The Health Advocate

Your voice in healthcare

State-by-state oral health initiatives

Big data, health equity, COVID-19

Keeping People out of Hospitals Project

Person-centred care

Oral health; Equity in healthcare

+MORE INSIDE

The official magazine of the Australian Healthcare and Hospitals Association

ISSUE 59 / May 2020

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Cover: pixabay

The Health Advocate

ISSUE 59 / May 2020

ALISON VERHOEVEN
Chief Executive
AHHA

Health equity, value-based health care and COVID-19

Welcome to the May 2020 issue of *The Health Advocate*. Since our last issue, a lot has happened—to say the very least. We, and the world, are now living through the greatest challenge to our health for more than a century.

It's often said that times of crisis, like the current COVID-19 pandemic, reveal the weaknesses in our current systems—we are presented with opportunities to learn and adapt so we are better prepared next time, and not only for pandemics.

Crises can also embolden governments to act quickly and decisively—as the Australian Government has with the expansion of access to telehealth services, expanding the roles of nurses and other health professionals, and brokering a deal with private hospitals to join public hospitals in the COVID-19 fight.

On the other hand, some weaknesses remain that we have known about, talked about and advocated about for some time, but to date are still in the 'too hard' basket.

I would place equity and value in health in that basket.

Universal healthcare, through Medicare, is a much-loved feature of our Australian way of life. It's built on equity principles—every Australian having equal access to quality healthcare based on medical need, not the size of their wallets.

Health statistics tell a different story, however. Some Australians, including Aboriginal and Torres Strait Islander people, people on low incomes and people living in rural areas have worse health and less access to healthcare services.

The impact of health inequities has been starkly highlighted with the onset of the COVID-19 pandemic.

People with chronic disease, experiencing homelessness or sudden income loss, or who are living in remote communities are all at greater risk, not only of COVID-19, but also potentially of poorer long-term health as their living circumstances deteriorate as a result of economic downturn.

Our health system will inevitably undergo major adjustments once the initial emergency response to COVID-19 has passed—but the changes being made now, such as reforms to telehealth services and workforce roles, have the potential to support greater equity and value in the longer term.

In a recent Deeble Institute Issues Brief, *Can value-based health care support health equity?*, we explored equity in the context of value-based health care strategies and health care reforms currently being implemented or considered in Australia.

We recommended factoring the social determinants of health, such as housing, income and employment into our health policy decisions.

We suggested renewed efforts to break

"People with chronic disease, experiencing homelessness or sudden income loss, or who are living in remote communities are all at greater risk, not only of COVID-19, but also potentially of poorer long-term health as their living circumstances deteriorate as a result of economic downturn."

down the silos between departments of health, and community and social services.

We should also be sharing good data and evidence across these three areas and looking for smart ways to achieve better health outcomes and address health disparities.

We also recommended that service design efforts include codesign and patient engagement strategies to promote both value and equity.

And finally we suggested that effort must be focused not only on health services as they are currently delivered, but also on emerging treatments and therapies, to ensure that the benefits of innovation and research investment are realised across the population, not just by those who can afford to pay for these. Otherwise there is a significant risk that Australia's universal health system, which already demonstrates levels of inequity, will be further eroded.

These are tough times and there are a lot of pressing issues out there. But in the end equity in healthcare is not just about better health for Australians—it's about the kind of society we want. ha

The Deeble Institute Issues Brief no. 34, Can value-based care support health equity? is available here.

The Health Advocate

THE HEALTH ADVOCATE GOES QUARTERLY

From May 2020 our member e-magazine, *The Health Advocate*, will be published quarterly instead of every 2 months.

Issues will now be published in February, May, August and November each year.

The current e-pub format will be retained, but there will be more pages, more multimedia content, and up to three topic themes for each issue.

Readers will still be able to download and print *The Health Advocate*; occasionally we may produce professionally printed hard copies for promotional purposes.

AHHA in the news

6 APRIL 2020

GraphicStock

Using the Delphi method to engage stakeholders in these COVID-19 times

As the health sector and researchers seek to adapt to the changing circumstances in which we are now working, new ways of engaging with stakeholders are needed.

An effective methodology that the Australian Healthcare and Hospitals Association (AHHA) has used to engage stakeholders where face-to-face contact is not possible is the Delphi method.

Named after the ancient Oracle of Delphi, the method was originally conceived in 1944 to forecast the impact of technology on warfare. It has been adapted and modified in thousands of ways since.

The method works on the premise that group opinion is more valid than individual opinion. It is especially useful for obtaining and integrating the opinions of a group of expert individuals about a complex problem or issue—particularly where there is incomplete knowledge.

The latest Perspectives Brief from the AHHA's Deeble Institute for Health Policy Research looks at opportunities to conduct health sector consultations when traditional methodologies are not able to be used.

The use of Delphi method for remote consultations discusses considerations when

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

designing engagement activities, including leveraging strengths, mitigating risks, and adapting the method to best meet the purposes of the engagement.

At its core the Delphi method uses a series of carefully designed, anonymous, sequential questionnaires, interspersed with controlled information and feedback, to achieve the most reliable consensus of group opinion.

The method can be superior to traditional roundtable discussions, where outcomes can become a compromise between divergent views, or unduly reflect the views of the participants with the loudest voices. Roundtable discussions can also be influenced by an unwillingness to abandon publicly expressed opinions in front of a group, as well as the 'bandwagon' effect of majority opinion.

With the Delphi method, respondents are able to raise aspects of discussion that might not normally have influenced the opinions of others, with others then able to independently re-evaluate their earlier responses based on these alternative perspectives. ha

The use of Delphi method for remote consultations **is available here. The AHHA's *Just Health* consultancy services are available to support organisations undertaking consultation processes. We regularly develop custom surveys, facilitate focus groups and adapt methodologies that enable clients to engage with stakeholders in a meaningful way. More information is available at ahha.asn.au/JustHealth.**

3 APRIL 2020

Nurse practitioners, doctors and Medicare payments analysed

The collaborative arrangements that nurse practitioners are required to have with medical practitioners in order to receive Medicare-subsidised payments are analysed in the April 2020 issue of *Australian Health Review* (AHR), the academic journal of the Australian Healthcare and Hospitals Association.

