The Health Advocate

Your voice in healthcare

Why good health policy goes bad

The road to 2030

Delivering what matters

When are medicine and technology not enough?

An evolving health system

+MORE INSIDE

The official magazine of the Australian Healthcare and Hospitals Association

ISSUE 57 / December 2019

PRINT POST APPROVED PP:100009739

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The Health Advocate

ISSUE 57 / December 2019

ALISON VERHOEVEN
Chief Executive
AHHA

Health system has to evolve

Welcome to the December 2019 issue of *The Health Advocate*, the sixth and final issue in what has been a busy year for AHHA.

Our theme for December is 'An evolving health system'. Evolve it must, but we wish it would change more quickly than that, in the direction of person-centred, value-based care that pays attention to outcomes as well as inputs.

Perhaps we put this sentiment most bluntly in our October 2019 media release when we said: *'Time to change the game in health to get the results we want'*.

We had just released our Deeble Institute for Health Policy Research Issues Brief, *Reforming for value: opportunities for outcome-focused national health policy*, written by Dr Kate Raymond from Dental Health Services Victoria.

As we said at the time, 'The days of incentivising number of appointments attended instead of the outcomes achieved should be confined to the medical waste bin because rising health costs are unsustainable'.

'Unnecessary or ineffective care needs to be cut out altogether. And preventive healthcare, which provides value for money by reducing the need to seek healthcare in the first place, needs to be prioritised.'

In the end it's all about evolving (quickly!) to provide the right incentives for what we want to achieve. Whether it's health, sport, taxation, or home loan interest rates, sometimes the rules need to be changed to encourage changes in the activity itself.

Alternatively, a brave and innovative person or group of people need to set up something new and show that it pays off in terms of efficiency and effectiveness, and then try to ensure that the new way is incentivised by the guardians and umpires of the system, namely governments at all levels.

Even then, it's not all plain sailing to get good ideas turned into good policy, as our leading event for the year showed.

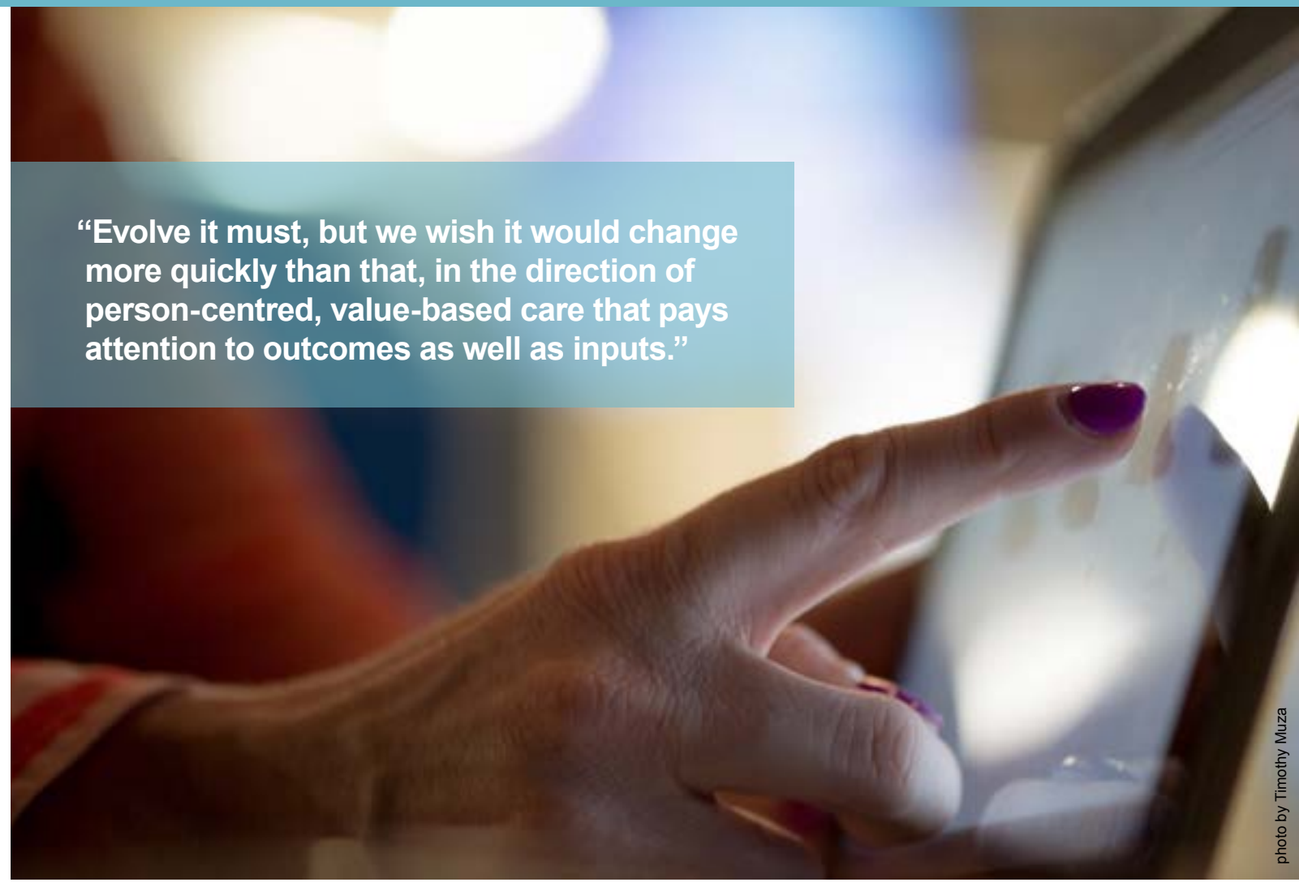
On 18 October 2019 we held the inaugural annual John Deeble Lecture and panel discussion.

We were honoured to have the lecture delivered by Professor Nigel Edwards, from the UK's Nuffield Trust. Nigel spoke most eloquently, firstly on why good health policy goes bad, then on some practical measures to fix it.

Excerpts from Part 1 of the lecture (why good health policy goes bad) are available to THA readers elsewhere in this issue. Excerpts from Part 2 (how to fix it) will be published in the February 2020 edition.

Getting back to our evolving health system, we have some interesting perspectives for THA readers this month.

For example, Queensland Health's Nick Steele (Deputy Director-General, Healthcare Purchasing and System Performance) writes on 'Delivering what matters'. The article focuses on Queensland Health's Rapid Results Program—a 'whole-of-system, transformational program of work focusing on prevention, value, culture and access, to deliver better health services and improved outcomes for Queenslanders'.



"Evolve it must, but we wish it would change more quickly than that, in the direction of person-centred, value-based care that pays attention to outcomes as well as inputs."

photo by Timothy Muza

Professor Jeffrey Braithwaite from the Australian Institute of Health Innovation writes on 'The road to 2030', where he predicts, on the basis of his research and what is happening right now, where healthcare will be in a little over a decade.

Elsewhere you can read about a Community-based Integrated Diabetes Education and Assessment Service at Eastern Melbourne Primary Health Network. You can also read about a proposed hub in Melbourne that combines community health services with housing—under the one roof, so to speak.

That's not all. We also have an article from Brisbane South PHN on evaluating person-centred care, and survey results from All.Can—a cancer collaboration dedicated to tackling inefficiency in cancer care.

Interprofessional education is part of an 'evolving health system', and is reported on by a team led by Associate Professor Roger Dunston, University of Technology, Sydney.

Finally, Professor Adrian Barnett and Alison Farrington from the Australian Centre for Health Services Innovation ponder choice of best path for end-of-life care in 'When are medicine and technology not enough?'

Happy reading, and a great festive season to all!

AHHA in the news

HAVE YOUR SAY...

**We would like to hear your opinion on these or any other healthcare issues.
Send your comments and article pitches to our media inbox: communications@ahha.asn.au**

1 NOVEMBER 2019

Australian Government must fund more home care packages to meet overwhelming levels of unmet need

'The Commonwealth must take immediate action to reduce the waiting times for Australians approved for home care packages', said Australian Healthcare and Hospitals Association (AHHA) Acting Chief Executive Dr Linc Thurecht.

'Australians who have been assessed as needing aged care services, should not be left waiting in a queue.

'We have more people waiting for home care packages at their approved level, than are currently receiving packages.

'Waiting times for those in the queue are too long. The median wait time has continued to increase and it is now 137 days, with many waiting more than a year for higher level care. One-quarter of people waiting for a level 4 package are waiting three years.

'Australian research has shown that shorter wait times for home care packages are associated with people living longer and being able to stay in their own homes.

'Being unable to access aged care services, or care that is at the appropriate level, has broader impacts outside the aged care sector, with greater burdens placed upon carers, families, communities and the health sector.

'The Interim Report by the Royal Commission described access to home care and the national prioritisation queue as a 'cruel and discriminatory system' and neglectful.

'Previous reviews have recommended phasing out supply caps for aged care places. For these reforms to be considered and sustainably implemented, we need investment to increase workforce capacity within the sector and better data to measure and monitor unmet need and equity of access.'

UPDATE: The Australian Government announced funding for an additional 10,000 home care packages on 25 November 2019. While this additional funding is welcome, it addresses less than 10% of the waiting list. More people died while on the waiting list last year (16,000) than will be supported by this additional funding. ha

30 OCTOBER 2019

Private health insurers covering GP bills would undermine Medicare

'We do not support the recent suggestion by private health insurers to operate outside the hospital system to cover visits to GPs and specialists', said Australian Healthcare and Hospitals Association (AHHA) Acting Chief Executive Dr Linc Thurecht.

'This would undermine our universal healthcare system we have with Medicare and raise fundamental issues of equity around who can access and afford to pay for their healthcare.

'While reforms that shift care away from hospitals to less expensive primary and community healthcare settings deserve consideration (for example provision of rehabilitation services outside of hospitals), this should not be done in isolation from broader health reforms.

'There are many interdependencies in our current system, and a change in one area will have impacts, possibly adverse impacts, in another.

'This is why AHHA has been calling on the Government for over two years for an independent Productivity Commission review of the whole healthcare system, both public and private components, to determine how best to keep quality and timely healthcare affordable—for governments and for all Australians regardless of the size of their wallets or where they live.

'This review should also investigate and clarify the public policy objectives that are being served by Government support of private healthcare and private health insurance, through publicly-funded subsidies and other mechanisms.

