AUSTRALIAN HEALTHCARE AND HOSPITALS ASSOCIATION

AHHA Pre-Budget Submission

Federal Budget 2013-14

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1 Introduction

The Australian Healthcare & Hospitals Association is Australia's largest health care group and advocates on behalf of members for universal high quality healthcare in public hospitals, aged care, community and primary health sectors.

The following paper outlines eight critical issues of current concern to AHHA members and stakeholders in these sectors. Our members strongly believe that additional Commonwealth Government funding in these areas will enhance their capacity to deliver quality services to the community and ensure greater viability and sustainability in these areas. It is strongly recommended that the Government consider funding these important initiatives in its 2013-14 Budget.

2 Social Determinants of Health

In 2005, the World Health Organization (WHO) established the Commission on Social Determinants of Health (the Commission) to "marshal the evidence on what can be done to promote health equity, and to foster a global movement to achieve it". In 2008, the Commission released its report "Closing the gap in a generation" which identified preventable health inequities arising from the circumstances and environment in which people live and work and the political, social and economic influences on these circumstances.[1]

The three broad recommendations of the Commission were:

- Improve daily living conditions – the circumstances in which children are born, grow, and learn, and improve the conditions in which all people live, work and age.
- Tackle the inequitable distribution of power, money and resources
- Measure and understand the problem and assess the impact of action.

2.1 Government response

While the Australian Government's support for the Commission's report as described in the subsequent Rio Political Declaration on Social Determinants of Health is implied by way of Australia's membership of the WHO, no explicit statement of support appears to have been made and there is limited reference to the Commission's report in easily accessible Department of Health and Ageing documents.[2]

The National Preventative Health Strategy, Australia: The Healthiest Country by 2020, identifies action on social determinants as essential to address inequities in obesity, tobacco use and alcohol consumption.[3] The recent success with tobacco packaging aside, much of the activity in response to the Strategy remains within the health sector's scope of work and there has not been significant

[1] Commission on Social Determinants of Health. *Closing the gap in a generation: Health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health.* Geneva, World Health Organization: 2008

[2] World Conference on Social Determinants of Health. *Rio Political Declaration on Social Determinants of Health: Rio de Janeiro, Brazil, 21 October 2011.* Geneva, World Health Organization: 2011

[3] National Preventative Health Taskforce. *Australia: The Healthiest Country by 2020.* Canberra, Commonwealth of Australia: 2008

cross-sector or cross-Department action. However, there is evidence of successful engagement with the Commission's recommendations at the State level, particularly in South Australia (Health in All Policy approach) and Tasmania (Fair and Healthy Tasmania).[4, 5]

2.2 Cost of inaction

On behalf of Catholic Health Australia, the National Centre for Social and Economic Modelling (NATSEM), University of Canberra, examined the cost of Government inaction in addressing the social determinants of health; that is to reduce the preventable inequities in health resulting from social and environmental circumstances.[6]

NATSEM reported that the adoption of the Commission's recommendations would result in:

- 500,000 Australians avoiding suffering a chronic illness
- 170,000 extra Australians could enter the workforce
- Annual savings of $4 billion in avoided welfare payments
- 60,000 fewer individuals admitted to hospital per year, over 500,000 fewer hospital separations and a reduction of 1.44 million hospital bed days, saving $2.3 billion in annual hospital expenditure
- 5.5 million fewer Medicare services per year, saving $273 million annually
- 5.3 million fewer PBS scripts per year, saving $184.5 million annually.

In an environment characterised by increasing accountability and a drive for efficiencies and savings, the benefits available through the adoption of a coordinated approach to reduce health inequities must be a priority.

The increasing burden of chronic and preventable diseases and the ageing of Australia's population add further weight to the argument for immediate action.

AHHA Recommendation No. 1: That the Australian Government make a formal statement of support for the recommendations of the WHO Commission on Social Determinants of Health.

Projected cost and timeline: Nil

AHHA Recommendation No. 2: That the Australian Government, in collaboration with States and Territories, develop an action plan to implement the recommendations of the WHO Commission on Social Determinants of Health.