An author team led by Professor Mary Chiarella from the University of Sydney sought to clarify the arrangements in relation to collaboration, control, supervision and any reported difficulties in establishing and operating the mandated relationships.

Nurse practitioners are master-degree-qualified with a minimum of 3 years experience at advanced clinical nursing practice level. They are endorsed to prescribe medications, initiate pathology and diagnostic imaging, and refer patients to other healthcare practitioners. They often work in specialised areas such as emergency departments, cancer care, diabetes and heart failure.

In 2009 the Federal government introduced limited access to Medicare and the Pharmaceutical Benefits Scheme for nurse practitioners, but only if they entered into a collaborative relationship with a medical practitioner or an organisation that employs medical practitioners.

The authors agreed with the Medicare Benefits Schedule Review's nurse practitioner reference group that the collaborative relationship requirements should be scrapped. ha

AHHA in the news

30 MARCH 2020

COVID-19: Vulnerable older Australians cannot wait over 12 months for home care packages

Older people waiting for home care packages need urgent support now to ensure they can stay living safely at home and receive the care they need.

This need is urgent as the community faces unprecedented health risks—and family and other support may not be readily available.'

In the third week of March the Department of Health released its regular quarterly report on Home Care Packages for the first quarter of 2019-20. It shows that the government is releasing more and more packages, and we commend them for doing so—but as a whole it's not enough.

Around 112,000 people are either waiting for a package or have been offered a package at a lower level than they have already qualified for.

And the waiting time to get on a package at all levels other than the basic Level 1 is listed in the report as '12+ months'.

The report says that 97.8% of all people waiting for a home care package at their approved level at 30 September 2019 'had been provided with the opportunity to connect to some form of Commonwealth subsidised home care support'.

'It's not good enough—people should have the care they need. There are too many people on the waiting lists—and they have been waiting too long.

Right now it's obviously a busy time for all involved in health and healthcare. Nevertheless, it's essential that government gets needed nursing and community care services now to older Australians who will be at increased COVID-19 risk without appropriate support. ha

23 MARCH 2020

Planned telehealth expansion welcome, but must look beyond doctors alone

Four leading health organisations (Australian Healthcare and Hospitals Association, Consumers Health Forum, Australasian Institute of Digital Health, Australian Primary Health Care Nurses Association) urged the Government to expand telehealth to nurses to reduce COVID-19 infection risks and support care of chronically ill people at home.

We welcomed the government's intention to move to 'Stage 4' use of telehealth MBS items, involving four doctors organisations co-designing 'best practice expansion of telehealth items for all patients, with or without COVID-19, to see any general practitioner, medical specialist, mental health or allied health professional during the COVID-19 health emergency'.

We did have the following concerns, however:

1. Nurses were not included among health professionals who can be consulted using telehealth items.
2. Only doctors organisations were named as being involved in the 'co-design'. For a 'best practice' result, we think that organisations representing consumers, and hospital and other healthcare workers should be included.

There was no date given by which Stage 4 will be implemented. ha

[We are pleased the Australian Government responded to this call, and has subsequently included general practice nurses in the new telehealth funding arrangements.]

GINO CIRILLO
Manager Community
Dental Services,
Dental Health Services,
Western Australia

Fissure Sealant Program

Western Australian School Dental Service

The Western Australian School Dental Service (SDS) provides free emergency and general dental care to enrolled schoolchildren aged 5 to 16 years throughout WA via 126 fixed school Dental Therapy Centres (DTCs) located in school grounds, serving 4–7 schools. In addition, 25 mobile DTCs provide services to outer metropolitan and rural WA.

There are about 335,000 students enrolled in the SDS program, with near 300,000 occasions of service provided yearly.

Since 1977, the SDS has annually recorded 12-year-old caries experience of a sample of children examined within the SDS in a calendar year, reported as Decayed/Missing/Filled Teeth or DMFT.

The introduction of the universal free SDS in WA in 1974 and the introduction of fluoride to 90% of Western Australia's drinking water has seen a dramatic decrease in the caries experience of 12-year-old children enrolled in the SDS.

After a period of dramatic improvement between the 1970s and 1990s, the DMFT of enrolled 12-year-old students plateaued as shown in Figure 1 below.

