



The Health Advocate

Your voice in healthcare

'It's high time the health system evolved'

Higher education and health policy

The paradox of consumer-centred care

Value engineering and healthcare

My Health Record

An evolving health system

**+MORE
INSIDE**



no butts about it

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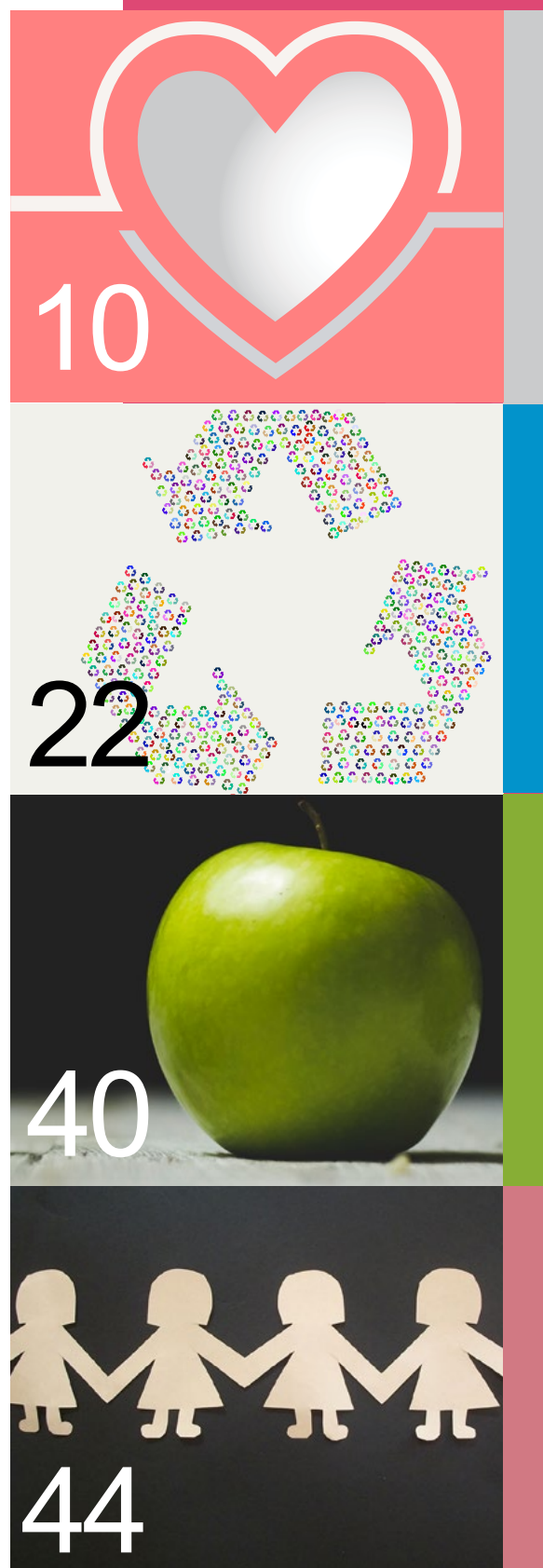
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**DEBORAH COLE**

Board Chair, Australian Healthcare and Hospitals Association (AHHA)

If we want our health system to evolve, we need to get cracking

Knowing that something needs to be done and rolling up your sleeves and doing it are two very different things—just ask any dietician or personal trainer. Similar to those failed New Year’s resolutions, as healthcare providers we often start a project with a bang, but when things get tricky or a bit too challenging, we take our foot off the accelerator or revert to the familiar.

When it comes to healthcare reform, we are great at researching, analysing, planning and discussing how the health system needs to evolve but the ‘doing’ part can be fraught with trepidation and a reluctance to move away from ‘the way things have always been done’.

We know that our health system needs to evolve if we are going to meet increasing demands for services and provide patient-centred care that improves health outcomes. We know that we need an integrated system that focuses on prevention and early intervention provided in a healthcare ‘neighbourhood’ rather than a hospital silo. An integrated system will require reform to the current commissioning environments that divide the roles and responsibilities of the health system into public and private entities, and government. This needs to change so that healthcare providers are incentivised, not by their funding stream, but by the desire to improve the health outcomes that matter to patients.

The consensus for an integrated health system is there, the intent is clear, and the technology is available—but often we find ourselves tinkering on the edge of system reform rather than diving in and actioning real change. Australians expect better and they deserve better.

One vital component in providing integrated and person-centred care is an

ability and willingness to embrace information and communication technology. I was recently chatting to a friend who has two preschool-aged children. She also suffers from an auto-immune disease which requires ongoing medication and regular blood tests. When her children were born, she was encouraged to sign her family up for a My Health Record, a secure online portal where she could access health information from doctors, specialists and hospitals. She was thrilled that she wouldn’t have to remember and repeat her family’s health history every time they visited a new provider and would be able to easily access pathology reports and details about any health conditions.

Five years after signing up, her family’s My Health Record still contains zero information. When she recently had to visit a new endocrinologist, she had to go to her GP and get a printout of all her test results and medications, as nothing was available online. This is just one example of a missed opportunity—the technology is there but it’s not being used. The result is a lack of integration between service providers and a family feeling disempowered in the management of its own health and wellbeing.

I’m not saying it’s as simple as finding the right technology and implementing it—there are several barriers when it comes

to harnessing the power of information and community technology in healthcare settings. Firstly, it’s expensive and often the big tech companies pay no attention to small scale operations with limited budgets. Secondly, a lot of systems don’t integrate well with other systems because the creators want to protect the value and functionality of their product. Thirdly, a lot of us just don’t understand the technology and find it all a bit foreign and daunting. We also feel like we don’t have time to learn a new way of doing things—clinicians and staff are too busy treating back-to-back

patients. I’m the first to put my hand up and say I fall into the technologically challenged camp. Lastly, it’s about will. We need to want to record the data because it’s important to the people receiving our services.

There is some fantastic work happening in the integrated care space across Australia. We can see it in Primary Health Networks, the National Disability Insurance

Scheme, Health Care Homes and a range of other innovative pilots. There are so many learnings that can be leveraged for better integration. Too often it feels like we are aiming to get on Mars but still learning to cross the road safely. Unfortunately the clock is ticking and we need to get a move on. **ha**

“The consensus for an integrated health system is there, the intent is clear, and the technology is available—but often we find ourselves tinkering on the edge of system reform rather than diving in and actioning real change. Australians expect better and they deserve better.”



ALISON VERHOEVEN
Chief Executive
AHHA

World Hospital Congress 2018 to point the way to health system evolution

The theme of this issue of *The Health Advocate* is 'An evolving health system'. Many will argue that we need more pace than that—maybe revolution rather than evolution!

It's no coincidence that the theme of the World Hospital Congress 2018, to be held in Brisbane from 10-12 October 2018, is *Innovate, Integrate, Inspire—How can healthcare evolve to meet 21st century demands?*

Issues such as unsustainable healthcare costs, increasing rates of chronic disease, ageing populations and a growing demand for healthcare services are challenges common to many nations around the world.

These challenges are serious, and in many instances will require a complete re-imagining of how healthcare is delivered in hospitals and other settings.

AHHA, with our host partner Queensland Health, has been working very hard to attract the kinds and calibre of speaker that you will want to listen to, and get inspired by, in your own efforts to improve hospital and healthcare systems. We were very mindful that this is a once-in-20-years opportunity for many Australian-based delegates, as well as a once-in-20-year opportunity for overseas delegates to visit our great country of Australia.

We have been successful beyond expectation. We received over 520 submitted abstracts before the January deadline. The already-burdened scientific committee suddenly had a very big rather than 'big' job on their hands!

Speakers and presenters at the conference will be talking about: value; patients being at the centre rather than service providers; integrated care to cope with multiple and complex chronic conditions; finite resources; and about the best use of data and technology to assist in making the right health system decisions.

Our first selection of keynote speakers was announced in mid-March and includes:

- Stanford University clinical professor and *Forbes Magazine* contributor Dr Robert Pearl
- #hellomynameis movement co-founder Chris Pointon
- Nuffield Trust Chief Executive Nigel Edwards
- Patient Advocate Melissa Thomason
- University of Queensland's Professor Claire Jackson
- Vision Australia General Manager Advocacy and Engagement Dr Karen Knight
- Australian Institute of Health Innovation Foundation Director Professor Jeffrey Braithwaite.

Dr Pearl and another conference speaker, Dr Lance Lawler, President of the Royal Australian and New Zealand College of Radiologists, have kindly written articles for this issue of *The Health Advocate*.

In the meantime, let me tempt you into attending the World Hospital Congress by profiling a selection of our keynote speakers. More profiles will be published in the next issue of *The Health Advocate*.

Nigel Edwards, Chief Executive, Nuffield Trust (UK)—Nigel will be a particularly interesting speaker for all delegates interested in health system reform and universal healthcare. He has a deep understanding of the UK's National Health Service and the challenges it faces to deliver universal healthcare in an environment of austerity. He will share his views on sustainability, new models of service delivery, and the transformation required to build high-performing health systems that can support universal healthcare.

#hellomynameis movement co-founder Chris Pointon—Chris has inspired health leaders, patients and communities around the

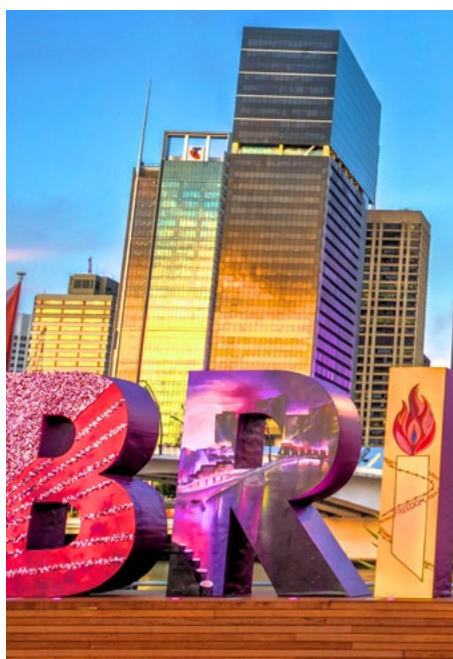
world with his advocacy for more compassion in health systems. This grew from when his late wife, Dr Kate Granger MBE, was diagnosed with terminal cancer. During a hospital stay Dr Granger noticed that many staff did not introduce themselves before delivering care. The couple started a global campaign for improving patient care through a basic message of introduction.

Dr Robert Pearl, author of *Mistreated: why we think we're getting good health care and why we're usually wrong*—Recently named by *Modern Healthcare* as one of the top 50 most influential physician leaders, Robert argues the need to raise quality, increase convenience and lower the cost of healthcare, and notes that integration is an essential first step: 'Just as the Mom and Pop store morphed into the large mall and most recently to online, so healthcare will need to evolve. Done right, healthcare can be both high tech, and high touch', says Dr Pearl.

Professor Claire Jackson, Director, MRI-UQ Centre for Health System Reform and Integration, University of Queensland—Claire is an international expert on achieving value and better health outcomes through a strong primary health system and a focus on integration. She has been a national driver in the Health Care Home initiative for nearly a decade, publishing and presenting widely on the topic and sitting on national Advisory Committees. Claire will help shape a World Hospital Congress conversation on how we can move from the traditional concept of bricks-and-mortar hospitals to a healthcare 'neighbourhood'. 

More information on the World Hospital Congress is available at www.event.icebergevents.com.au/whc2018.

AHHA in the news



1 FEBRUARY 2018

Over 520 abstracts received for World Hospital Congress 2018 in Australia

'This level of interest is extremely gratifying for Australia as the host nation, and reflects the appeal of the conference theme—"How can healthcare evolve to meet 21st century demands?"', said AHHA Chief Executive Alison Verhoeven.

'Issues such as unsustainable healthcare costs, increasing rates of chronic disease, ageing populations and a growing demand for healthcare services are challenges common to many nations around the world.

'They are serious challenges that in many instances will require a complete re-imagining of how healthcare is delivered in hospitals and other settings.

'Australia is ready to join the conversations, share our experiences and learn from other nations in seeking solutions to these issues', Ms Verhoeven said.

4 FEBRUARY 2018

Health insurance review only sensible way forward

'Years of premium increases in a time of low wage growth and well-above-CPI increases, combined with proliferating exclusions, gap fees and policy documents which are constantly changing and often incomprehensible, has left many Australians wondering why they bother with health insurance.

'This is an industry subsidised to the tune of \$6 billion by taxpayers; has accrued \$1.8 billion

in profits; and holds around \$6 billion in excess capital stocks above and beyond prudential requirements. It's time for independent scrutiny by the Productivity Commission to determine if taxpayer dollars are being well-spent and to investigate if there are better ways to finance our public-private health system', said Ms Verhoeven.



7 FEBRUARY 2018

Time for leadership and real reform in health

'Health Ministers and First Ministers will shortly begin negotiations on new public hospital funding arrangements to apply beyond 2020', Ms Verhoeven commented in the lead-up to the February 2018 COAG meeting.

'Do we really want the same overcrowding in public hospital emergency departments, the same lengthy waiting times for public elective surgery, escalating out-of-pocket costs, and the same fights about private hospitals and private health insurance premiums?'

'If Ministers are committed to a healthy

Australia supported by the best possible healthcare system, they must seize this opportunity to show real leadership and commit to some real and much-needed reforms.

Our *Healthy people, healthy systems* document is a solid blueprint with a range of short, medium and long term recommendations on how to reorientate our healthcare system to focus on patient outcomes and value rather than throughput and vested interests.

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



Gary Radler

8 FEBRUARY 2018

To Close the Gap we need partnership with First Peoples and a commitment to self-determination and reconciliation

'All governments—federal, state and territory—must urgently work together and in meaningful partnership with Australia's First Peoples if we're serious about Aboriginal and Torres Strait Islander Australians living just as long and as healthily as non-Indigenous Australians.'

Australian Healthcare and Hospitals Association (AHHA) Chief Executive Alison Verhoeven was commenting on today's release of a 10-year review of the Closing the Gap Strategy by the Close the Gap campaign, of which AHHA is a member.

'Last year, the Prime Minister reported that six out of the seven targets were not on track.'

'The burden of disease for Aboriginal and Torres Strait Islander Australians is 2.3 times higher than for the rest of the population.'

'Let's not see governments play the blame game when it comes to the health of our First Peoples.'

'Let's see the federal government properly fund primary healthcare services for Aboriginal and Torres Strait Islander peoples—the current funding shortfall is a major reason First Peoples experience a significantly higher burden of disease.'

13 MARCH 2018

Best of the best in health booked for Brisbane—World Hospital Congress comes down under

'We are offering Australian health leaders a once-in-20-year-event on their doorstep, and we are offering international health leaders a once-in-20-year professional reason to visit our great country.'

'The Congress' theme, *Innovate, Integrate, Inspire—How can healthcare evolve to meet 21st century demands?*, addresses a series of wicked problems all health systems around the world are trying to deal with.

'Across the Congress's three days, we are talking about value; we are talking about patients being at the centre rather than service providers; we are talking about integrated care to cope with multiple and complex chronic conditions, and finite resources; and we are talking about the best use of data and technology in terms of making the right health system decisions.'