Projected cost and timeline: $0.72 M in 2013-14

2.3 Inter-agency action

The Commission, NATSEM and others, in identifying the opportunities to reduce the impact of the social determinants point clearly to the need for action beyond the health service environment. At the AHHA annual conference, Mary Anne O'Loughlin, Executive Councillor, COAG Reform Council, stated that the Government's performance on employment and housing will have a critical impact

[4] http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+reform/health+in+all+policies
[5] Department of Health and Human Services. *Fair and Healthy Tasmania Strategic Review: Final Report.* Hobart, Government of Tasmania: 2011
[6] Brown, L, Thurecht, L, Nepal, B. *The Cost of Inaction on the Social Determinants of Health.* Canberra, Catholic Health Australia: 2012

on health outcomes. The Adelaide Statement on Health in All Policies describes the need for "joined-up government".[7] This reflects the need for intra- and cross-agency coordination, and partnerships between the community, government and the private and non-government sectors.

There is currently little evidence of successful cross-agency collaboration or cooperation at the Commonwealth level to address the social determinants of health. The adoption of models similar to those of South Australia and Tasmania are required to overcome the policy and program silos which persist within and between Commonwealth Agencies.

AHHA Recommendation No. 3: That the Australian Government immediately develop and implement a 'health in all policy' approach and require the completion of Health Impact Assessments to inform policy development and legislative change.

Projected cost and timeline: $1.75M over three years

AHHA Recommendation No. 4: That National Partnership Agreements across all Departments include a Health Improvement Dividend section to identify and quantify the impact on the social determinants of health and health outcomes arising from the Agreements content.

Projected cost and timeline: $0.3M in 2013/14

2.4 Coordination and Leadership

In order to raise community awareness and stimulate discussion and appropriate action, this must become a high profile issue supported by strong leadership. This would be supported by the establishment of an Australian Commission to oversee and report on progress in the implementation of the WHO Commission recommendations. Additionally the Commission would audit and report on the implementation of the Health in all Policy approach and the use and quality of HIAs and promote successes and learnings from across all Governments.

AHHA Recommendation No. 5: That an Australian Commission on the Social Determinants of Health be established to coordinate inter-agency action and report annually on progress to address the social determinants and reduce health inequity.

Projected cost and timeline: $0.78M per annum

3 National Health Reform

3.1 Reform evaluation

The National Health Reform Agreement aims to deliver "better access to services, improved local accountability and transparency, greater responsiveness to local communities and provide a stronger financial basis for our health system into the future through increased Commonwealth funding".[8] The Reform process is supported by a range of Agreements, frameworks and models. The strength of the evidence supporting these programs as facilitators and drivers of change and improvement is variable and there is limited information available to determine what contribution the implementation process and context will make to the effectiveness of the reform program.

[7] WHO. *Adelaide Statement on Health in All Policies*., Government of South Australia, Adelaide 2010
[8] http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhra-justreleased

Additionally there is an absence of mechanisms to determine if the policy and reform program of the Government is the best approach for the Australian healthcare system.

A comprehensive research and evaluation program is required to examine the effectiveness and appropriateness of the National Health Reform agenda. This program will identify the essential success elements and drivers, guide the ongoing implementation agenda, and inform future health policy development and implementation.

AHHA Recommendation No. 6: That comprehensive research and evaluation of the National Health Reforms be undertaken.

Projected cost and timeline: $0.75M per annum

3.2 Enhancing Coordinated and Integrated Models of Care

One of the major intentions of the National Health Reform is to strengthen primary healthcare through establishing Medicare Locals (MLs). MLs are charged with identifying the needs of local communities through detailed planning in collaboration with other service providers such as Local Hospital Networks and to meet those needs by providing targeted primary health care services, particularly for those with chronic conditions, mental illness and the aged.

To do this effectively, MLs will have to orchestrate a high level of service coordination and integration by connecting primary / community, secondary and tertiary health services within and across Local Health Network boundaries as well as health professionals working in teams.

This will be a complex and difficult task, the mechanisms and incentives for which are still not clear. The challenges of service integration include the need to invest without guarantee of eventual cost savings, the dominance of the provider perspective, and the cultural and organisational shifts required.[9] However, evidence demonstrates that well-coordinated and integrated care leads to the more efficient use of health care resources, reduced health service utilisation and higher patient satisfaction. Studies clearly demonstrate that communication and leadership are vital to improving service integration, and that effective coordination depends on better utilising existing organisational structures rather than reinventing and applying new structures.[10,11]

To support achievement of the National Health Reform intentions a National Health System Coordination and Integration Program is required. This program would be designed to develop best practice in coordinated and integrated care across the boundaries of primary / community, secondary and tertiary health services including Local Health Network boundaries and between health professionals working in teams. The program would consist of three components - collaborative research, promoting the translation of research evidence into practice and supporting existing innovative practices