>

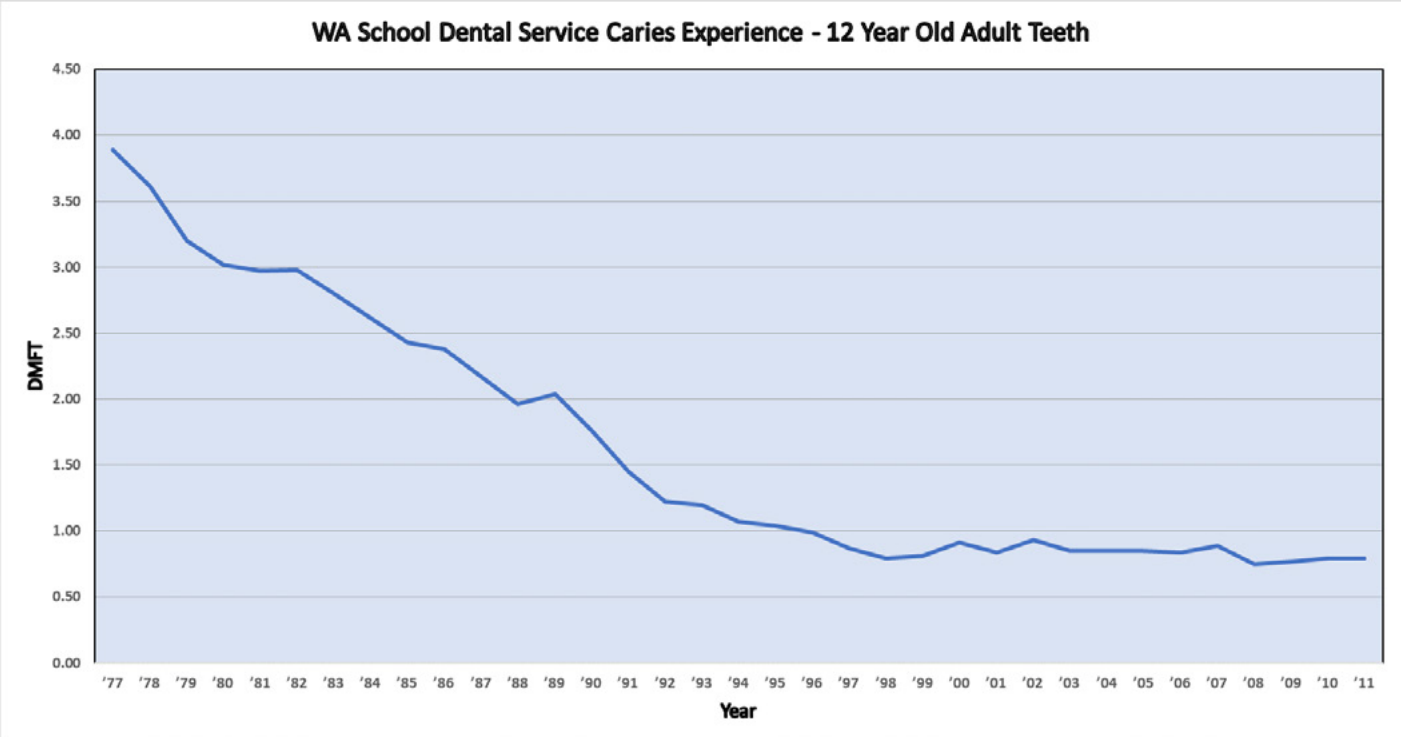


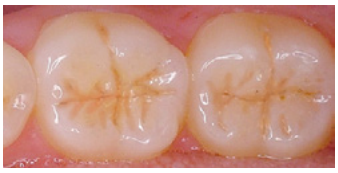
Figure1
WA School Dental Service caries experience, 1977–2011

Analysis, and the case for fissure sealants

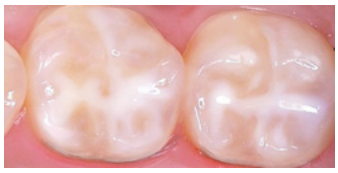
Dental Health Services WA undertook an analysis of the location and nature of dental decay occurring in enrolled SDS students. The decline in decay that has occurred over the past 30 years has been accompanied by a major change in pattern of caries within the mouth.

Ninety per cent of caries are now located in the pits and fissures of molar teeth. Fluoride has limited success in preventing caries occurring in pits and fissures due to their complex anatomy—fluoride is much more effective on the smooth surfaces of teeth.

A preventive modality for pit and fissure caries is known as a fissure sealant. A fissure sealant is a tooth-coloured film that is professionally applied to the fissures on molars to prevent caries. Fissure sealants are non-invasive, and the glass-ionomer material used by the WA SDS releases fluoride, which provides additional protection against decay.



Fissures present in molar teeth



Fissure sealants in place

A new approach

Traditionally fissure sealants in the SDS have been placed following an individual patient risk assessment that included evidence of active caries or a caries-contributing diet. These students are offered fissure sealants on permanent molar teeth to assist with decay prevention.

Dental decay is a chronic disease, and like other chronic diseases is unevenly distributed, being more common in less advantaged socioeconomic groups.

A pilot project was undertaken in the SDS Rockingham Area in the mid-2000s under the supervision of Dr Peter Arrow. Rockingham is a southern outer metropolitan suburb of Perth populated by less advantaged socioeconomic status groups, and children presenting to the SDS with high burdens of dental decay.

Dr Arrow established a process where all DTC clinicians in this area would place fissure sealants in all permanent molars regardless of individual risk of dental decay. That is, a population-based risk approach was undertaken for the placement of fissure sealants.

Geo-mapping of caries experience rates was undertaken in 2008 and showed that although disease rates in the Rockingham area were high for 5-year-old children entering the SDS (similar to other Perth outer metropolitan areas), there was a large improvement in the decay experience of 12-year-old children as the population-based fissure sealant pilot project took effect.

Following on from the success of the pilot project, DHS agreed that a population-based risk approach to fissure sealing, in addition to individual risk assessment, would begin in 2013. That is, social as well as economic indexes would be used to help determine which students would receive fissure sealants. DHS needed to find a suitable socioeconomic measure that was applicable to schoolchildren.

Index of Community Socio-Educational Advantage

DHS reviewed the Index of Community Socio-Educational Advantage (ICSEA) created by the Australian Curriculum, Assessment and Reporting Authority (ACARA). This index was created to enable meaningful comparisons of National Assessment Program—Literacy and Numeracy (NAPLAN) test achievement by students in schools across Australia.

Key factors in students' family backgrounds (such as parents' occupation, school education and non-

school education) have an influence on students' educational outcomes at school. The ICSEA values are published on the Commonwealth Government's My School website and allow for fair comparisons of NAPLAN results between schools of similar ICSEA level.

Because the SDS treats schoolchildren, and each school has an ICSEA score, this index was seen as a 'good fit' in determining which schools are socially and economically least advantaged.