Compassion Connect www.flickr.com/photos/compassionconnect

14 MARCH 2018

It makes sense to make better use of pharmacists in flu pandemics

Pharmacists are a largely untapped resource when a flu outbreak is happening, according to an Issues Brief published by the Australian Healthcare and Hospitals Association's Deeble Institute for Health Policy Research—*Improving pharmacist involvement in pandemic influenza planning and response in Australia*.

The paper was written by 2018 Deeble Scholar Libby McCourt, from the Faculty of

Health, Queensland University of Technology. The Deeble Scholarship was sponsored by HESTA (Health Employees Superannuation Trust Australia).

'Despite being the third most common health professional in Australia after doctors and nurses, pharmacist skills are not well used or incorporated into pandemic planning', Ms McCourt says.

AHHA in the news

15 MARCH 2018

National Close the Gap Day effort needed on key medicines for Aboriginal and Torres Strait Islander patients

In 2010 the Australian Government introduced the Closing the Gap Pharmaceutical Benefits Scheme (PBS) Measure, and the Remote Area Aboriginal Health Services \$100 program to improve Aboriginal and Torres Strait Islander access to medicines and pharmacy services.

While the programs are both of great benefit, a key problem is that they are limited by location—substantial gaps remain around access for people when they are away from home, whether in a regional town visiting family, or in a metropolitan hospital receiving treatment for a serious illness.

This problem has been highlighted in work the AHHA is doing in partnership with the Heart Foundation to improve cardiac care for Aboriginal and Torres Strait Islander people in public hospitals—the Lighthouse Hospital Project.

AHHA has suggested a number of administrative changes to address this in its 2018 pre-Budget submission to Treasury.

19 MARCH 2018

Time to dust off your healthcare organisation's business continuity plan—we did, *before* the fire...

'Our head office was totally destroyed by fire in the very early hours of Monday 3 July, thankfully without any resulting injuries.'

'But it also became the best of times because, by working together efficiently and effectively, guided by a recently updated business continuity plan, we had the organisation, with 400 staff and a turnover of more than \$36 million operating across 11 sites, remaining fully operational throughout the period with new corporate offices established within 5 business days.'

(Read more about Merri Health's response in the article on page 40.)



26 MARCH 2018

Cultural safety crucial in Aboriginal and Torres Strait Islander healthcare

If we want Australia's First Peoples to have the best possible healthcare, then all healthcare providers and professions have to seriously embrace the concept of cultural safety.

Cultural safety in this context involves health professionals examining their own beliefs, behaviours and practices, as well as issues such as institutional racism, in ensuring that their services are perceived as safe—by the patient rather than the provider.

'For much too long Aboriginal and Torres Strait Islander people have found health services unwelcoming, and even traumatic to the point where they will discharge themselves from hospital against medical advice', AHHA's Strategic Programs Director, Dr Chris Bourke said.

AHHA strongly supports the statement on cultural safety in healthcare recently released by the nation's five leading nursing and midwifery bodies.

28 MARCH 2018

Choice in health ok—but not at any cost, and only if it leads to better outcomes

'A number of the Productivity Commission's health related recommendations would empower Australians to get the healthcare and health outcomes they want', said Australian Healthcare and Hospitals Association (AHHA) Acting Chief Executive Dr Linc Thurecht.

Commenting on the Productivity Commission's report, *Introducing Competition and Informed User Choice into Human Services*, Dr Thurecht added, 'They also align with the recommendations put forward in AHHA's blueprint for outcomes-focused and value-based healthcare, *Healthy people, healthy systems*.

'It's now for Commonwealth, state and territory governments to act on a number of the Commission's recommendations in order to transform our healthcare system into a fit-for-purpose 21st century system that would meet the needs and expectations of Australians.

Careful stewardship by government is required to ensure that greater competition and choice doesn't result in increased costs, as seen when competition was introduced in markets such as energy and water, or greater difficulty accessing care, including longer waiting times if state governments are asked to remove measures such as requirements for patients to attend specific health services.



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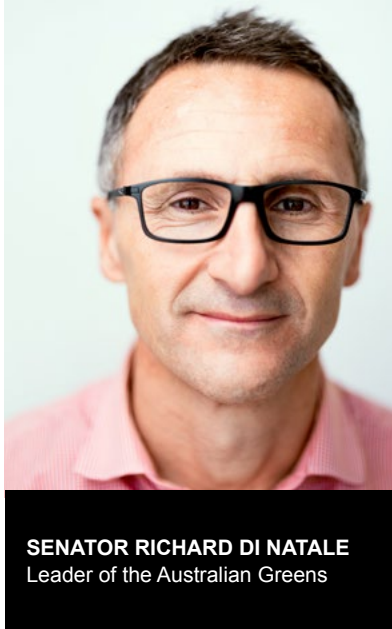


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IN DEPTH

SENATOR RICHARD DI NATALE
Leader of the Australian Greens

It's high time the health system evolved

The Australian health system is without a doubt among the best in the world. The emergence of Medicare in the 1970s was a seismic shift in the system, and after a few years of tussle to bed it down, we saw the concept of universality take its place at the heart of our country's approach to health care delivery.

These days, every proposed health reform is measured against or even directly compared to the introduction of Medicare. But in recent years we have seen precious little in the way of actual reform or 'evolution' in the health system.

There are constant impediments to meaningful reform that governments seem either incapable or unwilling to address:

- the constant obsession of governments to cut funding to healthcare rather than seeing spending in health as

an investment;

- the influence of vested interests stymieing reform; and
- perpetual cost-shifting between state and federal governments.

Firstly, we absolutely have to get past the really destructive, and erroneous, narrative that our spending on healthcare is 'unsustainable'. It's true that in the last 25 years overall spending on health as a percentage of GDP has slowly grown—from 6.5% in 1990 to 9.7% today. And it is projected to keep growing—by another 1% of GDP in the coming decade. But this is not unusual by comparable global standards, with average spending on health in the OECD being about 9% of GDP.

As a wealthy country, we have the ability and means to ensure we invest in our health, which means making the choice to spend

more on new and emerging treatments and technologies. We should be proud of that fact and make the investment, knowing that the dividend is greater productivity and happier, healthier Australians.

But cuts to hospital funding and the MBS in recent years put the brakes on any meaningful debate about reforms. Everyone became solely focused on battening down the hatches rather than looking to the next evolution of our system.

It has also meant that whenever a policy reform is brought in which may have merit, like the Health Care Homes trial, it is prevented from any real impact by being drastically underfunded. Here is a concept that was universally supported in principle that is in the process of becoming undermined by failure to make the required investment. As a former GP

“As a wealthy country, we have the ability and means to ensure we invest in our health, which means making the choice to spend more on new and emerging treatments and technologies.”



who has seen first-hand the need for reform to better manage chronic disease, I am so disappointed to watch this unravel.

Secondly, we shouldn't ignore the role of vested interests in holding back the evolution of the health system in this country. The one thing that is evolving, of course, is the nature of the conditions Australians are suffering from—the huge rise in chronic illness is the clearest case in point. To turn this around we need real reforms to the way junk foods are promoted and regulated, as well as genuine investment in preventive health.

There is a reason this hasn't happened. Despite near-universal support across the experts that we need bans on junk food advertising to children and the introduction of a tax on sugar-sweetened beverages, big junk food stands in the way of any of

these interventions. The losers are ordinary Australians, but it's the junk food industry, not you and I, that make huge donations and invest deeply in constant lobbying. The Australian Greens have an ambitious plan to invest in preventive health and implement the regulatory measures we know will help reduce chronic disease.

Finally, the constitutional reality, in which the federal government is responsible for primary care while the states have carriage of our hospitals, leads to seemingly inevitable and intractable cost-shifting between the two layers of government. As long as each side is trying to push the costs of care off their balance sheet and onto the others', patient care loses out. This is why an Independent National Health Authority, which sits at the centre of the AHHA's *Blueprint for a Post-2020 National Health*

Agreement is such a critical reform for this country. Only when we have an agency like that, which takes the responsibility for funding away from individual governments and into an independent entity, will we see patient outcomes actually sit at the heart of reforms.

It is high time the Australian health system evolved. We face new health challenges which threaten the very real possibility of handing our children a shorter life expectancy than our own. We are a wealthy country that can afford to make the investment and innovations required to keep Australians healthier, longer. The Australian Greens have the courage to advocate for health reform that is in the best interests of everyday Australians, not vested interests, and we will remain absolutely committed to that goal. 



DR TINA CAMPBELL
Managing Director
Healthily

IN DEPTH

New approach to digital patient education for integrated care and health care homes

“By empowering people with the knowledge, skills and confidence to better self-manage their health we will help improve health outcomes, prevent complications and reduce avoidable hospitalisations.”

THE INCREASING BURDEN OF CHRONIC DISEASE

The prevalence of chronic disease is growing so rapidly that health systems worldwide are struggling to cope. In Australia, approximately 85% of the burden of disease and 85% of healthcare costs are attributable to chronic conditions. The recognition of the substantial personal and economic effects of chronic disease is driving the adoption of strategies to address its influence.

The past decade has seen a shift to integrated person-centred healthcare delivery, and the transformation of the patient-practitioner relationship into a collaborative partnership in which patients are supported to take a more active role in their own healthcare.

Integrated Care is a key national strategy to transform the health system to deliver

more person-centred, seamless, efficient and effective care. The establishment of Primary Health Networks and the recent rollout of the Australian Government's Health Care Homes initiative further demonstrates the government's commitment to coordinated, flexible care for patients.

At State level, the NSW Integrated Care Strategy is one of three strategic directions in the NSW State Health Plan, highlighting the priority placed on developing new and innovative models of care.

YOU DON'T KNOW WHAT YOU DON'T KNOW

Health literacy is an important factor in the success of integrated care. Low health literacy has an impact on the quality and safety of healthcare and contributes to higher healthcare costs.

Healthcare providers and organisations have a crucial role to play in addressing health literacy. The National Statement on Health Literacy (2014) details a number of

actions they can take, including 'provide education programs for consumers aimed at developing health knowledge and skills'.

USING TECHNOLOGY AS AN ENABLER

In response to the Australian health system's need to support health literacy, Healthily has developed a patient education web application, GoShare Healthcare, that assists health practitioners to deliver tailored health information directly to patients.

GoShare Healthcare hosts thousands of fact sheets, patient stories (video format), animations, links to credible websites, apps and tools relevant to a broad range of health and wellness topics. Health practitioners—GPs, nurses, allied health professionals, health coaches, care coordinators, pharmacists and others—can send customised bundles of credible health resources via email or SMS directly to their patients or clients.

Health practitioners select the content in the bundles according to the individual



Western Sydney Local Health District and Primary Health Network health professionals, including Care Facilitators and the Rapid Access and Stabilisation Service (RASS) teams, participate in a GoShare training session.

patient's health literacy and information needs. Bundles can be sent on an ad-hoc basis, or automatically delivered as a digital program at a selected frequency.

COLLABORATION BETWEEN WENTWEST AND WESTERN SYDNEY LOCAL HEALTH DISTRICT

To address health literacy and patient education needs in the Western Sydney region, WentWest (Western Sydney Primary Health Network) and Western Sydney Local Health District are collaborating with Healthily to achieve the first region-wide adoption of the GoShare Healthcare program in NSW. A phased rollout commenced in January 2018, with an early focus on general practices taking part in the Health Care Homes trial, and the Rapid Access and Stabilisation Service clinics at Westmead and Blacktown hospitals. A range of services will adopt this digital platform throughout 2018, improving their patient-centred education and achieving better health experiences for consumers.

Walter Kmet, CEO of WentWest said his organisation was looking forward to a strengthened long term partnership with Western Sydney Local Health District, Healthily and health professionals to enhance the health literacy and self-care capabilities of patients, especially those who live with a chronic condition. 'By empowering people with the knowledge, skills and confidence to better self-manage their health we will help improve health outcomes, prevent complications and reduce avoidable hospitalisations', he said.

Danny O'Connor, CEO of Western Sydney Local Health District, said health professionals across the continuum of hospital-based care through to community-based care would be given access to the GoShare platform. Benefits delivered to WSLHD health professionals and patients included improved integrated and patient-centred care.

SELF-MANAGEMENT IN THE FUTURE

Central to disease prevention strategies is

the requirement to change attitudes and behaviours through the provision of timely interventions and credible information, tailored to individual needs.

Early indications from current and potential users of GoShare Healthcare across the aligned Western Sydney Primary Health Network and Western Sydney LHD region are that its patient education and support capabilities can be used in a range of areas other than chronic disease management, including maternity, rehabilitation, allied health and discharge support. Content development and aggregation is already being undertaken with stakeholders in these specialist areas and others, including alcohol and other drugs, mental health, and cultural and social issues—all of which can be contributors to the burden of chronic disease on the health system. ¹⁴

More information on the GoShare platform is available at www.healthily.com.au/goshare/.

The paradox of consumer-centred care

Are we there yet?



GraphicStock

A GRADUAL PROCESS

The concept of consumers taking a pivotal role in health services decision-making is becoming more accepted just as it makes common sense to have consumers engaged in decisions about their care. Yet it is one of the paradoxes of health care that consumer-centred health care is a central but often missing component.

‘What is health care if it is not consumer-centred?’ you might ask. There is the cynic’s view that patient-centred care is where

you, the patient, sits in the centre while the clinicians and officials tell you what to do.

How often do patients’ simple needs, such as prompt attention and individually-focused care get overlooked while priority is given to the demands of the system and the practitioner? Are we getting any closer to the patient-centred ideal set out by cardiologist and medical thinker, Eric Topol, in his book *The Patient Will See You Now*?

This has proven at best a gradual process getting practice to meet aspiration.

PATIENT-CENTRED CARE AND THE AUSTRALIAN HEALTH WORKFORCE

Just over a year ago, our journal *Health Voices* explored the reality of patient-centred care in the Australian health workforce. Our survey of health workforce organisations showed that despite the high level of recognition of the benefits of patient-centred care, only 50% of respondents felt that they had access to adequate resources from either internal or external sources to assist in supporting a patient-centred model of care.

“How often do patients’ simple needs, such as prompt attention and individually-focused care get overlooked while priority is given to the demands of the system and the practitioner?”



LEANNE WELLS
Chief Executive Officer
Consumers Health Forum

This was also reflected in the extent to which patient-centred care is enshrined in organisational policy: 45% of organisations reported that patient-centred care is a stated objective in their code of conduct or professional standards and 40% reported that their organisation had a patient engagement policy.

TIME TO WALK THE TALK—THE COLLABORATIVE PAIRS TRIAL

So it seems while attitudes in our health system are evolving to accept an active role for consumers, many practitioners have yet to walk the talk. Patients or consumers need to be seen by providers and managers as an asset to planning, priority setting and decision making, not just advocates.

The King’s Fund in the UK has recognised the need to address the clinician/patient relationship as the key to transforming the health system. Their program ‘Collaborative Pairs: leading collaboratively with patients and communities’ brings together consumers, patients and community leaders to work together in pairs with a service provider, clinician or manager on a specific project or program. The program’s objectives are to build skills in developing collaborative partnerships and to break down the cultural barriers that often exist between those providing the services and those receiving them.

CHF is currently partnering with the King’s Fund, four Primary Health Networks and the Australian Commission on Safety and Quality in Healthcare to undertake a national demonstration trial in Australia. It is our hope that Collaborative Pairs will be a tool for building the capacity of the health system to become consumer-centred.

