The Health Advocate

Your voice in healthcare

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Caring for our most vulnerable
Innovative projects reaching out to at-risk groups

Integrated healthcare

Promoting partnerships between and within our health sectors

Revolutionising public dental health
An overview of the Child Dental Benefits Schedule

Future challenges
Health and reform of the Federation

+MORE INSIDE

The official magazine of the Australian Healthcare and Hospitals Association

ISSUE 27 / December 2014

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2014 winners, left to right: Zoe Sabri, Stephen Brown and Jeanine Young representing the Pepi-pod® Program.

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Issue 27 / December 2014

In depth

Briefing

From the AHHA desk

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

Towards a better connected future

Federalism, integrated care and eHealth leading the way

Following on from our call for Australia to step up its response to the growing Ebola crisis in West Africa, the AHHA has commended the Government on its decision to commit increased funds, technical capacity and staffing to the development and management of treatment facilities. Australia has an excellent medical workforce, willing and capable to assist in times of need. International efforts should be no exception, especially in today's globalised and highly mobile world, where disease is not so easily confined.

While Ebola presents an immediate and specific health concern — and one that dominates media headlines — we must not forget broader issues facing the future of healthcare in this country. Australia's health system requires a 'big picture' perspective with regard to the growing and ageing population, and the increased burden of chronic disease that will inevitably follow. How Australia's states and territories work together with the Commonwealth to manage these challenges is something that Linc Thurecht looks at in his article on federalism and health. It is also the emphasis of the *Future Solutions in Australian Healthcare White Paper*, which Avnesh Ratnanesan discusses on page 12 in this edition of *The Health Advocate*.

No plan for the future of Australian healthcare would be complete without a commitment to improving Indigenous health. Two articles in this edition comment on this issue specifically. The first details the work of Henrietta Marrie — named in the Australian Financial Review and Westpac list of the *100 Women of Influence* for 2014 — to abolish institutional racism and improve the health, wellbeing and general autonomy of Indigenous Australians. The second is an overview of the *Life Giving Music and Dance DVD* initiative of the Northern Territory Medicare Local and the importance of developing culturally-relevant resources to build resilience and maintain positive mental health throughout the community.

Understanding the need for targeted approaches to healthcare comes from greater awareness of the issues each patient faces, the types of services that they need and have access to. An integrated primary care sector is critical to achieving such a patient-centred healthcare system. The AHHA has long advocated for a more integrated approach to care, and has recently sought to put these ideas into practice with some of the leading health experts in the country at its Integrated Care Simulation at Old Parliament House in October. The event was a 'test environment' for how current policy considerations might impact on health services and system integration. The recommendations from various stakeholders across public, private and not-for-profit sectors provide valuable insights for future integrated care initiatives.

Australia's health system requires a 'big picture' perspective with regard to the growing and ageing population, and the increased burden of chronic disease that will inevitably follow.

As other authors of the magazine have shown, a holistic and long-term approach to healthcare is vital if there is to be real and lasting reform. This includes acknowledging the importance of things integral — though not always at the forefront of discussion — to health and wellbeing: things like oral health (as discussed by Martin Dooland with regards to the Child Dental Benefits Schedule), environment (as Louisa Deasey shows with regards to hospital design) and lifestyle (demonstrated by walk-at-work ANU academic, Amelia Simpson).

Fundamental to better health care are the connections established and maintained through the collection and sharing of health information. The value of online technologies for information sharing has been emphasised throughout this magazine. Steve Hambleton — former President of the Australian Medical Association and current Chair of the National E-Health Transition Authority — writes about the need to capitalise on IT infrastructure to connect points of care. Greater Metro Brisbane Medicare Locals discuss their use of online information portals to train and support doctors in the diagnosis and treatment of patients, as well as to track the prevalence of chronic disease.

In showcasing these topics and more, *The Health Advocate* continues to stand as a testament to the value of the AHHA as an organisation that brings together a wide variety of health stakeholders' perspectives. With 2014 drawing to a close, and on behalf of the AHHA, I would like to wish all of our readers a happy and safe holiday period. I look forward to welcoming you back in 2015 and continuing to celebrate the important work of our diverse membership. ha

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

AHHA welcomes action on Ebola crisis

On 5 November, the AHHA welcomed the announcement by the Prime Minister and Health Minister of the expansion of Australia's contribution to international efforts to address the Ebola crisis in West Africa. The decision to commit increased funds, technical capacity and staffing to the development and management of a 100-bed treatment centre, was applauded.

The AHHA was also pleased that Australia will be contributing to the development of the World Health Organisation regional response plan.

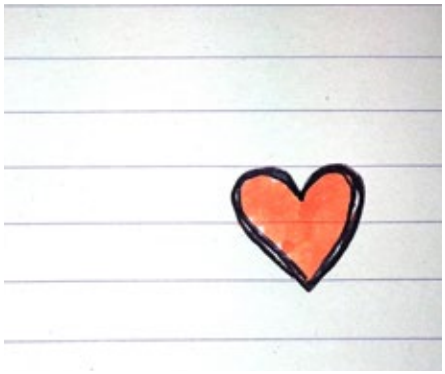
"Today's announcement is a welcome change to the Australian Government's approach to the Ebola crisis and one commensurate with Australia's international standing. The Australian Healthcare and Hospitals Association wishes to commend the Government on this commitment and believes that the further injection of expertise into on-the-ground assistance will be a positive contribution to addressing this major humanitarian crisis," said AHHA Chief Executive, Alison Verhoeven.

Co-payments for healthcare: What is their real cost?

The Federal Government's recent Budget proposal to introduce a $7 co-payment for doctor visits, pathology tests and diagnostic imagining will have the most significant impact on disadvantaged and vulnerable Australians. This is the finding of research published in the AHHA's academic journal, the *Australian Health Review*.

In the study, evidence is provided on how out of pocket expenses disproportionately impact people of lower socioeconomic means, those with a chronic disease or long term illness, those receiving income support payments and Aboriginal and Torres Strait Islander people.

While the Federal Government has justified the co-payment as a price signal to deter unnecessary visits to doctors, the lead author of the article, Dr Tracey Laba, noted that it "cannot be assumed that consumers know the severity and prognosis of a condition before a consultation and can discriminate between necessary and unnecessary services."



Working together for positive outcomes in acute coronary care

A new model of care, linking practitioners with cultural knowledge, is making waves in the field of acute coronary syndrome among Aboriginal and Torres Strait Islander patients, according to a report published in the latest issue of the AHHA's academic journal, *The Australian Health Review*.

The report, "Implementing a working together model for Aboriginal patients with acute coronary syndrome: an Aboriginal Hospital Liaison Officer and a specialist cardiac nurse working together to improve hospital care", details how the use of a culturally-aware Aboriginal Hospital Liaison Officer (AHLO) in partnership with a specialist cardiac nurse was able to facilitate better outcomes for Aboriginal patients.

According to the report, cardiovascular disease is a significant contributor to the difference in life expectancy between Aboriginal and non-Aboriginal Australians.

Contributing to the disparities between Aboriginal and non-Aboriginal Australians is the lack of access to culturally appropriate hospital cardiac care.

The report suggests that to improve Aboriginal patients' experience, hospitals should provide a culturally safe environment.

New public health strategies are needed to respond to climate change

Immediate and longer-term impacts of climate change have the potential to seriously affect Australian health and social environments. The threat posed to Australian health by climate change is at the heart of a new issues brief, published by the AHHA, and presented at the Greening the Health Sector Think Tank in Brisbane on October 14.

According to lead author Tony Walter, new public health strategies are required, including assessing regional health risks to identify vulnerable populations, collecting enhanced surveillance data and developing monitoring indicators.

"Politicians, health bureaucrats and other interested parties must formulate comprehensive, coherent policies to address the direct and indirect impacts of climate change on public health, including allocation of appropriate financial resources as part of a National Plan for Health in Responding to Climate Change," says Mr Walter.

'Virtual ward' helps ease the burden on hospitals

Providing rehabilitation services in the home rather than the hospital bed can improve patient outcomes and create various efficiencies, according to a new study that was published in the *Australian Health Review* in early November.

AHHA Chief Executive Alison Verhoeven said the study, undertaken by the University of Western Australia and the Fremantle Hospital and Health Service, highlights that rehabilitation in the home (RITH) services can be a safe and effective alternative for many, including older people.

The model sees patients assessed for RITH suitability while they are hospital inpatients, entering a 'virtual ward' upon discharge and commencing home-based rehabilitation based on their individual needs.

"The study shows that, through using existing systems and databases, we are able to assess clinical outcomes of large RITH services, find useful predictors of poor outcomes and, ultimately, improve the way these services are run," Ms Verhoeven said.

Medical research should not come at the cost of affordable care

In responding to news that an action group had been formed to support the GP co-payment in order to establish the Medical Research Future Fund, the AHHA reconfirmed concerns in relation to affordable care for those most in need.

"The AHHA agrees that increased funding for medical and health services research in Australia is of the utmost importance, however we cannot support this increased funding coming at the cost of affordable primary health care," said AHHA Chief Executive, Alison Verhoeven.

The AHHA remains concerned that if this investment comes at the cost of people accessing timely and appropriate health care the treatments and care models developed through this research will have gone to waste.

"Patient care and improving health outcomes for all Australians, especially those most vulnerable, should be the driving force behind health policy and funding decisions," Ms Verhoeven said. ha

ALISON VERHOEVEN
Chief Executive
AHHA

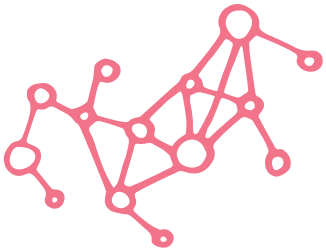
The road to Primary Health Networks

Findings from the Primary Healthcare Roadshow

The primary healthcare sector in Australia is undergoing a transformation with the wind up of the Medicare Local (ML) system and the introduction of Primary Health Networks (PHNs). While much of the information around PHNs is yet to be released, interest in the new organisations — their functions, roles and performance measurement — is high.

Against this background, participants in the Primary Healthcare Roadshow — jointly undertaken by the AHHA and the Public Health Association of Australia (PHAA) across five cities in September — identified a broad range of opportunities, challenges and recommendations for the new PHNs. They highlighted that while the PHNs have the capacity to be drivers of reform and value for money in healthcare, there are significant concerns that their larger size will make it challenging for them to meet the needs of all people in their region.

In particular, given the reduced number of PHNs compared with MLs, it may be difficult to effectively meet health needs in rural and remote areas. This is especially important in areas with significant numbers of Aboriginal and Torres Strait Islander people, due to the fact that Indigenous people suffer a burden of disease and chronic illness that is 2-3 times greater than that of the non-Indigenous community. This is compounded by issues around access and cost of delivery, as well as the need for greater health literacy. Therefore, while there may be advantages related to economies of scale given the larger size of PHNs, a major challenge will be to ensure they are locally responsive; not just to population, but to need.