The average ICSEA score for schools is 1,000. DHS determined that all children attending schools with an ICSEA score of less than 1,000 would be offered fissure sealants regardless of caries risk. Children attending schools with an ICSEA score of 1,000 or more would be offered fissure sealants on an individual risk assessment basis.

In 2012, the final year before introduction of the new 2013 arrangements, about 46,000 Fissure Sealants were completed by the SDS. The average DMFT score for 12-year-olds enrolled in the SDS in 2012 was 0.69.

Results

The implementation of the new fissure sealant program in 2013 has seen the number of fissure sealants inserted rise dramatically compared with previous years, from 46,000 in 2012 to 125,000 in 2018.

The program has also seen a dramatic reduction in the DMFT rate of 12-year-old SDS-enrolled students, from 0.69 in 2012 to 0.33 in 2018 (see table below and Figure 4).

Year	Number of fissure seals inserted	DMFT in 12-year-old SDS-enrolled students
2012	46,000	0.69
2013	110,000	0.65
2014	134,000	0.61
2015	105,000	0.60
2016	115,000	0.52
2017	120,000	0.46
2018	125,000	0.33

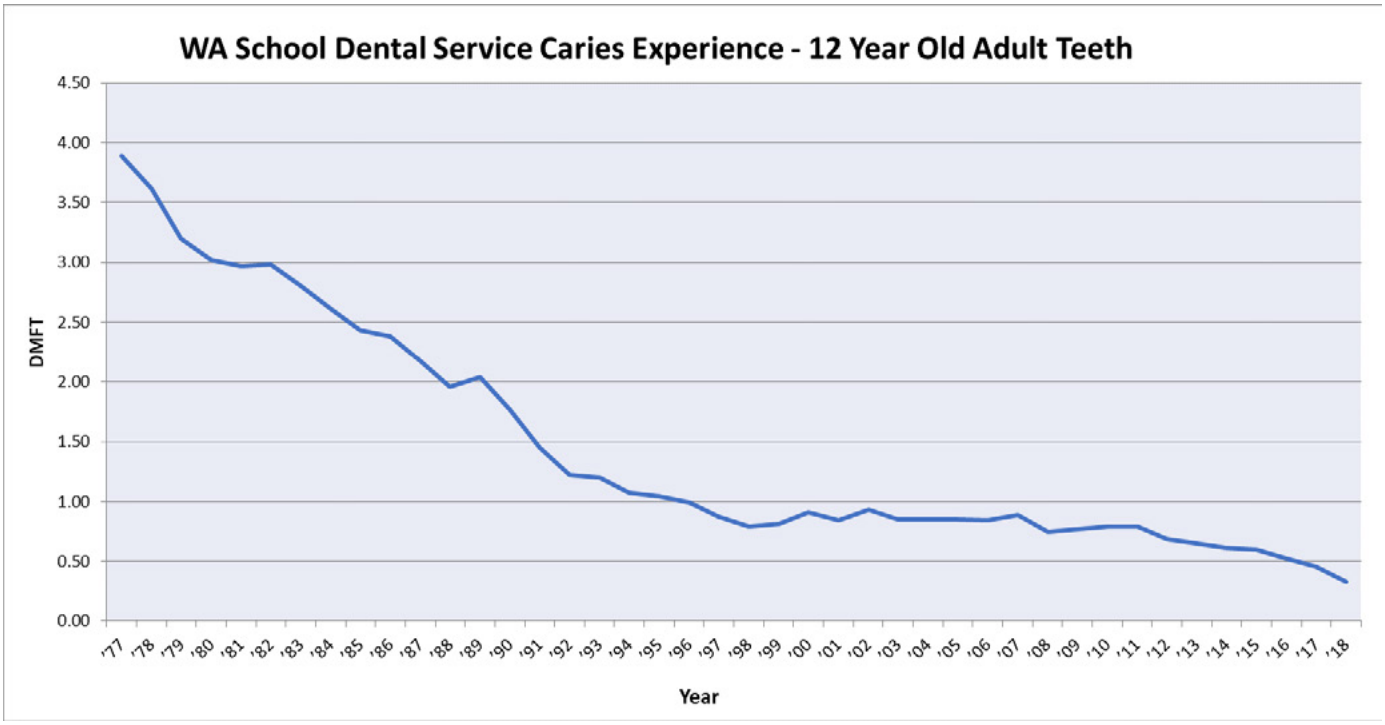


Figure 4
WA School Dental Service caries experience—12-year-old adult teeth, 1977–2018

DR SHARON LIBERALI
Director, Special Needs Unit, Adelaide Dental Hospital, South Australian Dental Service

The South Australian Dental Service Special Needs Dentistry Network

What is Special Needs Dentistry?

The Dental Board of Australia defines Special Needs Dentistry (SND) as:

> *'The branch of dentistry that is concerned with the oral health care of people with an intellectual disability, medical, physical or psychiatric conditions that require special methods or techniques to prevent or treat oral health problems or where such conditions necessitate special dental treatment plans.'*

It has a diverse patient profile, and includes people with special needs who are in tertiary medical centres/hospitals, long-stay residential care, living at home, or in secure units, as well as people experiencing homelessness.

Some patients with special needs may have multiple impairments and/or medical conditions, which often increase with age.

Special Needs Dentistry has a broad-based philosophy which takes a holistic view of oral health and requires specialists to liaise and work with all members of an individual's care team, including family members.

Why do we need Special Need Dentistry?

The spectrum of disability, medical complexity and/or social issues for people with special needs may cause difficulties in accessing mainstream dental services.