POLICY DEVELOPMENTS

On the broader policy stage, refreshingly, we are seeing calls for a patient-centred focus coming from two unexpected sources: the Federal Treasurer, Scott Morrison, and the Productivity Commission.

Mr Morrison recently stated that a reboot of health including priority for integrated patient-centred care could lead to better outcomes worth up to \$200 billion to Australia over 20 years. This followed publication of the Productivity Commission’s report, *Shifting the Dial*, which accepted that while Australia’s experience in integrated care was not extensive, it was sufficient to affirm international evidence that integrating GP and hospital services to provide better wrap-around patient care delivers better patient outcomes at lower cost.

The report recommended all Australian governments should re-configure the health care system around the principles of patient-centred care. This could include:

- developing measures of people’s experience of care and outcomes and integrate these into disease registries;
- publish results for clinicians, hospitals and patients to see grass roots system results;
- improve patient health literacy so far more people can self-manage chronic conditions, interpret clinical information and make informed end of life decisions; and
- use My Health Record and other IT platforms to involve people in their health decisions.

CLINICAL DEVELOPMENTS

At the clinical level there are developments giving effect to the value of patient experience in improving healthcare. An example is the Real People Real Data (RPRD)

toolkit, developed by the Consumers Health Forum to record and analyse patient stories about their health care experience as a means of informing and improving health services.

Recently Crohn’s & Colitis Australia deployed RPRD as a guide to collect and analyse the stories of 20 patients living with inflammatory bowel disease. This lifelong condition is marked by fluctuating symptoms that are often debilitating and can require serious surgery. They can also result in psychological and social impacts, and pose great challenges to patients and carers. Access to care is inequitable and in many cases inadequate.

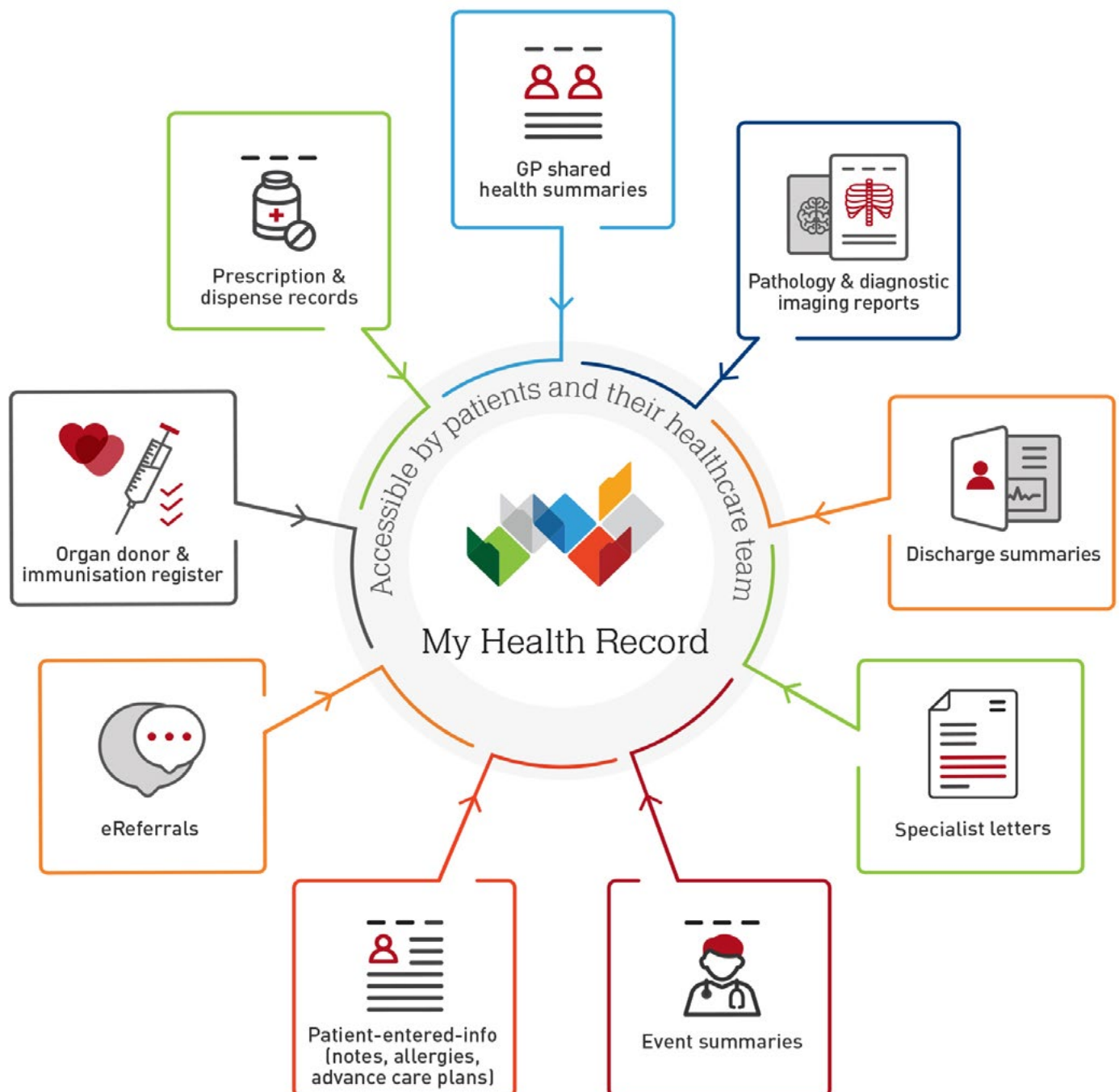
The resulting report, *My IBD Story*, presents a diverse range of positive and negative health care experiences reported by patients that clinicians, hospitals, planners and funders can use immediately in planning services. Experiences range from delays in diagnosis to variable standards of care and the benefits of responsive gastroenterologists. Areas for further focus are also outlined in the report.

Recently, CHF has partnered with the AHHA to undertake some masterclasses and produce a toolkit on *Experienced Based Co-Design* which again is focused on building the capacity of healthcare providers to work in partnership with consumers in designing components of the health system.

And as *My IBD Story* states: ‘The growing participation of consumers in their own healthcare and improvement of care, compels the healthcare industry to engage consumers to achieve the best possible quality improvement outcomes’.

Achieving a patient-centred health care system is about developing consumer and clinical leaders who can work together to transform the health system. 

My Health Record



The connection to accessible information at any time.



TIM KELSEY
Chief Executive Officer
Australian Digital Health Agency



LEONIE ABBOTT
Hospital Pharmacist
University Hospital, Geelong

By the end of this year, every Australian will have a My Health Record unless they decide they do not want one—and all healthcare providers need to be prepared wherever they are.

Already 5.5 million Australians—more than 20% of the population—have a My Health Record.

Almost 1,000 public and private hospitals around Australia have connected to the My Health Record system via their electronic medical record systems. Across Australia, 72% of public hospitals are connected to My Health Record—covering approximately 81% of available beds nationally.

Hospital pharmacist Leonie Abbott from the University Hospital Geelong, at Barwon Health in Victoria, has been uploading records to, and using My Health Record, since 2013.

She said having My Health Record accessible '24/7' is an extremely useful benefit of the system.

'Within a busy emergency department, being able to access information at any time is essential. Patients come in at any time of the day or night with emergencies, and often they have little healthcare information with them, including knowledge of their medicines.

'My Health Record is a summary of multiple clinical information software all in one record. It gives some preliminary information that may allow you to identify which healthcare practitioner in the community to call. This avoids unnecessary phone calls, or faxes and time wasted', Ms Abbott said.

In August 2017, the Council of Australian Governments Health Council approved Australia's National Digital Health Strategy (2018-22). The strategy—*Safe, seamless, and secure: evolving health and care to meet the needs of modern Australia*—identified seven key priorities for digital health in Australia.

Establishing a My Health Record for every Australian who wants one by the end of 2018 is one of these priorities.

The strategy puts the consumer at the centre of their healthcare and provides choice, control and transparency.

Australian Digital Health Agency CEO Tim Kelsey said the implementation of My Health Record nationally this year will deliver a system that provides universal functionality, clear and concise content and, critically, a safe and secure clinical health service for all Australians.

Ms Abbott said My Health Record provides a starting point for conversations with patients.

'It improves my efficiency and that of community pharmacies, particularly as they receive many calls each day for medication histories. Interruptions can also impact dispensing accuracy which is an important issue.

'Additionally, shared health summaries from GPs can be very useful—they are busy practitioners and cannot be accessible at all times. Being able to view My Health Record information can help before you make a phone call', Ms Abbott said.

Hospital staff can use My Health Record via connected systems every day, including to provide input into discharge summaries documenting a patient's encounter in the hospital. To date, more than 1.5 million discharge summaries have been uploaded to the My Health Record system.

The need for uniform and accessible discharge summaries was highlighted in research published in the February 2018 issue of the *Australian Health Review* (AHR).¹

The research concluded that: 'The quality of medical data captured and information management is variable across hospitals' and the researchers recommended medical history

documentation guidelines and standardised discharge summaries be implemented in Australian healthcare services.

AHR chief editor Professor Gary Day said that the researchers also supported integrating these into a solely electronic system such as My Health Record, with the proviso that information uploaded to My Health Record could only be as good as information contained in the clinical systems contributing to it.

The Agency has partnered with Australia's 31 Primary Health Networks to support pharmacies and GP practices to complete their registration with My Health Record and to raise awareness of the benefits of My Health Record. Staff from PHNs are available to visit onsite to work with staff to ensure the registration and connection process runs smoothly.

Agency CEO Tim Kelsey said: 'My Health Record can reduce the risk of medical misadventures by providing treating clinicians with up-to-date information'.

'The benefits of digital health for patients are significant and compelling. Digital health can improve and help save lives', he said.

Real and ongoing benefits from My Health Record will be felt over time as more and more health information is added to a person's My Health Record. 

For further information on and to register for My Health Record, visit www.myhealthrecord.gov.au

Reference

1. Allen-Graham J, Mitchell L, Heriot N et al. 2018. Electronic health records and online medical records: an asset or a liability under current conditions? *Australian Health Review* 42(1)59-65. At: <https://doi.org/10.1071/AH16095>



TOM SYMONDSON
Chief Executive Officer
Victorian Healthcare Association

IN DEPTH

How Australia's health system is evolving

A shift from the traditional comfort of 'beds, beds and more beds'.

Australia's first public hospital opened its doors in 1816 in Sydney and was known as the Rum Hospital because it was built by a pair of enterprising merchants in return for a monopoly on the importation of rum to New South Wales.

Putting aside its dubious origin for a moment, I wonder if the matrons and surgeons could have imagined that some 200 years later, three in four people would suffer from a chronic disease. They certainly wouldn't have imagined that—with all the fresh food, education and technology we now have access to—two-thirds of us would be classified as overweight.

Today's challenges are not completely unique to the 21st century—after all the Rum Hospital was built in response to a growing population, albeit largely unwilling immigrants from Britain, and the need to improve the standard of care. But back then the hospital system was dealing with a completely different cohort of people with predominantly acute health needs. These days, while the acute burden of disease is declining, an increasing prevalence of chronic and complex conditions and increasing community expectations mean the demand for

high quality, accessible and equitable public healthcare is skyrocketing and shows no sign of slowing.

As the decades have passed, treatments have improved at an exponential rate, allowing us to manage and even banish many of the diseases that dominated the lives of those early carers, and increasing life expectancy by more than 40 years in the past two centuries. Our systems of care delivery have also evolved. We have seen the system grow beyond the limits of the hospital walls, with services increasingly delivered in community settings, thriving not-for-profit and community sectors, and the increasing recognition of the crucial role played by the GP. More recently still, improved technology has made it possible to provide care in remote areas by linking specialists to local hospitals via telehealth, and in people's homes through wearable devices.

Sadly, these changes to care delivery have been slow and our system is still overwhelmingly focused on expensive, hospital-based care. And the cost of that care continues to increase year on year, far outstripping inflation. And our governments have consistently struggled to keep pace,

despite the many billions of dollars pumped into our system every year.

Funding is, however, only one part of the equation: if we are to address this fundamental issue, we have to change the way we deliver, and even think about, care.

Our system responds phenomenally well to sickness and disease, trauma and injury. But what about the challenges of supporting people with chronic health conditions, the massively increased incidence of mental health issues in our community, or providing culturally safe care for Aboriginal communities? Our current funding and system design do little to help. Activity-based funding is brilliant at dealing with a broken leg or a heart transplant, but not a person with a complex set of health or social issues. And all too often our disjointed and fragmented system leaves people whose needs are more complex, or not visible, to work out for themselves how best to seek support. With low levels of health literacy and a system that at times requires a PhD to navigate, we don't exactly have a recipe for success.

But there is reason to be optimistic. Australian governments have been largely focused on—some might say obsessed with—

“There is a need to further support the primary care workforce to effectively meet these challenges and to continue to deliver high quality, safe, best-practice care.”

the financial efficiency of our system in recent decades, which is understandable given the overwhelming strain it places on treasuries across the nation.

But there are a rash of initiatives underway which aim to address demand. The piloting of Health Care Homes by the Commonwealth is one positive example, and in Victoria we have seen the state government launch Health Links, enabling acute hospitals to ‘cash out’ a portion of activity-based acute funding to provide a more holistic response to those patients who attend hospitals the most often, our so-called ‘frequent flyers’. While these are both relatively small programs, they signal a willingness by policy-makers to think outside the traditional political comfort zone of ‘beds, beds and more beds’.

We also benefit from a strong non-acute health system. In Victoria, for example, our community health sector continues to play a vital role in supporting people through their holistic focus on the individual, rather than simply their condition(s). Their ability to bring together multiple, often small, funding streams in a community setting has allowed them to largely buck the increasing trend in our health and social support sectors towards over-specialisation and narrow service offerings driven by our financial environment. Blended with the best principles of the NDIS towards enabling greater individual choice and control, this is a part of our system which should be nurtured if we are to reduce demand on our hospitals and improve outcomes for our population.

Ultimately, if the healthcare system is to truly evolve to deal with the challenges of today, as opposed to those of centuries past, it must be empowered to do so. We must incentivise keeping people in their homes or receiving care in their community wherever possible and reward providers from across the spectrum for giving people the information they need to make healthy choices. Typically, evolution is slow and steady but the sector is ready for change and it must change. **ha**





MELINDA DALEY
Commissioning Manager
Sydney North Primary Health Network

BRIEFING

Local Coordinated Networks in northern Sydney

How Sydney North PHN is bringing care closer to home.

As with other areas in Australia, the primary healthcare needs of residents in northern Sydney are characterised by a growing burden of chronic disease, multiple co-morbidities and an ageing population. There is a need to further support the primary care workforce to effectively meet these challenges and to continue to deliver high quality, safe, best-practice care.

The Sydney North Primary Health Network (SNPHN) examined a range of primary care models in Australia, New Zealand, the US and the UK before developing an innovative framework of its own. The framework aims to strengthen the role of primary healthcare providers in supporting the patient journey through the complex health system, while also bringing services closer to patients' homes.

The SNPHN solution involved working closely with general practices and wider primary care services to establish local

coordinated networks (LCNs) in the northern Sydney region.