'To allow private health insurers to operate even further into Medicare-funded territory fundamentally threatens the principles of Medicare because insurers are about profits for shareholders and prioritising value for their policyholders, not about the best care for insured and uninsured alike. It would also raise fundamental concerns for the one-half of all Australians not covered by private health insurance.

'We should be cautious of a sector whose track record is one of escalating premiums and reductions in cover, and a very strong say in where and how you are going to be treated and what you are and are not covered for.

'Such a system has all the characteristics of the American system, which relies on private health insurance to function—it is the most costly health system in the world, where one-half of all bankruptcies are caused by high medical bills.' ha

AHHA in the news

HAVE YOUR SAY...

We would like to hear your opinion on these or any other healthcare issues. Send your comments and article pitches to our media inbox: communications@ahha.asn.au

29 OCTOBER 2019

Healthcare in aged care facilities—more to be done

'The Australian Government is working towards fixing quality-of-care issues in government-funded residential aged care facilities—but to be top of the class they could do more', says Australian Healthcare and Hospitals Association (AHHA) Acting Chief Executive Dr Linc Thurecht.

Dr Thurecht was commenting on the Australian Government's response to the House of Representatives Standing Committee on Health, Aged Care and Sport's *Report on the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia*.

'The government has either supported or supported-in-principle 12 out of the report's 14 recommendations. They have chosen to "note" the other two recommendations, citing other government initiatives already under way or planned in those areas.

'Importantly the government supports better access to GPs by residential aged care residents. Earlier this year they implemented changes to the Medical Benefits Schedule that recognise the time and additional costs incurred by GPs in delivering these services.

'We think the government could go further by investigating the cost-effectiveness of innovative primary healthcare services such as follow-up telephone or video conversations with their general practitioner, physiotherapist, pharmacist or palliative care support person.

'The government is treading carefully—maybe too carefully—in "noting" the Committee's recommendation that residential aged care facilities have one registered nurse on duty at all times.

'While we support the Government's thinking that every aged care facility's situation is different in terms of staff/resident mix and clinical activity, we also think that medicines access is required 24 hours a day, and that this will likely require registered nurses.' ha

25 OCTOBER 2019

Time to change the game in health to get the results we want

'It is time to change the game in health to reward outcomes for patients using best value-for-money healthcare', says Australian Healthcare and Hospitals Association (AHHA) Acting Chief Executive Dr Linc Thurecht.

'The days of incentivising number of appointments attended instead of the outcomes achieved should be confined to the medical waste bin because rising health costs are unsustainable.

'Unnecessary or ineffective care needs to be cut out altogether. And preventive healthcare, which provides value for money by reducing the need to seek healthcare in the first place, needs to be prioritised.'

Dr Thurecht was commenting on the release by the AHHA's Deeble Institute for Health Policy Research of an Issues Brief, *Reforming for value: opportunities for outcome-focused national health policy*, by Dr Kate Raymond from Dental Health Services Victoria.

'It's about providing incentives for what we want to achieve', Dr Thurecht said.

'In many facets of life, whether it's sport, taxation, or home loan interest rates, sometimes the rules are changed to encourage changes in the activity itself. The same has to happen in health.

'Our health system could be so much better. Costs are running away from us. Health disparities have persisted or widened under a system measured and rewarded by amount of healthcare activity no matter what outcomes are achieved.

'Providers currently have strong incentives to maximise the number of appointments with patients, while the aim really should be to improve a person's health and reduce how often they need to see a doctor or other healthcare professionals.' ha

23 OCTOBER 2019

1 in 6 women can't afford healthcare when needed, experience discrimination

'An alarming 1 in 6 women in Australia say they cannot afford to see a health professional when they need one—and the same proportion experience discrimination when doing so', says Australian Healthcare and Hospitals Association (AHHA) Acting Chief Executive Dr Linc Thurecht.

Dr Thurecht was commenting on the release by the Jean Hailes for Women's Health organisation of its annual National Women's Health Survey for 2019.

'Over 10,000 women were interviewed for the survey, covering all states and territories.

'Women aged 18–35 found it hardest to afford a health professional—comprising about 1 in 5 in this age group,', Dr Thurecht said.

'There was quite a gap between the rich and not-so-rich. People who said they were "living comfortably" almost universally could see a health professional whenever they needed to.

'For people who said they were "just getting by", around 40% could not afford to see a health professional.

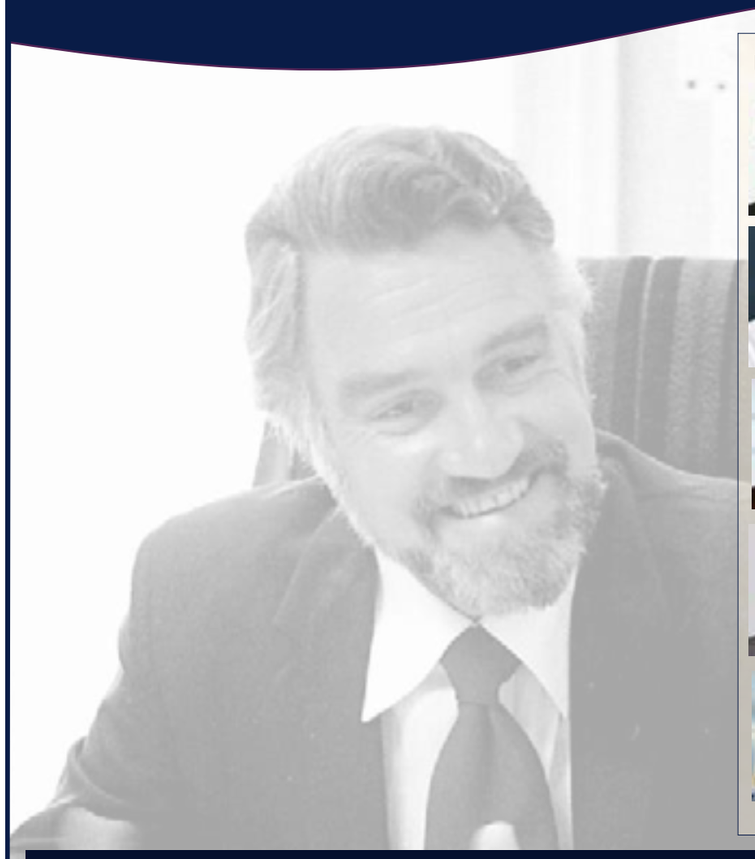
'For people who declared they were "finding it very difficult", a staggering 80% said they could not afford to see a health professional when they needed one.'

'Around 16% of the total number of women surveyed felt they experienced discrimination in accessing healthcare—but this appeared to improve with age from 20% in the younger age groups to 9% for the oldest (80+) women', Dr Thurecht said.

'For Aboriginal and Torres Strait Islander women, the proportion who felt discriminated against was around 35% compared with 16% for non-Indigenous women.' ha

Did you miss out on the John Deeble Lecture & Panel Discussion?

You can now listen to it by visiting *ahha.asn.au/health-advocate-podcast* or searching 'The Health Advocate' in your podcast app. This podcast is a two part series, covering common issues in policy implementation, how we can avoid them and the achievements and lessons from our guest speakers.



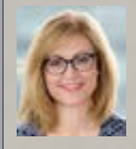
Featuring;

Professor Nigel Edwards CEO Nuffield Trust, UK

Professor Ian Frazer AC FRS
University of Queensland.
Co-Inventor HPV Vaccine
Australian of the Year 2006

Romlie Mokak
Commissioner
Indigenous Evaluation Strategy, Productivity Commission

Hon Nicola Roxon
Chair, HESTA
Minister for Health and Aging 2007-2011



Professor Johanna Westbrook
Director Centre for Health Systems and Safety Research, Macquarie University

AHHA's Health Advocate Podcast provides listeners with the latest news surrounding healthcare and features interviews with leading health professionals from around the world.

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The Palliative Care Online Training Portal is funded by the Australian Government.

CHANGE IS COMING

Aboriginal and Torres Strait Islander people are finally becoming equal partners in decision making about their own lives.

Thank you to all those who have supported Close the Gap and the advocacy for co-design.

We look forward to the systemic change, shared responsibility and genuine collaboration that Prime Minister Morrison spoke of in his 2019 Closing the Gap Report.

Take the Survey

The Coalition of Aboriginal and Torres Strait Islander Peak Organisations want to hear your ideas on what is needed to make real change in the lives of Aboriginal and Torres Strait Islander people. Have your say now!

https://www.naccho.org.au/programmes/coalition-of-peaks/have-your-say/

CLOSETHEGAP

PROFESSOR NIGEL EDWARDS
Chief Executive, Nuffield Trust, UK

Why good health policy goes bad

Excerpts from the inaugural John Deeble Lecture 2019—part 1

"There would be much more emphasis on patient choice and competition, including price competition. The idea was also to simplify the system and, a favourite of all politicians, to 'reduce bureaucracy."

The John Deeble Lecture was established by the Australian Healthcare and Hospitals Association (AHHA) as an annual event to commemorate the life and achievements of the late Professor John Deeble AO as a distinguished scholar, health economist and health policy leader.

Excerpts from the lecture are published below. The focus in these Part 1 excerpts is on policy failings. In the February 2020 edition of* The Health Advocate *we will publish Part 2—Professor Edwards' suggestions about what needs to be done to improve the health policy-making process, including his arguments that traditional calls to get more evidence into policy miss important aspects of the world we now inhabit. He suggests some helpful strategies to overcome these problems.

1. So big it can be seen from space

Andrew Lansley became Secretary of State for Health (UK) in 2010, having spent an unprecedented six and a half years in the shadow role—he had a plan based on his experience as a civil servant involved in the privatisation of energy and telecoms utilities, but it was not really clear who he listened to in developing his ideas.

His plan was to boost the National Health Service (NHS) quasi-market, giving GPs purchasing power and organising them into groups to do commissioning. There would be much more emphasis on patient choice and competition, including price competition. The idea was also to simplify the system and, a favourite of all politicians, to 'reduce bureaucracy'. As part of this, and as an attempt to remove ministers from the day-to-day running of the NHS, it was proposed to establish an NHS Board to oversee this system and an economic regulator to deal with competition and pricing issues. Both of these were to be independent of direct ministerial oversight and would be at arm's length from government.

The half-finished project of making hospitals autonomous would be completed and there would be greater private sector involvement.