The National Oral Health Plan 2015-2024 identifies people with additional and/or specialist health care needs as having a higher incidence of poor oral health, and states that:

> *'A lack of dentists with adequate skills in Special Needs Dentistry was the most frequently reported problem for carers from family homes and community houses, followed by a lack of dentists willing to treat people with disabilities, resulting in long waiting lists.'*

The following factors continue to drive the increasing need for Special Needs Dentistry:

- an ageing population
- better survival of children with complex/ multiple disabilities, requiring transition of care from paediatric dentists to appropriately trained dentists/specialists
- complexity of medical care provided
- increased life expectancy for people with disabilities and chronic disease
- disability or progressive chronic disease extending into middle and older age
- population expectations of retaining natural teeth
- survival from cancer, with oral morbidity
- extent of oral disease experience, particularly among socially disadvantaged groups.

Why was the Special Needs Dentistry Network established in South Australia?

As Special Needs Dentistry is a relatively new specialty, there are very few registered specialists in Australia. At the time of development of the

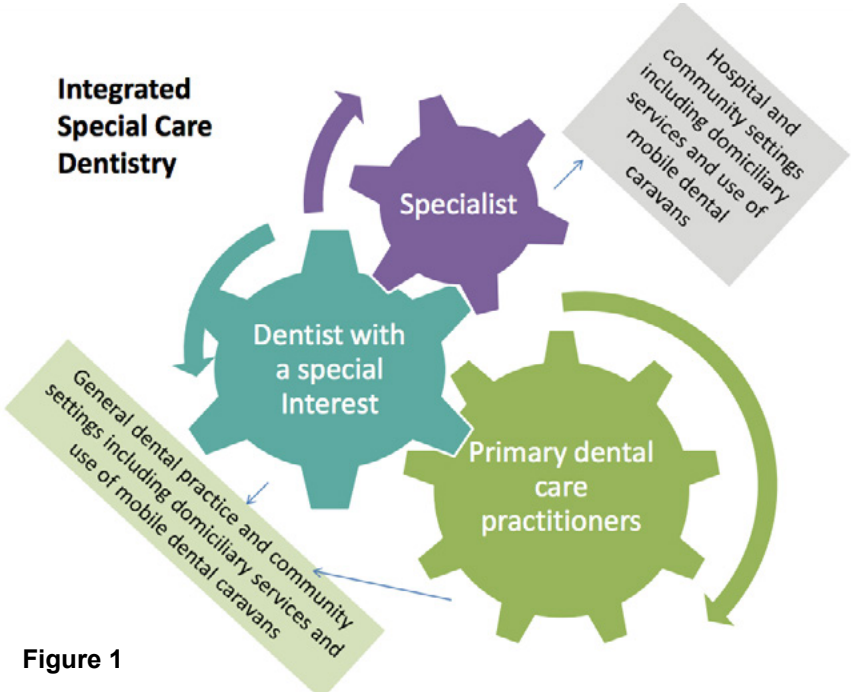


Figure 1

Special Needs Dentistry Network in 2014, there were only four registered SND specialists in South Australia. All were employed in the Special Needs Unit of the Adelaide Dental Hospital, working a total 2.5FTE—however, two had signalled their intention to retire.

Waiting lists were increasing, and it was clear that there would be increasing barriers to care and/or undersupply issues unless a solution was found.

One possible way forward in treating patients with special needs was to develop the capacity of interested general dentists in the Community Dental Service within the SA Dental Service.

In the United Kingdom, the training of 'Dentists with Special Interest in Special Care' enabled an integrated care pathway for clients with special needs between primary dental practitioners who provided the majority of dental care and specialists in Special Needs Dentistry (see Figure 1).

In this integrated network the general dentist 'upskilled' in SND was a point of referral:

- from other general dentists for assessment and provision of oral health care and dental treatment of less complex SND patients
- to SND specialists for provision of oral health care for complex SND patients
- from SND specialists for provision of maintenance or preventive care for stabilised SND patients.

How was the Special Needs Dentistry Network established?

Specialists and dentists of the Special Needs Unit, Adelaide Dental Hospital, provided a week-long SND training program for 25 interested senior Community Dental Service dentists from key metropolitan and country locations. While this enabled initial upskilling in SND, it was clear that this would be of limited benefit in the long term if not supported by an ongoing robust mentoring relationship. Since 2014, all members of the Special Needs Dentistry Network have met quarterly, enabling further didactic training and case discussions, with SND registrars included in the Network from 2017.

What have been the benefits of the Special Needs Dentistry Network?

Over the last 5 years, a strong working relationship has developed between the Specialist/Director, General Dentists and Registrars in the Special Needs Unit with community-based dentists of the Special Needs Dentistry Network. Increased numbers of SND patients are now treated in the community setting and waiting lists in the Special Needs Unit have reduced by approximately 50% as only the most complex patients are referred for specialist care. Patients, their families and/or carers—particularly those residing in outer metropolitan and country areas—have also been appreciative of receiving their dental treatments locally. ha

Putting some bite into oral health education

Oral Health Services Tasmania senior clinician Dr Ioan Jones is passionate about collaborating with other health professionals to achieve better patient outcomes. This has led him to work with many fellow health colleagues and university students to educate health professionals on oral health issues and how they contribute to overall health.

Education for health professionals

With a high number of hospital emergency presentations being due to oral health problems, it is important hospital emergency department and other clinicians are knowledgeable in oral health practices and pathways.

GPs also have an important role in patients' oral health—in addition to patients who specifically present with dental issues, GPs can opportunistically check patients for underlying oral health problems.

'We also work with other Tasmanian Health Service colleagues, with OHST's health promotion coordinator Jenny McKibben, working closely with midwives and child health and parenting professionals', Dr Jones said.

'Oral health professionals working in partnership with other health professionals allows all of us to collectively provide our patients with the best care and outcomes possible. It is truly the most satisfying thing I have experienced in my career,' Dr Jones said.

Dr Ioan Jones with friend

'It is important to identify other areas in health where it could be appropriate and useful to opportunistically refer a patient to oral health services, or discuss ways to improve their oral health. It could be something as simple as convincing hospitalised patients to brush their

Dr Malcolm Vernon of the Australian Antarctic Division during training at OHST with Dental Assistant Alex Brakey (centre) and dentist Dr Jasmine Holgate

teeth twice a day, or getting midwives or child health professionals to discuss good infant and child oral health habits with new parents,' Dr Jones said.