Reflecting a 'medical neighbourhood' model, an LCN is a grouping of general practices within a locality. Multidisciplinary teams and services work in collaboration with those general practices so that together they can provide services which best meet the needs of their local population. The establishment of LCNs also provides a significant opportunity for SNPHN to work in partnership with the Northern Sydney Local Health District, private hospitals, private health insurers and local government councils in aligning services and co-designing and co-

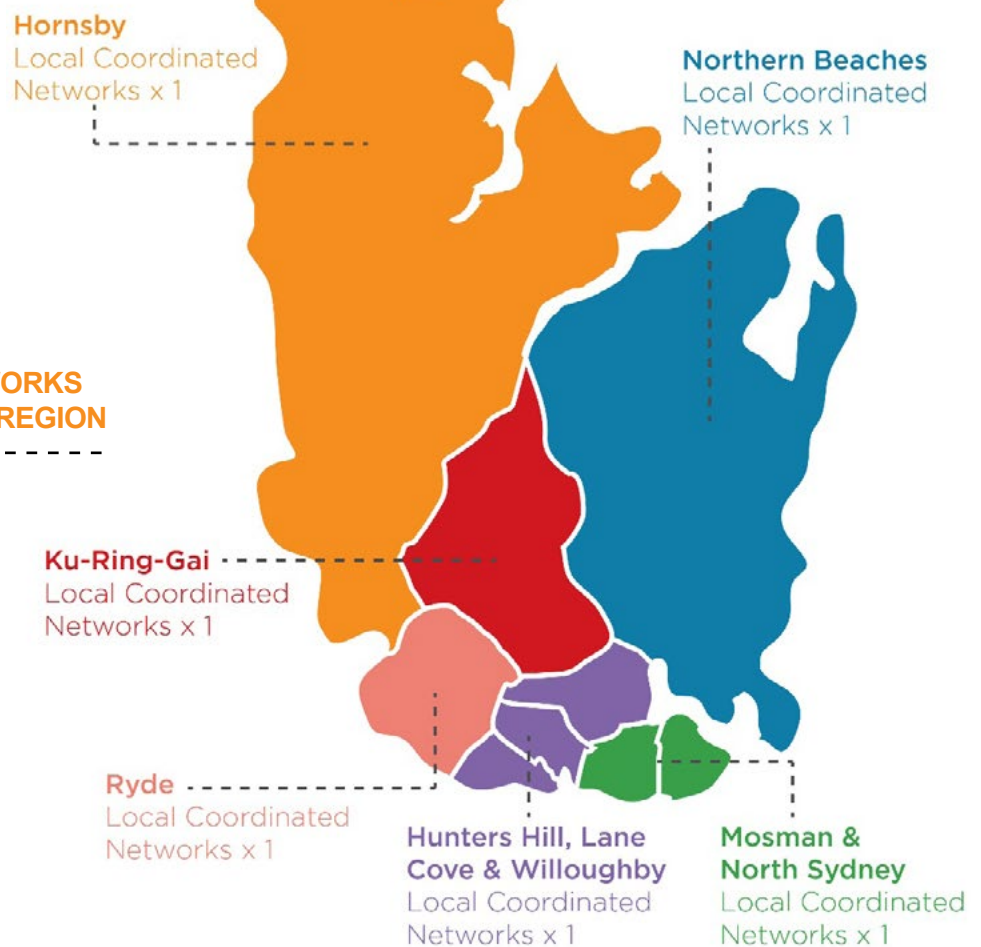
"There is a need to further support the primary care workforce to effectively meet these challenges and to continue to deliver high quality, safe, best-practice care."

commissioning local solutions relevant to each Local Coordinated Network.

For the last 12 months SNPHN has worked closely with general practices from each Local Coordinated Network as well as consumers and other stakeholders to better understand the needs of consumers as well as the needs of service providers, in order to drive service improvements, with positive impacts on patient experience of care, patient outcomes and ultimately population health.

Key issues for individual LCNs were identified through co-design sessions and needs assessment data. SNPHN then provided funding to support and enhance

LOCAL COORDINATED NETWORKS IN THE SYDNEY NORTH PHN REGION



local service delivery and commission services in the following areas:

- Aged care social work services.
- Aged care services for people with dementia.
- Chronic and complex care coordination.
- Falls prevention programs.
- Clinical care and support for members of the community experiencing severe and complex mental illness.

Additional benefits of the LCN model include:

- Primary healthcare services commissioned to address local need for greater impact.
- Reaffirming general practice as having a key role within the health system.
- Better understanding of local population health needs and priorities.
- Care provided closer to the patient's medical home.
- Improved use of data to measure the impact on patients, including health outcomes.

Further opportunities for LCN activity include:

- Opportunities to test new ways of working.
- Networking with general practice, community providers and the Northern Sydney Local Health District.
- GP involvement in commissioning of community-based services based on identified needs within their network, e.g. social work, allied health, mental health.
- Closer working relationships with acute services to agree on priority areas and investment,
- Providing specialist outreach support services, care coordination, and co-commissioning.
- Further development of localised care pathways.
- Simplifying access to and navigation of the local system.
- Working with local government councils to explore opportunities for

collaboration, co-commissioning, and a systems approach to meeting local needs.

- Alignment of commissioning funds to LCNs to ensure best use of resources for local needs.

SNPHN is working with the NSW Health Agency of Clinical Innovation (ACI) and the Northern Sydney Local Health District to act as a pilot site for a 'Healthcare Neighbourhood', using the Local Coordinated Networks.

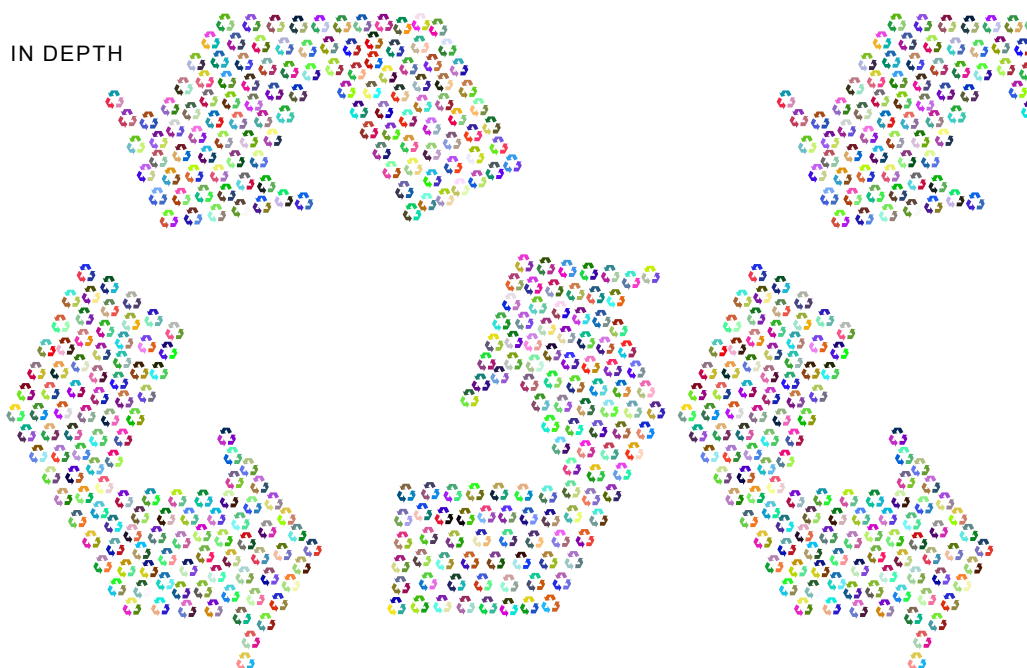
The Healthcare Neighbourhood is a localised health system that adopts the vision, and supports the implementation, of the person-centred medical home. It aims to form a single cohesive system to enable a person-centred approach to care.

SNPHN will continue to work closely with general practice in the development of the LCN framework to promote GP ownership and support of enhanced integrated services in northern Sydney. 



CATHERINE O'SHEA
Environmental Sustainability Officer,
Western Health, Victoria

IN DEPTH



Holding ground

With the recent spotlight on problems with recycling in Australia, and China's clamp-down on imports, healthcare services are concerned about losing the small but hard-won ground on improved recycling behaviour by healthcare staff.

Interest in healthcare sustainability issues is growing as clinicians connect the dots between the increasing tide of single use items (SUI), plastic oceans, energy-hungry buildings and climate change. However, interest is not enough to turn this tide. Industry-appropriate action is imperative considering the tremendous waste impact of healthcare.

Today's patients produce approximately four times the volume of waste that they did a couple of generations ago. We also know that this volume is growing, not shrinking. Greg DeFries, CEO DeFries Industries, suggests that Victoria's single use item (SUI) market currently makes up around 70% of all healthcare items purchased in the public sector and 75% in the private sector, compared to 45% in Victoria five years ago, and more than 95% currently in the USA.

Reusable equipment is perpetually being replaced by single-use technologies, including thermometers, pulse oximeters, endoscopes, mattresses, gowns and linen, to name just a few. Change is driven by globalised ('bargain')

prices, convenience and (largely unfounded) statements about infection prevention, or time saved. Sadly, consumer opinion and waste impacts do not get the chance to influence most procurement decisions. There is a distinct cognitive dissonance when older nurses tell stories of their early nursing days, operating with reusable needles, syringes and sterile gloves that were washed and re-sterilised, as were most things.

SINGLE USE VERSUS REUSABLE

Forbes McGain, Anesthetist/ICU Physician at Western Health, and colleagues, strive to provide information from research that will broaden decision-making perspectives on purchasing decisions.

Their studies aim to encourage consideration of economic, environmental and social impacts when assessing an SUI proposal. For example, 'Life cycle analysis' (LCA) is a technique used to assess environmental impacts associated with all the stages of a product's life—from raw material extraction through materials processing, manufacture, distribution, use, repair and maintenance, and disposal or recycling. Dr McGain compared single use versus reusable dressing trays, breathing circuits and other anaesthetic equipment, and pharmaceuticals.

This research has provided a sound environmental and financial rationale to keep reusable equipment in operating rooms and

stem the tide of SUIs pitched as 'cost saving' or 'convenience'. Conversely, on occasion this work has also led healthcare services to rethink the value of their 'old fashioned' equipment. Plastic will not be disappearing any time soon though, as it is an effective blood barrier and ultra-cheap.

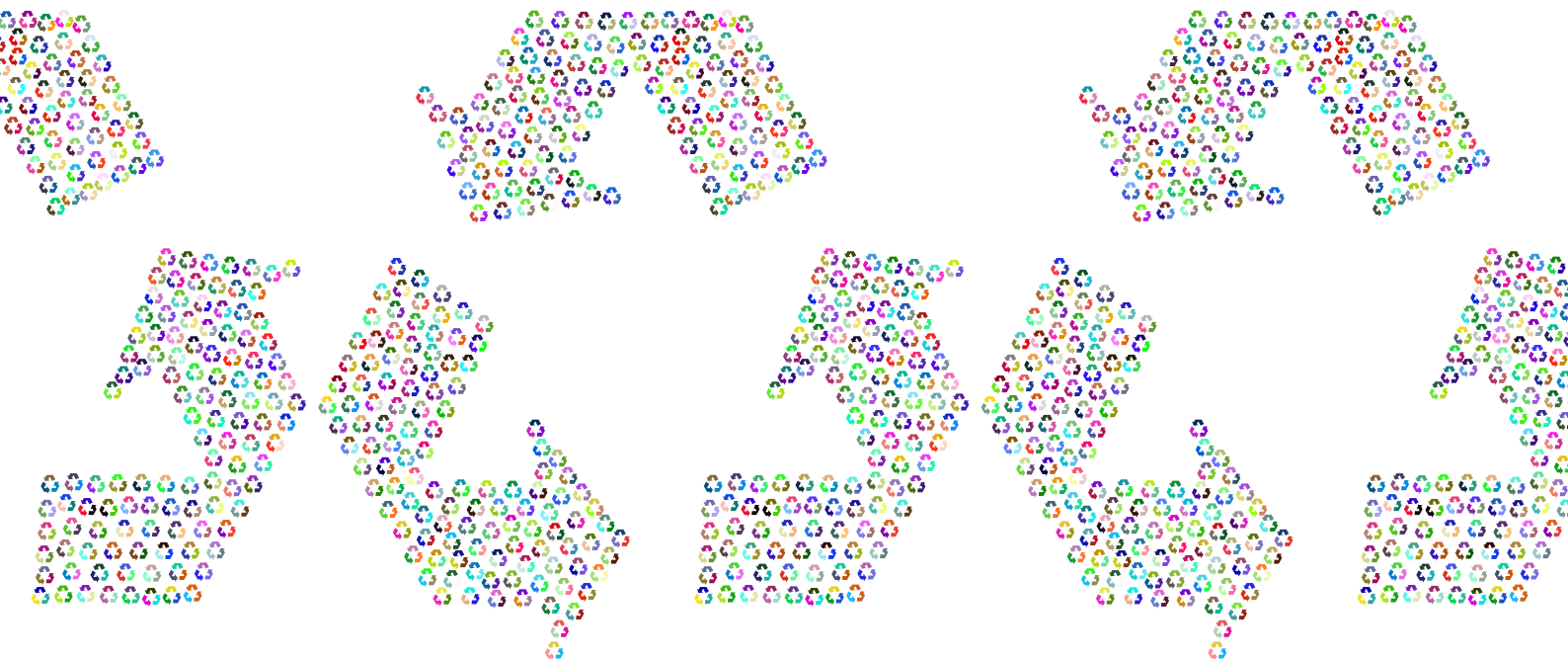
RECYCLING

Space limitations, infection prevention, occupational health and safety, and vague regulations shape recycling programs in healthcare. There are predictable though not insurmountable barriers to developing such programs.

Unlike the 'pantry products' or industry packaging that China remains open to, therapeutic goods are rarely labelled with a resin code (plastics) or explanatory text on their constitution. Recycling programs are best tailored to a particular healthcare service. 'If in doubt, chuck it out!' is a practical necessity to maintain quality streams of recyclate acceptable to manufacturers.

To be effective change agents, clinicians need to be astute and willing to take the time to learn and remain familiar with their organisation's recycling practices. Staff education is challenging, with perpetual staff turnover, rotations and life-or-death priorities obscuring good intentions.

However, with excellent recycling practices healthcare can create relationships with local



Waste minimisation in healthcare.

industry to feed steady volumes of valuable recycled input to manufacturing processes. Such programs are a clear win for industries, the environment and clinicians who feel the tension of their professions' waste impacts.

'Closed loop recycling', where the waste of one product is used to make another product, generally reduces the impacts that industrial activities and waste disposal have on the environment and preserves supply of natural resources. Victorian examples include:

- sterile wrap that becomes outdoor furniture and infrastructure
- intravenous fluid and irrigation bags, oxygen tubing, and face masks become hosing
- polystyrene that is repurposed into the construction industry
- printer and toner cartridges that return to the same (i.e. re-used).

Healthcare can act as a steward, buying recycled products that create a 'pull-through effect' in the industry. Common examples include Australian-made recycled office paper and recycled toilet tissue. Healthcare suppliers are increasingly interested in demonstrating corporate social responsibility in this space, and we need to support them. Choosing a 'green' alternative healthcare product can require a bit of research, and product suppliers would do well to provide clearly catalogued environmentally preferable products via a reputable ecolabel to leverage industry confidence. 

"...making steel from recycled single use instruments uses 75% less energy than when producing steel from raw materials."

