

> Appropriate diagnosis and management can reverse symptoms, reduce risks of long-term complications and improve overall quality of life.

> Coeliac Australia is a national not-for-profit body supporting people with coeliac disease. Coeliac Australia has around 20,000 members and provides a range of support and information services to make living with coeliac disease easier. The organisation also seeks to raise vital funds to support research and is dedicated to raising awareness of coeliac disease and the gluten free diet within the medical profession, the food and hospitality industry and the general public.



## Consider coeliac disease

**coles**

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13-20 March

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# A blueprint for the future

The Australian Health Policy Collaboration points the way forward on chronic disease

**T**he growing burden of chronic disease in Australia is one of the health sector's biggest challenges, but the Australian Health Policy Collaboration (AHPC) has laid out a blueprint to highlight the way forward on managing it.

The AHPC, based at Victoria University, has said chronic disease threatens the health of individuals, communities, and even Australia's future economic prosperity. Australia has an unacceptably high rate of risk factors for chronic diseases, including high levels of obesity, physical inactivity, alcohol misuse and poor nutrition. Action is urgently required in relation to modifiable risk factors that contribute to disease and disability in Australia.

Chronic diseases are responsible for nine out of ten deaths in Australia. Many people living with chronic diseases such as diabetes, mental illness and cancer, experience reduced quality of life and disability over many years. Chronic

diseases result in a significant economic burden because of the combined effects of healthcare costs and lost productivity. It has been estimated by the Business Council of Australia that eliminating chronic diseases could increase the workforce by 10 per cent and thus boost the productivity of the Australian economy.

Although cost-effective interventions to prevent chronic diseases are available, Australia has a mixed record when it comes to implementing a thorough approach to prevention. Spending on public health (including prevention) is 1.5% of total recurrent health spending, and the system focuses on treating illness, rather than keeping people well.

AHPC's *Blueprint for preventive action*, by Dr Sharon Willcox, lays out three strategic priorities and a number of action areas. The *Blueprint* is based on several principles including a systemic approach, evidence-based action, tackling inequity and taking a life course approach. At a forum hosted by

AHPC in November last year, participants focussed on the strategic priority of creating accountability for action and monitoring progress. A tailored Australian set of chronic disease targets and indicators were produced by working groups prior to the meeting. The working groups accepted many of the World Health Organization's global indicators for noncommunicable disease prevention, but also added new indicators including the national suicide rate; selected emergency department presentations for injury; and one-year survival rates for specified cancers.

The forum supported the development of a chronic disease report card, to highlight the size of the problem and urgent need for action. Participants discussed what "success" in chronic disease prevention could look like in 12 months' time – November 2016 – in the areas of accountability, community engagement and prevention. In an ideal world, participants, who included health experts from a variety of areas, wanted to see:



**“Australia has an unacceptably high rate of risk factors for chronic diseases, including high levels of obesity, physical inactivity, alcohol misuse and poor nutrition.”**

AHPC has hosted forums focusing on how to reduce the burden of chronic disease.

### Accountability

- A comprehensive national chronic disease surveillance system that enables the systematic collection of primary health data against targets and indicators
- Bipartisan commitment for another Australian Health Survey and a commitment to measure health literacy (the last Health Literacy Survey was conducted in 2006)
- Adoption by the National Strategic Framework for Chronic Conditions and NGOs of the chronic disease targets and indicators
- Primary Health Networks KPIs incorporating the indicators and systematically collecting data

### Community engagement

- The burden of premature deaths converted to an “Australian lives saved” figure and timeline with a multi-pronged campaign and strategy

### Prevention

- Prevention and health promotion as part of all political party agendas
  - Tobacco continuing to have sustained political and policy attention
  - The Commonwealth Government’s Healthy Food Partnership holding bi-partisan support
  - A national bi-partisan commitment to front-of-pack labelling for all foods and improved public awareness
  - Bi-partisan support to regulate and/or tax sugar sweetened beverages and regulate salt
  - Practice Improvement Payments reflecting increased uptake of health screenings
- To achieve these goals, a number of “intervention options” were considered. Among the more audacious was a proposal to fund government health promotion campaigns through a tax on industry marketing and advertising of unhealthy products. Participants also suggested

directing all tax raised on sugar-sweetened drinks and alcohol to prevention efforts.