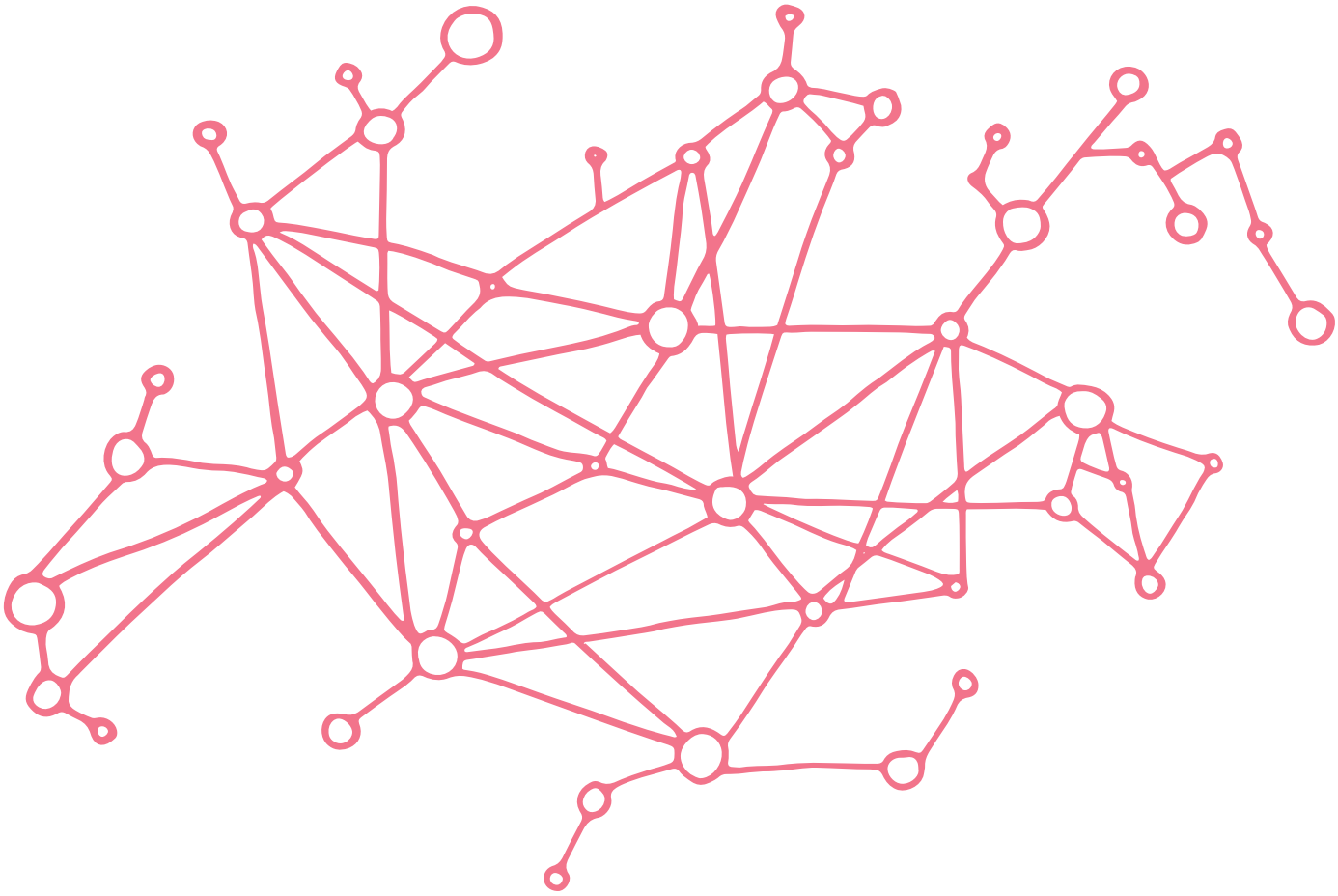
While there may be advantages related to economies of scale given the larger size of PHNs, a major challenge will be to ensure they are locally responsive; not just to population, but to need.

Another concern surrounding the PHN model, like the ML model before it, is that it appears to be vague in terms of objectives, performance measures and targets, but more rigorous in terms of process. This is the wrong way around. Greater rigour in objectives and measurement, coupled with a less detailed approach to process, would help provide the clarity and flexibility required for a high-performing health system.

It is also not clear whether current activities are reform or just reorganisation of the primary healthcare sector, and caution will needed to ensure the work of PHNs is based on robust evidence and research rather than experimentation. The AHHA can help in this area, with activities such as the AHHA's recent Integrated Care Simulation (see page 31) testing major potential policy initiatives before they are implemented. By doing this, we're involving stakeholders and also uncovering potential unintended consequences before they occur.

In further minimising this risk of 'experimental policy', lessons need to be taken away from the ML experience, and the good work done in areas such as data collection, warehousing and reporting platforms must continue. There is an opportunity for PHNs to focus on integration of health services to help provide seamless, appropriate, affordable and accessible care, especially for diversity and 'close the gap' initiatives. However, this will take time, and we cannot expect PHNs to deliver on the requirements of their funding agreements straight away. We recommend that a provision be made for an establishment period.

One other recommendation to come out of the roadshow was the need for the Commonwealth to drive an agenda of communication and consistency in primary health across Australia. While variation based on local needs is desirable, a culture



of information-sharing can help drive system improvement and ensure PHNs work together rather than in isolation. Partnerships are an integral feature of the proposed PHNs and, given the complexity of issues, funding arrangements and increasing demand for primary health, better communication is essential.

In the absence of a funded national alliance for PHNs, non-government peak bodies such as the AHHA are prepared to step in and support PHNs and a national organised primary care system. We now have the opportunity to establish formal partnerships between industry and research through a renewed research program that is focused on implementation of evidence-based improvements in service delivery. However, the benefits of sharing learnings and information across the country will only be realised if adequate funding support is available to facilitate data collection and collaboration.

There has been bipartisan agreement about the central role of primary healthcare in ensuring a robust and sustainable health system in Australia, and PHNs have significant opportunities to be drivers of reform and value for money. This will require both a policy and funding mandate. In particular, PHNs will need to have a stewardship role for the health of Australians, rather than a focus on episodic care; they need to have a long-term approach to turning the tide on the growing burden of chronic disease.

PHNs should also be consumer-focused, promoting and supporting reform to the models of primary healthcare delivery. One such model is the 'medical home' concept, which is characterised as patient-centred, comprehensive, coordinated, accessible and committed to safety and quality. Moreover, PHNs should aspire to the Triple Aim described by the Institute for Healthcare Improvement: improving patient experience, improving population health and reducing the per capita cost of healthcare.

The AHHA is well placed to provide support through the transition to a more integrated and accessible primary healthcare sector, and to maintain an open dialogue with our political leaders to assist the PHNs to meet these goals. ha

The AHHA and PHAA Communique 'Primary Health Networks: Opportunities, Challenges and Recommendations' is now available at www.ahha.asn.au/policy-issue/community-and-primary-healthcare

Reform of the Federation of Australia

AHHA's **Linc Thurecht** re-examines inter-governmental relations and, in particular, how taxes are raised and distributed

Two major processes currently underway at the Federal level could fundamentally change the relationship between governments at all levels in the delivery of public services and the way taxation revenue is raised and allocated. These reviews will also be set against the background of the pending fourth Intergenerational Report that will project Federal government finances over the next four decades. Taken together, these processes will be of significant importance to the Australian healthcare system.

In June the Prime Minister announced the terms of reference for a *White Paper on the Reform of the Federation* to be coordinated with the previously announced *White Paper on the Reform of Australia's Tax System*.

The objectives are, in part, stated as ensuring "the states and territories are sovereign in their own sphere" and will consider achieving agreement on "distinct and mutually exclusive responsibilities" (PM&C, 2014:v).

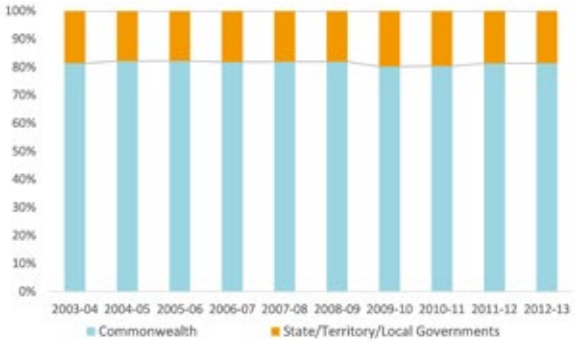
This suggests the Commonwealth Government may be preparing to relinquish or reduce its involvement in a number of areas of public policy including health, education and housing. This would represent a fundamental shift in the gradual flow of powers and responsibilities to the Commonwealth over the last century in areas that constitutionally belong to the states and territories.

At the same time there is a recognition of the considerable imbalance in revenue-raising powers between the Commonwealth and the state, territory and local governments to fund the delivery of these services.

As Figure 1 shows, over the past decade, the Commonwealth government has raised a fairly consistent 81.6% annual average of taxation revenue with state, territory and local governments collecting the remainder (ABS, 2014). In turn, Figure 2 shows the proportion of total revenue of the two lower tiers of government that was sourced from grants and subsidies. Over the past decade, this has represented an annual average of 38.5% of state, territory and local government total revenue (ABS, 2014). Figure 3 shows the share of total health expenditure funding across three main sources. The economic term "vertical fiscal imbalance" is used to describe this mismatch between the Commonwealth's revenue raising capacity and the state and territory expenditure responsibilities for health and other services.

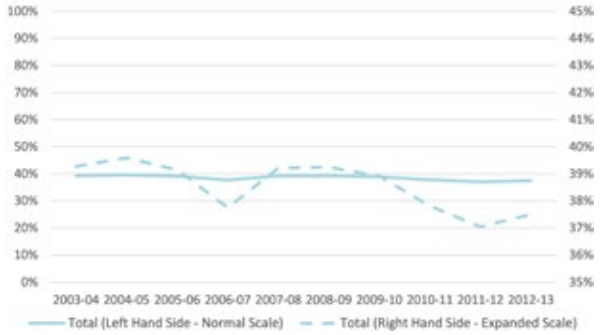
The Commonwealth Treasury Secretary has also recently described the Australian taxation system as "unsustainable" (Parkinson, 2014). In this economic environment, savings measures announced by the

Figure 1. Proportion of taxation revenue raised – Commonwealth compared to state, territory and local governments



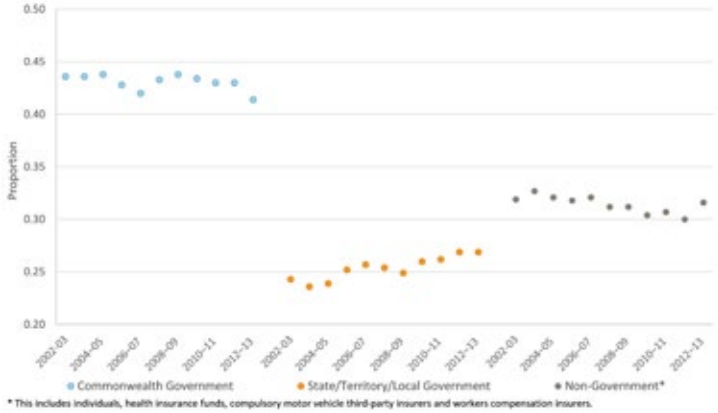
Source: ABS (2014).