[9] Leutz W. *Five Laws for Integrating Medical and Social Services: Lessons from the United States and the United Kingdom*. Milbank Q. March; 77(1): 77–110. 1999

[10] McMurchy D. *What are the critical attributes and benefits of high quality primary healthcare systems? Report submitted to the Canadian Working Group on Primary Health Care Improvement.* Canadian Health Services Research Foundation. 2009

[11] Audit Scotland. Review of Community Health Partnerships. Auditor General for Scotland and the Accounts Commission. June 2011

Component 1 - Research: To support national research into the challenges associated with delivering coordinated and integrated care, taking into account existing practice in Australia. This component would have a particular focus on collaborative research aimed at finding solutions to problems and translating research evidence into practice. A key focus of this component would be to identify innovative service models designed to improve the patient journey through the health system and which could be implemented on a nationally consistent basis.

Component 2 - Implementation: To foster the translation of research evidence of successful models of integrated care across a range of healthcare settings (in line with the Research Component above) by providing grants to selected health services (criteria to be developed). A key focus of this component would be to improve the patient journey through the health system and test nationally consistent models of coordinated and integrated care.

Component 3 - Evaluation: To ensure analysis and distribution of outcomes from the program. A key focus of this component would be the national application of an integrated system of care.

AHHA Recommendation No. 7: That a National Health System Coordination and Integration Program be established.

Projected cost and timeline: $4.5M over three years

3.3 E-Health: Enhancing Discharge Planning and Referral

The AHHA supports the Australian Government's commitment to facilitating the transition from paper-based clinical record keeping to electronic platforms. Effective electronic transfer of information between hospitals and primary healthcare / community services is vital for effective discharge planning and the management of people post-discharge, particularly those with chronic and complex diseases. Such a program would complement the National Health System Coordination and Integration Program described above.

However, due to the fragmentation of the health system, there are numerous information management systems in place with varying capacities for information collation and transfer which impacts negatively on integration of services.

Multiple studies have found that effective discharge planning processes require accuracy, completeness and timeliness. There is little reliable evidence that these factors are consistently evident in discharge planning across Australia.

A study from KPMG, for example, that examined the lead sites introducing the Electronic Discharge Summary Systems, found that the use of e-health technology for discharge summaries was not simply about making existing processes electronic.[12] Careful consideration also needs to be given to what constitutes best practice in the first instance. Implementing successful electronic systems requires considerable thought and planning around training, change management and consultation to ensure that they deliver improvements rather than entrench poor practice.

[12] Australian Commission on Safety and Quality in Health Care. *Safety and Quality Evaluation of Electronic Discharge Summary Systems Final Report.* ACSQHC. Sydney. 2011

A recent study by the University of Tasmania, commissioned by the Australian Commission on Safety and Quality in Health Care and NSW Department of Health, examined discharge and referral practices in Australia.[13] It noted that:

- much of the research on discharge planning is hospital focused, which could lead to a misunderstanding that these processes are the sole responsibility of hospitals
- discharge planning and referral were predominantly treated as independent processes and examined in isolation
- one of the most significant risks in discharge planning was medication safety and management, which is particularly relevant for the elderly, those with confusion or dementia, people with chronic and complex disease, patients on multiple medications, migrants with low levels of English and people with low levels of literacy.

NEHTA's e-Discharge Summaries Program will develop key specification requirements for software vendors, GPs and hospitals.

This program needs to be accompanied by strategies that support quality improvement and best practice discharge planning across the nation and supported by dedicated funding in order to develop and deliver national discharge planning protocols including quality standards, supported by electronic tools.

AHHA Recommendation No. 8: That a National Discharge Planning and Referral Program be established.

Projected cost and timeline: $3.6M over 3 years

4 Aboriginal and Torres Strait Islander Health and Cardiovascular Care

The health of Aboriginal and Torres Strait Islander (ATSI) people in Australia continues to lag behind the rest of the Australian community. While improvements have occurred, including a small reduction in the life expectancy gap between ATSI and non-ATSI Australians, there are several issues that remain outstanding. They include access to timely and effective acute care for acute coronary syndrome.