CASE STUDY—SINGLE USE METAL INSTRUMENTS (SUMI) RECYCLING

Western Health has endeavoured to minimise waste, having created many stable recycling streams to divert 40% of waste from landfill to local recyclers and industries (PVC, sterile wrap, printer and toner cartridges, mattresses, and various metals). Bulk mixed comingled recycling remains a statewide contract currently at the mercy of international policy. The future of this largest recycling stream is currently on shaky ground without state government intervention to invest in local recycling infrastructure.

Recently, Western Health demonstrated a compelling case for recycling single use metal instruments (SUMI) from the clinical environment. This project provided enough social, financial and environmental benefits to win the Victorian Premier's Sustainability Award in the healthcare category in 2017. Financial benefits flowed from the SUMIs being recycled instead of disposed to Clinical (Sharps) Waste. Environmental benefits were secured by avoiding chemical decontamination and reducing logistics associated with waste treatment.

Further, making steel from recycled single use instruments uses 75% less energy than when producing steel from raw materials.

However, the greatest aspect of the win was the social benefits. When asked about the issue of environmental sustainability in healthcare, clinicians often cited this behaviour as 'wasteful' and 'unsustainable'—that is, they don't like doing it. Their initial uptake of the program proved this. Within one year, however, they had adapted and were recycling about 80% of all instruments purchased!

In the wise words of Margaret Mead,
'Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has'.



Investing in the future of health care

HESTA invests our members' super in ground-breaking health care businesses to create the highly skilled jobs of tomorrow.

Did you know that HESTA invests in projects that develop new products and services for the health and community services sector?

HESTA also supports the success of large, publicly listed health care companies through investing in their shares. That means our members' super has directly supported the construction of much-needed health infrastructure for communities across Australia.

BUILDING HIGH-TECH HOSPITALS

Some of our investments in health infrastructure include providing debt finance. Examples include supporting the construction of hospital facilities like the Royal Adelaide Hospital and the Victorian Comprehensive Cancer Centre (VCCC) in Melbourne.

The purpose-built, state-of-the-art \$1 billion VCCC supports patients and their families, and researchers focused on finding better treatments for cancer.

SUPPORTING INNOVATION

Some of our investment managers also invest on our members' behalf in a range of small and growing health care companies.

These private equity investments are designed to help small private companies not listed on the stock exchange to develop ideas for new products, services and technologies. They can also help grow established businesses with a proven track record of high performance.

IMPROVING HEALTH CARE PRODUCTS AND SERVICES

A vocational training and education provider is one example of a business we support that has a specific focus on improving health care services and products. This particular provider focuses on improving the quality and access to training for professionals in health and aged care, and other operators in the sector.

Another company is working to expand the availability of bulk billed in-home

GP services, improving access to high-quality healthcare.

A BETTER TOMORROW

We know our members are passionate about what they do. That's why we're helping them build not only a better future for themselves, but for the next generation of health professionals – and for all Australians. 

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Prof David Hood AM
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Engineer



Tim Longhurst
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The Institute of Healthcare Engineering, Australia (IHEA) invites you to register for the 25th Congress of the International Federation of Hospital Engineering (IFHE) to be held on **6-11 October 2018 at Brisbane Convention & Exhibition Centre** with the theme: 'Healthcare Engineering – Building on Sustainable Foundations'.

Visit www.ifhe2018.com to register, read more about the keynote speakers and to receive email updates.

PARTNERSHIP OPPORTUNITIES

Partnering or exhibiting at the congress will provide an excellent opportunity to promote your organisation. To view the partnership opportunities visit www.ifhe2018.com or contact the event organisers: Krysty Monks from Iceberg Events on **+61 7 3876 4988** or krysty@icebergevents.com.au

YOU CAN CLOSE THE GAP

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

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

National Close the Gap Day is your opportunity to keep the pressure on government and ensure we achieve health equality within a generation.

Find out more and register your activity in support of health equality for all Australians.

Photo: Jason Malouin/OxfamAUS

Support health equality for Alyssa,

support Indigenous health equality

oxfam.org.au/closethegapday

CLOSE THE GAP



DR ROBERT PEARL

Author of *Mistreated: Why we think we're getting good health care and why we're usually wrong*



How healthcare can evolve to meet 21st century demands

The four pillars of transformation.

Healthcare systems around the globe are relatively unchanged in structure from the ones created half a century in the past. As a result, they are unable to solve the health care challenges of the 21st century.

Although there is variation by country, fragmentation of clinical care continues, with doctors working independently from each other, and hospitals disconnected from outpatient services. Reimbursement remains predominantly through a fee-for-service mechanism, and volume, not value is rewarded.

As a result, prevention is seen as less important than intervention, and medical error remains unacceptably high. In addition, the information technology available in doctors' offices lags nearly all other

industries and fails to connect with the electronic health record systems used in most hospitals. As a result, patient data is rarely available to all clinicians treating the same individual, video remains underutilized and predictive analytics exist only in their infancy.

Overall, there is a paucity of clinical operational leadership capable of simultaneously raising quality, improving patient convenience and lowering costs. All of this will need to change for healthcare to meet 21st century demands.

FOUR PILLARS FOR SUCCESS

In *Mistreated: Why we think we're getting good health care and why we're usually wrong*, I provide a road map for the future and outline four pillars that will be

essential to transform healthcare delivery. Medical problems and treatments today are completely different than in the last century. Chronic disease has replaced acute problems. Costs have become unaffordable for nations and individuals. And medical procedures and pharmaceuticals are more complex, expensive and dangerous.

I look forward to expanding on this theme at the World Hospital Congress in Australia in October 2018. All four pillars will be needed to support the healthcare system of the future, and together they can raise quality, increase convenience and lower cost—as we have seen in the other areas of our lives from finance to retail. Integration is an essential first step. Just as the 'Mom and Pop' store morphed into the large mall and most recently to online, so healthcare will need to

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evolve. Done right, health care can be both 'high tech' and 'high touch'.

INTEGRATION: THE FIRST STEP AND THE FIRST PILLAR

There are four types of integration required to maximise the health of people and communities:

1. Horizontal within specialties—When physicians within the same specialty collaborate, there are major opportunities to offer patients better outcomes and added convenience. Integration facilitates sub-specialisation, adequate volume for maximal clinical results and more rapid access to care based on patient preference. This is particularly important in specialties such as orthopedics, cardiology, oncology, general surgery and ophthalmology. A common electronic health record and physician leadership are needed to make this process successful.

2. Vertical between primary and specialty care—By working together in managing each patient, as many as 40% of patients who would have been referred to a specialist can have their medical problems solved immediately without having to miss work, and at a much lower cost. As a result,

specialists can focus on those individuals for whom they can add the most value, and thereby diminish the backlogs that plague many nations around the globe. A common electronic record and a prepaid/capitated reimbursement model are essential for this to work.

3. Longitudinal between hospital and outpatient—Patients with chronic illness have medical issues before and after an inpatient stay. Integration, collaboration and coordination allow rapid hospital treatment and provide continuity of care following discharge to avoid readmission and medical errors. Modern technology, including video, supports these processes and reduces cost, particularly for those with the most severe medical conditions such as heart failure, cancer, and end-of-life frailty.

4. Comprehensive between the health care system, local community agencies and governmental organisations—Increasingly the social determinants of health are being recognised as equal in importance to medical factors in achieving optimal outcomes for individuals and populations of patients. A combination of educational resources and social support systems can reduce the need for hospitalisation and decrease the likelihood

of a life-threatening complication for those with chronic medical illnesses. Across the globe, diabetes continues to increase in prevalence and smoking remains a major factor leading to premature death. Millions of lives could be saved annually, through a fully integrated model.

CONCLUSION

The hospital of the past was developed when inpatient care was relatively inexpensive and there were few alternatives available. All of that has changed, and disruption is inevitable if improvements don't happen in the near future. An integrated health care system, which is focused on value, not volume, supported by modern technology and effectively led, can maximise quality, and make care more convenient and easier to access at a lower cost. The time for change is now. **ha**

Robert Pearl will be speaking at the 2018 World Hospital Congress in Brisbane on a road map for the future, and will outline the four pillars that will be essential to transform healthcare delivery. For more information on the World Hospital Congress program visit www.hospitalcongress2018.com.



DR LANCE LAWLER
President, Royal Australian and New Zealand College of Radiologists

Radiology in the hospital of the future

Radiology was born in 1895 with Röntgen's discovery of x-rays, a discovery that had an immediate and significant impact on our ability to diagnose and treat trauma and disease. Since then we have seen other major technological advances such as ultrasound, MRI and PET, which have also produced sharp changes in healthcare delivery—and the rate of these changes is speeding up.

Within hospitals, almost every patient admitted will have some sort of imaging procedure. Modern hospital designs have accommodated this by placing radiology departments centrally and more recently providing imaging closer to the patients with CT scanners in emergency departments and point-of-care ultrasound units. At the same time, networked digital imaging has moved the radiologist closer to our clinical colleagues, often in real time—virtually, if not geographically.

Today, the 'buzz' is all about artificial intelligence (AI), with the debate on this technology replacing humans, not just in radiology but throughout the economy. But how realistic is it to think about doctorless hospitals?

As a clinician, I instinctively know patients need to trust they are being looked after by people who care about them. That's why 'healthcare' contains the word 'care' (and why we never hear about 'bankingcare' or 'legalcare'). Health systems of the future will always depend first and foremost on the work of the health professionals who work within them, whether or not they are using augmented reality, teleradiology, convolutional neural networks, robotic radiosurgery or a host of other innovations to practise their medicine.

However, if Stephen Hawking was right when he said robots may replace us entirely,¹ there will be no need for hospitals anyway—

just workshops, garages and recharge stations. So why are we hearing that AI will be the end of radiologists?

Many of the stories we read and hear about AI are propagated by the technology makers themselves. These companies are adept at using hype to generate interest in their latest products, which are often only incremental improvements to existing products. This may help them gain more funding and influence, but the hyperbole distracts us from the real benefits new technology brings, which are better tools to aid in faster and more accurate diagnoses. We should 'forget the hype' and concentrate on how we can best use technology in healthcare for those who need it.

For example, the field of radiomics uses sophisticated algorithms to extract clinically valuable data from medical images. With continuing gains in data processing speeds, and software able to learn from experience,

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the field is growing fast in capability. This is particularly evident in oncology, where we are seeing increasingly automated processes to: segment images into 'areas of interest'; select, extract and analyse tumour features such as size, shape, texture and density; and aid in the prediction of clinical outcomes. Such advances do not spell the end of radiologists. However, it is clear radiomics is likely to change the nature of our work, taking us further away from the interpretation of images and towards the curation of databases on disease processes.²

I believe it is crucial all stakeholders work together on the ground rules for the application of any new technology. Many issues arising from discussions about the application of AI in medicine are not fundamentally scientific or even medical in nature. The thorniest issues are the ethical and moral questions raised by the interface between humans and machines. I have already mentioned the importance of trust in healthcare, but there are others.

As machines become more intelligent they will be allowed increasingly to choose between two (or more) non-ideal clinical outcomes, both of which carry a risk of harm.

The choice will sometimes depend on human values such as dignity, respect for others and quality of life. Just because the decision is made by a machine doesn't change that. The machine will need some sort of moral code built in, but who will write the code and what biases will be embedded in the decision algorithms as a result? The issue has arisen already in the development of driverless cars³ and I have no doubt the problem will soon emerge in medical applications of AI.

The same problem arises in legal settings too. If an intelligent machine makes a poor decision in determining a course of treatment for a patient, who is legally liable? The manufacturer? The IT support team?

It is therefore evident governments and health regulators need to be reassured that hospital patients will reap the benefits of technological advancements without being exposed to increased risk or sub-standard care.

Radiologists will continue to embrace these advancements and incorporate them into their work, which is one of the reasons why the professionals our College helps develop are world-class and highly sought after in their field. The future of hospitals

and the future of radiology within them will require greater cooperation and interaction among all healthcare professionals to consider not only the development of specific treatments, but also how we can enhance our patients' ability to make choices about how they are looked after while preserving their dignity and respecting their wishes. All the technology in the world cannot replace the human aspect of this. **ha**

References

1. Medeiros J 2017. Stephen Hawking: 'I fear AI may replace humans altogether'. Wired, 28 November, at www.wired.co.uk/article/stephen-hawking-interview-alien-life-climate-change-donald-trump.
2. Latour P 2015. Radiomics could change role of radiologists. RSNA News, 1 February, at www.rsna.org/NewsDetail.aspx?id=14704.
3. Strang E 2017. How do we navigate the moral compass of machines?. Idealog, 31 January, at idealog.co.nz/casestudies/how-do-we-navigate-moral-compass-machines.

Lance Lawler will be speaking at the 2018 World Hospital Congress in Brisbane on 'Visions for the Hospital of the Future'. For more information on the World Hospital Congress program visit www.hospitalcongress2018.com.



JOLANTA BILINSKA
Chair
International Alliance of Patients
Organizations

BRIEFING

How value engineering can help patient organisations and service providers in co-designing of healthcare services

BEHIND THE HEALTHCARE SERVICE DESIGN CURVE

In traditional models of healthcare provision, patient organisations and carers often find themselves ‘behind the curve’ when it comes to policy concerning healthcare service design and provision.

The first both may know of any problems with a healthcare service is during its implementation stages—when things start going wrong. The patient organisation could be notified early—at which point damage could possibly be limited—or at a later critical stage when the consequences can be catastrophic.

The latter can be the result of what is euphemistically called a ‘perfect storm’—when a variety of critical factors and inherent design faults come together to overwhelm a service at peak times, affecting thousands.

Preventable healthcare service failure can be trying, potentially tragic, and bad for staff morale as well as patient safety. Sometimes

there have been no risk management arrangements in place. Subsequent enquiries can establish that failures were foreseeable, with negative effects on the reputation of the healthcare service and its staff.

VALUE ENGINEERING (VE) AND THE CONSUMER ELECTRONIC INDUSTRY

The modern consumer electronic industry long ago acted to minimise late stage failure and improve user experience by establishing a co-designing and co-producing culture, and partnerships with end-users, at the earliest stages of major project and service design. The processes were collectively termed ‘Value Engineering’ (VE).

The healthcare sector can learn much from the consumer electronic industry’s adoption of VE in the late 1980s. The Pareto Principle holds that 20% of the earliest design decisions will result in 80% of the late lifecycle failures and cost overruns. VE can help reduce this.

THE VE PROCESS

VE is a comprehensive and a creative user-led review of design. It is formally instituted at all levels of an organisation—systematic as well as systemic. It involves analysis of the requirements of a project to extract the essential functions and build in the lowest total costs (finance, capital equipment, staffing, energy, maintenance) over the life of the project.

In an open and safe enabling environment, a group investigation is held involving experienced users sitting with in-house multi-disciplinary expert design teams to improve the ‘value’ and economy of the product or service. This is done by exploring alternative arrangements, designs, material mixes, and delivery and manufacturing methods, without short-changing the client’s (end users) requirements and the project’s main functional and value objectives. It is a win-win analysis.

A VE group typically follows this five-step process:



“VE is a comprehensive and a creative user-led review of design. It is formally instituted at all levels of an organisation—systematic as well as systemic.”

VE has evolved into various user-centric (UC) design approaches, with many health systems adopting VE/UC principles within cultural change programs, allowing patients to become co-designers and co-producers.