Figure 2. Grants and subsidies – Share of state, territory and local government total revenue



Source: ABS (2014).

Figure 3. Funding for health expenditure as a proportion of total health expenditure by source of funds



Source: AIHW (2014).

In the wings: White Paper on the Reform of the Federation ↔ White Paper on the Reform of Australia's Tax System ↔ Fourth Intergenerational Report

Commonwealth Government in its 2014-15 Budget for hospitals and schools are expected to save over $80 billion by 2024-25 (CoA, 2014b).

Reform of the Federation recognises the need for equity, sustainability and durability in funding for public services. Consistent with this, *Reform of Australia's Tax System* is intended to "provide a longer term considered approach to tax reform that is consistent with the Government's core principles of fairness and simplicity" (CoA, 2014a:19).

While these two White Papers are broad in their scope, another imminent Commonwealth report will provide a long-term economic context against which all of this will be considered. The fourth *Intergeneration Report* is to be released by January 2015, and is required to "to assess the long term sustainability of current Government policies over the 40 years following the release of the report" (CoBH, 1998: Part 6.21).

Past iterations of the *Intergenerational Report* have highlighted the structurally ageing Australian population and the associated pressure this will create for spending on healthcare services. Healthcare and funding of the system have always been closely related and this will be central to any recommendations made in the two White Papers. Healthcare spending has recently been identified as representing "the Commonwealth's single largest long run fiscal challenge" (Shepherd *et al*, 2014:95).

With any deliberation about changes in relationships between governments, taxation, and the funding of public services, sustainability of the healthcare system and its capacity to delivery positive health outcomes for all Australians must never be compromised.

While these are fundamental and far reaching changes that are being canvassed in the way governments fund and provide essential public services, at the AHHA, we emphasise two essential principles when considering all these issues.

The first is that any proposed changes in responsibilities for the delivery of healthcare services to the public, or in how revenue is raised and distributed, must be considered as a whole. Cherry-picking individual proposals according to narrow and short term political interests does not produce good public policy. Any comprehensive set of integrated proposals on reform to the Australian healthcare system should not then result in only selective recommendations being implemented, such as occurred with the *Henry Tax Review* in 2010 (Henry *et al*, 2010).

The second is that any proposed changes that will impact on the healthcare system must only be considered with the sustainability of good patient outcomes for all in mind. Health has long been a political football, not only between the Commonwealth and the states and territories, but also within these tiers of government. The early discussion around *Reform of the Federation* recognises and seeks to overcome these tensions and must be steadfastly adhered to.

With any deliberation about changes in relationships between governments, taxation, and the funding of public services, sustainability of the healthcare system and its capacity to delivery positive health outcomes for all Australians must never be compromised.

Affordability, accessibility and equity must always be at the heart of our healthcare system. ha

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AVNESH RATNANESAN
Chief Executive Officer
Energesse

Future solutions in Australian healthcare

A new White Paper for public review

The *Future Solutions in Australian Healthcare White Paper* was developed in collaboration with 21 key healthcare thought leaders to help solve Australia's major health challenges and guide the future of the healthcare system leading up to 2020. Collectively, these healthcare thought leaders manage over $8 billion of Australian healthcare expenditure and hold roles that influence over $30 billion of healthcare industry annual turnover.

Presented to leaders in both Federal and State Governments as well as several national health conferences, this White Paper offers a "big picture" perspective on future trends. It is a resource for organisational strategy or government policy which could be utilised by any healthcare leader, organisation or government body in Australia. Produced independently by healthcare consulting firm Energesse, in collaboration with four other international consulting firms, the White Paper captures a range of provocative ideas and strategies, as well as identifies common priorities that require more urgent attention.

Australia has a generally solid healthcare system that is regarded as one of the finest in the world. Approximately $140 billion is spent on healthcare in Australia, which amounts to more than 9.1% of Gross Domestic Product — around the mean compared to other OECD countries. Studies also show that the average life expectancy and overall wellbeing both rank as being the 6th highest in the world

However, epidemics such as obesity, diabetes, cardiovascular disease and cancer are growing at alarming rates. Approximately 29% or 5.2 million adult Australians are obese, a major contributor to the rise in co-morbidities. Sedentary lifestyles, smoking, alcohol, prolonged sun exposure and the prevalence of fast food are behavioural patterns that are placing unparalleled demands on the sickness end of the healthcare spectrum.

Combined with the rises in cost of medical treatment and technologies, Treasury projections estimate the growth rate of healthcare expenditure vs. Gross Domestic Product will rise from 4% to a staggering 7% by 2050. This phenomenon will be compounded by an ageing population and the burden of chronic disease. The system's failure to ensure equitable access to healthcare services, particularly in rural and regional communities, is reinforced by life expectancy estimations of young Aboriginal and Torres Strait Islander population to be 10 years lower than non-Indigenous males. The state of care in such communities is further challenged by funding requirements and the lack of skilled healthcare professionals able and willing to serve in these locations.

The Australian healthcare system, like many others around the world, has been guilty of measuring what is easy rather than what is important.

Detailed analyses of interviews with thought leaders reveal six major challenges that contribute to a self-propagating "Vicious Cycle" in the healthcare system. Cracking the code to the system's overall picture unveiled disparities in incentive models, uneven workforce utilisation, as well as inertia to innovate in an uncoordinated system — all of which contribute to this downward spiral.

The Vicious Cycle is potentially costing the government and healthcare organisations tens of billions of dollars and preventing the system from better caring for millions of Australians, now and into the future. In order to fix these issues, the solutions mentioned in the White Paper break patterns of the Vicious Cycle and transform it into "Virtuous Cycle" of positive gain. Solutions include reforms to funding and incentive structures which ensure that future budgetary changes force more productive results. Changes also include managing workforce levels and introducing measures for better long-term planning to ensure that quality services are more aligned with national population needs.

The Australian healthcare system, like many others around the world, has been guilty of measuring what is easy rather than what is important. It is easy to measure the number of patients a clinician sees in a day; it is far more difficult to measure the "quality of life outcomes" of the patient before and after a consultation. If, as a healthcare stakeholder, you had to pick one solution from the range of practical and revolutionary strategies presented in this paper, it would be to implement a suite of far more appropriate success measures. ha

Dr Avnesh Ratnanesan is an international consultant working with US, UK and Australian health organisations and a keynote speaker on healthcare and wellness. He is the lead author of *Future Solutions in Australian Healthcare*, which is currently available at www.energesse.com

Henrietta Marrie – a woman of influence.

A woman of influence

The AHHA's **Dominic Lavers** chats to Henrietta Marrie about a new framework for abolishing institutional racism and improving the health and wellbeing of Indigenous Australians.

While Henrietta Marrie says it was an "overwhelming honour" to be named in this year's *100 Women of Influence*, the Australian Indigenous rights advocate hopes it can become a platform for improving Indigenous health services and inspiring young Indigenous women.

As an Aboriginal Australian from the Yidinji tribe in Queensland, Henrietta has been advocating for the rights of Indigenous peoples for more than 30 years. With her husband, Adrian, she has recently developed a framework, or "Matrix", for monitoring institutional racism, an issue that sees Aboriginal and Torres Strait Islander people excluded or alienated at all levels of Australia's healthcare system.

Henrietta says the Matrix is an integral tool in realising the goal of an Australian health system free of racism and inequality by 2031, as set out in the Australian Government's National Aboriginal and Torres Strait Islander Health Plan 2013-2023. "The Matrix has been developed to hold public hospitals and health services accountable for First Nations people and the community as a whole," Henrietta said. "It's a flexible assessment tool that can monitor an organisation's progress towards Indigenous equality; you can assess yourself, note the changes that need to be made and then, in a few years' time, see whether you've achieved what you set out to achieve."

The framework is outlined alongside a case study of the Cairns and Hinterland Hospital and Health Service, but can be adapted to assess any organisation against the set of criteria. Some of these criteria include community engagement, service delivery and cultural competence, as well as Aboriginal and Torres Strait Islander representation in both governance and the workforce. From board composition and organisational structure to newly-reformed policies, employment contracts and public reporting, the Matrix looks at the root of institutional racism. This is in contrast to just examining the end result, which often sees Aboriginal and Torres Strait Islander patients withdrawing from the health system and either self-discharging or simply not seeking help to begin with.

While some organisations may be hesitant about being measured against the framework, Henrietta says it's important to cast those fears aside and, if issues are identified, to be proactive and work towards correcting them. "Just by looking at the criteria some people will know that their organisation is not inclusive of First Nations people," she said. "But, if you're doing it for yourself, no one has to see the results; do it, assess yourself and then simply say 'right, we're going to change'."

Where high levels of institutional racism exist, organisations need to change the institutional culture and become more inclusive of Aboriginal and Torres Strait Islander people. For this to happen, and for healthcare services to become more culturally appropriate, there needs to be communication between the Indigenous populations and those institutions. "While I know that it takes resources, it's important to talk with individuals in the community, not just the representative bodies," she said. "The community members have to feel comfortable going in there. If you give them part ownership by asking for their opinions, health services can only improve and become more culturally appropriate."

After speaking with many Aboriginal and Torres Strait Islander people, both within organisations and those using health services, Henrietta says she was deeply affected by the scope of the inequality and the impact institutional racism was having on their lives. "Since beginning this work, my eyes have really been opened to the extent that racism can exist in a health institution that is supposed to work for the betterment of all people. The people I spoke to about it were very emotional and they had put up with it, not for one or two years, but for 10 years or so," she said. "In some cases, the employment of First Nations people in these institutions has declined because they were getting put off. In hearing these stories and having members of my family go through similar experiences, I just thought 'this has to stop, we have to do something about it'."

When discussing being named in the Australian Financial Review and Westpac's list of the *100 Women of Influence*, Henrietta focussed on what it could mean for future generations of Indigenous women. "I hope it will inspire other First Nations women and girls to get up there, take their dreams and move beyond where they feel comfortable and make a difference; we Indigenous women can actually achieve what we want," she said. "There are many successful First Nations women in this country and they've achieved great things, not just for First Nations people but for the whole community. We need to get these women out there, recognise them and the contribution that they've made to the overall social fabric of society."