Above all, the government was in a great hurry and was not interested in the detailed scrutiny of its proposals. In fact it didn't have the expertise or machinery to do so—they abolished it on coming to power. This meant that No.10 failed to understand the radical scope of Lansley's project.

It soon became clear that the commitment to avoid a major reorganisation didn't work. The reforms created a logic that left many parts of the structure without a clear role. With the added pressure to reduce costs, this led to organisational changes which the then CEO of the NHS described as 'so large [they] could be seen from space'. Further trouble came from different sources and came very fast.

Lansley thought he had the British Medical Association (BMA) on-side. He didn't. The Treasury and many politicians became very nervous at the idea of £80 billion being handed to independent contractors with what seemed to be very little accountability or oversight—the NHS was already in financial trouble and the reforms risked a complete loss of grip on the money

Political opposition came from many quarters and over 2,000 amendments were put down—Lansley had in the words of one critic 'managed to unite Luddites and reformers'.

The general verdict was that the Bill was still a mess and most stakeholders were not happy. It was neither what Lansley envisaged, and the compromises left many issues unresolved.

Lansley was demoted and things moved on.

The governance structure of the NHS was not simplified. And although the number of managers fell initially, this has grown back.

Many aspects of the reforms have unravelled. As is the case with many large complex organisations, you have to really break it to stop it returning to its previous form. Lansley even failed at this and the system has evolved to get around almost all of its most unhelpful and competition-oriented components. Much of the legal framework has been ignored or worked around—especially that related to competition regulation and mergers, choice, competition between providers and the separate roles of the regulators.

2. Lessons

There are a number of important policy design lessons here—and a few that this case doesn't teach which I will bring into what follows.

MODELS AND THEORIES

The theory of policy-making as a purely rational process has long been superseded by theories >

"Policy-makers in large systems have a particular problem because of large variations in the starting points of local systems, the burden of local history layered on the national picture and other contextual factors."

that acknowledge bounded rationality in which some options are not considered and policy-makers will 'satisfice' rather than optimise or maximise.

The problems of Lansley's reforms go beyond those of this type of rational choice approach—they were to a large extent based on a theoretical model drawn from the economics and policies of privatisation of utilities.

While all models are flawed, some can be useful, so the first step is to ask, is the model useful? The danger is that the model has been developed in different times or sectors and that it does not properly translate into the current context or that the model relies on theories and evidence that have been oversimplified, distorted or are just wrong. Lansley designed his reforms in a period of plenty and implemented them in austerity—he made no attempts to change them.

CONTEXT AND HISTORY

The second step when examining a policy idea—whether it is a model, theory-based or a more pragmatic response—is the extent to which it fits with the context and history.

The neglect of context and history often leads to bad ideas being resuscitated or borrowed from elsewhere and applied in situations in which they are unlikely to work. It's also worth checking that the ideas being borrowed actually work as well as is claimed.

Policy-makers in large systems have a particular problem because of large variations in the starting points of local systems, the burden of local history layered on the national picture and other contextual factors. They sometimes find it convenient to ignore this and create 'cookie cutter' policy which works 'on average' and therefore, has a poor fit in places that are not average.

Even worse is the temptation to design the policy for the least capable part of the system.

POOR CONCEPTUALISATION

Some poor design emerges from a failure to really understand the nature of the problem or how the problem interacts with the system. Common issues here include:

- Faulty logic and theories about causality—it's not uncommon to see logic models in which the connection between the actions and the results are not really supported by evidence
- Conceptualising problems as being about a failure of incentives, structures or rules when they are more about culture, behaviour and relationships and therefore some way out of reach of most policy instruments.
- Assuming that the recipients of the policy will respond in the way that you intended.

A tempting response to the problems of complexity, context dependence, heterogeneity, etc. is to simplify the issue—but this means that many of the subtle qualifications and conditions to make the idea valid are lost. A particular hazard comes from the personal experiences of politicians being used as a guide to the other 60 million users of the system.

TOO MANY OR UNCLEAR OBJECTIVES

Policy-making theory recognises the problems of trade-offs between objectives but there is a particular problem where policies are created with more objectives than they can sustain or which generate tensions. Amongst other things, Lansley's reforms aimed to reduce bureaucracy while creating a very large volume of transactions and attempting to increase accountability.

Mission creep and 'Christmas tree' policy-making, in which additional objectives are loaded onto the policy, can happen at any point in the development process and is a particular feature where there is internal competition between policy leads. These policy entrepreneurs will try to grab the opportunity of attaching their policy goal to an instrument that is fashionable or is gaining traction.

POOR DESIGN PROCESS

In 2002, the then Secretary of State Alan Milburn announced 'radical plans to allow the private sector, charities and universities to take over management of England's failing hospitals'. The idea was called franchising—borrowed from the commercial sector. This illustrates three interesting design problems:

- Retrofit—the policy idea was announced before it had been worked out. Unhelpfully Milburn added enough detail to the idea that it constrained the policymakers' ability to turn it into something sensible.
- Cargo-cult policy—the idea was borrowed but without a clear understanding of what it really meant, so that the outward appearance of the idea was replicated but the actual active ingredients which made the policy effective in, for example, McDonalds, was not.
- Solutions looking for problems—it was by no means clear that the reason for the problems that the hospitals were having were related to the quality of its existing management.

Another element of a poor design process that is far too common and was a major feature of the Lansley debacle, is failing to elicit or listen to feedback—particularly from wider stakeholders beyond the usual suspects or people you can guarantee will agree.

This failing is often associated with selective use of the evidence, ignoring findings that do not support the direction—policy-based evidence, rather than evidence-based policy. ha

A full-text version of the lecture (Deeble Institute Perspectives Brief no. 6), and two podcasts, of the lecture (podcast 16) and subsequent panel discussion (podcast 17), are available on the AHHA's website at ahha.asn.au/health-advocate-podcast.
Part 2 of the Deeble Lecture 2019 excerpts will be published in the February 2020 edition of *The Health Advocaate*.

The 2019 John Deeble Lecture and Panel Discussion was supported by the Australian National University's College of Health and Medicine and Crawford School of Public Policy; the Australia and New Zealand School of Government (ANZSOG); and the Centre for Health System and Safety Research at the Australian Institute of Health Innovation, Macquarie University.

PROFESSOR JEFFREY BRAITHWAITE
Founding Director, Australian Institute of Health Innovation, Macquarie University

The road to 2030

Where are we headed in healthcare?

Where will you be in 10 years? Watching your family grow, forging a career, enjoying retirement or slowing down with advancing older age?

Just as our requirements as individuals change over time, so do our healthcare needs alter with our changing life circumstances. We need more care when younger (for baby health and immunisation) and older (for arthritis, heart disease or aged care), and for special circumstances (breaking a leg, having a baby, getting the flu).

But what we often don't think about is that the health system itself is evolving to support us. Drawing on research I've been conducting with colleagues in Australia and internationally, we can point to four key trends and one conclusion that will pave the healthcare road to 2030.

More people will live longer with more illness

Worldwide, people are living longer. In Australia a man who is 65 years old today can expect to live another 20 years, and a woman a couple of years longer. Already more than half a million Australians are aged over 85 years and this is on the rise.

In addition, one in every two Australians is now living with the long-term burden of at least one chronic disease such as diabetes, heart disease, kidney disease, asthma or cancer.

Obesity is also concerning across all age brackets. It's a slow-ticking problem, as being obese is associated with other illnesses such as diabetes, stroke, heart disease, some forms of cancer, breathing problems, gout and poorer mental health outcomes.

The challenge for the future health system will be to provide high quality, safe healthcare for growing numbers of people who are not only living longer but coping with more than one long-term illness. More people in the emergency room, the GP clinic, and in acute care puts more pressure on the system.

More changes will occur, rapidly

New medicines, technologies and ways of delivering services are emerging constantly. Whether or not they make it into the health system to benefit the community, however, depends on many factors. The availability of financial and other resources, the ability of clinicians and clinical teams to take them up, and the dynamics between policymakers, politicians and the expectations of the public, all play a part.

Right now, we are seeing the rapid advancement of artificial intelligence (AI), bringing with it considerable opportunities and risks. While AI can greatly improve some diagnostic services, particularly in radiology, there are many questions that remain unresolved around ethics (Should a machine's algorithm decide on my care?) and the privacy of data (Who gets access to all the computer information AI generates?).

The health system of the future must be engineered to safely, ethically and effectively assess and manage rapid advances in technology, medicine and services. Otherwise, there will be diminished trust in the very system we need for our future wellbeing.

More care will be more personalised

Imagine having an instruction manual that predicts all the ways you will personally react to treatment for your diseases and illnesses. While in the future we will know so much more, already that instruction manual is being written, based on astonishing advances in genome sequencing.

It's healthcare re-invented, custom-designed for the specific individual.

Scientists are learning how a change to a single cell could be the difference between inheriting a disease or not. They are also investigating what genomic factors determine how cancerous cells grow and replicate and what causes of an individual patient's disease at the molecular level leads to, say, diabetes and cardiovascular disease. Clinicians will be able to prioritise your care based on this information. Understanding your biology and the prognosis of the diseases you might develop, and your likely responses to a specific treatment, means much better tailored care for you.

So, the good news is that clinicians will be able to use this 'instruction manual' to accurately map treatments to your individual needs. They and you will have so much more deeply insightful and accurate information available to make informed decisions—not only about what care might be best for you, but what recommendations you will choose to accept, reject or modify.

The health system will need to build supports around this powerful new paradigm. The new information systems, diagnostic capacity, genomic tests and clinical training will not be cheap. But many people think that price will be worth paying so that healthcare professionals know >

how best to apply the new knowledge, privacy issues are resolved, and patients are counselled and guided in their decision-making.

Fewer people will be admitted to hospital

In a time when we seem to be building large numbers of new hospitals and beds in every State and Territory, this fourth point might sound strange. But in the future, less people will be cared for in acute settings. Advances in technology and new models of care will mean that services will be available in the community that otherwise would have required a hospital visit. There will also be more emphasis on preventative measures that will keep people healthier longer and less in need of the type of acute care offered by specialists in hospital.

The federal government this year committed more than $11 million to research projects investigating how to keep people out of hospital and focusing on better management of heart disease, kidney disease, diabetes and mental health. That's only a down payment on what's needed.

Telehealth services, health apps and internet-based symptom-checkers are already emerging as key enablers. These services can be available online 24/7 and are an alternative to visiting the GP or emergency department for non-life-threatening illness. There are simply more resources available to people seeking health information than ever before.