Community mobilisation was also identified as a key area of chronic disease prevention. Publicity campaigns through social media to share information comparing the health of respective communities was one option floated, along with the publishing of the impact of chronic disease on children. More than one in four Australian children are now overweight or obese, and 95% of children do not meet the guidelines for fruit and vegetable intake. This is likely to have adverse long term consequences for these children and the health system.

The benefits of reducing the incidence and impact of chronic diseases are nationally significant. The AHPC will pursue the development of the report card in 2016, to present an overall summary of the status of chronic disease in Australia, and promote action to address risk factors and improve health. [ha](#)



Accessible hospital food packaging makes it possible for patients with arthritis or other disabilities to easily open their own food.

**M**any consumers take for granted the ability to open food packaging easily. But for the elderly or those with a disability, food packaging can be an insurmountable barrier. In a hospital, the inability to open food packaging often means the food isn't consumed, presenting significant nutrition and patient safety risks.

Various single serve foods and portion controlled packages have been available in health environments for a number of years, but these products are often difficult to open for many patients due to the level of dexterity, strength and fine motor skills required.

This has the potential to reduce their

nutritional intake, delay patient recovery and increase the risk of complications.

The issues associated with single serve food packaging were identified in the Report of the NSW Special Commission of

Inquiry into Acute Care Services in NSW Public Hospitals 2008 (Garling Report).

Working together, Health Purchasing Victoria (HPV) and HealthShare NSW have mandated that public hospital suppliers provide Packaging Accessibility Ratings

for the packaged catering goods that they supply to hospitals.

The rating system was developed in collaboration with HealthShare NSW,

Arthritis Australia, Nestlé and GTRI (USA). These ratings estimate the percentage of consumers who can safely open portion control food packaging.

The rating system uses a scale, with the highest rating being a +8 denoting a product that can be easily and safely opened for 95% of people, to a -8 denoting it's hard to open and may cause injury for over 40% of the population.

The rating is used on a comparative basis, for example if one supplier has a higher rating than another, it will provide them with a competitive advantage when hospital staff select products from the HPV and/or HealthShare Catering Supplies contract.

There is no minimum rating, but working collaboratively with suppliers and providing them a real incentive to innovate via the rating has resulted in continuous improvement, and feedback from patients is

**“Arthritis Australia welcomed the landmark initiative and called for other health procurement bodies to adopt the approach of Victoria and NSW.”**



# Food at your fingertips

Accessible hospital food packaging now a reality in **Victoria and NSW public health**

that the food packaging is increasingly easier to open.

HPV and HealthShare NSW combined represent more than half of Australia's public hospitals. HealthShare NSW provides around 22 million meals each year for patients across its network of local health districts and 165 hospitals. In Victoria, 84 public hospitals and health services access the mandated HPV Catering Supplies contract and had a choice of 28 suppliers on the contract.

Arthritis Australia welcomed the landmark initiative and called for other health procurement bodies to adopt the approach of Victoria and NSW.

"It is both frustrating and unnecessary to see food go uneaten because of hard to open packaging, especially when many suppliers have redesigned their packaging to make it easy to open," Arthritis Australia Director

and Consumer Representative Wendy Favorito said.

"Arthritis Australia calls on the remaining state governments and private health care providers to follow the lead of HPV and HealthShare NSW and put the patient at the centre of the procurement process."

"This is a win for patients, and a win for industry, and delivers better value for money in health care," says Carmen Rechbauer, Director of Food and Patient Services, HealthShare NSW.

For HPV, "best-value" procurement decisions in a hospital context were inextricably linked to quality patient care.

"As a health procurement organisation, our sourcing decisions are driven by what supports better patient care. When it comes to food products in a hospital, we had a responsibility from a procurement perspective to source an accessible product

that wouldn't impede quality care. We know from health service feedback that in many cases if a patient is unable to open the packaging, they simply don't eat the food," said HPV Chief Executive Megan Main.

HPV has also provided suppliers with a set of Packaging Accessibility Design Guidelines to assist manufacturers to design easy to open and read packaging. These guidelines identify the most common accessibility issues associated with packaging and suggest possible ways these issues can be overcome.

They are available upon request from HPV and HealthShare NSW. The ratings are increasingly shared with other public and private hospitals and aged care nationally.