She also hopes that the honour will go some way to combating institutional racism and other inequality that exists within Australia's healthcare system. "Let's use the award as a way of promoting the change that needs to happen out there," she said. "If it provides a platform to use, I say 'let's use it'. Let's create that change, let's create a movement to make people sit up, listen and want to make that change." ha

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Henrietta Marrie is currently a Senior Fellow at the United Nations University. In June 2014, she and her husband Adrian Marrie published *The Cairns & Hinterland Hospital and Health Service (CHHHS): A Case Study in Institutional Racism* in support of the Australian Human Rights Commission's National Anti-Racism Strategy.

Boys from Milingimbi, featured in the DVD.
Image courtesy of NT Medicare Local.

TIM KEANE
Principal Program Officer, Mental Health Services Rural and Remote Australia
Northern Territory Medicare Local

Giving life through music and dance

The culturally-relevant resource that is building resilience in Indigenous communities

Building resilience through music and dance is the aim of a DVD resource produced by the Northern Territory Medicare Local (NTML) together with Aboriginal communities in the Top End of the Northern Territory.

The DVD, titled *Life Giving Music and Dance*, was filmed on location in the communities of Galiwin'ku and Milingimbi. It explores traditional and contemporary music and dance and the importance of music and dance in maintaining strong mental health and wellbeing and, in turn, preventing suicide.

Life Giving Music and Dance tells the story in Djambarrpuynu language of the ways that music, dancing, singing, laughing and being around others can improve overall mental health. For Yolngu people, music and dance are vital ingredients to building resilience and maintaining positive mental health.

Themes of identity, connections to land, culture and local customs mean that the DVD is culturally-relevant to the Yolgnu communities in East Arnhem. For Yolngu, this is seen as "positive psychology" and affirms how the importance of deep connections to, and involvement with, a person's cultural customs and ceremonies can improve emotional wellbeing.

Launched at Mental Health Week in Galiwin'ku during October 2013 and at the Milingimbi festival "Gattjurk" in November 2013, the DVD has continued to receive remarkable national attention and overwhelming positive feedback. The DVD has been screened on the national stage, including the Australian Rural and Remote Mental Health Symposium in Geelong, October 2013; at the inaugural NT Suicide Prevention and Wellbeing Conference in Darwin, June 2014; and the National Suicide Prevention Conference held in Perth in July 2014.

Joan Dhamarrandji – Program Manager in the Mental Health Team Galiwin'ku, Ngalkanbuy Clinic – at the DVD launch. Image courtesy of NT Medicare Local.

The DVD has been distributed to 16 different communities across East and West Arnhem Land as a tool to be used in health education and promotion. It is screened in clinic waiting areas, schools and other community facilities and events. The DVD is also being used in Perth by the Telethon Institute for Child Health Research and Kulunga Research Network.

The DVD was developed in response to the disproportionally high suicide rates faced by the Northern Territory's Indigenous populations. Many factors contribute to this alarming rate, including a lower availability of psycho-social support, coupled with a greater percentage of people falling within high-risk categories. Ongoing efforts are required to reduce — and counter — the impact of these contributing factors.

To build resilience, communities need access to current, culturally safe, relevant and appropriate resources to ensure they are widely used by community members in a range of settings, such as health centres, schools, community events, and as part of education and training. The NTML is focussed on raising awareness around the characteristics of healthy and resilient communities in order to reduce the high suicide rate in the NT. ha

To view Life Giving Music and Dance, please visit www.ntml.org.au or to request a copy, please contact Tim by phone on 08 8982 1006 or via email at tim.keane@ntml.org.au

Reaching out to the streets

How the **Youth Projects' After Hours Primary Care Service** is providing a helping hand to young people doing it tough in Melbourne

When you're homeless or living rough, getting access to primary health care like first aid or mental health support can seem out of reach.

That's where the Youth Projects After Hours Primary Care Service comes in, actively targeting people living in rooming houses, crisis accommodation and on the street in the Melbourne CBD.

The nurse-led service then provides immediate and primary care to those in need, including health and social assessments, professional nursing care, counselling and active support, first aid and medication management.

The service, funded by Inner North West Melbourne Medicare Local (INWMML) and operated by city based not-for-profit Youth Projects, is an assertive health outreach program that seeks to meet the urgent primary care needs of our most vulnerable community members.

Clients can also be linked with existing local services for ongoing health and medical care, such as the Living Room Primary Health Service — also operated by Youth Project — to provide access to doctors, nurses and a range of allied health professionals.

The service has already provided more than 1,000 episodes of care since beginning as a limited trial at the beginning of 2013, and Youth Projects CEO Melanie Raymond said it has been invaluable for people living rough in the city.

"From a slow start, the episodes of care have now doubled and we have built a strong network of trust so people can come forward for help," Ms Raymond said.

"Referral from our other outreach programs and to clinics also increases the impact of the program so effective referral and follow up is in place."

The service was developed as a partnership between INWMML and Youth Projects, after a comprehensive health assessment of the Inner North West region of Melbourne showed much higher levels of homelessness than the Victorian average.

The assessment also identified that people experiencing homelessness have limited access to after-hours medical support and may delay seeking care until the problem becomes urgent.

This need for greater access to care led to establishment of the After Hours Homelessness Outreach Service, which provides two nurses per shift to offer care, referral and support to people experiencing homelessness within the Melbourne CBD.

These nurses walk a designated route in the city, Friday, Saturday and Sunday from 7pm to 11pm. Many of their clients require wound care or pain management, and recurring mental health issues are also commonly reported.

"This program builds close links between primary care, mental health and substance abuse issues among people who are most in need," Ms Raymond said.

"Early detection of illness and disease with referral to appropriate specialist services ensures health resources are used efficiently, and more costly interventions can be avoided."

And the service itself has received a boost recently, with INWMML extending funding for the program for another year.

INWMML Chief Executive, Associate Professor Christopher Carter, said it's great to be able to support the success of the program, which has had recent media coverage on A Current Affair, Channel 9 news and local media outlets.

"With Melbourne having the highest rates of homelessness in our region, this nurse outreach service is crucial to our community," A/Prof Carter said.

"As well as providing medical care where it's needed most, the nurses can help prevent small problems becoming bigger ones and landing people in hospital - potentially saving thousands of dollars for the health system each time."

"With Melbourne having the highest rates of homelessness in our region, this nurse outreach service is crucial to our community"

A/Prof Carter said the extension of the contract until 30 June 2015 means INWMML has now committed more than $300,000 over three years to support the service.

"It's a really important service and we're happy to be able to keep supporting its work for another year." ha

For more information about INWMML's After Hours services please contact Tessa Saunders on (03) 9347 1188.

Help for youth living rough on the streets of Melbourne.

MARTIN DOOLAND
Consultant
Public sector dentistry

Revolutionising public dental health

The Child Dental Benefits Schedule is a good start on a long journey towards universal dental care

Most Australians are not aware that something of a minor revolution in dental public health started in January 2014 with the introduction of the Child Dental Benefits Schedule (CDBS). The title of the program may not be very exciting but the program itself certainly is.

Based on the 2012 recommendations of the National Advisory Council on Dental Health, the CDBS allows most children to receive Commonwealth-funded/subsidised dental treatment. This looks a lot like the much talked about "Denticare". However, the scheme is not quite universal being limited to children in families eligible for Family Tax Benefit A (around 80% of children). The program is also limited to $1,000 every two years and only covers basic care such as check-ups, preventive services (such as fluoride applications), fillings and extractions — although these services account for the overwhelming majority of treatment needs. Importantly, both private dental practices and public dental clinics may provide treatment under the CDBS. While private practitioners may charge a co-payment (gap amount), public clinics must bulk bill.

So how is the program going? Well, it is still fairly early days and uptake is very variable across Australia. This may be, in part, because state and territory dental services have been busy expanding their programs for the treatment of more low income adults as a result of new National Health Partnership funding. Even so, there are already lessons to be learned. For example, while parents can take their children to private dental practitioners to receive Commonwealth-funded dental care, informal feedback from states/territories with vibrant School Dental Services suggest that parents seem to be sticking with the public dental option when it is available.

Some have asked why the state public dental sector would remain in the child dental field now that private dentists can provide Commonwealth-funded treatment for children. There are several very important reasons. First, the public dental services make far wider use of dental and oral health therapists rather than dentists to provide most of the treatment. As a result, the public dental services are able to provide the treatment for somewhat less than the fee paid by the Commonwealth. This "profit" becomes available for other uses, ideally much-needed dental services for high need groups. For example, it is important to recognise that the simple availability of treatment through the general CDBS does not mean that children from vulnerable groups will use it. Active programs that seek out these children and smooth the pathway to treatment are still needed and this is where the public dental sector can take the lead.

Health policymakers need to stop ignoring the wider cost of poor oral health with dental disease being the third most common reason for preventable acute hospital admissions and second only to cardiovascular disease in terms of cost. Simple interventions, such as the CDBS, are available to do something about it.

The CDBS also provides a stark lesson in the value of dental workforce reform. The public dental sector's use of dental and oral health therapists to treat children is a real world demonstration of the potential value of the far wider use of these oral health professionals to treat other high need groups. The dental and oral health therapists may need some further education to make this possible in a flexible way, but the CDBS is showing that this educational cost is trivial compared with the benefits.

It will be important that the CDBS is properly evaluated. For example, we do need to monitor the mix of services that children receive in the public and private dental sectors. However, the CDBS is already looking like an excellent model for dental programs for other high need groups. In the context of the national debate about the sustainability of health expenditure, it may be unlikely that an Australian Government will embrace a move to a full universal Denticare program. But the CDBS is showing that the journey to Denticare can be taken in small, affordable steps.

Health policymakers need to stop ignoring the wider cost of poor oral health with dental disease being the third most common reason for preventable acute hospital admissions and second only to cardiovascular disease in terms of cost. Simple interventions, such as the CDBS, are available to do something about it. ha

ANDREW MCAULIFFE
Executive Director / Chief of Staff
AHHA

Australian Health Review goes live

Authors published in AHHA's peer-reviewed journal gather in Brisbane to discuss their research

The AHHA's peer-reviewed journal, the *Australian Health Review* (AHR), hit the road in October with the inaugural edition of AHR Live in Brisbane.

AHR Live is a new initiative by the AHHA designed to provide greater exposure for authors publishing their research in the AHR.

Co-hosted by AHHA member Metro South Hospital and Health Service at the Princess Alexandra Hospital in Brisbane, the session was attended by more than 50 people with others joining by video link.

In welcoming those attending, Dr Stephen Ayre, Executive Director of PAH-QEII Health Network, highlighted the importance of research to improving the effectiveness and efficiency of the public health sector and to improving patient outcomes.