High quality, safe community-based services will also develop in tandem. It's all designed to enable everyone, but especially older Australians, to stay at home longer and delay or avoid entry to hospital or residential aged care.

Our health system *will* evolve

Looking ahead, and with the benefit of rigorous and insightful research from both here and overseas, we can say with confidence that our health system will evolve, and it will be shaped to a considerable degree by the four trends I have outlined. It will be guided by people working in the system who care deeply about each other, their patients, the service they provide and the broader community. Most importantly, the leaders of this new caring system of the future will love new knowledge, and continuous improvement. It's the only way for it all to work out well in the end. ha

Photo by Joshua Sortino

NICK STEELE
Deputy Director-General, Healthcare Purchasing and System Performance, Queensland Department of Health

Delivering what matters

Better value care for Queenslanders.

The Rapid Results Program is changing how we transform healthcare across Queensland

The Queensland Health Rapid Results Program is a whole-of-system suite of projects focusing on prevention, value, culture and access, to deliver better health services and improved outcomes for Queenslanders. Queensland Health's vision is to make Queensland's population among the healthiest in the world.

The Program uses a collaborative and innovative approach to identify, co-design and implement solutions, involving the people who know the health system best—clinicians and consumers—as well as hospital and health system leaders, and industry experts.

Innovative projects are being accelerated and scaled across the system to achieve benefits sooner, both now and into the future.

'The Rapid Results Program is showing that rapid changes can be made when you put the right people and a reasonable amount of resources together'—Martin Chambers, Consumer

'We've had consumers involved in a lot of our planning. I think it's absolutely central. They bring to the table a lived experience, identifying problems that perhaps clinicians don't see and really help inform service design.'
—Ed Heffernan, Director, Queensland Forensic Mental Health Service

Delivering what matters to Queenslanders—the right care, at the right place, at the right time

The 'Right care, right place, right time' Rapid Results Area has a focus on initiatives that deliver outcomes that matter to Queenslanders.

For example, the *Frail and Older Persons Collaborative* has implemented Specialist Residential Aged Care Facility Support Services across Queensland that will improve care options for frail older persons across the state.

Financial savings delivered through better value for money procurement of cardiac prosthetics will support the sustainability of front-line services in Queensland.

Consumers with chronic renal conditions will be able to receive care closer to home through services designed and implemented through the *Advancing Kidney Care Collaborative*.

The health system will be able to be more responsive to what really matters to patients through implementation of a statewide patient-reported outcome measures and patient-reported experience measures solution.

These are just a few examples of the Rapid Results projects underway.

'The involvement of consumers has been quite extraordinary really. It's been a true partnership. It's been lovely to see change in the conversation when you have consumers at the table helping make those decisions.'
—Linda Patat, Health Service Chief Executive, South West Hospital and Health Service

Leveraging clinical and consumer leadership to drive rapid change

At the core of this program is clinician and consumer engagement and co-design—it is imperative to success. This collaborative and transformative approach runs deep across these projects, with not only input from the leaders of the system but from members of the public, who understand the impact this change can have on their lives.

'Consumer engagement is extremely important. If you want to deliver the best health service that delivers the best outcome and the best value, then you need to effectively ask your customers which is your health consumer. And if you involve them at all stages, especially early on, you're going to get a better outcome that delivers what your patients and their families need.'
—Keren Pointon, Consumer

'Collaboration can lead to much higher levels of trust and you need the trust to be able to be successful in implementing any program.'
—Martin Chambers, Consumer

Dr Catherine McDougal, Deputy Director of Orthopaedics, The Prince Charles Hospital, Metro North Hospital and Health Service, facilitating a recent co-design workshop with consumers, clinicians, hospital and health system leadership and industry experts

Clinical leadership and data-driven decision-making in orthopaedics

Queensland Health is enabling a clinician-and-consumer-led, data-driven approach to accelerate this process. This is particularly evident in Getting It Right First Time Queensland (GIRFT Qld).

GIRFT Qld is focused on identifying and addressing system-level barriers to optimise value in orthopaedic care for consumers, clinicians, and the broader health system. The program is focused on leveraging data to drive peer-to-peer conversations among orthopaedic clinicians to understand variation and identify opportunities to improve patient experience, and clinical and system outcomes.

Using a peer-to-peer review methodology, clinicians are developing bespoke action plans that target local opportunities to deliver better value health services. Supporting the identification of best practice, exemplar service models in Queensland will inform a quality framework to support clinicians to continually deliver high quality services by understanding variations in care.

'We are about providing care to people in their home, close to their home, in the community, close to hospitals, not just in hospitals, that's the big takeaway. It's got to be focused on what patients, consumers and citizens need and want, not just about what medical practitioners and people like me think they should have.'—Prof. Keith McNeil, Assistant Deputy Director-General and Chief Clinical Information Officer, Clinical Excellence Division

Woman with vision

Even though retirement is still far away for Amy, she's actively engaged in making good choices now for her future self.

When Amy entered the workforce in the mid-2000s super was something that was already integral to Australian working culture. "I love that as a young woman, I had an investment portfolio being managed for me through my super, as I navigated my first job. I loved that my involvement in this didn't have to be large, straight off the bat. After all, the world of investment is a daunting thing!" says Amy.

These days, Amy works in medical imaging where she looks at functional issues with the body. "My work is a little-known branch of medical imaging, with 'nuclear' in the title so patients are often in a state of high anxiety when they see me. Patients can be in the department for an hour or more, so I work hard to make this section of healthcare feel safe."

A safe and secure future

Like many healthcare professionals, making people feel safe and secure is of utmost importance to Amy. It's no surprise then that being actively involved in her super is also a high priority for her.

"I have made contributions that attracted the government co-contribution. I currently salary sacrifice extra into my super and I changed my investment to Eco Pool within my first two years of having a HESTA account," says Amy.

"I'm excited to have control over my life when I retire. I don't want my retirement to be determined by money stress, I want it to be full of things I want to explore and enjoy!" says Amy.

Why Amy chose HESTA

Amy has been with HESTA for many years. "HESTA is an industry super fund with a long history in healthcare, they're visible in the community, and I have stayed with them because of the great work HESTA does in advocacy.

"I've always found HESTA easy to deal with, I'm happy with their transparency, and I love reading the HESTA newsletter."

For Amy, retirement is still a long way off. When she's not working she spends her time involved in amateur theatre. "I find so much joy in creating beautiful productions from months of hard work, making connections with people on and off the stage, and in the audience and wider community. I've written, directed, performed, been a committee member and set builder," says Amy.

Advice for other young women

As someone who's got a clear vision of what a secure retirement looks like, Amy is an advocate for other young women to plan ahead. "Get involved early, watch for government co-contribution schemes, think about boosting your super before childbearing years if that's something you're planning and make sure you watch that balance grow for your future. Nobody wants to be without choice upon reaching the end of your working life."

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ELDAC is funded by the Australian Government Department of Health

LANIE HARRIS
Advocacy and Communications, cohealth

A hub for health and housing

Can community health centres be part of a solution to the housing crisis?

If it wasn't for cohealth, thousands of vulnerable Victorians would struggle to afford healthcare, including the elderly, migrants, people in unstable housing and the unemployed.

Community health services have long cared for people facing disadvantage, but a groundbreaking proposal in Victoria could see them also tackling one of the most significant 'upstream' drivers of poor health—poor housing.

In a joint proposal, two of Victoria's leading not-for-profits are lobbying the Victorian Government for funding to bring community health and social housing together under one roof.

Cohealth—a community health service, and Unison Housing—a social housing provider, have outlined their vision for a 'health and housing hub' based in Collingwood in Melbourne's inner north.

The benefits of co-locating community health services and low-cost housing

'We know that people in insecure housing or experiencing homelessness are more likely to suffer from poor health. And the perverse cycle continues because people with high health needs are more likely to be living in substandard accommodation, or at risk of homelessness,' says cohealth's Interim Chief Executive Nicole Bartholomeusz.

'Our idea is to create a "supercharged" health centre complete with health and social services on the ground floor and build social and affordable housing above.

'We have a unique opportunity to partner with a community housing organisation to tackle two significant social problems.'

The housing crisis is hurting the health of vulnerable people

As housing affordability in Australia worsens, and household wealth between rich and poor widens, community health services such as cohealth are seeing the impacts of poor housing on vulnerable clients.

'People living in substandard rooming houses, families in severely overcrowded homes, young people sleeping in their cars—these are all situations that we can see are having a marked negative impact on individuals' health', said Ms Bartholomeusz.

'The dots have been joined between poverty, housing and poor health for a very long time, >

cohealth's current community health clinic at 365 Hoddle Street Collingwood Victoria, an ageing clinic which supports around 12,000 clients every year.

“After 50 years of operation the clinic is in urgent need of an overhaul. A rising local population and growing demand from increasingly complex clients means 365 is currently struggling to meet local community needs.”

as well as the knowledge that we can prevent many illnesses by addressing the social determinants of health rather than paying for expensive hospital care.

‘More than 190,000 Australians are waiting for social housing—so using space above a new health centre to boost housing stock makes a lot of sense.’

Secure housing as part of health treatment

cohealth says the proposed health and housing hub would allow the elderly and other disadvantaged people with high health needs to live close to the health services they need.

cohealth and Unison’s proposed hub would include a range of services such as general practice, community nursing, chronic disease specialists, physiotherapy, pharmacy, dietetics, family violence support, alcohol and drug services, and housing support, all working in an integrated way.

‘By co-locating housing with primary healthcare in this way we can have a community hub centred on the whole person’, said Ms Bartholomeusz.

‘Imagine health practitioners being able go upstairs to do a home visit or check on a client who has missed an appointment!’

Hubs could reduce isolation and loneliness

Isolation and loneliness are emerging as serious health-related problems, particularly for older people who are living longer and living alone in their later years. Health and housing hubs could be part of the solution.

Australia is increasingly moving toward ‘hub’ models of care. Already there are examples of co-location of low-cost housing for families alongside services that they’ll need, such as childcare—but we’ve yet to see community health services and housing co-located.

International evidence

In 2010, the US Department of Housing and Urban Development released a report that strongly recommended the co-location of health services and housing. The report found that when housing was combined with appropriate services, practitioners reported residents experiencing better outcomes across health, quality of life, education, and self-sufficiency.