Embedding oral health in university degrees

A major success for Dr Jones and Oral Health Services Tasmania has been the introduction of oral health into the curriculum for third year medical students and pharmacy students at the University of Tasmania (UTAS).

'Building a strong relationship with the university in this way will help improve the oral health knowledge of our future doctors and pharmacists. It will also help doctors to better identify oral health issues in patients, make appropriate diagnoses, and have a good working knowledge of oral health referral pathways.

Oral health questions are included in UTAS medical student exams.

Dr Jones said pharmacies were often the first place visited by people with oral health pain. The advice provided at that point was extremely valuable in determining eventual outcomes.

'Educating pharmacy students for such scenarios is therefore essential in ensuring that sound information is provided to the community along with an appropriate referral to oral health and dental services.'

Antarctic, rural and remote medical training

GPs are often the sole primary health professional in rural and remote communities.

Of all such communities, none is as remote as Antarctica. Training doctors in oral health before they head to Antarctica is therefore an important and unique part of Oral Health Services Tasmania's education strategy. This ensures oral health medical support is available in one of the most remote places on Earth.

Dr Jones also hosts live webinars on oral health topics for rural and remote GPs working in communities that have limited access to dentists.

Future developments

In the short term, Oral Health Services Tasmania aims to introduce oral health into the UTAS Bachelor of Nursing curriculum.

'Nurses build strong relationships with patients and their families in all stages of life and across all medical disciplines', Dr Jones said. 'It makes sense to equip nurses with the skills and knowledge to be effective oral health advocates for all Tasmanians.'

'In the medium to longer term we are looking to connect with more health services and community groups, providing education, resources, and information on oral health issues and pathways,' Dr Jones said. ha

Investing in the future of healthcare

The latest HESTA investment initiative means your super will support two of the fastest-growing industries in Australia – and help build a brighter financial and professional future for you.

HESTA has committed $200 million to a property mandate that will focus on investment opportunities in Australia's fast-growing healthcare sector.

Managed by the industry super fund-owned ISPT, the new HESTA Healthcare Property Trust will invest in opportunities such as private hospitals, general medical and residential aged care.

HESTA CEO Debby Blakey says this is another example of how HESTA is building on our deep relationships with the sector to generate strong, long-term returns for members and support jobs and growth.

"We are actively looking for investment opportunities as Australia's aging population will see the need for a significant expansion in services and facilities in the coming years," Debby says.

"HESTA has been a trusted industry partner for more than 32 years and our patient, long-term investment approach means we are ideally placed to support our sector as it seeks to meet future demand.

"We're very excited by the potential opportunity and, given performance meets our expectations and appropriate investments can be identified, we're open to increasing our exposure."

HESTA CIO Sonya Sawtell-Rickson says the focus on healthcare and aged care property would provide diversification for the broader HESTA property portfolio.

"Healthcare and aged care property assets are not as exposed to the economic cycle as other types of large-scale commercial or retail property investments we have in the portfolio," Sonya says.

"We believe the strategy and approach we will take through this mandate and our strong

connections and knowledge of the sector will unlock opportunities that can provide strong long-term risk-adjusted returns and alignment with our members."

Our investment team, in partnership with ISPT, is focusing on metropolitan and regional city locations and a broad range of opportunities.

"We're a long-horizon, patient investor so we're very aligned with health and community services organisations that are similarly wanting to make very long-term decisions about their real estate needs and want a stable, trusted investor to partner with.

"We believe the opportunities we're targeting can also free up capital for these healthcare and aged care providers so they can invest in other opportunities like new technologies, upskilling their workforces and expanding into new areas of operation."

HEALTH CARE TRANSFORMATION LEADERSHIP PROGRAM

A value-based health care program for Australian health leaders commencing July 2020

Prof. Elizabeth Teisberg
Executive Director, Value Institute for Health & Care

Prof. Scott Wallace
Managing Director, Value Institute for Health & Care

Prof. Alice Andrews
Director of Education, Value Institute for Health & Care

CUSTOMISED PROGRAM FOR CLINICIANS AND HEALTH PROFESSIONALS, INCLUDING AUSTRALIAN CASE STUDIES AND CONTENT

HIGHLIGHTS:

- Developed by the Value Institute at the University of Texas, the Australian Healthcare and Hospitals Association and the Australian National University
- Web-based leadership rounds for busy clinician leaders and health professionals
- Tailored individual and organisational mentoring programs with an Australian focus
- Direct access to leading experts in value-based health care

This program aims to build the skills and knowledge of health services leaders, managers, clinicians and patients to successfully deliver value-based health care in Australia.

Your unique opportunity to access internationally-renowned Value Institute training in Australia

Australian Centre for Value-Based Health Care

ahha australian healthcare & hospitals association

Australian National University

The University of Texas at Austin
Value Institute for Health and Care
Dell Medical School & McCombs School of Business

2020-21 EDUCATION PROGRAM

Interactive Leadership Rounds

Six 90-minute web-based leadership rounds presented by the Value Institute, contextualised to the Australian setting, commencing July 2020.

- Implementing high value health care
- Creating value for individuals and families
- Measuring what matters
- Evaluating costs for strategy decision-making
- Leading teams towards transformation
- Strategy for high-value health care

Fee: $4,000 + GST per participant

Workshop: Measuring Outcomes That Matter

Face-to-face workshop presented by the Value Institute in Perth in March 2021. Focusing on how to measure outcomes, including designing care differently, knowing when outcomes have improved, and when to redefine outcomes.

Fee: $2,000 + GST (by 31 August 2020); $2,500 + GST (after 31 August 2020).