The session consisted of three presentations from authors published in the June 2014 edition of the AHR with a common theme of managing patient flow and hospital demand.

Dr Andy Wong, who works in the field of Decision Science at QUT, presented research from staff at QUT, Princess Alexandra Hospital and the University of Queensland which tracked patients across three databases (HBCIS, EDIS and ORMIS). The second paper, presented by Dr Justin Boyle of the CSIRO Australian e-Health Research Centre at the Royal Brisbane Hospital, examined the impact of capacity alert calls on acute hospital overcrowding. The third presentation, delivered by Dr Julia Crilly, looked at the impact of expanded emergency department capacity on predictors of admission and clinical outcomes

The session was chaired by Professor Christian Gericke, Associate Editor of the AHR and CEO of the Wesley-St Andrew's Research Institute, who described the event as a great success. "AHR Live provides a unique vehicle for dissemination of research findings directly to the clinicians and managers who are at the forefront of responding to the changing health environment," he said.

AHHA CEO Alison Verhoeven said that the success of the inaugural AHR Live demonstrated the sector's interest in research and quality improvement. "The AHR Live concept supports the AHHA's goal of promoting evidence-based policy and service development. It takes the research work off the page and into the clinical work environment enabling policy makers, service managers and researchers to interact and share their knowledge and experience," she said. "The flexible nature of the AHR Live structure enables us to deliver sessions in a variety of locations and settings. As well as major cities we hope to take the concept to more regional settings where access to professional development activities can be harder."

Planning is under way for the 2015 AHR Live schedule with sessions to be held across the country. To view the original AHR articles of the inaugral AHR Live presenters, see details below:

Author Panel (left to right): Sankalp Khanna, Justin Boyle Julia Crilly, Robert Eley and Andy Wong.

Wong, A.; Kozan, E.; Sinnott, M.; Spencer, L. and Eley, R. (2014). Tracking the patient journey by combining multiple hospital database systems. *Australian Health Review* 38(3): 332–336.

Khanna, S.; Boyle, J. and Zeitz, K. (2014). Using capacity alert calls to reduce overcrowding in a major public hospital. *Australian Health Review* 38(3): 318–324.

Crilly, J.L.; Keijzers, G.B.; Tippett, V.C.; O'Dwyer, J.A.; Wallis, M.C., Lind, J.F.; Bost, N.F.; O'Dwyer, M.A. and Shiels, S. (2014). Expanding emergency department capacity: a multisite study. *Australian Health Review* 38(3): 278–287. ha

Andy Wong presenting at AHR Live.

JANE FRENCH
Director of Human Services
Medibank Health Solutions

1800RESPECT

Supporting health professionals to respond to sexual assault, family and domestic violence

One in three Australian women will experience domestic or family violence. One in five will experience sexual assault.

These concerning statistics on gendered violence highlight how important it is to provide accessible services information advice and referral. 1800RESPECT provides a free 24-hour telephone and online counselling services, but we know that most women do not seek specialist help. Health professionals frequently encounter women who have been affected by gendered violence and they have a crucial role in responding. This is where 1800RESPECT can help.

As women affected by violence may reach out for assistance from health professionals, it is imperative that we equip workers across the health and human services sectors with the necessary skills to assist.

A recent survey of nurses by 1800RESPECT found that 56% suspected a client may be experiencing gendered violence.

The survey also found that, while 88% say they feel they would be able to manage a client disclosure, almost all want more support responding to the violence their client's experience.

The dedicated 1800ERSPECT website (www.1800RESPECT.org.au) provides information for nurses, health professionals and other front line workers to recognise and respond to gendered violence. It also has extensive information and ideas about how best to work with clients who may be at risk.

The 1800RESPECT website has been prepared by experts to help workers recognise signs of sexual assault, domestic and family violence and respond appropriately. It has dedicated pages for specific professions, making it quick and easy to find information, advice, training and support. Workers can also refer clients to the website for information, and there's a dedicated section for family and friends too.

1800RESPECT provides free, 24-hour support that is accessible for all Australians including. Support is particularly focused on:

- how to recognise the signs;
- how to open a space for client to talk about their experience;
- how to respond to a disclosure; and
- how to ensure the client gets the professional help and support they want to take the next steps.

While it's okay not to have all the answers, it's important to know where to find help and support because, crucially, responding is everyone's business. ha

'Here Comes The Sun...' by Nathan Csonka. Image sourced from Flickr via a Creative Commons Attribution 2.0 Generic Licence (https://flic.kr/p/7j5BWG).

STEVE HAMBLETON
Chair
National E-Health Transition Authority

Making the right connections

Public hospitals and health centres across the country are embracing eHealth technologies

What is eHealth? It is probably one of the sectors most discussed terms, and yet, one of the most misunderstood. This is disappointing because there are few developments over the coming years that will have as much impact on how patient care is delivered.

An effective eHealth system is essential for Australia. A huge amount of investment has gone into IT in this country, and I think there is a real opportunity to make sure we leverage off the investment we've made so far and get outcomes that are meaningful.

The National E-Health Transition Authority (NEHTA) has delivered the solid foundational products that are the basis of a robust eHealth solution. They are the individual healthcare identifiers, the medicines and diseases terminologies, secure messaging, and the background infrastructure. This has, in effect, created the national eHealth rail gauge (and some of the rolling stock) for securely transporting and sharing clinical information.

Having a health system where the points of care can finally be connected, and deliver safer, better quality care with fewer errors, and ultimately, fewer lives lost, will be a watershed moment for Australian healthcare at a time when it needs it most.

Public hospitals and health centres across Australia are starting to connect to Australia's personally controlled electronic health record (PCEHR) system.

A number of jurisdictions are already submitting discharge summaries from all — or almost all — public hospitals that have the ability to produce electronic discharge summaries. These jurisdictions include the ACT, Queensland, South Australia and Tasmania. Two of these jurisdictions—ACT and Queensland—allow viewing of the PCEHR by clinicians across these public hospitals, as well as (in the case of Queensland) other public facilities such as community health centres and outpatient clinics.

Tasmania has begun uploading medication information (prescription, dispense and discharge medications) to the PCEHR, with plans to implement PCEHR viewing in November 2014. New South Wales has already implemented the ability to upload inpatient and emergency department discharge summaries across five health regions (Western Sydney, Nepean Blue Mountains, Sydney Children's network, South Eastern Sydney and Illawarra Shoalhaven), as well as PCEHR viewing within these regions.

Victoria has gone live with Eastern Health's seven facilities now uploading discharge summaries. Two other regions in Victoria — South West Alliance of Rural Health and Lodden Mallee — are scheduled to commence uploading discharge summaries. The Royal Perth Hospital in Western Australia is now live and NEHTA is working with the Albany health region to get them connected to the national system.

This is just some of the progress being made in eHealth across the healthcare sector with the goal to eventually have all Australian public hospitals connected to the national system. Much of the planning and development conducted by NEHTA since 2005 has now been delivered. However, the promise of eHealth is ultimately not about technology — it's about people. People like you and me, people that share the eHealth goal of safer, quality healthcare for all Australians.

Ultimately, we all want to see meaningful use of the PCEHR — it needs to be delivered in a seamless way that fits with the way health practitioners work. Importantly, the right people need to be registered — those with complex and chronic disease and those who need to see multiple providers. Having a system where we can access a patient's medical information quickly would make our job quicker, safer and more efficient.

NEHTA's programme of work for the next 12 months will focus on creating a critical mass of users who are connected and meaningfully using eHealth to deliver better healthcare. While it is essential that the focus on quality and safety benefits remains front and centre, there needs to be strong emphasis on ensuring that reliable information from a connected community of healthcare providers is available in the record.

The eHealth "technical solution" has been delivered and all stakeholders including the Commonwealth, the jurisdictions, the NEHTA Board and the peak health bodies are working together to improve usability and drive meaningful use.

I'm proud to have been appointed NEHTA Chair, and to have the opportunity to provide the NEHTA Board with a direct connection to my colleagues at the front-line of Australian healthcare. ha

Dr Steve Hambleton was appointed Chair of NEHTA in June 2014. Prior to taking on this role, he was the Federal President of the Australian Medical Association (AMA).

A patient in Cabrini Health's heart failure program.
Image courtesy of Cabrini Health.

SALLY HOWE
Director of Business and Service Development, Cabrini Health

Understanding the importance of integrated care

Efforts to promote private/primary care partnerships and alternatives to in-hospital care

The core aim of primary care is to keep people in the community as well as possible, for as long as possible, particularly those with chronic illness and complex needs. With this in mind, Cabrini Health has actively sought to partner with the primary care community to promote greater cross-sector engagement and to strengthen the provision of person-centred, accessible and integrated care.

We have been working closely with the primary care sector for some time now in an effort to introduce new services and programs that meet the needs of the community, particularly the chronically ill as well as those who are older and have more complex health needs. Through our relationships with primary care services, we are able to support better integration across sectors – specifically, where patients have multiple care transition points. With our current primary care partnership organisations – the Southern Melbourne Primary Care Partnership and the Bayside Medicare Local (BML) and Inner East Melbourne Medicare Local (IEMML) – we hope to strengthen integration and communication initiatives to help patients move between hospital and primary services. We'd also like to reduce the need for patients to continually re-tell their stories.

To gain more insight into the current issues faced by local primary care providers, in February 2014, we hosted a community forum with BML to engage GPs in the region. The event highlighted that residents of the Bayside community use a range of private and public healthcare services. As such, it is important for BML to work with local private health service providers to ensure continuity of care between the primary and acute care services. This message seems to have been carried through, as since the event, there has been an increase in direct referrals from GPs to all services.

Cabrini's other Medicare Local partnership with IEMML has a strong emphasis on aged care. Similar to the event at Bayside, a community forum was hosted in October 2014 at Cabrini's Residential Aged Care facilities in Ashwood, a joint venture with IEMML to engage with local GPs. At this event, the focus was on a shared-care palliative care chronic disease model, fibromyalgia and advances in pain management.

With this integrated care model in mind, the facilities at Ashwood have been equipped to allow major GP clinics to visit residents on set days/times each week. Promoting improved access and services to residents (and their families) even further are the new after-hours locum service and telehealth resources, both of which have been made available through Cabrini's partnership with IEMML. Such private-primary partnerships are important for ensuring that health professionals remain informed of advances in specialist treatments and services available in their region.

With our current primary care partnership organisations... we hope to strengthen integration and communication iniatives to help patients move between hospital and primary services. We'd also like to reduce the need for patients to continually re-tell their stories.

Being aware of these kinds of resources is also essential for helping reduce the burden on hospitals. This was demonstrated by the Secondary Prevention and Readmission Risk Pilot, a study conducted by Cabrini and Medibank Private with 441 people over a two-year period. The study showed a 70% reduction in the number of hospital readmissions among people with heart failure and respiratory conditions through the provision of community-based programs involving education and person-to-person care. The programs also reduced the number of emergency department presentations for this casemix.