The report also found that these benefits can translate directly into public cost savings due to reduced reliance on emergency services

50-year-old clinic could be part of the solution

The 1,700 m2 site of the proposed development is in a prime location at 365 Hoddle Street, Collingwood, and is currently home to cohealth’s ageing community health centre (known as ‘365’).

Nearly 12,000 people each year use the 365 centre—a 30% rise in numbers is expected by 2031.

After 50 years of operation the clinic is in urgent need of an overhaul. A rising local population and growing demand from increasingly complex clients means 365 is currently struggling to meet local community needs.

Cohealth and Unison are currently seeking funding for their health and housing hub proposal from the Victorian Government across several portfolios, including Housing, Health, Ageing, Mental Health and Women. ha

ROBIN WHYTE
Chief Executive Officer,
Eastern Melbourne
Primary Health Network

Community-based Integrated Diabetes Education and Assessment Service

Changing lives—closer to home

Every day, 280 Australians develop diabetes (85% of which is type 2 diabetes). According to Diabetes Australia, the total annual cost impact of diabetes in Australia is $14.6 billion.

Complications from diabetes can include blindness, amputations, and cardiovascular disease—Australia’s number one killer.

These complications can take an enormous toll on people and their carers, impacting ability to live well and participate in their communities.

With rates of type 2 diabetes increasing, in 2017 Eastern Melbourne Primary Health Network (EMPHN) considered initiatives that could evolve and be expanded to areas within our community that had high rates of type 2 diabetes.

Changing how services are delivered

The Integrated Diabetes Education and Assessment Service was developed by Carrington Health and Eastern Health’s Endocrinology Department in 2008.

IDEAS aims to provide effective, integrated, team-based multidisciplinary diabetes care, as well as providing a response to existing and pending financial pressures and increasing waitlists for hospital diabetes services.

Eastern Health’s Professor Chris Gilfillan said there is an imperative to treat people in a community rather than hospital setting, closer to home, with a care team they can build rapport with. >

“It’s important for people to be involved in decisions about their health—it makes a real difference to people changing their lifestyle and managing their diabetes.”

‘The specialised care team at IDEAS aims to support people to better manage their diabetes, prevent complications and reduce the need for hospitalisation. It’s an example of how partnerships can change the way services have historically been delivered, diverting care from an outpatient to a community-based service that’s effective and accessible’, he said.

The IDEAS team includes:

- Eastern Health endocrinologists (doctors who specialise in diabetes care)
- diabetes nurse educators
- community health nurses
- podiatrists
- referrals to dietitians and other group programs and health services.

The team coordinates care in a seamless and continuous manner, using a person-centred approach to tailor healthcare to individual needs.

IDEAS uses:

- standardised risk assessment tools to direct people with diabetes to the most appropriate setting for care, with many people redirected into IDEAS within the community (it may also involve escalation of care from the community into Eastern Health)
- a common assessment form used by all team members, including the short form of the PAID (Problem Areas in Diabetes—a standardised and validated tool)
- a common care plan to document the person’s goals, the practitioners involved in their care, and progress towards their goals.

With funding from the Australian Government under the PHN program, EMPHN supported the expansion of IDEAS to six community health organisations, including Carrington Health, EACH (Eastern Access Community Health), Access Health and Community, Eastern Health and Inspiro.

A successful model

A pilot study evaluating the IDEAS model of care showed participants attending IDEAS rated the quality of diabetes care they received more highly than did participants attending the hospital outpatient clinics.

In particular, IDEAS participants perceived they received more consistent advice from their health professionals, and found it easier to make appointments (and therefore gain access to their health professionals) than did hospital participants.

Previous research has shown that people with diabetes have strong views about what constitutes quality diabetes care, and that positive evaluations of quality of care are associated with improved diabetes outcomes such as fewer treatment-related problems and diabetes complications.

Outcomes from IDEAS include:

- IDEAS operating within three acute/subacute settings at six community health service sites
- 1194 referrals received—737 from GPs, and 1170 individuals seen (since expansion)
- mean reduction in HbA1c of 1.16 percentage points (overall picture of average blood sugar levels over a period of weeks/months) after six months for people starting with HbA1c greater than 7%—demonstrating that IDEAS is effective at supporting people to manage and lower their blood sugar levels
- 94.2% of people reported good, very good or excellent experiences with IDEAS
- reduction in levels of diabetes distress
- improved sense of self-efficacy
- IDEAS attendance delayed median time to readmission for people admitted from 85 to 260 days.

At the IDEAS clinic Lilydale launch: Carina Martin, Carrington Health; Sue Sestan, Inspiro; Tony Stevenson, Yarra Ranges Mayor; Hon. Tony Smith MP, Federal Member for Casey; Robin Whyte, Eastern Melbourne PHN; and Dr Chris Gilfillan, Eastern Health.

According to Carina Martin (General Manager Partnerships and Service Development, Carrington Health), fostering engagement with the service, and ensuring people with diabetes have a positive experience, need to be priorities in diabetes healthcare.

‘It’s important for people to be involved in decisions about their health—it makes a real difference to people changing their lifestyle and managing their diabetes’, she said.

Positive experiences

Developing and improving the service in response to client experience has been key.

Although IDEAS involves specialist care and monitoring, many service users talk about understanding what they need to do to avoid complications and feel confident in managing their diabetes—for example, through care plans:

‘The dietitian asked me questions and then I wrote down what I was going to do on the care plan. We did it together and I did feel that it was my care plan—I felt some ownership of it.’

People attending IDEAS report being engaged with the service—they feel supported, see their role in managing their condition, make (multiple) behaviour changes, and have lower levels of worry and higher levels of satisfaction through being listened to and involved in decisions.

‘I worry less because they help me solve issues, provide reassurance and give me hope. I am making much better choices.

‘They have also referred me to other services such as the psychologist that has really helped me deal with anxiety and depression.’ ha

Inefficiencies in cancer care

Survey puts spotlight on patient insights
All.Can Australia

The All.Can survey

All.Can—a cancer collaboration dedicated to tackling inefficiency in cancer care across 13 countries—has released the results of new research that puts the spotlight on potential waste and inefficiencies experienced by cancer patients around diagnosis, treatment, psychological support and medical costs.

International and local insights point to crucial opportunities to improve outcomes and experiences for Australians diagnosed with cancer.

The research was coordinated by the Australian chapter of All.Can, which has been operating locally since 2018. It represents the first opportunity to compare the lived experience of Australians with cancer to that of patients in 10 other countries.

The All.Can Australia Steering Committee comprises 15 representatives from cancer organisations, patient advocacy groups, the biopharmaceutical industry, oncologists, nurses, pharmacists, hospitals, health economists, universities and health insurance. *[AHHA is represented on this Committee—Ed.]*

All.Can defines inefficiency in cancer care as anything that does not focus on what matters most to patients. All.Can Australia is focused on ensuring funding and resources are directed to solutions that support patient-centred care. The international All.Can patient survey was used to understand key areas of inefficiency and potential opportunities for improving cancer care from the patient perspective.

Survey findings

COMMON CONCERNS

There were 850 Australians affected by cancer who participated in the global survey, which revealed key insights about their experiences with diagnosis, treatment, support and out-of-pocket costs—see the snapshot below.

Experiences of Australians with cancer

- Australians with cancer said delays in initial diagnosis and managing ongoing side-effects were the biggest causes of inefficiency.
- One in eight respondents (12%) whose cancer was detected outside of a screening program waited over six months to be diagnosed.
- 50% of respondents reported not receiving enough support to deal with ongoing symptoms and side-effects during and after treatment.
- 41% of respondents reported not receiving enough understandable information about signs and symptoms that could indicate that their cancer might be returning or getting worse.
- 79% of cancer patients reported out-of-pocket costs and 32% reported travel costs
- 77% of respondents said they were not asked to be part of a clinical trial, while 86% said they would like to have had the opportunity.

A key similarity among all countries participating was that patients named 'diagnosis' as the most inefficient area.

Apart from accuracy and speed, sensitive communication of diagnosis is crucial. Respondents reported lack of empathy and poor timing, such as being told they had cancer on a Friday night and would have to wait until the following week for any further information.

Another common area of concern was the need for psychological support. In Australia, 64% of respondents reported that they needed some sort of psychological support during or after their cancer care; however, 35% said it was not available. Among international survey respondents, 69% said they needed psychological support.

> *'I think the psychological involvement part is forgotten. It is true that the main thing is to survive, but it is also necessary to feel accompanied and understood'*—Respondent from Spain

KEYS TO IMPROVEMENT

Professor John Zalcberg, Co-Chair of the All.Can Australia Steering Committee, Head of the Cancer Research Program at Monash University and a consultant medical oncologist at Alfred Health, said feedback from the global survey highlighted the need to look at why people are experiencing delays during their 'diagnosis' phase.

'This was a major inefficiency across all involved countries, with impacts on a patient's understanding of their condition, treatment options and outcomes', Professor Zalcberg said.

'These data also show how we can best support patients during their cancer care. For example, around one-quarter of respondents (28%) said they were not provided with enough understandable information about their cancer care and treatment, and 35% did not feel involved enough around decisions regarding their treatment.

'We also can't ignore the gap between wanting and receiving psychological support, experienced by such a large proportion of patients, both in Australia and around the world.'

Richard Vines, Chief Executive Officer of Rare Cancers Australia and also a Co-Chair of the All.Can Australia Steering Committee, said maximising resources while minimising inefficiencies in cancer care was obviously crucial to driving better patient experiences in the longer term.

'We think there are four key improvement areas based on the responses to the survey:

- Ensure swift, accurate and appropriately-delivered diagnoses—how and when diagnoses are made can affect patient perceptions of the whole care journey
- Improve information-sharing, support and shared decision-making at appropriate points along the care pathway
- Make integrated multidisciplinary care a reality for all patients—many feel they don't get it
- Address the financial impacts of cancer—they can last well beyond the duration of the disease.'

What's next?

Now that we have gathered these insights from thousands of patients, we want them to be heard by those in a position to make positive changes. We will be taking the survey findings to policy-makers and advocating that in order to truly deliver cancer care focused on what matters to patients, we must consider these patient insights alongside economic and clinical data. ha

AHHA is a member of the All.Can Australia Steering Committee—contact Alison Verhoeven on 02 6162 0780 for more information.

Those wishing to stay updated on All.Can news in Australia are encouraged to follow @AllCanAustralia or the global @AllCanGroup on Twitter.