A 2006 report from the Australian Institute of Health and Welfare (AIHW) found that compared with other Australians, Aboriginal and Torres Strait Islander people had:

- three times the rate of major coronary events, such as heart attack
- 1.4 times the out-of-hospital death rate from coronary heart disease (CHD)
- more than twice the in-hospital death rate from CHD
- a 40% lower rate of being investigated by angiography
- a 40% lower rate of coronary angioplasty or stent procedures
- a 20% lower rate of coronary bypass surgery.[14]

[13] Cummings E. Showell C. Roehrer E. Churchill B. Turner B. Yee K.C. Wong M.C. Turner P. *Discharge, Referral and Admission: A Structured Evidence-based Literature Review.* eHealth Services Research Group, University of Tasmania, Australia. 2010

The Heart Foundation and the AHHA have already developed a number of strategies designed to improve the quality of care Indigenous people with acute heart conditions receive whilst in hospital.[15] Best Practice Case Studies are currently being collected from across Australia for publication to increase knowledge sharing.

These case studies, together with research undertaken by the CRC for Aboriginal Health, can form the basis for a Demonstration Hospitals program supporting the implementation of best practice models across partner hospitals and health services for the management of acute cardiac events in ATSI patients.[16] It is anticipated that this approach would be transferable to other health conditions and patient groups.

AHHA Recommendation No. 9: That a National Indigenous Hospital Demonstration and Mentoring Program be funded that focuses on Indigenous heart health

Projected cost and timeline: $6.9M over three years

5 Oral and Dental Health

Oral health is vital to overall health and well-being. Dental problems impact on people's ability to eat (affecting nutrition), socialise, find employment and fully participate in society. If untreated, dental problems can develop into more serious health conditions requiring intensive treatment and sometimes hospitalisation. While these problems are widely recognised, gum disease and dental caries still account for two of the top five public health issues in Australia.

Almost half a million people remain on waiting lists for public dental treatment, with an average waiting time of approximately two years. It makes no health, social or economic sense to allow people to languish without access to regular preventative dental care and treatment. Many people who start out on waiting lists for preventative or restorative treatment become emergency cases by the time they receive treatment.

The Australian Healthcare & Hospitals Association (AHHA) has consistently called for increased public funding to underpin a revitalised national oral health scheme as a critical component of a more equitable and effective health system.

The long-term trends suggest that the degree of inequality in dental care access has increased over the last 30 years and these inequalities appear to have been influenced by government policies.[17] The community's lack of access to affordable dental health services means that Australia ranks among the bottom third of OECD countries for rates of dental decay among adults.[18] There is also

[14] Mathur S, Moon L, Leigh S. *Aboriginal and Torres Strait Islander people with coronary heart disease: further perspectives on health status and treatment*. Cardiovascular disease series no. 25. Canberra:AIHW, 2006.
[15] National Heart Foundation of Australia and Australian Healthcare and Hospitals Association. *Better hospital care for Aboriginal and Torres Strait Islander people experiencing heart attack*. 2010.
[16] Willis, J, Wilson, G, Renhard, R, Chong, A & Clarke, A. *Improving the Culture of Hospitals Project: Final Report.* Australian Institute of Primary Care, Melbourne. 2010
[17] Australian Institute of Health and Welfare Dental Statistics and Research Unit. *Commonwealth Dental Health Program*, Research Report 3, University of Adelaide. 1996
[18] National Health & Hospitals Reform Commission Final Report 2009

evidence that the oral health of Australian children has declined, reversing the gains made in the 1970s and 1980s.[19]

5.1 Universal dental care

Our goal is for all Australians to have universal access to preventive and restorative oral health care, regardless of their ability to pay.

The AHHA recognises that a universal access scheme would require a phased implementation, commencing with a focus on early intervention and treatment for disadvantaged groups concurrently with enhancing health promotion and prevention programs. The dental reform initiatives announced by the Australian Government in August 2012 represent the foundation activities in preparation for the establishment of a universal scheme.

In order to progress the proposed reforms to the a truly universal scheme additional investment is likely to be required to address the needs of those that are not eligible for pubic dental services but still struggle to meet the costs of private services.

AHHA Recommendation No. 10: That a Universal Oral and Dental Health Scheme for All Australians be implemented within five years.

Projected cost and timeline: $2.0B per annum from 2015/16
(in addition to existing commitments and rising to $3.0 B p.a. from 2018/19)

AHHA Recommendation No. 11: That the impacts of the government's investments announced in August on access and equity be formally evaluated and develop/calculate requirements for full universal coverage.