Patient satisfaction data for the study show that people in the community want healthcare programs that help them join the dots and provide continuity of care, as well as advice on remaining healthy. The results also indicate that patients can make significant changes to their own health behaviours over time and that they can demonstrate improvements in their levels of function and confidence. What they need is integrated, patient-centred care programs that empower them, their families and their carers, to become more capable in managing their health conditions. ha

Team 8 of the Integrated Care Simulation.

Simulating integrated care

AHHA's **Bronia Rowe** and **Dominic Lavers** discuss what happens when 85 health leaders gather to discuss major health policy initiatives

On 23 October 2014, the AHHA held an Integrated Care Simulation, which included three major potential health policy initiatives, health leaders and policy-makers, a few disgruntled 'patients' and a couple of roving journalists stirring up trouble.

The objective was to turn Old Parliament House into a realistic but stage-managed test environment, where participants from the public, private and not-for-profit sectors could help the AHHA gain insight into how these current policy considerations might impact on health services and system integration.

After an opening address from the Federal Member for Boothby, Dr Andrew Southcott MP, the participants dived into the topics, which included the introduction of bundled care packages for people with chronic diseases, a role for private health insurers in the financing of primary care services, and the formation of Primary Health Networks.

While the Simulation made obvious a number of faults inherent in the health system such as the funder-provider divide, AHHA Chief Executive Alison Verhoeven highlighted the renewed potential for 'game-changing' thought and collaboration.

"We challenged health leaders from across the system, including academics, healthcare providers, insurers and consumers, to think about positive changes to develop better integrated care, and what became clear was the need for thoughtful leadership in the national conversation about our health system," Ms Verhoeven said.

"The simulation has helped shine a light on the importance of evidence to inform health policy development, and well-planned implementation to ensure purposeful change and anticipate and mitigate any unintended consequences. Many participants commented that the simulation reinforced the need to tackle issues collaboratively engaging all stakeholders. It was also noted that, at times, those high level talks forget the most important stakeholder in the system—the patient."

Much discussion about each of the topics centred on equity, choice and respect for the individual, with participants generally being in agreement that these values are central to an optimal health system.

Another key theme that emerged during the three scenarios was the disconnection across the various parts of the health system. When a broad change was proposed to the system, it was observed that each party was mainly concerned with how it affected them, rather than the system as a whole. It was also noted that while there is an assumption that policy makers work in the best interest of patients, not much consultation occurred with them. Broader consultation, better communication and collaboration were seen as being integral to better policy planning and implementation.

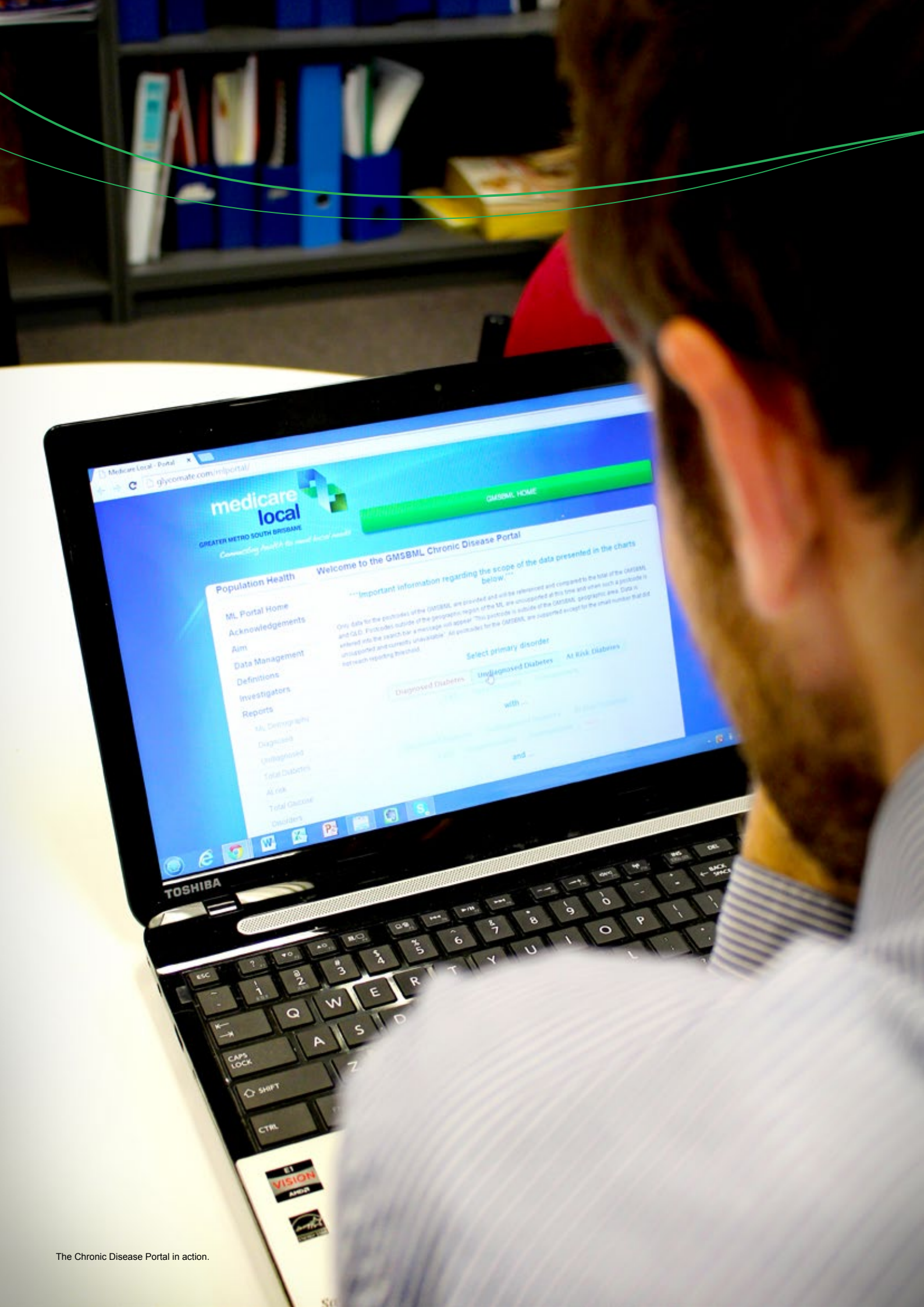
"The simulation has helped shine a light on the importance of evidence to inform health policy development, and well-planned implementation to ensure purposeful change and anticipate and mitigate any unintended consequences."

TOP 5 RECOMMENDATIONS

- Health policy needs to have clear goals, be evidence-based, well-thought through, taking account of all potential consequences, and specific on details for all elements of the system, including providers and patients.
- While financial sustainability of the health system is critical, policy makers must not lose sight of patient interests – these must be central to health policy.
- People working within the health sector need to engage regularly with policy makers at all levels in government to highlight any perverse or unintended consequences of policies, as well as to offer alternative solutions.
- Healthcare cannot operate in isolation from social supports and care, and policy and planning should be undertaken together for this reason.
- Integrated strategies and models could work well for people with high health care needs, however more research is required to better support health promotion and illness prevention strategies, including for generally well people.

A detailed report from the event highlights the key themes, recommendations and policy analysis emerging from the Integrated Care Simulation. It is available at www.ahha.asn.au/event-reports/integrated-care-simulation. ha

The AHHA acknowledges the generous support of Novartis for this work.



The Chronic Disease Portal in action.

SIMON JAMES
CEO, Greater Metro South Brisbane Medicare Local

A public/private partnership with huge potential

Greater Metro South Brisbane Medicare Local (GMSBML) partners with local GP to create the Chronic Disease Portal

Irrespective of the shape of Primary Health Networks when they evolve from Medicare Locals in July 2015, GMSBML recognises that innovative initiatives with strong empirical research should be supported.

GMSBML partnered with Dr Chrys Michaelides last year to fund the creation of a Chronic Disease Portal (CDP) to track the prevalence of diabetes and other chronic diseases by geographic area.

Dr Michaelides is a leading expert on diabetes treatment and management in the primary healthcare sector. His strong track record of innovative diabetes research and treatment had previously attracted funding from Novo Nordisk Australasia to create an interactive web-based tool that summarised HbA1c data from different geographic regions in Australia.

After researching and trending the data for over six years, Dr Michaelides wanted a vehicle to share this insight with GPs to effect real change. While his original tool plots levels of control in diabetes patients, our new Chronic Disease Portal tracks cardiometabolic indicators by postcode, state or by our GMSBML region.

While the majority of type 2 diabetes is managed in primary care, most research and data is from tertiary centre studies. The CDP's HbA1c data is sourced directly from primary care via Sullivan Nicolaides and QML pathology test results. The data is then "cleaned" (i.e. checked for duplicates and other anomalies), analysed and uploaded to the portal. GMSBML's goal is to expand this geo-epidemiological data to include population health benchmark data such as lipids, renal function and osteoporosis.

The CDP has a flexible "dashboard" appearance that is compatible with the PenCAT data extraction tool. This will allow the inclusion of geo-epidemiological data sets based on both pathology and radiology diagnostic test data in the future.

The portal provides a suite of cardiometabolic decision and management tools designed to optimise outcomes for patients, time management for GPs and business outcomes for practices. The CDP identifies the geographic areas requiring intervention and engages these communities, GPs and clinics by providing support and resources.

Our aim is to promote behaviour change in patients with chronic disease and in the health professionals who support them. By successfully treating chronic disease in the primary healthcare system, we can vastly decrease the burden on the secondary and tertiary health systems.

Our aim is to promote behaviour change in patients with chronic disease and in the health professionals who support them. By successfully treating chronic disease in the primary healthcare system, we can vastly decrease the burden on the secondary and tertiary health systems.

Benchmarking the minimum prevalence of diagnosed, undiagnosed and those patients at risk of diabetes means GPs will be more aware of the hidden burden of disease at a practice level. This is for both the diagnosed (thereby preventing secondary complications) and the potentially undiagnosed who can be identified and supported with lifestyle modification programs.

After extracting data on their practice area, general practices can then analyse their internal patient database and flag patients with relevant markers. We hope this instigates a discussion about their chronic disease profile, their treatment options and community support available via GMSBML's positive impact program and our other chronic disease, diabetes and health and wellbeing programs.

Beyond the initial aim of identifying patients, developing interventions and engaging healthcare providers, GMSBML hopes to develop a chronic disease surveillance system by inviting GPs to contribute de-identified clinical data on anthropometrics, prescribing, smoking, exercise and past medical history to the existing data set, although this will require another ethics application.