For more information about the All.Can initiative in Australia, visit www.all-can.org/national-initiatives/australia/

PROFESSOR ADRIAN BARNETT
Principal Research Fellow, Australian Centre for Health Services Innovation (AusHSI), Queensland University of Technology (QUT)

MS ALISON FARRINGTON
Research Project Manager, AusHSI, QUT

When are medicine and technology not enough?

Advances in medicine are important. They mean that health care professionals can prolong life and cure disease. Who doesn't want access to the latest technology and cutting-edge practice for themselves and their families?

However, some procedures, investigations or treatments have a low chance of providing tangible benefit to some patients, especially older patients at the end of their lives[1].

Australia's healthcare system is dealing with an ageing population, with more people living with frailty and physical and cognitive disabilities, and rates of hospitalisation for those older-aged patients increasing[2]. Further, dying in Australia is becoming increasingly institutionalised and medicalised, with more than one-half of Australians now dying in hospital.

Most people don't think much about the end of-life phase, whether their own, or someone they care for or may care for in the future. They are unlikely while fit and healthy to wonder if they will be one of the 50% of people who die in hospital, or whether they will be in the one-third of patients estimated globally to receive non-beneficial treatment at the end-of-life[3].

Few people contemplate if it will be someone they know who, according to a recent study, will be in the 12% of older-age Queensland patients who experience up to 15 days of non-beneficial treatment or up to 5 days in the Intensive Care Unit in their final hospitalisation[4].

Caring for this older-aged patient population in acute care settings is a challenging area of practice for clinicians. It can be harder to stop or withdraw treatment than to just continue, even if the outcome does not always benefit the patient.

Barriers in transitioning to a less active treatment pathway include: the characteristics of treating doctors (for example, their orientation towards curative treatment, discomfort or inexperience with death and dying, concerns about legal risk, and communication skills); requests for further treatment by patients or their families which can include requests to 'please keep dad alive long enough to attend his granddaughter's wedding'; and hospital factors (including a high degree of specialisation and organisational barriers to diverting a patient from a curative to a palliative pathway)[5,6].

There is a need for interventions to support clinicians to provide patients with care and treatment appropriate to the individual at the end of their life.

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The InterACT study: An intervention to promote appropriate care and treatment

In 2020–2021, a Queensland University of Technology team will trial an intervention to promote appropriate care and treatment towards the end of life in three large Queensland hospitals. The study will use two validated tools to prospectively identify elderly patients who are at-risk for receiving non-beneficial treatment at the end of their lives.

The intervention will provide a prompt to treating clinicians to raise their awareness of the risk profile of their older patients, aiming to improve the capacity of those clinicians to promote better end-of-life care for vulnerable older patients.

Each hospital will engage an executive advisory group, providing support for clinicians and enabling the intervention to be tailored to local policies, workflows and context. The study will examine the impact on patient outcomes, healthcare resource use and costs. It will also evaluate the sustainability and adaptability of the intervention in other hospitals and healthcare settings.

The InterACT study aims to improve outcomes for those patients where the most beneficial care requires a focus on quality of life, patient comfort and patient wishes, and the acceptance of a non-curative or non-active treatment pathway.

The InterACT study is led by the Australian Centre for Health Services Innovation and the Australian Centre for Health Law Research—QUT, in partnership with Metro North Hospital and Health Service, Gold Coast Hospital and Health Service, Palliative Care Australia and the Deeble Institute for Health Policy Research at the Australian Healthcare and Hospitals Association.

InterACT is funded by a National Health and Medical Research Council Partnership Grant.

More information: Please visit the AusHSI website at www.aushsi.org.au/.

Evaluating person-centred care in primary health care

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In response to the National Health Reform Agenda and in line with international evidence, Brisbane South PHN has introduced their model for Person-Centred Care. The model informs how Brisbane South PHN commissions and strengthens primary health to transform care, in keeping with Person-Centred Care principles (see Figure 1).

The Person-Centred Care model (see Figure 2) considers the broad needs of the person, in the context of their environment and encompassed by an integrated system of health and social support structures.

The challenge

Person-Centred Care is increasingly a focus of high performing health systems and services, but comprehensive implementation and evaluation is a challenge.

Brisbane South PHN sought to develop an evaluation framework to measure the impact and effectiveness of its Person-Centred Care Model initiatives. The framework had to be:

- **Responsive**—provides meaningful information in a timely manner, promoting responsiveness to findings and guarding against negative consequences.
- **Practical**—requires minimal data collection burden for providers, and consumers (recognising the busy operating environment of healthcare providers, including general practice), offers direct value for these stakeholders, and can be adapted as the program evolves.
- **Reliable**—able to report and communicate findings in a way that guards against misconceptions, biases, distortions and errors.
- **Relevant**—in the operating context of the Primary Health Networks program, including outcomes defined by the Quadruple Aim in healthcare (see Figure 3), the PHN Performance and Quality Framework, and underpinned by the principles of Person-Centred Care.

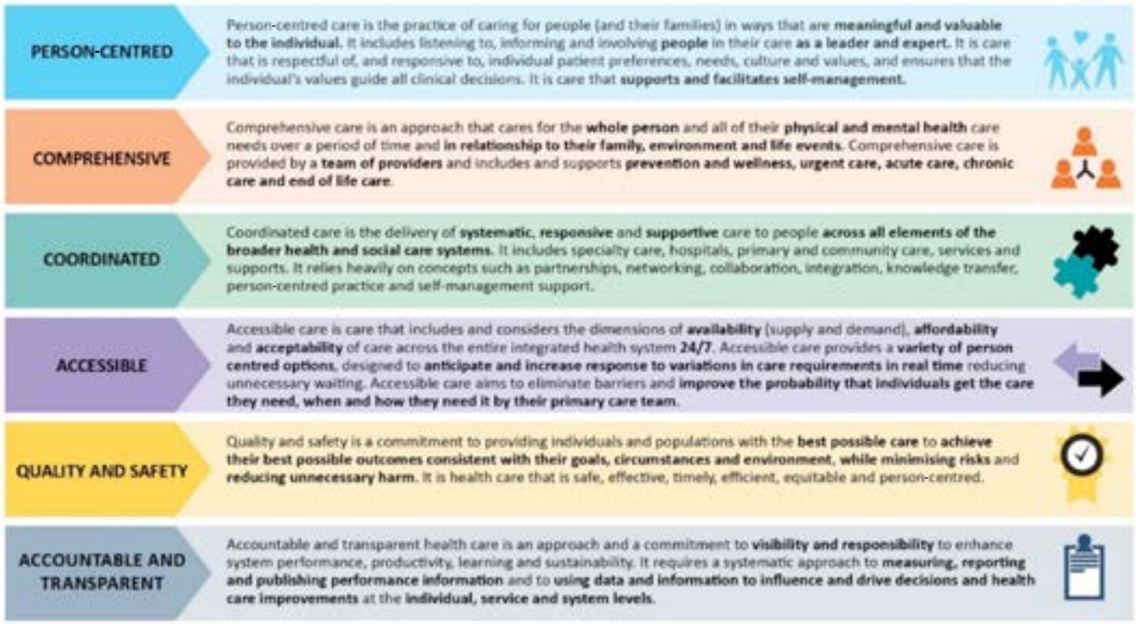


Figure 1: Person-Centred Care principles

Models of integrated care seek to create value by reducing fragmentation and coordinating health and social services to meet people's complex care needs. Such initiatives are often designed and implemented in complex adaptive environments characterised by imperfect information, changing policy agendas, and often target a range of stakeholder groups. A strong focus on formative evaluation is needed when implementing programs in such a context, supporting ongoing learning and iterative adaptation. Development of the evaluation framework drew on international and local evidence and experience (particularly that of health consumers, primary care providers and hospital services).

Multiple activities are delivered or commissioned by Brisbane South PHN based on the Person-Centred Care model. Consequently, evaluation approaches need to assess the impact, effectiveness and reach of programs both individually and collectively across the PHN. >

Figure 2: Brisbane South PHN's model of Person-Centred Care

'GPs, their teams and other service providers are busy. Data collection should not add to the burden of work, and ideally have inherent value for both providers and consumers. Any data we collect must be used to action quality improvement at the service level, and demonstrate outcomes from participating in the model.'—Anthony Elliott, Program Manager Primary Health Innovation and Integration

The result

Brisbane South PHN, with the Australian Healthcare and Hospitals Association, developed an evaluation framework (email pccc@bsphn.org.au for more information) that combines components of the:

- Quadruple Aim in healthcare (improved health outcomes, patient experience, provider experience, and cost efficiency/sustainability)
- PHN Program Performance and Quality Framework
- Patient-Centred Medical Home model
- Brisbane South PHN's Person-Centred Care model and related initiatives (see Figure 2).
-

The initial evaluation framework encompasses two specific initiatives:

1. Person-Centred Care Practices initiative
2. Care Coordination Service for adults with chronic disease.

The framework has been designed to enable other initiatives and activities to be added over time (see Figure 4).

Indicators were identified for monitoring trends in Quadruple Aim outcomes, as they relate to the Person-Centred Care model. These are drawn from established data sources, including routinely collected and reported data at the state, PHN, SA3 and general practice level. Indicators at a service level are also collected routinely by Brisbane South PHN.

As part of the evaluation framework, Brisbane South PHN also developed the *PCC-PA (Person Centred Care Practice Assessment)*, a brief survey tool based on Patient-Centred Medical Home Change Concepts. The PCC-PA was validated with general practice teams, and a variation analysis was conducted against the PCMH-A (Patient-Centred Medical Home Self-Assessment).