Projected cost and timeline: $3.35M over four years

5.2 National leadership and coordination

After many years of minimal involvement in the funding of dental programs by the Australian Government there are now a myriad of programs being administered by a range of Departments and Agencies. There is a significant risk of inefficiency, duplication and waste as a result of an uncoordinated approach to the planning and implementation of new initiatives and integration with existing programs.

This is evidenced in the multiple initiatives with associated allocations for capital investment which have resulted in a patchwork of building, refurbishment and equipment programs including the Graduate Year programs for dentists and oral health therapists, the Mobile Indigenous Infrastructure program, the Health Workforce Australia student placement and training programs, the regional/remote private practice relocation and establishment programs and University dental school expansions.

There is an urgent need for cross-Department coordination of the Government's oral and dental health reform program to ensure that the maximum benefits are delivered in an efficient and equitable manner.

[19] Mejia GC, Amarasena N, Ha D, Roberts-Thomson K & Ellershaw AC. *Child Dental Health Survey Australia 2007: 30-year trends in child oral health*. Dental statistics and research series no. 60. Cat. no. DEN 217. Canberra: AIHW 2012

The AHHA strongly believes there is a need for a body to provide regular advice on the design, implementation and progress of the Commonwealth's dental programs, particularly given that the significant level of funds will be expended in the coming years.

The AHHA is concerned that the Commonwealth Department of Health and Ageing does not have a clear source of independent, evidence-based advice around public dental care, particularly when their programs need to be implemented in a complex federal environment in which state and territory dental services are also provided. This form of advice is distinct from negotiations that are held with the States and Territories in the context of Health Ministers' meetings or COAG. Furthermore, it is critical for Government to receive ongoing advice on the best mechanisms to systemically include oral health in the National Health and Hospitals Network reforms.
The capacity of such a body to provide clear and balanced advice is demonstrated through the work of the National Advisory Council on Dental Health.

Australia is the only country in the region that does not have a Chief Dental Officer or equivalent advisory body with a Chair. Action in oral and dental health requires national leadership and coordination. The Canadian Office of the Chief Dental Officer (COCDO) provides a suitable model for Australia. The COCDO is responsible for:

- Provision of evidence-based oral health perspectives on a wide range of health policy and program development issues
- Provision of expert oral health advice, consultation and information
- Integration of oral health promotion with general health (wellness) initiatives
- Assisting in gathering epidemiological information for program planning on federal/provincial/community levels and establish priorities for research
- Developing integrated collaborative approaches to preventing and controlling oral and associated diseases
- Providing a point of contact/liaison with professional associations, jurisdictions, academic institutions, and other non-government organisations on oral health issues.

The responsibilities of an Australian Chief Dental Officer would include:

- Chairing a high-level advisory committee
- Coordinating and informing cross-agency policy and program development and implementation
- Oversee national planning and performance evaluation and management.

AHHA Recommendation No. 12: That the position of Chief Dental Officer and associated support staff be established to lead, inform and coordinate the Government's oral and dental health program.

Projected cost and timeline: $3M per annum

6 Refugee Employment in the Health Services Program

There are sound reasons for employing refugees and migrants in health services. It provides benefits to the individual and facilitates social inclusion and social cohesion. Health services also gain from employing refugees because it enables them to fill skill and labour shortages. Young refugees who are educated and trained in Australia should be targeted as potential health service employees. Employing refugees also broadens the workforce demographic and develops a staff profile that

reflects the cultural diversity of the wider community. It also makes it more likely that health care services will become more accessible to the local refugee population.

Very few refugees trained in health professions overseas will arrive in Australia with the clinical skills necessary to work here. Even those with the necessary skills and qualifications will, for the most part, need a period of adjustment in order to acquire the English and cultural skills.

Australian health services continue to work hard to meet the challenge of providing appropriate, equitable and accessible healthcare for refugees. Evidence shows that refugees newly arriving in Australia can sometimes experience difficulties accessing healthcare services due to language, cultural and economic barriers.[20] Further hurdles are sometimes created by health employees who are not adequately trained to meet the special needs of refugees.

While the Australian Government provides a number of settlement programs to assist refugees, training programs in English language skills are often not long enough for many refugees to become proficient. Language training programs also tend to be focussed on settlement, so they do not provide any specific training that could help someone gain employment in the health sector. As a result, the types of employment people can seek can be restricted and mean that many refugees take up unskilled and casual positions with limited career prospects.

By providing training positions in health services in rural and regional areas of Australia, refugees can be helped to settle in and secure stable employment.