The Chronic Disease Portal went live on 15 August 2014 and is now accessible to general practice via the GMSBML website www.gmsbml.org.au. ha

Map of medicine

Greater Metro North Brisbane Medicare Local
supporting medical training through a new online tool

Metro North's new Map of Medicine pathways offer evidence-based guidance and clinical decision support at the point of care, and one Brisbane GP is optimistic about their educational benefit.

Dr Meg Cairns was involved in a group of around 80 General Practitioners, allied health professionals, and hospital clinicians, who worked together on developing the clinical pathways, local to the Metro North Brisbane region. "A lot of the clinical information and the information about referral pathways or local services available in the Map of Medicine is already available to doctors. But sometimes it's difficult to know how and where to access the information and it can be inconvenient having to go to many sources for it," Dr Cairns said. "One of the aims of the Map of Medicine was to get all of that information in one place. It's convenient to have such an enormous amount of clinical information available on your desktop, on one site, without having to search text books or other websites."

One of the main advantages which quickly became apparent to Dr Cairns and the other consultants involved in the pathways working groups was its usefulness as a training tool. "Hospital residents and registrars come from all over Queensland to work in Metro North," Dr Cairns said. "They come from all over Australia, they come from other parts of the world, and when they come here, they may not know a lot about the local area and may not even know a lot about the Queensland Health system. Using a product like this helps educate and familiarise them."

"Sometimes it's difficult to know how and where to access the information and it can be inconvenient having to go to many sources for it," Dr Cairns said. "One of the aims of the Map of Medicine was to get all of that information in one place."

Likening the tool to an online textbook, Dr Cairns said the Map of Medicine followed internationally and nationally accepted clinical pathways that had been localised in terms of the services available for patients. To demonstrate how the Map of Medicine worked, she simulated a hypothetical case where a patient was suspected of having Rheumatoid Arthritis.

"You would take a history from them about their condition. You would do an examination. You would then think about whether they needed any investigations, such as x-rays or blood tests. You'd also think about whether you could make a diagnosis based on that information or whether other diagnoses needed to be considered. If you can make the diagnosis, you are then able to follow the pathway to look at options for managing the condition. If you weren't sure of all the questions you should ask a patient, the Map of Medicine pathway gives you some help with this. Then in the history section, it gives you very specific information about the things that particularly affect patients with Rheumatoid Arthritis."

Dr Cairns went on to outline other features of the pathways. "In the examination box, it gives you the key features that you see when you examine the patient and in the investigations box it talks about the appropriate blood tests, x-rays and other investigations you might do," she said. "It also shows us there are many types of arthritis and that Rheumatoid Arthritis is just one of them, and there are red flags which tell us when we should plan to refer someone early. For a patient with Rheumatoid Arthritis, early treatment with the appropriate medications can change the course of the disease for that patient."

If a diagnosis of Rheumatoid Arthritis was made, Dr Cairns said the pathway offered advice to General Practitioners about how to manage that patient while they were waiting for an appointment with a Specialist.

"Looking at primary care management, the pathway gives us very broad topics around things like how you manage someone's symptoms, how you're making them feel better, and how you're helping them make lifestyle changes that might make their condition better. Then it lists some of the very good patient self-management and education programs available for arthritis because, as with most chronic and complex conditions, the management of the condition must involve multidisciplinary care. You would involve Allied Health Professionals when you're looking after a patient with Rheumatoid Arthritis and the pathway provides information about the local allied health services and the different ways you might help a patient access them. Then there's information about the specific medicines for Rheumatoid Arthritis and about how you would refer a patient. It lists the Queensland Health facilities and private specialists, so this basically explains how you would find a Rheumatologist in Metro North. Then once you've instituted a patient management plan, the pathway guides you on following up with the patient and the longer term monitoring of their condition," she said.

Again emphasising the Map of Medicine's advantages in relation to doctor training, Dr Cairns said the clinical information was only part of the picture. "It's also about the process you go through to make a diagnosis and to manage a patient, and if you need to refer them or put together a multidisciplinary team this is shows you the steps to do that." ha

Dr Meg Cairns demonstrating one of the Map of Medicine pathways. Image courtesy of Metro North Brisbane Medicare Local.

LOUISA DEASEY
Freelance journalist
Health / Medicine

High-risk patients to benefit from hospital redesign

A state-of-the-art makeover for one of Melbourne's busiest public hospitals

A year ago, if you were a patient in one of Box Hill Hospital's high risk wards — such as intensive care, maternity, paediatrics, oncology, cardiology or respiratory care — during visiting hours you would be restricted to an unchanging landscape of non-descript walls, white noise and artificial lighting. And if you were well enough to go to the nearest patch of nature, Box Hill Gardens, you were basically well enough to go home.

Even though hundreds of studies confirm the healing benefits of nature, fresh air, gardens and sunshine, this proposition presents a tricky conundrum for hospitals. Infectious disease protocol mandates that any outside risk — such as water, gardens, cobbled paths or dirt — is kept at an absolute minimum, if not avoided altogether. The result is what anyone who has ever had a long stay in hospital comes to expect: less-than-inspiring visuals of a clinical environment and very little privacy when family and friends come to lend their support.

As of September 30, high risk patients at Box Hill Hospital will be admitted into a state-of-the-art redevelopment which provides an airy environment, an outdoor space on many of the lower levels, 200 more beds and kinetic sculptures in outdoor courtyards, accessible either physically or visually from each ward.The hospital's multi-million-dollar multi-level project, which has been under process for three years and developed in close conjunction with the Victorian State Government, Lend Lease, Silver Thomas Hanley Daryl Jackson Architects, and the work of local sculptor Rudi Jass, is a creative and innovative response to infection control risks with immune-suppressed patients.

According to Leanne Houston, head of Infection Prevention Control at Box Hill Hospital, the constraints in a hospital setting called for a particularly creative response. "With cancer patients, and other immune-suppressed patients such as those in intensive care, we know there is a risk of legionella and mould and fungal spores with potting mix and water features commonly used in a garden setting. You've also got to think of how you'll be watering them, as sprays can aerosolise those organisms," Leanne said.

Instead of a garden, Box Hill Hospital engaged the services of local sculptor Rudi Jass, who created seventeen large scale sculptures to be seen and explored in each of the courtyards on various levels of the building. The series of kinetic sculptures of trees and plants are based on a nature theme. Leaves on the trees change with light and shade, provide a canopy from the sun much like a small park, and move with the wind.

This new setting hopes to replicate the benefits from a famous study, published in Science in 1984, which showed that patients recovering from surgery who had a view of nature from their bedside window recovered, on average, a day faster, needed less pain medication, and had fewer post-surgical complications than patients who instead saw only a brick wall.

In addition to the courtyards, the hospital's ward layout has also been designed with healing and privacy in mind, with 50% single rooms and 50% double rooms — all equipped with their own bathroom and with an external view to benefit from natural light. These windows are especially important for patients too ill to go outside, as the sculptures can still provide visual stimulation from afar, changing in light, colour and movement throughout the day. Another significant feature of the newly-designed wards is the availability of day beds for overnight stays by relatives if required.

Liz Maddison, Project Director of the redevelopment, has over three decades of experience that spans national and international hospital projects. "If someone is sick, or dying, families just want to be together. And during visiting hours, you need some form of life or nature to break the monotony. So it's a matter of minimising the risks involved in that and making a supportive environment that is also safe," Liz said. ha

Kinetic scuptures and outdoor views make for a more pleasant hospital stay. Images courtesy of Box Hill Hospital.

Exercising both body and mind

Amelia Simpson is a senior lecturer at the Australian National University's College of Law. Though her speciality is constitutional law, by walking up to 25km a week at her desk, Amelia's work practices shine a light on the little steps that workplaces can take to improve health and wellbeing on a daily basis.

AHHA: What made you take a stand?

AS: As a working mum with young children, I was struggling to fit regular exercise into my daily routine. I also struggled a bit with my blood sugar and had observed, over a few months, that it was generally higher after a day sitting at a desk and lower when I'd been more active. I'd also seen a few articles in American newspapers and magazines over recent years, enthusing about the walking desk, and I thought 'What's to stop me from trying that?'

AHHA: Take us through your daily routine, step-by-step.

AS: I fire up my treadmill within minutes of walking into my office. I usually make a pot of tea first, which I've become pretty good at pouring and drinking while walking. I put my sneakers on, crank up my treadmill to around 2km per hour — a gentle strolling pace — and then while walking I check my email, perhaps have a quick look at the papers online, and decide on my priorities for the day. Walking at that pace I can read a book or a pile of papers, read documents on the computer, touch type just as fast as I would if sitting, and make phone calls. Every 90 minutes or so I take a 10 minute sitting break in a lounge chair in my office — I usually have some portable work to do there. My treadmill computer keeps a record of my steps, distance, time, and calories burned throughout the day. Most days I would end up walking for at least 4 hours.

AHHA: How hard is it walking the walk and talking the talk?

AS: It took me less than a day to become comfortable with the walking and working routine. It's surprisingly easy to walk at a slow, steady pace and continue to do things like type, edit, and analyse. It's almost subconscious — not quite. I actually find that my concentration is better when I'm walking, as it seems to substitute somewhat for fidgeting and daydreaming (which is the upside of it's requiring a small amount of conscious attention).

AHHA: Can you please walk us through the health benefits you've experienced?

AS: Incidental exercise has been described as the 'secret' of healthy weight maintenance and good metabolic indicators. Slow walking is like constant incidental exercise. My blood pressure — previously low — has normalised. My blood sugar is significantly improved throughout the day and into the evening. Neck and shoulder stiffness and pain that I experienced with prolonged sitting — and also to a degree when standing to work — has disappeared. And it's lovely to go home with a healthy appetite and feeling energised.

AHHA: What advice would you give to people wanting to follow in your footsteps?

AS: I realised early on that I would struggle to get my workplace to fund this unorthodox arrangement, and so I put my energy into convincing my management to approve the use of a treadmill that I would purchase myself. The cost is around $1,900 if one has an existing standing desk, and more like $2,400 if an attached desk is needed. My doctor wrote a supportive letter, describing my pre-existing health problems that might be helped if I could walk while working. A University Occupational Health and Safety (OH&S) officer did a workplace assessment. I was fortunate that she was open-minded and supportive. I provided her with product literature showing that the treadmill could not be operated on a gradient nor at a running speed. This seemed to be important in securing OH&S approval. As for naysayer colleagues, the main objection to my arrangement seemed to be 'Why does she have one of those but I don't?', which was easily answered with 'Because I paid for it …'.

AHHA: How far away do you think this is from becoming the norm?

AS: There are workplaces in the United States, in both private and public sectors, where treadmill desking is ubiquitous. The main impediment to greater uptake of this kind of arrangement is cost. I already have colleagues in my workplace who are seriously considering following my example. A few years from now, I think there'll be several who've taken to the walking desk. As the body of research supporting treadmill desking's health benefits grows, lincreasing popularity will have to follow.