Figure 3: The Quadruple Aim in healthcare

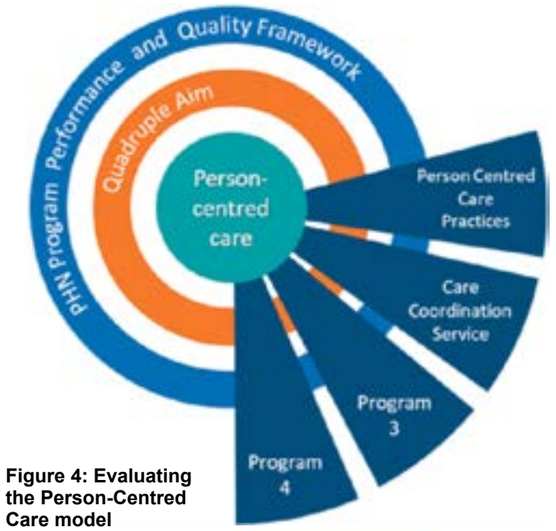


Figure 4: Evaluating the Person-Centred Care model

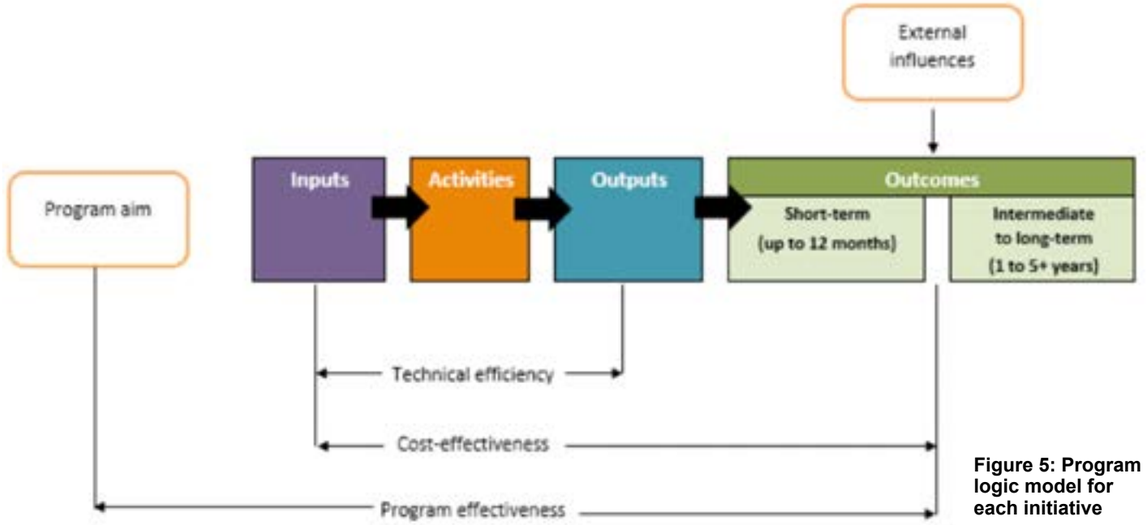


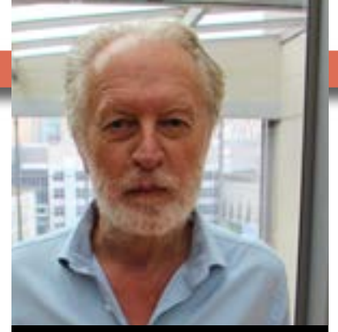
Figure 5: Program logic model for each initiative

A program logic model guides the evaluation of each program as a systematic way of determining the relationship between inputs, activities, outputs and outcomes (see Figure 5). Process, output and outcome measures gathered from quantitative and qualitative data are identified in the framework.

The structure of the evaluation framework also supports refinements to indicators and measures to be considered concurrently. The framework has been designed to enable iteration and adaptation based on the principles of quality improvement and action research.

'We are committed to our vision of "Better System, Better Health". Evaluation is an important part of our work—determining what works well and what can be improved, to ensure we are meeting our goals. This evaluation framework sets us up with a systematic mechanism for understanding how what we do is making a difference to people's lives.'— Sharon Sweeney, General Manager Primary Health

The Person-Centred Care Evaluation framework is currently being implemented by Brisbane South PHN. ha



ASSOCIATE PROFESSOR ROGER DUNSTON
University of Technology, Sydney

ASSOCIATE PROFESSOR MONICA MORAN
University of Western Australia

PROFESSOR GARY ROGERS
Griffith University

Interprofessional education for collaborative practice

Helping to meet current and future healthcare needs.

Interprofessional education (IPE) involves students or practitioners from different health professions learning with, from and about each other in order to improve collaboration and the quality of health services.

Healthcare and health promotion are becoming more complex in the face of an ageing population, multiple morbidity and increasing recognition of the social and environmental determinants of health. Consequently, effective collaboration between the health professions has never been more important.

A 12-year cycle of research and development in Australian interprofessional education known as the SIF Project (Securing an interprofessional future for Australian health professional education and practice), has recently concluded (see https://sifproject.com/).

The project has charted the evolution of IPE's:

- increasingly recognised importance
- place within the curriculum
- increasing prominence in national accreditation
- national governance.

These evolutionary changes have positioned Australia as a global leader in IPE. Four corresponding major developments are set out below

Development 1: Rethinking the place and contribution of IPE—the formation of a national consensus

IPE and interprofessional collaborative practice (IPCP) used to exist on the margins of health professional education and health practice. They are now positioned centre-stage, globally and nationally.

High quality IPE for health students is now recognised as essential to ensure that all members of Australia's health workforce have the capabilities needed for collaborative practice in addition to practice capabilities specific to their own particular profession.

It has also become clear that systemic and skilful collaboration among all health professionals, as a consequence of effective IPE, will impact positively on some of the country's most complex and persistent health problems, including: patient safety in acute care; mental health issues; disability, chronic disease and multiple morbidity in an ageing population; the 'gap' between First Peoples' health outcomes and those of non-Indigenous Australians; and the health inequity experienced by rural and remote populations.

There is now a national consensus around the importance, value and necessity of IPE and IPCP as core elements of Australian health and higher education. A recent example of this consensus can be seen in the Final Report of the Council of Australian Governments' Independent Accreditation Systems Review within the National Registration Scheme for health professions, *Australia's Health Workforce: strengthening the education foundation*, released in November 2017:

> *… there is sufficient robust evidence and cross-sector support for the inclusion of a standardised approach to IPE within accreditation standards that reflects an agreed definition and focuses on the achievement of learning outcomes related to patient-centred, comprehensive care. (p. 86)*

Development 2: Building an integrated uni-professional and interprofessional curriculum

The changes noted above have generated increasing calls for Australian health professional education to expand its focus from primarily educating students for uni-professional practice to preparing all students for both uni-professional and interprofessional practice. This is changing how we understand working together, and learning with and from each other.

It is now recognised that many curriculum activities can be used to develop collaborative as well as uni-professional capabilities. Consequently, our ideas about the nature of effective professional practice and learning are also being expanded and transformed.

Development 3: Acting to adopt IPE and IPCP as part of all national and local accreditation

One of the major challenges facing the further development of Australian IPE and IPCP is the need for interprofessional practice and education standards to be collectively adopted as part of all accreditation systems for both health professional education programs and for health services.

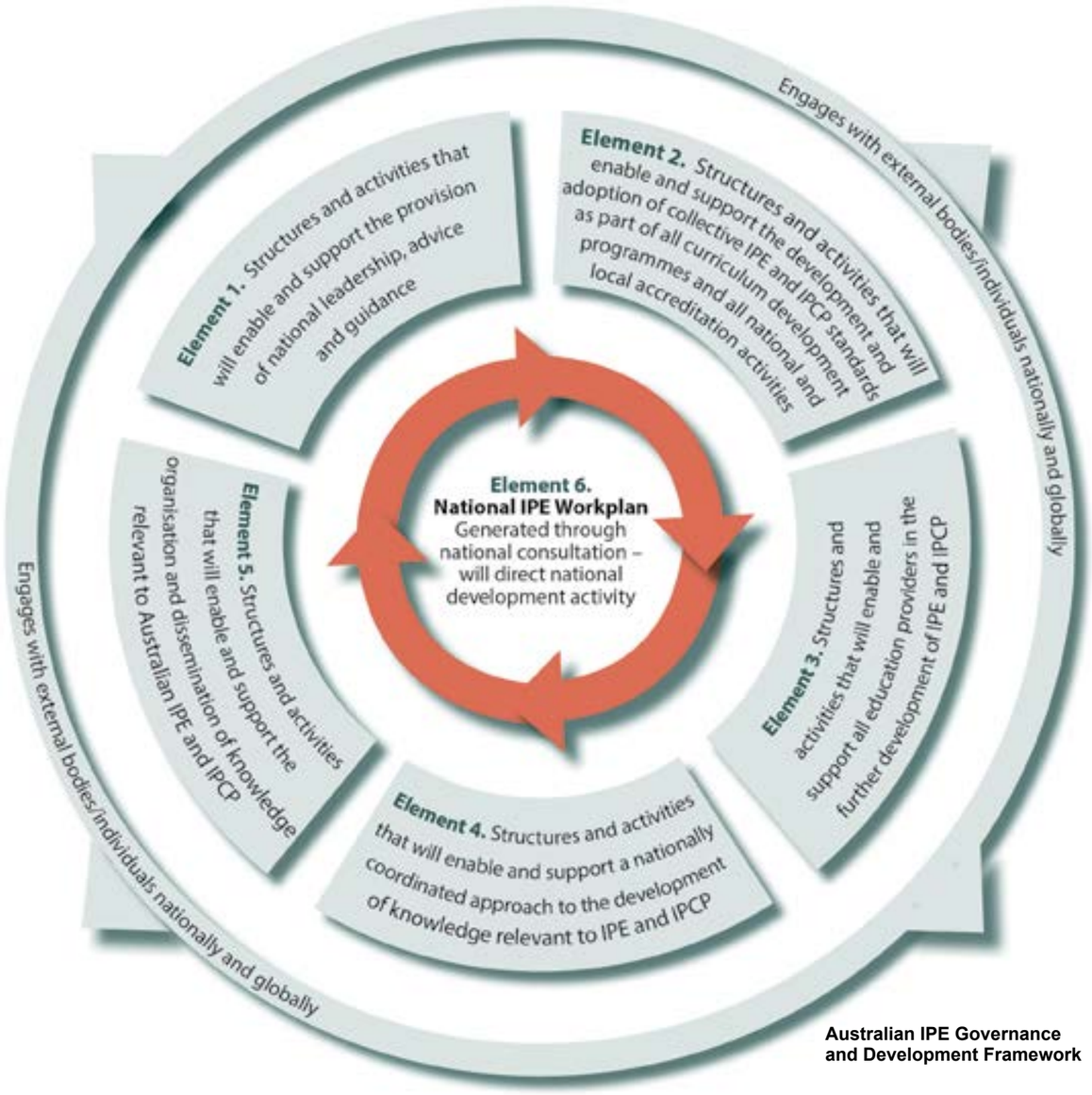
Achieving this outcome would confirm, embed and further support the development of Australian IPE for IPCP.