Employment in the health sector would be enhanced by a program to support up-skilling and vocational education for refugees in Australia, including those with overseas health qualifications, funded through the National Workforce Development Fund. Training options in the health sector include traineeships in administration, patient services assistants and health support services such as catering and cleaning.

Additional support should also be provided for refugees to undertake English language training so that they can reach the level of English required to be accepted into a minimum of Vocational Education and Training (VET) Certificate III level course in a health related area.

A mentoring program for employment of refugees in the health sector similar to the Australian Government's Building Australia's Future Workforce package would be funded from the National Workforce Development Fund. This would increase refugees' participation rate in the workforce and enable employers to provide the additional support to train refugees.

AHHA Recommendation No. 13: That a National Refugee Employment in the Health Services Program be funded with two components.

Projected cost and timeline: $6.2M over two years

[20] Murray S.B. and Skull S.A. *Hurdles to health: immigrant and refugee health care in Australia*, Australian Health Review, February 2005 29:1. 2005

7 Ambulance access

Timely access to emergency care is critical to improving health outcomes in cases of Acute Coronary Syndrome and other conditions. The current variable system of ambulance service funding across jurisdictions does not support equitable access to potentially lifesaving care. It is impossible to justify the fact that people suffering suspected heart attacks are delaying or avoiding calling an ambulance due to concerns about costs.

With the evidence showing a clear socio-economic gradient influencing use of ambulance services the time is right for governments at the Commonwealth, State and Territory level to work together to address these inequities. Immediate action is required to improve service access and to recognise the role of paramedics and the ambulance services in the provision of emergency health care.

Cost estimates developed by the Heart Foundation suggest a total cost for pre-hospital care of around 2.25B per annum. The additional funding required would be less than this due to existing state contributions.

AHHA Recommendation No. 14: That a National Ambulance Access Scheme be established.

Projected cost and timeline: $2.25B per annum

8 Greening the Health Sector

While much of the policy debate on climate change in Australia and elsewhere has focused on the environmental impacts and the economic impacts of the policy response, there has been relatively little discussion about the consequences of climate change on human health and the demands on the health system.

Yet the consequences are significant: according to the Australian Climate Commission, "climate change is harming our health in Australia, and poses a significant threat for the future".[21] In 2009, a commission established by *The Lancet* and University College London said climate change is "the biggest global health threat of the 21st century".[22] A recently published article in the Public Library of Science *Medicine* journal suggests that in the medium and long term, climate change could constitute a health crisis at least as wide-ranging as that currently caused by tobacco.[23, 24]

A joint paper by The Climate and Health Alliance and The Climate Institute has highlighted the health benefits obtainable through climate action.[25] These benefits include reductions in cardiovascular, respiratory and nervous system diseases by reducing reliance on coal-fired power generation and reducing the risk of ischaemic heart disease, dementia and depression by switching to active transport options like walking and cycling.

[21] http://climatecommission.gov.au/wp-content/uploads/111129_FINAL-FOR-WEB.pdf
[22] Costello A, Abbas M, Allen A, et al. *Lancet and University College London Institute for Global Health Commission: managing the health effects of climate change*. Lancet; 373: 1693-1733. 2009
[23] Nilsson M, Evengård B, Sauerborn R, Byass P. *Connecting the Global Climate Change and Public Health Agendas.* Public Library of Science *Medicine* 9(6): e1001227. doi:10.1371/journal.pmed.1001227. 2012
[24] Nilsson M, Beaglehole R, Sauerborn R. *Climate policy: lessons from tobacco control*, *The Lancet*, Volume 374, Issue 9706, Pages 1955 - 1956. doi:10.1016/S0140-6736(09)61959-0. 2009
[25] http://caha.org.au/wp-content/uploads/2010/11/OurUncashedDividend_CAHAandTCI_August2012.pdf

With the health sector responsible for 7 per cent of total carbon emissions from buildings in Australia, there is significant scope for the sector to reduce its carbon footprint through greater energy efficiency measures. While greening initiatives have often been viewed as costly investments with little or no direct cost benefit to the organisation, it has been clearly demonstrated that the adoption of sustainable practices can achieve realisable cost savings at the institutional level.[26]

In conjunction with the launch of the Global Green and Healthy Hospital Network in Australia, the Australian Healthcare and Hospitals Association held a Policy Think Tank which brought together participants from a range of health facilities, state departments and universities and commenced the important conversation on the role of the health sector in mitigation and adaptation in response to climate change. [27]

It was agreed that the health sector has a major role to play in climate action; both in terms of reducing the carbon footprint of the sector and as a leader and influencer of opinion at the community level. In Australia, as elsewhere, there has been significant debate around the causes and indeed the reality of global warming. A health sector led focus on the positive health improvement 'side effects' of actions intended to address climate change has a greater potential to promote community engagement than the current economic and political debate occurring in many regions.