For more details on the initiative, visit: [www.healthshare.nsw.gov.au/services/food-patient](http://www.healthshare.nsw.gov.au/services/food-patient) 



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time. So, locating and rolling over – or consolidating – your super into one account makes sense and it could mean more money to retire on.

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HESTA's online super finder tool helps you locate any super accounts in your name using your tax file number (because it's unique to you). It's a quick four-step online process.

## If you find lost super

Consider the benefits (like insurance) of each of your funds to work out which fund suits your needs best.

To roll all your accounts into HESTA, simply download a pre-populated rollover form (one for each of your old funds) at [hesta.com.au/rollover](http://hesta.com.au/rollover)

After signing the completed form, just

send it to your old funds for processing (they may ask for certified proof of identity) and we'll let you know when it arrives at HESTA.

To find out if you have lost super, go to [hesta.com.au/superfinder](http://hesta.com.au/superfinder) 

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# AHHA Collaboration Networks

**AHHA's Collaboration Networks have been developed to:**

- **Provide forums for ideas and discussion**
- **Promote collaborative and innovative practices**
- **Share and promote best practice**

Membership of the networks is open to all AHHA stakeholders with an interest in the relevant area. Members may be representatives of government agencies, community and private sector organisations, academics or other individuals with relevant expertise.

## Data Collaboration Network

The Data Collaboration Network seeks opportunities for better use of health data in Australia, including promoting the potential for cross-sector collaboration.

## Innovation Collaboration Network

The Innovation Collaboration Network provides an opportunity to promote innovation and innovative ideas in the health sector and exposes participants to new ideas, technologies and techniques.

## Mental Health Network

The Mental Health Network provides an opportunity to share information and expertise around mental health initiatives with a focus on primary health care.

In 2016, meetings of the Data and Innovation Collaboration Networks will be held together at:

17 February - Penrith, hosted by Nepean-Blue Mountains Primary Health Network

25 May - Sunshine Coast, hosted by Central Queensland, Wide Bay, Sunshine Coast Primary Health Network

26 July - Darwin, hosted by Northern Territory Primary Health Network

26 October - location TBA

In 2016, meetings of the Mental Health Network will be held at:

8 March – Brisbane, hosted by Brisbane North Primary Health Network

10 May – Newcastle, hosted by Hunter New England Central Coast Primary Health Network

27 July – Darwin, hosted by Northern Territory Primary Health Network

18 October - location TBA

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

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

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

[oxfam.org.au/closethegap](http://oxfam.org.au/closethegap)

## CLOSE THE GAP

# A cost effective, nutritious alternative for your patients

The provision of nutritious and accessible meals and snacks for patients in a hospital or aged care environment should be considered an essential part of their treatment, not just an added service.

Recent studies have shown that the median plate waste in hospitals is currently sitting at 30% by weight, much higher than other foodservice settings. Reasons for this wastage may relate to the condition of the patients, food and menu issues and service issues (including difficulty accessing food).<sup>2</sup>

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The SPC ProVital fruit cup recently achieved a + 8 rating from Arthritis Australia; meaning that 95% of patients with arthritis and fine motor skill difficulties will be able to easily open the fruit cup on their own.

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- 100% Australian Fruit
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## Texture Modified Puree Range



Suitable for  
Texture C Diets

### References

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### About SPC

SPC Ardmoma has been committed to bringing premium packed fruit and vegetables to Australians for nearly 100 years. The company's iconic food brands, Ardmona®, GOULBURN VALLEY®, IXL®, SPC® and TAYLOR'S® are strong performers in their product categories and are further developed and supported by continued investments in both marketing and product innovations. SPC Ardmoma is owned by Australian-listed company Coca-Cola Amatil.

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# 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

**T**he Australian Healthcare and Hospitals Association (AHHA) is an

independent national peak body advocating for universal and equitable access to high quality healthcare in Australia.

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

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

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

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

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

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

In partnership with the LEI Group, the AHHA also provides

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

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

To learn more about these and other benefits of membership, visit [www.ahha.asn.au](http://www.ahha.asn.au)



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# More about the AHHA

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

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

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## AHHA National Council

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

<http://ahha.asn.au/governance>

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

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## CERTIFICATION BODY

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.



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