Learning Sets

An extension program led by an experienced leader in value-based health care with expert guest speakers. Facilitated group sessions (4 x 2 days) will complement the interactive leadership rounds and provide a supportive environment for Australian-focused discussion, where participants can raise real problems, difficult questions and discuss sensitive issues.

Fee: $16,000 + GST

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DR MARK BROWN
Chief Dental Officer,
Queensland Health

Teledentistry in Darling Downs Health

All over the world, healthcare providers are looking at how we can harness the power of technology to make healthcare more accessible to patients. The oral health sector is no different. Over the last few years, teledentistry has enabled oral health practitioners to provide more patient-centred and integrated care. It does this by enabling patients to access care closer to home, and by fostering collaboration and knowledge-sharing among clinics.

Teledentistry was initially trialled at Darling Downs Health (DDH) in 2014 and has since been rolled out to a further seven Rural Aged Care Facilities (RACFs) across the region—Miles, Toowoomba, Oakey and Warwick, and at Millmerran, Inglewood and Texas Multipurpose Health Services.

The main objectives are to provide optimal oral health services to Residential Aged Care Facility (RACF) residents while minimising resident discomfort and disruptions to daily routine, and maximising dentists' clinical time.

DDH sends an oral health practitioner to the RACFs to conduct oral health audits and assessments. The oral health practitioner consults with nursing staff about their findings and receives live advice from a dentist via a TeleDental consult if and when required.

Before the introduction of teledentistry, a dentist from a DDH oral health clinic would visit an RACF. If a resident required dental treatment, they needed to travel, either with the Queensland Ambulance Service or a family member, to an oral health clinic. Referrals were received, variously, from residents, family members and/or staff, and treatment was sometimes ad hoc. This was a heavy burden for family members, RACF nursing staff and

photo by Timothy Muza

the oral health clinic—especially when coordinating arrangements for residents with complex medical conditions.

Improving the teledentistry process

The process for conducting TeleDental consultations has changed greatly over the past five years. Initially, a telehealth room needed to be booked within an RACF, and nursing staff would bring each resident to and from their TeleDental consultations. The resident would sit in front of a monitor and be assessed with a flexiscope inline camera. The system was cumbersome, had several cords and connectors, was difficult to transport, and needed to be plugged in to a mains power source. At some facilities it was possible for oral health practitioners to attend to some residents at their bedsides or in their rooms—but it was not easy.

In early 2018 DDH trialled a more compact Intraoral Dental Camera System. The picture quality was superior, and the smaller camera could be connected to a laptop USB port as its power source. The system was much easier to transport between residents within an RACF.

Consequently, the oral health practitioner now conducts TeleDental assessments in the comfort >

"Teledentistry has resulted in clinical and cost efficiencies, and care that is more patient-centred. The dentist's time is used more efficiently, and we have seen initial cost savings due to a reduction in ambulance and nurse escort use."

of residents' own rooms, thereby minimising potential disruptions and resident anxiety, fatigue and discomfort.

Dentists and oral health practitioners can share live vision from the camera in real time when both parties are logged in. After the TeleDental consultation the oral health practitioner will organise any required dental appointments, the completion of dental medical questionnaires in conjunction with nursing staff or a GP as necessary, and obtain appropriate consent. The oral health practitioner will also liaise with RACF staff and family members to notify them of TeleDental consultation outcomes.

The benefits of teledentistry

Overall, resident consultations are more convenient and time-efficient for residents, nursing staff and oral health practitioners. Feedback from residents and their respective families has been overwhelmingly positive. Many family members have shown great appreciation for the service as it benefits and supports their loved one's oral health and general health and wellbeing. Nursing staff appreciate the numerous positive resident health outcomes from teledentistry. Changes in resident behaviour can be more easily linked to oral pain (or otherwise) if a dentist is able to assess the resident promptly.

The introduction of teledentistry has seen a decline in the number of inappropriate referrals to the dental clinic because residents are being triaged appropriately. Transporting a resident unnecessarily to the dental clinic can be costly as well as disruptive, especially if an ambulance and attending nurse are required.

Delivering better outcomes for patients and clinicians

Teledentistry has resulted in clinical and cost efficiencies, and care that is more patient-centred. The dentist's time is used more efficiently, and we have seen initial cost savings due to a reduction in ambulance and nurse escort use.

More importantly, teledentistry has enabled us to be more aware of residents' oral health needs and overall comfort while minimising disruptions to their daily routines. Accessing care is easier as residents don't need to travel as often to an oral health facility—they can receive much of the care they need closer to home.

Moving forward

Future plans include integrating oral health and teledentistry with existing chronic disease and antenatal care services. In addition to live streaming, the planned system can also capture and forward referrals on to dentists as appropriate. ha

NIKKI DARGAN
Director Oral Health,
Top End Health Service,
Northern Territory Government

Oral health service delivery in Northern Territory Aboriginal communities

Dentist Michael Lawler with local Minjilang family after receiving dental treatment

Unique and full of adventure

The Northern Territory is about 1,346,200 square kilometres of vast open spaces. It covers approximately one-sixth of the Australian continent, and has a total population of about 250,000 people, of which nearly 30% are Aboriginal. These unique characteristics make delivering health services in the NT both complex and challenging, but can also be very rewarding.

From one of the best fishing spots in East Arnhem Land to some of the world-renowned Aboriginal art galleries of Hermannsburg and Yirrkala, to the culturally rich town site of Katherine to the iconic red centre of Alice Springs, and the best-secluded camping spots of the West MacDonnell Ranges to the bustling Darwin tropical markets, the Northern Territory is unique, vibrant, and full of adventure.

Aboriginal oral health

Aboriginal people experience some of the poorest health outcomes of all Australians. Compared to non-Aboriginal people, Aboriginal Australians have a shorter life expectancy, are more likely to be of low birthweight, are more likely to have a chronic disease or condition, and are more likely to have a number of risk factors for poor health and wellbeing.