Although the accreditation question remains a matter in discussion, there is a strong national momentum building to make this happen.

Development 4: National IPE leadership and governance—the next step

What has also become increasingly clear is that the development of system-wide IPE will not be possible without national and local structures and activities that serve to bring stakeholders together and lead, advise and build Australian IPE and IPCP capability.

The Federal Department of Education funded the SIF Project to lead and develop a whole-of-system approach to Australian IPE, including establishing national IPE governance. >



Australian IPE Governance and Development Framework

The following four national peak bodies have agreed to work together as a 'Collaborating Organisations' group to achieve this end:

- Australian Healthcare and Hospitals Association
- Consumers Health Forum of Australia
- Australian Health Practitioner Regulation Agency
- Australian and New Zealand Association for Health Professional Educators.

The Collaborating Organisations will support the establishment and operation of an Australian Interprofessional Education for Collaborative Practice Advisory Group. The Advisory Group will provide leadership and guidance to enable the further development of Australian IPE and IPCP as system-wide, coordinated and collective endeavours.

This work will align with the Australian IPE Governance and Development Framework (see illustration), which was developed through the SIF Project in consultation with partners and stakeholders. ha

PROFESSOR SONJ Ê HALL
Editor-in-Chief, Australian Health Review

Four new Associate Editors join *Australian Health Review* editorial team

2019—a big year for AHR

This has been a big year for *Australian Health Review*, the peer-reviewed journal of the Australian Healthcare and Hospitals Association.

Most recently four new Associate Editors have joined the team—Robert Borotkanics, Kim Dalziel, Odette Pearson, and Ben White—who are profiled below.

The associate editors join a refreshed 11-member Editorial Advisory Board, also listed on these pages.

One of the well-received innovations introduced this year has been our new 'Policy Thinking' piece in each issue. These reflections by eminent academics are designed to be provocative, and question where health policy is—or should be—going.

Professor Christobel Saunders AO wrote the inaugural piece on value-based care, followed by Professor Ian Hickie on structural reform in mental health.

In our latest issue (October 2019) the focus is again value-based healthcare, with a feature piece by Dr Sally Lewis from NHS Wales, 'Value-based healthcare—meeting the evolving needs of our population'.

For many years, the journal has prioritised articles on Aboriginal and Torres Strait Islander populations.

We are delighted that three Aboriginal and Torres Strait Islander Australians are on the AHR editorial team—Dr Odette Pearson as an Associate Editor, together with Professor Roianne West and Dr Chris Bourke on our Editorial Advisory Board.

Australian Health Review

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Luca Casali, Queensland University of Technology
Ann Dadich, School of Business, Western Sydney University
Ben White, Faculty of Law, Queensland University of Technology
Odette Pearson, South Australian Health and Medical Research Institute >

"For many years, the journal has prioritised articles on Aboriginal and Torres Strait Islander populations. We are delighted that three Aboriginal and Torres Strait Islander Australians are on the *AHR* editorial team..."

NEW ASSOCIATE EDITORS

ROBERT BOROTKANICS is currently a Senior Research Fellow at the Auckland University of Technology in New Zealand. He is the lead statistician on a number of clinical trials and health services research studies, including multiple international trials in the United States and Australia. Robert served in the civil service at the US Agency for Healthcare Research and Quality, was project officer for the US Institute of Medicine report, *Patient Safety: Achieving a New Standard for Care*, and is a former Guest Researcher at the US National Institutes of Health, within the National Institutes of Health's National Institute on Alcohol Abuse and Alcoholism. He was also a US National Institutes of Health Informatics Research Fellow. Robert completed his PhD at John Hopkins Bloomberg School of Public Health.

'AHR is a perfect venue for health services researchers, policy-makers and health managers to share knowledge and debate policy approaches and to share knowledge on successful quality implementations. In this way, we make a unique contribution to strengthening Australian, New Zealand and the larger Oceania health systems. I am excited about being a part of the unique AHR *nexus and its role in contributing to improving the standard of care across the region.'*

KIM DALZIEL is Associate Professor in the School of Population and Global Health and Deputy Director of the Health Economics Unit at the University of Melbourne. In 2018 she completed a year as Harkness Fellow in Health Care Policy and Practice at Michigan University.

Kim specialises in economic evaluation and health services research in the area of child health, with a particular interest in health equity and supportive health policy to improve the health of vulnerable populations. She was awarded a McKenzie Post-Doctoral Fellowship and an Australian Health Services Research and Policy Fellowship, and has held previous academic positions at the University of South Australia, Monash University, and Exeter University (UK).

'I am delighted to be joining AHR *as an Associate Editor and feel a great affinity for the journal. Australia has enormous potential in terms of future health policy innovation and reform to both strengthen our health system and provide international leadership.* AHR *provides a critical platform for showcasing leading Australian health policy research and I look forward to playing a small role in bringing this research and perspective to light.'*

ODETTE PEARSON, who is of far north Queensland eastern Kuku Yalanji and Torres Strait Islander heritage, gained her PhD in Health Economics and Social Policy from the University of South Australia. She is now a Senior Research Fellow at the South Australian Health and Medical Research Institute. Odette's work is strategically aligned with our vision for the AHR as an inclusive place where policy debate challenges ideas. In particular, her work traverses evidence-based policy development, health services research and epidemiology to identify and address health and social strengths and inequities experienced by the Aboriginal and Torres Strait Islander population.

'I believe Australian Health Review *is a valuable platform for researchers to translate findings to Australia's active healthcare providers and influential policy-makers. It provides our healthcare professionals with the most recent and robust evidence and current debate that can inform their practice and decision-making. I am pleased to become a part of the* AHR *community and hope to grow the community's understanding of Aboriginal and Torres Strait Islander health and wellbeing, with the aim of improving outcomes through beneficial healthcare policy and provision.'*

BEN WHITE is a Professor in the Faculty of Law at the Queensland University of Technology, and was a foundation Director of the Australian Centre for Health Law Research (2012-2018).
Ben graduated with first class Honours and a University Medal in Law from QUT and then completed a DPhil at Oxford University on a Rhodes Scholarship. He has also worked as an associate at the Supreme Court, and at Legal Aid Queensland. Between 2005 and 2007 he was appointed as the full-time Commissioner of the Queensland Law Reform Commission. Ben's area of research focus is end-of-life decision-making and his work is interdisciplinary, with publications in law, medicine, bioethics and social science journals. He is undertaking a program of funded research examining end-of-life law, policy and practice through a series of Australian Research Council and NHMRC grants. He is an editor of the leading text *Health Law in Australia* (2018, 3rd ed., Thomson) and an author of the website 'End-of-Life Law in Australia' (https://end-of-life.qut.edu.au/).

'I am delighted to join the editorial team at the Australian Health Review, *and particularly to contribute to the journal's recognition of health law's contribution to the provision of safe and high-quality healthcare.'* ha

Become an AHHA member

Help make a difference on 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 the 'voice of public healthcare'. We have been Australia's independent peak body for public and not-for-profit hospitals and healthcare for over 70 years.

Our vision is a healthy Australia, supported by the best possible healthcare system. AHHA works by bringing perspectives from across the healthcare system together to advocate for effective, accessible, equitable and sustainable healthcare focused on quality outcomes to benefit the whole community.

We build networks, we share ideas, we advocate and we consult. Our advocacy and thought leadership is backed by high quality research, events and courses, consultancy services and our publications.

AHHA is committed to working with all stakeholders from across the health sector and membership is open to any individual or organisation whose aims or activities are connected with one or more of the following:

- the provision of publicly-funded hospital or healthcare services
- the improvement of healthcare
- healthcare education or research
- the supply of goods and services to publicly-funded hospitals or healthcare services.

Membership benefits include:

- capacity to influence health policy
- a voice on national advisory and reference groups
- an avenue to key stakeholders including governments, bureaucracies, media, like-minded organisations and other thought leaders in the health sector
- access to and participation in research through the Deeble Institute for Health Policy Research
- access to networking opportunities, including quality events
- access to education and training services
- access to affordable and credible consultancy services through JustHealth Consultants
- access to publications and sector updates, including:
  -Australian Health Review
  -The Health Advocate
  -Healthcare in Brief
  -Evidence Briefs and Issues Briefs.

To learn about how we can support your organisation to be a more effective, innovative and sustainable part of the Australian health system, talk to us or visit ahha.asn.au/membership.

More about the AHHA

AHHA Board

The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation.

Dr Deborah Cole (*Chair*)
Dental Health Services Victoria

Dr Michael Brydon
University of Notre Dame

Dr Hwee Sin Chong
Darling Downs Health and Hospital Service

Mr Nigel Fidgeon
Australian and New Zealand College of Anaesthetists

Ms Lynelle Hales
Sydney North Primary Health Network

Ms Chris Kane
Western Australia Primary Health Alliance

Dr Keith McDonald
South West Sydney Primary Health Network

Ms Susan McKee
Dental Health Services Victoria

Ms Suzanne Miller
Nexus Primary Health

Ms Joy Savage
Cairns Health and Hospital Service

AHHA National Council

The AHHA National Council oversees our policy development program. The full list of Council members can be found at: ahha.asn.au/governance

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The AHHA is grateful for the support of HESTA Super Fund.

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

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ISSN 2200-8632

Australian Centre for Value-Based Health Care

WHO WE ARE

Established by the Australian Healthcare and Hospitals Association, the Australian Centre for Value-Based Health Care's vision is for a healthy Australia, supported by the best possible health care system.

We will do this by pursing the creation of a system where health care is funded and delivered with a prime focus on outcomes achieved at an affordable cost for patients and the health system.

The Australian Centre for Value-Based Health Care acknowledges the World Economic Forum definition of value:

The health outcomes that matter to patients relative to the resources or costs required.

OUR AIMS

In collaboration with our supporters and partners, the Centre aims to:

- To increase knowledge and understanding of the principles of value-based health care
- To build the skills required to successfully implement value-based health care
- To influence public policy to enable the transition to value-based health care, focused on outcomes and patient-centred models of care and supported by innovative funding models
- To curate and share best practice examples, theory and research on value-based health care
- To be recognised as the Australian thought leadership organisation for value-based health care

COLLABORATE WITH US

The Centre is actively seeking partners and supporters to get involved with our research, events, education and training. We are also actively seeking financial supporters who are able to fund pilots and research. For more information on how your organisation can become an Australian Centre for Value-Based Health Care partner, contact value@ahha.asn.au.