The health sector also has a much broader interest in the climate change debate: the direct impacts of climate change on human health. Climate experts now agree that the health impacts of climate change, such as the spread of infectious diseases, and illness and fatalities related to severe weather events, are significant, and pose a significant threat for the future. This requires adaption of existing health services and plans for future service models and health service facilities and structures.

Significant success in raising the awareness of the impact of climate change on health and the health sector and supporting mitigation and adaptation programs has been achieved by the National Health Service Sustainable Development Unit (SDU).

The role of the SDU includes:

- Leadership, expertise and guidance concerning sustainable development to all NHS organisations in England
- Raising awareness of the actions and responsibilities that the NHS has regarding sustainable development and climate change including promoting a culture of measurement and management which leads to a process of carbon governance
- Shaping NHS policy, locally, nationally and internationally
- Ensuring best practice and innovations on sustainability in the NHS and elsewhere are evaluated and costed and the mechanisms for implementation are made fully available to all NHS organisations.

AHHA Recommendation No. 15: That a National Sustainable Development Unit be established

Projected cost and timeline: $1.5M per annum

[26] http://www.noharm.org/us_canada/reports/2011/apr/rep2011-04-06_Cleanmed_Susan_Kaplan.pdf
[27] http://ahha.asn.au/event/greening-health-sector-policy-think-tank

9 National Postgraduate Nurse Program and Nurse Graduate Support Teams

Postgraduate nursing programs have been available since 1996. Most research on these programs is focused on students' perceptions and expectations, and management views of students within the post graduate programs.[28] Little research has been done on the value of working as an entry level nurse. Up to a third of the entry level nurses will leave graduate programs due to a range of factors, including being overwhelmed by the pressures of their first year of nursing. These factors are strongly dependent on the clinical support provided to the graduates in that first year.

Some argue that entry level nurses should not be required to have a Bachelor degree and that nursing is all about the body and bedside manner. However research shows that patients have better outcomes in hospitals that employ more nurses with Bachelor degrees (or higher).[29]

Based on preliminary research undertaken by AHHA, it is apparent that there is little consistency in new graduate nursing programs across Australia. Graduate Nurse programs are offered in many facilities, but student numbers are often limited and the amount of support and content of programs varies widely. As a result, many people question the effectiveness of these programs. Currently, students may be studying in one state and then may choose to move to another state purely based on the benefits, including higher salaries. This also leads to a pull of graduates to the metropolitan areas and a shift in graduates away from the most needed areas, such as rural and remote parts of the NT and NSW.

There is evidence that Graduate Nurse Programs do not offer enough positions overall for graduating nurse entering the workforce.

A standardised, evidence based graduate nurse program for all nurses is needed in Australia encompassing a 'Graduate Support Team'. A critical aspect will be adequate clinical and mentoring support. Socialization into the professional setting (work environment) with hands-on clinical experiences and in-depth mentoring and support, increase both personal and professional growth and development. A new graduate support team is an excellent model to standardise across all hospitals, LHDs and states within Australia.

A coordinated national approach is required to:

Component 1: Develop of a set of standards and framework for an evidence based graduate nurse program for all nurses in Australia. This program would establish standards for continued professional growth and development throughout the first year of nursing following graduation. It would reinforce conceptual learning and encourage in-depth clinical skills, enhance self-confidence and feelings of competency.

[28] Manias E. *Clinical teachers in specialty practice settings: perceptions of their role within postgraduate nursing programs*. Learning in Health and Social Care, 4(2), 67-77. 2005

[29] Aiken, L., et al. *Educational levels of hospital nurses and surgical patient mortality.* Journal of the American Medical Association, 290(12), 1617-1623. 2003

Component 2: Develop a national **Nurse Graduate Support Teams** program to provide for all new graduates to have access to a team dedicated to supporting them as they begin their career. This would strengthen graduates' commitment to nursing, provide a safe environment and support continuing professional development.

AHHA Recommendation No. 16: That a National Postgraduate Nurse Program be established.