AHHA: Our office recently acquired some adjustable/standing desks. Do you have any advice for us?

AS: I found standing much better than sitting, before moving to the walking system. My legs and hip joints would get tired from standing still, though, and so I needed an anti-fatigue mat and lots of stretching. The rest breaks in a chair are really important! ha

Amelia Simpson taking work in her stride.

Online palliative care training package proves to be a valuable learning tool, especially for health professionals in rural and remote areas.

Putting end-of-life care at the forefront

AHHA's **Yasmin Birchall** discusses how the organisation's palliative care online training package is delivering positive results

The AHHA's highly successful palliative care online training program continues to support the Commonwealth Government's National Palliative Care Strategy 2010 by building and enhancing the capacity of healthcare service providers to deliver quality palliative care.

Based on the Guidelines for a Palliative Approach for Aged Care in the Community Setting, the training is aligned with the National Palliative Care Strategy's focus on increasing awareness and understanding of the benefits of timely, appropriate access to palliative care.

Participant feedback indicates that the four-module package, which recorded 15,000 registered participants across Australia and internationally in October, has increased the knowledge and confidence of the palliative care workforce and enhanced the ability of participants to maximise the wellbeing and quality of life of individuals affected by chronic disease.

Around 98% of participants have recorded increased competence in providing a palliative approach to client care after undertaking the training. According to one participant, "the package was very comprehensive and although I am an experienced health practitioner, I found useful likes to sources of information that I wasn't yet familiar with."

This feedback supports research published in the British Medical Journal of Supportive and Palliative Care, which suggests that formal training in palliative care increases the confidence of clinical staff and impacts positively on the quality of palliative care provided to patients.

The online training package is one of the few formal education programs that encompasses the perspectives of all members of the multidisciplinary team involved in palliative care. More than 500 people from a diverse range of backgrounds and experiences complete the training each month. These participants include patients, consumers, paid employees of a wide variety of service providers and organisations, volunteers, and family members of patients or other informal carers.

AHHA's palliative care training is accessible at any time and open to all regardless of occupation or educational background. Of the participants so far, 59% work in urban settings, 35% in rural locations and 3% in remote areas.

There is a significant spread across professional skillsets amongst participants, with 55% identifying as nurses, 25% as care workers and 15% as other health professionals. Whilst most work in the aged care sector (68%), 10% work in the Aboriginal and Torres Strait Islander community and a further 10% in the Culturally and Linguistically Diverse community.

Access to training, particularly for those in rural or remote locations, can be problematic due to distance and time constraints and potential loss of pay. AHHA's palliative care training is accessible at any time and open to all regardless of occupation or educational background. Of the participants so far, 59% work in urban settings, 35% in rural locations and 3% in remote areas.

Participant feedback outside of the major city centres has been consistently positive. "I thought the package was great," one health professional said. "Please do another, as it is not always easy to get to in-services as most cost too much and are in the larger cities."

Overall, the palliative care online training program has surpassed expectations, with an extensive reach across the palliative care sector and beyond. To find out more about the training modules, visit our website: www.palliativecareonline.com.au. ha

Feedback from palliative care online training participants:

"I will be asking all of my staff who wish to work in palliative care in-home to undertake this excellent training."

"I will recommend this package as a mandatory part of our workplace's online training and also that it be completed by all new employees."

"This training is relatively easy to complete and is very accessible. I would encourage all organisations that say they provide a palliative approach to care to make this training part of the orientation process for new staff."

"[Completing this training] validated my practice and made me think about the broader perspectives of the multidisciplinary team. The resources were excellent."

Palliative Care Online Training

REGISTER ONLINE AT WWW.PALLIATIVECARE ONLINE.COM.AU

Do you want to make a real difference in end-of-life care? You're not alone...

Whether you work in aged care, acute or primary care, chances are, at some stage, you'll find yourself caring for someone with a terminal illness.

Every person's needs are unique and sorting your way through the emotional and social stresses faced by a dying person and their family can be difficult.

A new online training program has been developed to help health professionals who provide palliative care to aged persons in the community. The modules will help you develop your skills and confidence, so that the next person you care for at the end of their life will benefit from your experience.

The four online training modules have been developed to help you to:

- Reflect on the needs of people and their families as they approach the end of life;
- Build your screening and assessment skills;
- Develop confidence in having end of life conversations, especially around Advance Care Planning;
- Invest in your own self-care and build resilience;
- Connect you to a wider network of experts who can support and assist you.

Why do the training?

- **It only takes a few hours to complete online;**
- **It's accredited;**
- **It's FREE!**

For more information, contact the AHHA at admin@ahha.asn.au or by phoning us on 02 6162 0780.

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Who's moving

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

Ms **Kylie de Boer**, formerly of Genea, has joined the Monash IVF Group as General Manager NSW.

Professor **Bruce Waxman**, previously with Monash Health and The Valley Private Hospital, is moving to Epworth Richmond as Director of Medical Services.

Associate Professor **Harish Poptani** will be venturing to the University of Liverpool as Chair in Preclinical Imaging, moving across from the University of Pennsylvania.

Dr **James Adams** will be making the move from the University Hospital Southampton NHS Foundation Trust to join Western Health as the new Clinical Service Director of Sub Acute Care.

Ms **Heidi Evans** has taken on the role of Director of Nursing at Norwest Private Hospital, leaving Mount Wilga Private Hospital as Director of Clinical Services.

Dr **David Ware** is joining the Royal Victorian Eye and Ear Hospital as the new Director of Anaesthesia leaving Wollongong Hospital.

Professor **Simon Foote** is leaving his position as Dean of the Australian School of Advanced Medicine at Macquarie University to become the new Director of the John Curtin School of Medical Research.

Mr **Jagdish Ghadge**, Regulatory Affairs Manager at Mundipharma, is moving to Shire Pharmaceuticals to become Associate Director of Regulatory Affairs.

Professor **Tanya Monro** is joining the University of South Australia as the new Deputy Vice Chancellor for Research and Innovation. Professor Monro is leaving her current position as Director of the ARC Centre for Excellence in Nanoscale BioPhotonics and the Institute for Photonics and Advanced Sensing at the University of Adelaide.

Mr **Malcolm Stringer**, General Manager of Business Development at Healthscope Pathology, is moving to Queensland Health as the General Manager of Laboratory Operations for Health Support Queensland.

Professor **Kent Anderson** is moving from his position at the University of Adelaide as the Pro Vice Chancellor International it take up the position of Deputy Vice Chancellor Community and Engagement at the University of Western Australia.

Ms **Fiona Stoker**, Chief Nursing Officer at the Department of Health and Human Services in Tasmania, is moving to Canberra to take up the position of Chief Executive Officer at the Australian Nursing and Midwifery Accreditation Council.

Ms **Karen Bradley**, who has been most recently the Area Director of Nursing and Midwifery for South Metropolitan Area Health Service, has just taken up the position of Chief Nurse with WA Health.

Professor **Patrick McNeil** has been appointed the inaugural Executive Dean of the new Faculty of Medicine and Health Sciences at Macquarie University. Professor McNeil is currently the Executive Clinical Director of Liverpool Hospital, Chair of Arthritis Australia and leads a research team at the University of New South Wales.

Dr **Magdy Gado** is moving to Mundipharma as Senior Medical Adviser, coming from Eli Lilly Dubai as Regional Medical Adviser.

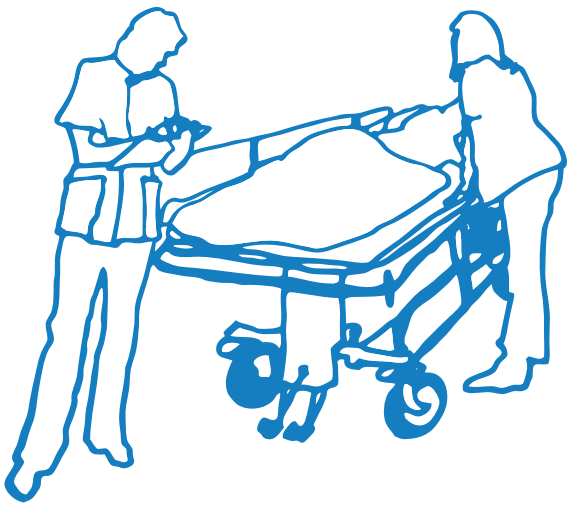
The current Head of School of Chemistry at the University of New South Wales, Professor **Barbara Messerle**, will be making a move to Macquarie University in January 2015. Professor Messerle has been appointed Executive Dean of the University's Faculty of Science.

Professor **Vernon Ward**, the current Head of Microbiology and Immunology Department at the University of Otago, has been named the next Dean of the Otago School of Medical Sciences.

Ms **Kerrie Hayes**, previous Director of Nursing at Calvary ACT, has moved to the Sunshine Coast Hospital to be their new Director of Clinical Services.

Ms **Annette Czerkesow**, previous General Manager of Brisbane Waters Private, has now gone to Mercy Health and Aged Care Central Queensland as Executive Officer of Rockhampton Hospitals.

Mr **Chris Preston**, previous Director of Health Advisory for Deloitte, has moved to Pathology Queensland as Commercial Director. ha



Ccentric Executive Search

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

Become an AHHA member

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

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

With over 60 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 onferences, seminars, policy think-tanks and workshops; and helps policymakers, researchers and practitioners connect when they need expert advice.

In addition to this guidance in health policy and research, the AHHA offers various business services through JustHealth Consultants. This is a national consultancy service exclusively dedicated to supporting Australian healthcare organisations at state, regional, hospital and community levels and across various sectors. Drawing on the AHHA's comprehensive knowledge of the industry, JustHealth Consultants provides expert skills and knowledge in areas including: corporate and clinical governance training; strategy and business planning advice; organisation design and improvement; health services planning and program evaluation; and board induction training.

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

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

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

AHHA Council and supporters

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

AHHA Board

The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation, the protection of its assets and the quality of its services. The 2014-2015 Board is:

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Immediate Past Chair
Prof Kathy Eagar
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Prof Gary Day
Member
Ms Lesley Dwyer
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Mr Walter Kmet
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The AHHA National Council oversees our policy development program. It includes the AHHA Board above and the following members:

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Australian Health Review

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

Prof Andrew Wilson
Editor in Chief
Dr Simon Barraclough
Associate Editor, Policy
Prof Christian Gericke
Associate Editor, Models of Care
Dr Lucio Naccarella
Associate Editor, Workforce
Dr Caroline Hadley
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The Australian Healthcare and Hospitals Association (AHHA), is the independent membership body and advocate for the Australian healthcare system and a national voice for high quality healthcare in Australia.

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

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