The World Health Organization's *Framework on integrated people-centred health services*

resembles a reordered set of VE/UC principles:

1. Engaging and empowering people and communities
2. Strengthening governance and accountability
3. Reorienting the model of care
4. Coordinating services within and across sectors
5. Creating an enabling environment.

For patient organisations and carer associations the message is clear. We have to work as 'whole-of-society' if we are to achieve the United Nations Sustainable Developmental Goal 3.8 of sustainable universal health coverage in all countries by 2030. This requires expert patient and carer engagement in health service co-design and co-production.

In 2006 the International Alliance of Patients Organizations produced a patient-

centred healthcare declaration (available at www.iapo.org.uk/sites/default/files/files/IAPO_declaration_ENG_2016.pdf).

Around that time in the UK, a VE/UC-based approach to healthcare services development emerged (Experience-Based Design) that is now known as Experience-Based Co-Design (EBCD).

The approach has gained increasing popularity, including in Australia. *Experience-Based Co-Design: a toolkit for Australia* was released last year by the Australian Healthcare and Hospitals Association and the Consumers Health Forum. The toolkit guides services in using the expertise and experiences of healthcare staff and patients in a genuine equal and reciprocal relationship to develop a better healthcare experience for all. The toolkit is available free of charge at www.ahha.asn.au/experience-based-co-design-toolkit. 



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HealthLit4Kids

Responding to a gap in health literacy education.

THE IMPORTANCE OF HEALTH LITERACY

*'Health literacy is the ability to make sound health decisions in the context of everyday life; at home, in the community, at the workplace, the health care system, the market place and the political arena. It is a critical empowerment strategy to increase people's control over their health, their ability to seek out information and their ability to take responsibility.'*¹

We know that health attitudes and behaviours formed during childhood greatly influence adult health patterns.² We also know that an individual's health literacy can be supported by members of their family, and their local networks and community.

Current definitions of health literacy no longer hold the individual solely accountable for it—rather, we recognise that health service organisations and their staff should assess and respond to each individual's health literacy needs. This new way of thinking also recognises that the individual's local community can play a key support role.

THE HEALTHLIT4KIDS PROGRAM

*'Strategies to build health literacy must be viewed as part of life-long learning and health literacy should be integrated into the school curriculum from a young age.'*¹

In 2016, Dr Rosie Nash and Dr Shandell Elmer designed HealthLit4Kids to respond to the eight Ophelia (Optimising Health Literacy and Access) principles.³ These principles, aimed at improving health and equity outcomes in communities, include:

1. Outcomes focused
2. Equity driven

3. Co-design approach
4. Needs-diagnostic approach
5. Driven by local wisdom
6. Sustainable
7. Responsiveness
8. Systematically applied.

HealthLit4Kids responds to a gap in health literacy education by providing professional development for classroom teachers. Our program is aligned to the Australian Curriculum Health and Physical Education theme areas. Through three workshops, teachers are supported to develop a shared understanding of health literacy and to define what a 'health literate' school may look like.

Currently no mechanism exists to gauge the health literacy of children under 10 years of age. We are hopeful our program will inform the development of a tool or profile that makes it possible to determine the health literacy needs of primary school age children.

When designing HealthLit4Kids we recognised that a 'one size fits all' approach does not work when responding to the health literacy of individuals and their communities. During the pilot, we therefore invited teachers to identify opportunities in their existing curriculum to insert a health literacy focus. In one instance, Grade 6 maths students were asked to devise a budget supporting a healthy lifestyle; in another, Grade 3/4 students were asked to compare the sugar and salt content on food labels.

HELLOTAS ORGANISATIONAL SELF-ASSESSMENT CHECKLIST

We supported the teachers to use the HeLLoTas (Health Literacy Learning Organisations Tasmania) organisational

self-assessment checklist. Originally designed for health service organisations, the HeLLoTas framework includes six domains (communication, leadership and management, consumer involvement, workforce, meeting the needs of diverse communities, and access and navigation). Self-assessment against the domains can support staff in organisations to ensure they are a health literate organisation.

Assessment against the HeLLoTas checklist led to the development of a school-wide Action Plan. The Action Plan aimed to answer the specific health literacy needs of the children, their families and their wider community.

STUDENT, TEACHER AND FAMILY ENGAGEMENT

We encouraged active student engagement through a school-wide HealthLit4Kids Artefact Showcase and competition. The children were invited to submit group and individual artefacts that represented a health issue of concern or interest to them. Artefacts submitted included drawings, paintings, sculptures, garden displays, songs, dances, drama performances, online apps, and Youtube videos. Local businesses and organisations with a health and wellbeing focus donated prizes in recognition of the children's efforts.

The competition invited families to discuss the artefacts with their children. Afterwards we held a people's choice vote. We observed teacher-to-student, child-to-parent and child-to-child exchanges of health information throughout the project. We collected 'before' and 'after' measures and asked teachers and parents to comment on the program. This enabled us to evaluate the impact of the program on the whole school community.



Holly Mindrup

LOOKING AHEAD

HealthLit4Kids aims to ‘cross boundaries’ to meaningfully bring members of the education sector together with others from the health sector to improve health literacy. We hope that improved health literacy will lead to improvements in children’s health outcomes and educational achievements—the literature describes a positive relationship between health literacy and educational achievement.^{4,5}

HealthLit4Kids received funding from the University of Tasmania to support the pilot phase in 2017 and development of a HealthLit4Kids Artefacts digital learning experience for children. The latter will be on show in mid to late April 2018 in Hobart.

In recognition of the community benefit of the program, the Tasmanian Community Fund has provided funding to support comparative evaluation (Context, Mechanisms, Outcomes) in four Tasmanian schools in 2018. Subject to funding, we aim to have HealthLit4Kids available to all primary school children in Tasmania after 2020. 

References

1. Kickbusch I, Wait S & Maag D 2005. Navigating health: the role of health literacy. Alliance for Health and the Future, International Longevity Centre UK.
2. DeWalt DA & Hink A 2009. Health literacy and child health outcomes: a systematic review of the literature. *Pediatrics* 124(Supplement 3):S265-S74.
3. Beauchamp A, Batterham RW, Dodson S, Astbury B, Elsworth GR, McPhee C et al. 2017. Systematic development and implementation of interventions to Optimise Health Literacy and Access (Ophelia). *BMC Public Health* 17(1):230.
4. van der Heide I, Wang J, Droomers M, Spreeuwenberg P, Rademakers J & Uiters E 2013. The relationship between health, education, and health literacy: results from the Dutch Adult Literacy and Life Skills Survey. *Journal of Health Communication* 18(sup1):172-84.
5. Beauchamp A, Buchbinder R, Dodson S, Batterham RW, Elsworth GR, McPhee C et al. 2015. Distribution of health literacy strengths and weaknesses across socio-demographic groups: a cross-sectional survey using the Health Literacy Questionnaire (HLQ). *BMC Public Health* 15(1):678.

“We are hopeful our program will inform the development of a tool or profile that makes it possible to determine the health literacy needs of primary school age children.”

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NIGEL FIDGEON

Planning and enacting a business continuity and disaster recovery strategy successfully

Surviving a fire at Merri Health.

For Chief Executive Officers, one of the many key leadership imperatives for a business is to ensure effective planning is in place in the event of the unlikely need to enact a business continuity plan (BCP). As is the case with many corporate plans organisations have in place, a BCP is often something that sits on the shelf, dusted off from time to time and never called upon.

Merri Health's experience of a disastrous fire in the very early hours of Monday 3 July 2017 demonstrated the importance robust

“The Merri head office was totally destroyed in the fire, thankfully without any resulting injuries. It was the worst of times as well as the best of times for us.”

and current business continuity planning has in any healthcare organisation to ensure the safety and effective management of the business at such challenging times.

The Merri head office was totally destroyed in the fire, thankfully without any resulting injuries. It was the worst of times as well as the best of times for us.

It became the best of times because, by working together efficiently and effectively, guided by a recently updated business continuity plan, we had the organisation, with 400 staff and a turnover of more than \$36 million operating across 11 sites, remaining fully operational throughout the period with new corporate offices established within 5 business days.

We basically lost everything—the whole

corporate office, IT equipment, records, management files, building plans, corporate history, funding agreements, and most of what we needed for end-of-financial-year processing. We are so thankful that we had a plan in place that we could follow immediately when there was no time to lose.

I know such thoughts about a business continuity plan sound idealistic. None of us truly envisaged ever having to enact it. But the unthinkable did happen. Because of that I felt compelled to write about how we developed and used the plan in the hope that it could help other healthcare organisations.

The resulting paper, *Planning and enacting a business continuity and disaster recovery strategy successfully in a health service*, has been published as a Perspectives Brief by the AHHA's Deeble Institute for Health Policy Research.

The paper describes the process we went through to develop the Business Continuity Plan, as well as how we enacted it.

In early 2016 the Merri Executive Team recognised that with Merri Health's continued growth in terms of revenue, breadth of services provided and expanding geographical reach, the existing disaster recovery and business continuity plan required a complete overhaul. We engaged an external consultancy firm to assist in providing a structured review process and framework to undertake this review. Over the course of seven months there was significant staff consultation and time invested to document all aspects of business-critical functions, options and alternatives required to successfully maintain critical services in the event of a disaster.

While this work was undertaken across the organisation, the thinking at the time was focused on the potential loss of clinical space that would potentially impact on service delivery to clients at one of our many sites. The main focus was not on back-of-house functionality.

The review process, having engaged with all key personnel, provided a core of expertise from across the organisation to document the potential impact an event would have on the organisation if one of the 11 sites was unable to operate.

In early 2017 planning was in place to provide external dedicated training on the

BCP for key personnel. This education process was being actioned at the time of the fire with the plan to undertake a mock BCP exercise. In essence, the activation of the BCP turned into a real-life test of our ability to recover and continue to function as a viable business in the face of an extreme disruption event.

Immediately after the (real-life!) fire, our Crisis Response Team used the clear and concise guidance available in the plan to quickly initiate, coordinate and implement the necessary procedures and activities in the aftermath of the fire. Critical business areas such as Finance, Facilities and Information Technology were obvious priorities. But, equally, so was the wellbeing of staff and ensuring no disruption to the vast array of client services we deliver on a daily basis over metropolitan Melbourne and regional Victoria.

Daily updates notifying all staff of the current status of the organisation's recovery, and key actions and activities, were very well received—staff reported feeling motivated to help in any way they could whenever required.

Strong and collaborative relationships with key providers and suppliers, as well as insurers and assessors, were also extremely useful in being able to re-establish facilities, hire suitable accommodation, and buy and configure equipment very rapidly.

Not everything went smoothly. We learned a lot from those experiences, which will help us, and perhaps others, to make sure those aspects are fully covered in future.

For example a crisis management plan setting out in detail the various roles of key staff would have helped in preventing some issues from slipping through the cracks. Also, we did not fully anticipate the strength of feeling of shock and loss experienced by staff. It was tough that, for understandable safety reasons, they were unable to salvage any personal items that may have survived the fire, as a form of closure. **ha**

The *Planning and enacting a business continuity and disaster recovery strategy successfully in a health service* perspectives brief is available at: www.ahha.asn.au/system/files/docs/publications/perspective_brief_no._1_merri_health.pdf.



**ASSOCIATE PROFESSOR
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Creating a workforce with interprofessional practice capabilities— how?

THE CURRICULUM RENEWAL STUDIES

This article reports on the findings and work of six Australian development and research studies—the ‘Curriculum Renewal Studies’ (CRS)—which together focus on the system-wide development of Australian interprofessional education (IPE). IPE involves health professions learning about and from each other for effective collaboration and to improve health outcomes.

The necessity for a health workforce with well-developed interprofessional and collaborative practice capabilities (IPCP) is a ‘given’ in national and global health policies. But embedding, growing and sustaining IPE has proved extremely difficult to achieve.

The CRS program was funded in 2007 and has been active since that time. Five studies have been completed. A sixth study, *Securing an interprofessional future for Australian health professional education and practice* (the SIF Project) is now in its second year of operation. Its focus is establishing an Australian IPE Council and, more broadly, a national IPE governance and development framework.

All six studies have been developed in collaboration with key organisations and individuals drawn from the higher education, health, health regulation and accreditation, government, and consumer sectors.

The CRS program has two overarching aims:

- develop new knowledge about the

development, successes and challenges of Australian IPE; and

- use this knowledge to design an approach to Australian IPE that will overcome the difficulties identified above.

The CRS team—an interprofessional team—is currently drawn from nine universities and two health professional education and IPE Australasian peak bodies.

HOW DID WE LEARN?

We used a mixed methods approach to data collection—national and local surveys, focus groups, interviews, documentary analysis, an environmental scan of the national and global literature, several consultative forums, and extensive data verification activities.

Making sense of all study data and exploring this in terms of its implications for health policy, health professional education, and health regulation and accreditation, was undertaken through the conduct of two national consultative fora held in 2015.

WHO PARTICIPATED?

We invited a wide cross-section of individuals and organisations to participate in providing data, their experiences and their thoughts about the future of Australian IPE. The preparedness to be involved, to contribute and to commit the considerable time this has required has been exceptional. Critically, in terms of enriching our database and ability

to interpret data we have also drawn on a large group of national and international IPE scholars through the CRS reference group.

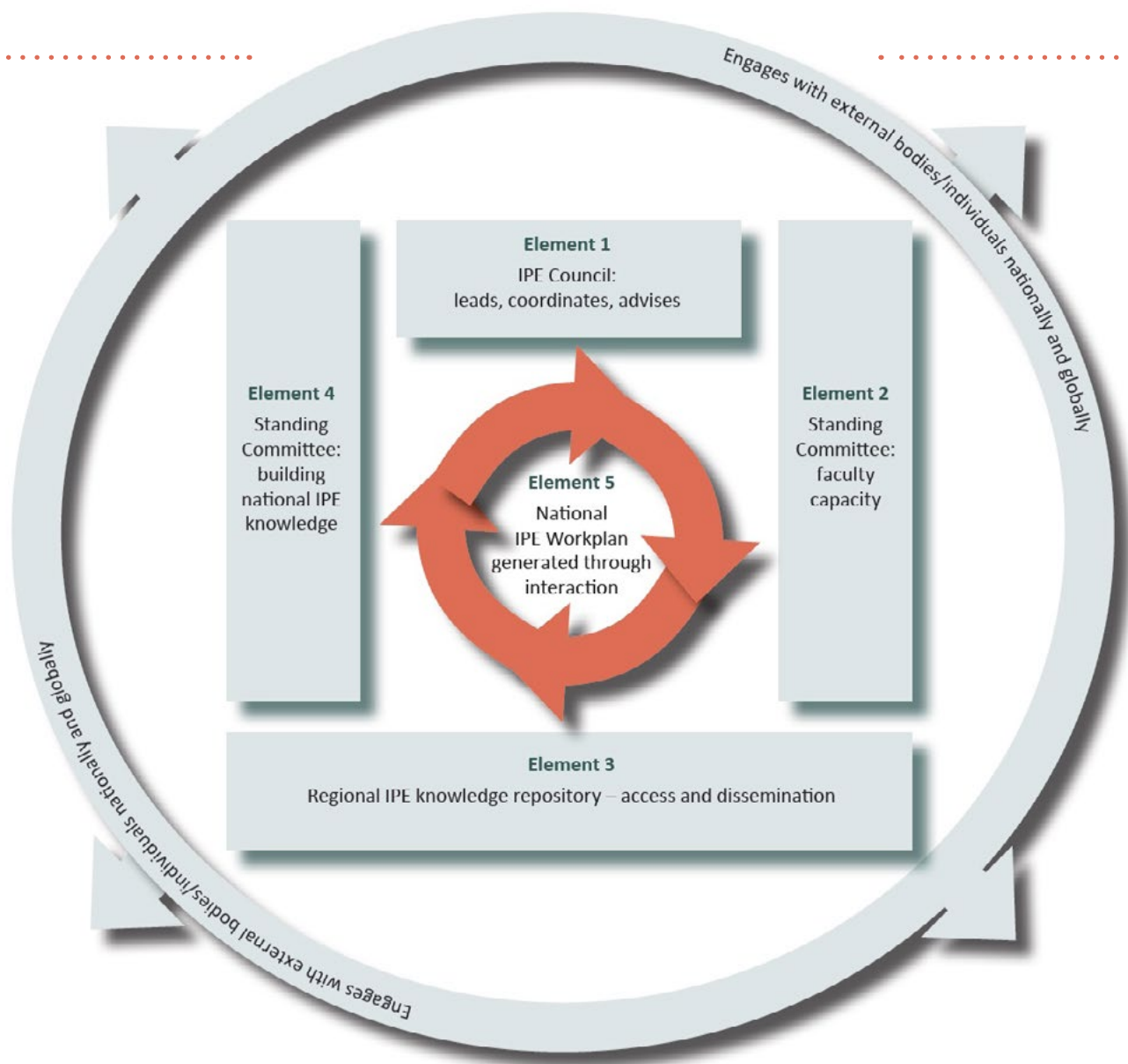
WHAT DID WE LEARN?