Projected cost and timeline: $2.7M over three years

10 A National Arts in Health Program

There has been increasing interest in, and scientific evaluation of, the impact of the visual, performing and literary arts on health, wellbeing and quality of life. Specific areas of endeavour include mental health, disability, ageing, chronic disease and health promotion.

There is strong evidence that utilising the arts in health settings can lead to greater effectiveness and efficiency in healthcare delivery. Additionally positive impacts of arts-based interventions can be observed at the individual, group and societal level. Evidence also suggests the potential for overall cost savings through better management of symptoms and reduced use of health services. [30]

Qualitative and quantitative research supports the benefits of the arts and creative activities in primary and acute care, community health, health promotion and medical education, encompassing visual arts, (painting, sculpture, photography, film, digital media), music, theatre, dance, creative and narrative writing, across the lifespan.

In 2009 the National Rural Health Alliance joined with Regional Arts Australia to support the publication of '*Seeded – great arts stories grown in regional Australia*'.[31] The publication documents 13 arts and health projects from rural, regional or remote Australia. They include the Tree project, a remarkable response to the disastrous Victoria bushfires; *Dust,* the theatre performance that brought home the issues of asbestos contamination to rural communities in Victoria; and the Cooma (NSW) multimedia project *Beyond Roundabouts* that addressed life challenges for young parents and won State and National Arts Health Foundation Awards in 2010. Also noteworthy is the Western Desert Kidney Health project which is helping to achieve significant preventive health outcomes in Aboriginal communities in Western Australia.

The '*Seeded'* projects above are examples of successful collaborations. There is a growing body of research evidence supporting the value arts and health collaborations have in improving patients' experiences and health outcomes. In a recent survey of 19 studies on this topic, researchers concluded that creative engagement could decrease anxiety, stress, and mood disturbances.[32] The study also recognised that much of the research in this area to date has been conducted in hospital and healthcare settings, rather than community settings. The *Seeded* projects provide evidence that programs do not need to be limited to clinical or institutional settings to have beneficial health outcomes. However there is a need for further research into the benefits of such programs.

[30] http://ahha.asn.au/publication/health-policy-evidence-briefs/there-compelling-evidence-using-arts-health-care
[31] http://nrha.ruralhealth.org.au/cms/uploads/publications/raa_seeded.pdf
[32] Stuckey H and Nobel J. *The connection between art, healing and public health: a review of current literature.* AmJPH 100(2): 254-263 2010

Component 1: Arts in Health Research focusing particularly on programs that improve the lives of aged people and those with dementia. Many aged care facilities utilise such programs and the award winning Aldergate Uniting Care Wesley program in Adelaide has received international recognition. Such research will add valuable knowledge needed to support future programs that may reduce health costs and burden in the long term.

Component 2: Arts in Health Programs which recognises the value of Arts in Health programs and provides funding for projects that:

- Showcase best practice Arts in Health programs for patients including those with cancer, dementia and mental illness and aged care
- Increase the capacity of aged care and health care providers or community services organisations to provide such programs with trained and skilled therapists and arts professionals
- Increase partnerships / alliances to enable communities to develop their capacity to utilise creative arts programs to deliver health-promoting lifestyles.

AHHA Recommendation No. 17: That a National Arts in Health Strategy be established and implemented.

Projected cost and timeline: $3.7M over two years

11 A Sustainable Future for Multi-Purpose Services

There are 134 Multi-Purpose Services (MPSs) operating across Australia in rural areas, some of which have been using the model since its inception in 1991. There is no consistent approach or application of the MPS model, nor a clear strategy of how it will evolve into the future. Nor are there coordinated data on the outcomes of MPS operations across Australia, which makes it difficult to assess how effective they are at coordinating and delivering healthcare services for their whole community.

Some states are increasing the number of MPSs. A national evaluation of the current model will help ensure that the MPS model is applied more consistently. By comparing MPS and other small health services in rural areas, it would be possible to identify critical success factors to inform expansion of the program. Such an evaluation would include analysis of the current funding arrangements and other data from all MPSs.

A National Evaluation of the Multi-Purpose Service Model is required to identify differences in how services operate across jurisdictions including variations in governance structures, reporting processes and factors that have facilitated success. A key outcome of this evaluation would be to develop a standard evaluation and data collection framework for MPSs as well as to recommend improvements so the model may continue to better support an ageing population in rural and regional communities.

AHHA Recommendation No. 18: That a National Evaluation of the Multi-Purpose Service Model be undertaken.

Projected cost and timeline: $0.9M in 2013-14