We had five key findings or messages.

Firstly, Australian IPE is, for the most part, a local phenomenon. Without the broader national structures and legitimacy of the uni-professional professions—medicine, nursing, pharmacy, etc.—it has needed to be opportunistic in working within local circumstances to find a place within the curriculum. While this has, at times, worked well, it has left IPE vulnerable to local ebbs and flows of support and non-support.

Secondly, and, as a consequence of the above, there have been no mechanisms to enable and support those involved with IPE/IPCP coming together to share, learn and mobilise. There is no ‘community of practice’ through which the development of IPE educators can individually and collectively occur. Discussion about the need to develop national IPE leadership has been one of the most consistent themes in CRS consultations.

Thirdly, although there is growing support for the importance and contribution of IPE overall, its local development has produced great diversity in terms of curriculum design, and teaching and assessment methods. While participants noted the importance



of local flexibility, they also stated the need for greater coherence, coordination, shared terminology, agreement on preferred methods, collaboration across campuses and shared learning.

Fourthly, many participants experienced difficulty in locating ‘evidence’ and noted the need to develop a more systematic and Australian focus in identifying, developing and disseminating IPE/IPCP knowledge. An important part of this discussion was for conceptual and theoretical work to be undertaken on how best to evaluate and research the process, impact and outcomes of IPE/IPCP.

Finally, it was clear to many who participated in the CRS program that non-inclusion of consistent and well elaborated IPCP practice standards and IPE learning outcomes criteria in the Australian regulation and accreditation system were major constraints on the status and development

of Australian IPE. In parallel to the CRS, the recently completed Council-of-Australian-Governments-initiated review of the Australian accreditation system (the Woods Report), has made strong statements arguing for the urgent inclusion of IPE/IPCP standards/criteria in all curricula and in the accreditation standards of all health professions. Additionally, the Woods Review has argued for these developments to be undertaken collectively.

WHERE TO FROM HERE—A BLUEPRINT FOR THE FURTHER DEVELOPMENT OF AUSTRALIAN IPE

Not surprisingly, the recommendations developed across the CRS program respond to the major problems and constraints associated with the development of Australian IPE (see illustration).

In short the recommendations focus on: national leadership; building national IPE capability and capacity; addressing knowledge gaps and developing and acting on an

Australian IPE/IPCP knowledge development agenda; and establishing an Australasian IPE/ IPCP knowledge repository (one-stop shop) and website and database that will be user friendly, up-to-date and technologically smart.

Working closely with all key bodies to achieve the inclusion of IPE/IPCP standards as a part of all curricula and the accreditation system is a priority. Arguably the most critical element of IPE development work currently occurring is the *Securing an interprofessional future for Australian health professional education and practice* study. As mentioned earlier, work is under way on establishing an IPE governance and development framework and structure through which future developments will be led and enabled. **ha**

For further information, or to notify your interest in participating in this development work, please visit the SIF Project web site at www.sifproject.com.



GraphicStock

Currently, in Australia, the lifetime risk of having a knee replacement is 1 in 5 for women and 1 in 7 for men,¹ and these risks have increased over time.

In 2016, 52,836 knee replacement procedures were undertaken in Australia² thanks to more people manifesting severe osteoarthritis due to living longer, and increased rates of obesity. In addition, more people are opting to undergo the surgery earlier in life, or, despite existing health issues, due to increased safety of surgery and anaesthesia.³

For people with severe arthritis, the surgery often results in considerable improvement in joint pain, quality of life, daily function and mobility.⁴ That said, deciding what kind of rehabilitation to undertake following surgery is an important step in the decision pathway.

Rehabilitation most generally involves whole body and knee-specific exercises to help restore mobility, muscle strength and joint range of movement. Programs are most often overseen by physiotherapists in outpatient physiotherapy departments and clinics, or in the home (domiciliary visits) often in conjunction with visits by nurses, or in inpatient rehabilitation hospitals. The latter also involves treatments and assessments

by rehabilitation physicians, occupational therapists and other health professionals as required.

The rehabilitation pathway varies most according to whether you are privately or publicly insured, with inpatient rehabilitation common for those that are privately insured. Data from the Royal Australasian College of Surgeons and provided by a major private insurer indicate that the median referral rate per surgeon to inpatient rehabilitation following knee replacement is 39%.⁵ In contrast, the median referral rate per surgeon for public patients is 11%.⁶ The differences are due to differences in access.

WHAT REHABILITATION PROGRAM OR PATHWAY PROVIDES THE BEST OUTCOMES?

Given the majority of people having knee replacement surgery do so in the private sector, and given inpatient rehab is common in the private sector, there is a need to determine efficiencies in the healthcare sector that result in the best patient outcomes.

Through several research grants from the HCF Research Foundation, my research team at the Whitlam Orthopaedic Research Centre investigated the value of inpatient rehabilitation after knee replacement, to

determine whether a pathway involving inpatient rehabilitation was worth investing in given the expense it adds to the total cost of surgery. Typically, a pathway involving inpatient rehabilitation (inclusive of both inpatient and community-based rehabilitation costs) adds a median of \$9,000 to \$10,000 to the acute-care costs.⁷

Three main studies were undertaken to determine the benefit. First, a randomised trial published in the *Journal of American Medical Association* earlier this year was conducted as part of Mark Buhagiar's PhD studies at the University of New South Wales.⁸ The team observed that 10 days of inpatient therapy followed by a simple clinician-monitored home program did not yield better recovery compared to the home program in terms of mobility, function, quality of life, or reduced complications and return-to-work time.

A second study published in the *Medical Journal of Australia* concluded that people with uncomplicated knee replacement who had an average of 12 days of inpatient rehab with or without ongoing community-based therapy did not have better recovery of knee joint pain and function, or quality of life, compared to those who went directly home. Patient and carer time-off-work outcomes were not better either among those who went

Do patient outcomes justify inpatient rehabilitation after knee surgery?



DR JUSTINE NAYLOR

Senior Principal Research Fellow, Orthopaedics, South Western Sydney Local Health District; Conjoint Associate Professor, University of New South Wales; and Director, Whittlam Orthopaedic Research Centre

to inpatient rehab—yet total rehab provider charges were 26 times as high.⁹

A third study, also conducted as part of Mark Buhagiar's PhD and published in *BMC Health Services Research*,¹⁰ investigated the factors that influence decision-making by privately insured consumers and clinicians when it comes to deciding which rehab pathway to take or promote. This study highlighted the fact that for consumers and clinicians, effectiveness of the program was not a main factor. Benefits important to consumers in terms of the pathway chosen included convenience—those who preferred inpatient rehab viewed it as a one-stop shop; those who preferred home preferred the convenience of their own environment. Other factors driving decisions were past experience of self or others, what their insurance covered and a sense of entitlement associated with their insurance cover.

DO THE OUTCOMES JUSTIFY THE COSTS OF INPATIENT REHAB?

Even though patients are highly satisfied with inpatient rehab, and the pathway provides a one-stop shop, our study results show that for many patients it is difficult to justify given the enormous cost differential, and virtually no difference in patient outcomes.

Inpatient rehab is justified for: people

who are the most impaired prior to surgery (e.g. wheelchair bound); people who have inadequate social supports; or those who suffer a significant complication. It is certainly not a one-size-fits-all approach, but in general, most people who have a knee replacement will do well if they are discharged directly home.

WHERE TO NOW?

Moving forward, if we are to ensure rehab after knee replacement in this country reflects what the high-level evidence suggests we provide, then this research shows there is a need for all stakeholders—government, private insurers, hospital administrators, patients, carers, clinicians and researchers—to support the development of guidelines to ensure the appropriate people receive the appropriate care.

Consumers should explore the various treatments and ask their surgeons and physiotherapists about what programs provide the best outcomes for their needs. Governments need to support high-value healthcare and evaluate low value healthcare with a critical eye for benefits beyond patient satisfaction in the absence of clinical benefit. 

References

1. I Ackerman, MA Bohensky, R de Steiger, CA Brand, A Eskelinen, A Fenstad et al. 2017. Substantial rise in the lifetime risk of primary total knee replacement surgery for osteoarthritis from 2003 to 2013: an international, population-level analysis. *Osteoarthritis Cartilage* 25:455-461.
2. Australian Orthopaedic Association 2017. National Joint Replacement Registry. Hip, knee and shoulder arthroplasty. Annual Report, available at <https://aoanjrr.sahmri.com/documents/10180/397736/Hip%2C%20Knee%20%26%20Shoulder%20Arthroplasty>.
3. *BMJ* 2017; 356 doi: <https://doi.org/10.1136/bmj.j1131>.
4. L Shan, B Shan, A Suzuki, F Nouh & A Saxena 2015. Intermediate and long-term quality of life after total knee replacement: a systematic review and meta-analysis. *Journal of Bone and Joint Surgery America* 2015;356:156-68. doi:10.2106/JBJS.M.00372 pmid:25609443.
5. <https://www.surgeons.org/media/25492528/surgical-variance-reports-2017-orthopaedic-surgery.pdf>
6. <http://www.acornregistry.org/images/2016%20ANNUAL%20REPORT%20SUPPLEMENTARY%20TABLE.pdf>
7. <http://www.worc.org.au/>
8. <https://jamanetwork.com/journals/jama/fullarticle/2610335>.
9. <https://www.mja.com.au/journal/2017/207/6/value-inpatient-rehabilitation-after-uncomplicated-knee-arthroplasty-propensity>
10. <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2379-9/open-peer-review>



ROBIN WHYTE

Chief Executive Officer, Eastern Melbourne Primary Health Network

IN DEPTH

Psychological, social and emotional wellbeing support for Aboriginal communities

An innovative new service in Melbourne's inner north aims to make culturally appropriate mental health services more accessible for Aboriginal and Torres Strait Islander people.

OVERCOMING EARLIER SERVICE SHORTCOMINGS

In 2015, PHNs were established Australia-wide with an aim to increase the efficiency and effectiveness of medical services for patients, and to improve care coordination to ensure patients receive the right care, in the right place, at the right time.

As a part of this mandate, PHNs are required to identify service gaps and commission psychological therapy services for people in underserved groups.

At the time of its establishment, Eastern Melbourne PHN (EMPHN) was delivering services consistent with this directive through the Access to Allied Psychological Services (ATAPS) program, designed to give priority to hard-to-reach groups. This program was complemented by another Commonwealth-funded psychological

service, not commissioned by PHNs, known as the Medicare Benefits Schedule (MBS) Better Access initiative.

Despite the many benefits of both of these programs, there were also shortcomings in design that had some potentially negative impacts on Aboriginal and Torres Strait Islander people, and to some degree may have contributed to low mental health service usage.

EMPHN saw a significant need for innovative psychological services and the importance of tailored psychological, social and emotional wellbeing strategies for Aboriginal and Torres Strait Islander people in our region.

In mid-2017, EMPHN commissioned Banyule Community Health Service to deliver a culturally appropriate Psychological Strategies initiative for Aboriginal communities in Melbourne's inner north.

Banyule Community Health Service is a mainstream provider of Aboriginal services, including a number of EMPHN-funded initiatives, and has 900 Aboriginal clients

registered with its general practitioners.

The innovative service is delivered by an Aboriginal health worker, and provides evidence-based, culturally appropriate mental health support to Aboriginal and Torres Strait Islander people with, or at risk of, mild to moderate mental health issues, with greater access to culturally appropriate care.

THE IMPORTANCE OF ACCESSIBILITY

Access to culturally appropriate, evidence-based mental health services is vital for Aboriginal and Torres Strait Islander people if they are to engage in services within the community in which they live.

This welcoming, safe and culturally appropriate service aims to help break down the stigma in Aboriginal communities around discussing mental health issues and is flexible in how it is delivered.

A client can receive help through trauma-sensitive cultural activities, group sessions, one-on-one sessions, sessions in their own home or a combination of these service options.

“This welcoming, safe and culturally appropriate service aims to help break down the stigma in Aboriginal communities around discussing mental health issues and is flexible in how it is delivered.”

EMPHN's strong commitment to meeting this objective of culturally appropriate mental health support has underpinned its commissioning process to ensure the needs of the Aboriginal and Torres Strait Islander people in our community are met.

SAM'S STORY

Sam is in her 50s and was part of the Stolen Generation. She has a long history of drinking, has experimented with illicit drugs, and has experienced domestic violence.

Sam's children are now illicit drug users, with one son currently serving time in prison. Sam also lost her four siblings in the space of two to three years, and was assaulted last year. This has all had an

immense impact on her mental health to the point where Sam was recently suicidal.

Sam was very reluctant to use mainstream counselling services and would often miss appointments, which led to reluctance from these services in making further appointments for her.

Sam has now been attending counselling sessions through Psychological Strategies at Banyule Community Health Service for the past four months and has found that service delivery is culturally and personally appropriate.

‘It has really allowed me to open up about many things, but also reconnect with my culture, and that's what I miss’, Sam said.

After her sixth session, Sam said ‘I don't have to drink to make myself numb now, I can now just talk’.

Sam's recovery is ongoing and involves re-connecting with her culture by attending an Aboriginal women's group, participating in an Aboriginal women's art group, and attending events with other Aboriginal elders.

Sam has also voiced her support for starting up an Aboriginal Women's Domestic Violence Support Group, which will help give her a sense of self and identity.

CONNECTION TO CULTURE AND COMMUNITY

Banyule Community Health CEO, Mick Geary, said responding to feedback from local Aboriginal people was crucial in the design of this support.

‘Local Aboriginal people accessing our services have told us consistently that support needs to be delivered in a manner that understands culture and community’, he said.

‘We look forward to providing a service that reflects this feedback and builds on the strengths of the community.’ 

For more information about the service, contact tua.enosa@bchs.org.au or (03) 9450 2000.

This service is supported by funding from the Australian Government under the PHN Program.



Trans vaginal mesh injuries

The medical catastrophe associated with Trans Vaginal Mesh implants is a cautionary tale about the vulnerability of the fail-safe mechanisms we rely on to protect our health system.

The life-changing impacts that thousands of women have endured as a consequence of their implants is a catastrophe 20 years in the making. But the back story of how a medical device touted as the 'gold standard' in pelvic prolapse and stress urinary incontinence repair even got to market, let alone evaded detection that it was causing life-changing injury, is a tragedy in its own right.

My own awareness of mesh began through the harrowing accounts of a group of mesh-injured women who participated in a consultation initiated by the Australian Commission for Safety and Quality in Health

Care. In a short time I learned that their mesh implants had caused devastating outcomes, and that no-one knew how many women had been similarly injured (in fact, the TGA had recorded fewer than 100 adverse mesh events over five years from 2012). Similarly no-one knew how many mesh implants had been carried out in Australia even though they had been in common use since the beginning of this century.

The Health Issues Centre, a Victorian-based consumer health advocacy organisation, decided to conduct its own due diligence, and through the use of social media and de-identified survey questions, we gathered 2,400 testimonials in six weeks.

There has been much reporting in the media of the stories of women whose lives have been irreparably broken by

mesh. But mesh has also exposed alarming shortcomings in our safety and quality regimes—shortcomings that if not addressed could see this tragedy repeated.

The calibre of a quality and safety system is not how it operates in a business-as-usual environment but how well it pre-empts catastrophic consequences. Consider the following questions raised by mesh:

- **Regulatory approval**—How low is the benchmark for clinical testing of medical devices if over 100 variants of a poorly evaluated device can make their way into the market?
- **Medical device register**—How could we not know how many of these devices have been implanted over a 20-year period other than to rely on manufacturer inventory estimates?
- **Adverse event reporting**—How could the mandatory process of adverse event



DANNY VADASZ
Chief Executive Officer
Health Issues Centre



How safe is our safety regime?

“How could the mandatory process of adverse reporting so dismally understate the magnitude of the problem?”

reporting so dismally understate the magnitude of the problem?

- **Complaints reporting**—How could the various state and federal complaints mechanisms fail to detect an alarming pattern of recurrence in mesh-related complaints and fail to sound the alarm?
- **Informed consent**—How is it that only 34% of women surveyed believe they were given sufficient information by their clinician to provide informed

consent to the procedure? And is even that percentage meaningful when none of them were forewarned that mesh is intended to be a permanent implant and that its removal is problematic?

- **Practice standards**—How can the relevant professional associations claim that the mesh catastrophe is a consequence of the inadequate training and inexperience of their own members yet refuse to accept any historical responsibility?
- **Conflict of interest**—How could we allow some practitioners to allegedly personally receive manufacturer kickbacks for performing mesh implants without disclosure of their pecuniary interest?
- **Product recall procedures**—Why can we respond to a single case of food contamination with a total national

recall within 48 hours, yet we leave discredited medical devices indefinitely in the marketplace?

- **Patient-centred care**—How does telling injured patients that they are imagining their pain or that it is a natural consequence of ageing square against our commitment to patient-centred care? Systems fail, they are imperfect. But a robust system holds up under pressure and should have the capacity to self-identify and address its failures so that the integrity of the system is not fatally compromised.

Unfortunately nobody has taken responsibility for the pain and suffering of countless women, and that leads to the ultimate tragedy of the mesh debacle—there is no-one to validate the experiences of all those injured women, even if with a simple ‘Sorry’. ^{ha}



BELINDA ROBINSON
Chief Executive
Universities Australia

Higher education and health policy

Meeting the workforce demands of an evolving health system.

Higher education is not often the subject of health policy articles. Yet when it comes to health workforce, it needs to be. After all, those educated in our universities today will be the health workers of tomorrow.

Just what that future workforce will look like is still an open question. New trends in demographics, disease, research and the changing nature of work will all shape our health workforce—and the nature of the jobs within it.

In Australia, we now live much longer—but with more years of ill health. Dementia has overtaken cancer as our second leading cause of death. Chronic disease continues to rise. Yet almost one-third of the cost to Australia of ill health could be prevented by addressing common risk factors.

Technology—from smartphone apps to aged care robots—will also become a larger part of how health practitioners deliver increasingly personalised medical treatment.

Looking at this picture of the future, one thing is sure: it will be complex and it will be dynamic.

As the Australian Healthcare and Hospitals

Association's *Healthy people, healthy systems* blueprint predicts, the future health workforce will need to be flexible, modern, intelligent, competent and data-driven for the 21st century and beyond.

To get there, we need to look at our health and education systems together. But getting all the different players together will not be easy.

Responsibilities and funding are already shared between a dizzying array of government and other health stakeholders. Add a whole other sector—higher education—into the mix, and it becomes even more challenging.

But if we want to get the health system and the future workforce needs right, higher education must be at the table—sitting alongside the accrediting agencies, the professional bodies, the researchers and the technologists.

If universities aren't at that table, opportunities will be lost and, at worst, policy decisions in one sector could work against policy goals in the other.

We're seeing an example of this now—with the \$2.2 billion in university funding cuts announced in the Mid-Year Economic and Fiscal Outlook last December.



This decision effectively re-caps student places and freezes university funding in 2017 dollars. That means universities who want to grow or maintain their student numbers to meet greater needs for health workers in their local communities will face a funding cut in real terms. It will restrict any university that wants to increase student places in a given discipline or innovate with new courses—even when there is a pressing need for them.

This raises problems in course areas with high future workforce demand. It is particularly concerning when you think about the predicted future shortages in some health professions.

The new funding system is also likely to disincentivise courses that are particularly expensive to teach or that have lower student contribution rates—like nursing, for example.

None of this is helped by the increasing tendency of health providers to charge universities for student clinical placements.

Health providers are part of the partnership responsible for ensuring the future supply of health workers and need to see training

as a shared responsibility.

With university health courses now facing less overall funding and greater clinical placement costs, dealing with increased demand in the health workforce will be even harder.

Numbers are only one part of the issue. There are other trends that raise new questions for Governments, universities and health providers. These questions go to the distribution, skill mix, and clinical exposure for those training to be in our future health workforce.

As machines become even more common in everyday life, we know technological skills will be critical. Using technology can help us to make greater advances in health services—including for older people and those with disability. It opens the prospect of gleaning new insights into how disease and illness can be prevented and treated most effectively. With depression now the leading cause of ill-health worldwide, a greater focus on mental health skills will also be required.

Future health workforce teams will need

to include a growing number of allied health professionals, and they will work alongside artificial intelligence systems and robot care assistants. There will be new roles that will be hard to even imagine—and some traditional roles may need to be expanded and changed.

This means preparing health and medical students to learn in simulators and with other technology; much more clinical experience in community settings beyond public hospitals; and lifelong learning that allows workers to re-train for changing roles.

Higher education is going to play a major part in these trends and developments. It will do so not only through the direct education of health professionals—but also by driving the research and technological developments that will shape this future.

Dealing with these challenges requires investment—something the rest of the world already recognises.

Addressing Australia's health needs, and remaining globally competitive in health research and training, will rely on us investing in—not cutting—higher education funding. **ha**



JENNIFER DOGGETT
Chair
Australian Health Care Reform
Alliance (AHCRA)

We need to talk about Medicare

Engaging the community in a conversation about the future
of our health system.

In 1983, when introducing the legislation to create Medicare into Federal Parliament, Health Minister Neal Blewett stated, 'In a society as wealthy as ours there should not be people putting off treatment because they cannot afford the bills. Basic health care should be the right of every Australian'.

This is the underlying vision for Medicare and one supported by the Australian Health Care Reform Alliance (AHCRA). AHCRA's members are committed to a system of universal health insurance as the most equitable and efficient mechanism for funding the delivery of health care.

MEDICARE FALLING SHORT

Medicare, as originally constituted in 1983, was not perfect but it did go a long way towards meeting the healthcare needs of the time. However, since 1983 these needs have changed and it is clear that Medicare, in its current form, is falling a long way short of delivering universal access to health care.

Therefore, AHCRA believes that significant reforms are required to equip our health system to meet our future health care needs.

We also believe that this reform should begin by acknowledging the many positive features of Medicare that should be preserved. These include:

- major reductions in inequities of access (compared to pre-Medicare days)
- an efficient payment system with low administrative costs

"Medicare, as originally constituted in 1983, was not perfect but it did go a long way towards meeting the healthcare needs of the time."

- a progressive tax-based funding system where people contribute on the basis of their ability to pay
- a widely acknowledged view that health care is a key 'common good' that should be available to all.

MAINTAIN THE POSITIVES

While recognising these positives, AHCRA has identified a number of specific issues which we believe should be the focus of the health reform agenda. These include:

- a fee-for-service system which does not meet the needs of many consumers and contributes to workforce maldistribution
- barriers to access due to co-payments (imposed by both governments and providers)
- uneven distribution of the health workforce
- limitations to the capacity of Nurse Practitioners and allied health professionals to work at the full scope of their practice
- a lack of focus on preventive health
- the Federal/State/Local Government split in roles and responsibilities, which results in gaps, duplications, inefficiencies and inequities
- minimal consumer/citizen engagement
- no means of addressing the social determinants of health
- only minimal provision of dental care.

AHCRA acknowledges that there have been a number of changes to Medicare since its introduction, including funding for defined services outside of the fee-for-service structure, such as chronic disease management and recognition of non-doctor health professionals into funding structures.

These may have had partial success in addressing Medicare's limitations. However, they have also resulted in a system that is convoluted with incentives, complex administrative arrangements and 'add on' payments, rather than being focused on the provision of core, high quality and consumer-centred services. More importantly, these policy changes have not reduced the inequities in access faced by a number of groups in the community, including: people on low incomes; people from rural and remote areas; people with chronic and complex conditions; and Indigenous Australians.

One of the major reasons for this is that successive governments have tried to address the symptoms of these issues in a piecemeal manner, rather than looking systematically at their underlying causes. Governments have also been unduly influenced, in some cases, by provider and industry groups, which often have a vested interest in maintaining the current system and so resist any disruption to the status quo.

THE NEED FOR COMMUNITY INPUT

AHCRA believes that future health system reform needs to be driven by the community, rather than by provider and industry interest groups, and needs to be grounded in a robust understanding of what values Australians want to underpin their health system.

As our population ages and healthcare costs increase, there are some tough choices that will need to be made about how and where we allocate our health dollars. It is therefore important that our funding decisions are guided by the interests of community as a whole, rather than a small group of stakeholders.

Australia has never undertaken a comprehensive consultation process on community views and preferences for health system reform (for example like Canada's Romanow Commission). This means that—to some extent—governments and policy-makers are operating in a vacuum when it comes to trying to meet community needs. It also can mean that they are more likely to listen to and be influenced by stakeholders with narrow sectional interests.

A CONVERSATION WITH AUSTRALIA

To address this issue, AHCRA proposes that we hold a 'Conversation with Australia' on the future of our health system. This would involve a meaningful national dialogue with citizens and consumers in order to create a common set of values, principles and priorities for the health system of the future. This would create the first national vision and framework for healthcare that all governments in Australia could use to guide the evolution of the health system. 

For more information about AHCRA's proposed Conversation with Australia, visit www.healthreform.org.au.

Become an AHHA member

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

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

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

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

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

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

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

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

In partnership with the LEI Group, the AHHA also provides

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

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

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



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More about the AHHA

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

AHHA Board

The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation, the protection of its assets and the quality of its services. The 2016-2017 Board is:

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Dental Health Services Victoria

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AHHA National Council

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

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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:

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Prof Christian Gericke
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Prof Sonj Hall
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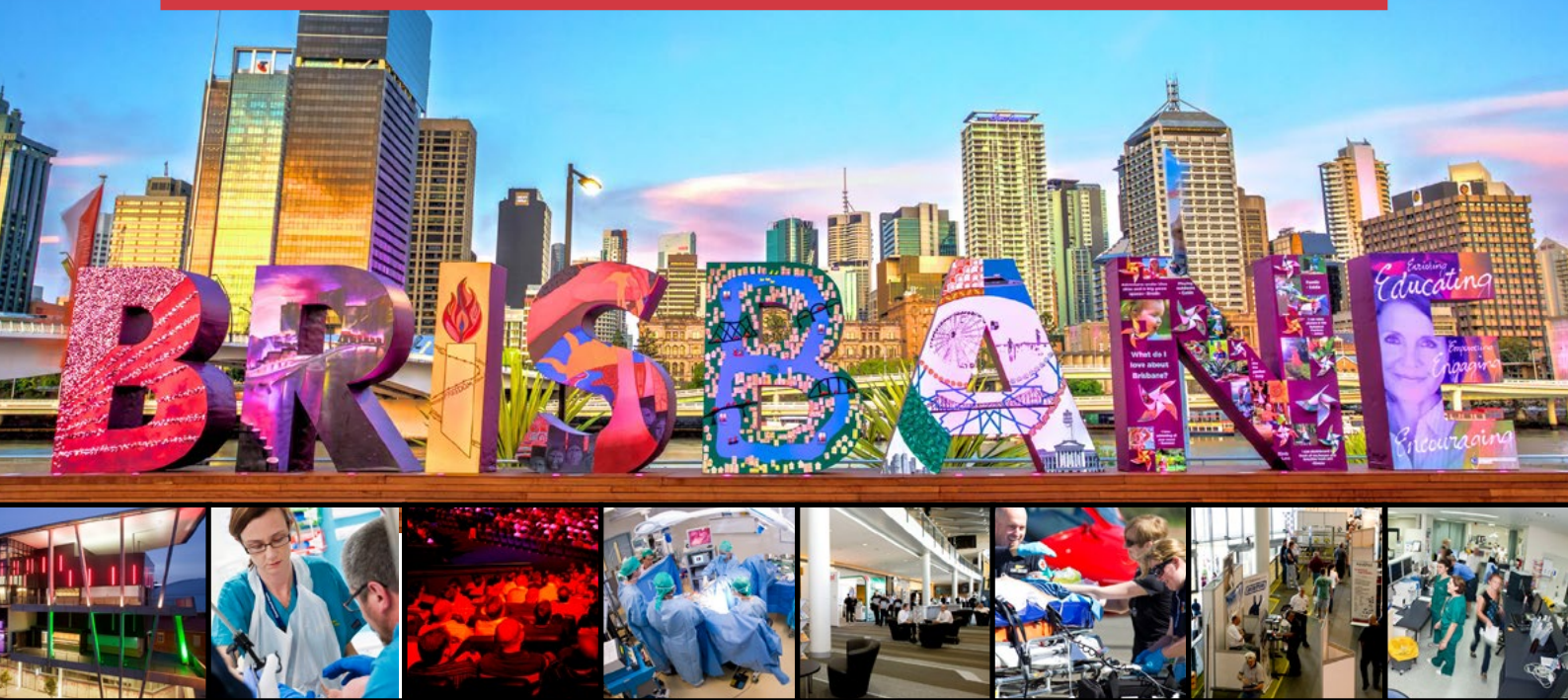


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