This extends to oral conditions. Aboriginal people experience decay at nearly three times the rate of non-Aboriginal Australians, and are twice as likely to have advanced gum disease.

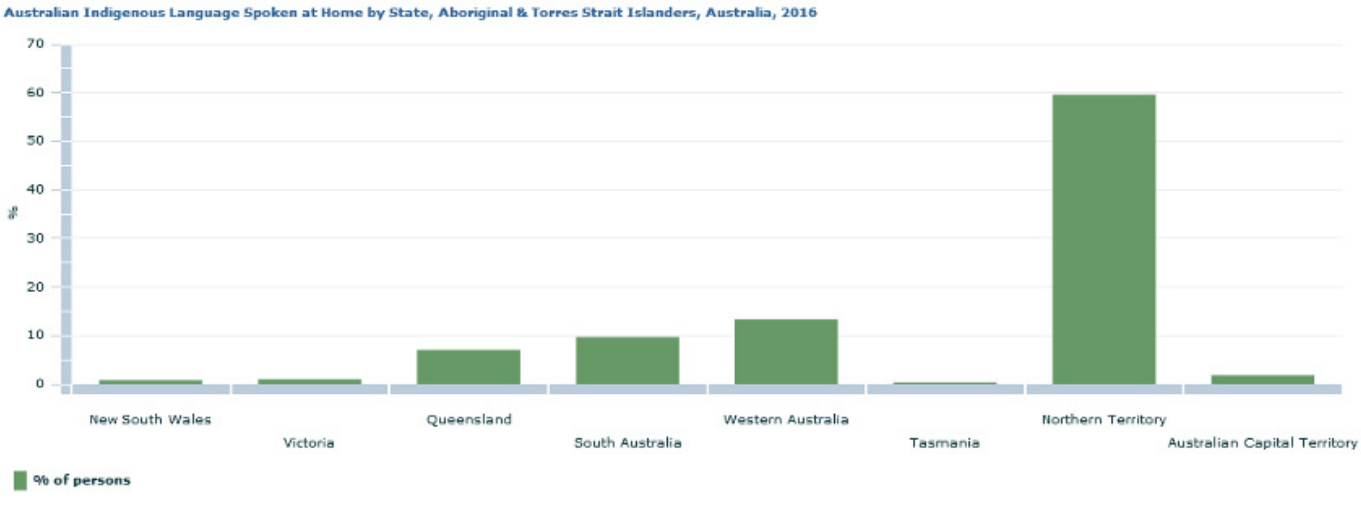
The centrality of culture

Aboriginal people have strong connections with, and traditional links to, their land and country, >

Sign displayed outside Wadeye Primary Health Centre to promote dental team visit


Dust storm on Central Australian roads


Aerial shot taken en route to Tiwi Islands



Australian Indigenous languages spoken at home by Aboriginal and Torres Strait Islanders, Australia, 2016 (Source: ABS)

and have commitments to fulfil cultural obligations. Before visiting remote communities, all clinical teams receive training on kinship, traditional ceremonies, law and cultural protocols.

Understanding expectations and scheduling patient appointments around important rituals such as 'men's business' and even cancelling or reducing trips due to 'sorry business' in a community is all part of remote service delivery. Recognising the centrality of culture to health and wellbeing is necessary to enhance all aspects of service provision in communities.

In many Aboriginal communities, people may be fluent in several Aboriginal languages and English is predominately a secondary language. Local Aboriginal liaison officers within the clinic help translate between clients and the clinical team. Engaging with the locals to build trusting relationships is paramount to the success of any dental visit.


Central Australia team's dental truck


Dental clinic in the bush

A day in the life of a dental team

A day in the life of a clinician in remote NT goes beyond the clinics and includes a few tough, yet rewarding challenges. Remote travel constitutes a crucial part of work life whether it is by air, road or sea.

Rosters are meticulously planned, but visiting dental teams need to prepare for the unexpected. Whether it be the harsh weather conditions or the wide range of clinical presentations that come through the door, or even the local wildlife sunbathing on the doorstep, there is never a dull moment.

Some people assume remote settings offer the same aspects of community life that exist in cities and major towns. Clinical teams learn very quickly that many aspects of remote living are vastly different and there can be a 'culture shock', especially for first timers to the Territory. However, once they have settled and get to know the community, they find remote work offers many rewards.

The harsh Territory terrain takes its toll on dental trucks travelling the outback roads of Central Australia. Faster than usual wear and tear on dental equipment such as autoclaves and sensitive imaging equipment, require constant repairs and replacement.

Ongoing maintenance of the dental trucks ensure they remain operational for their next long haul. Repairing and maintaining dental equipment in remote health centres also provides logistical challenges as tool bags and spare parts are squeezed between pilots and dental engineers as they fly in small aircraft high above the mainland overlooking waterways and islands.

Both distance and the need to share allocation of services to all remote communities means there is never any shortage of dental work when the team arrives at a community. Whether the dental team is stationed in a single-chair dental truck or within a remote health centre, what is freely available within an urban practice is not necessarily accessible when working remote. Such things as favoured dental materials or a colleague's second opinion may not necessarily be close-at-hand but remote telehealth systems is another option increasingly being used. Adaptation and flexibility are key attributes in keeping the services flowing.

The days can be very tiring, but are equally rewarding—teams are providing an essential service to a community that may not see another dental service for months, so they all work hard and make the most of it.

There is a high level of job satisfaction that comes from working alongside Aboriginal health workers and remote NT Health staff who, with the spirit of survival and a drive for equality, are making a difference, despite all the social inequalities and health issues.

Improving Aboriginal health and wellbeing is a serious challenge. The answers are complex. In committing to making a difference, it is important we acknowledge and respect the interests of Aboriginal people as Australia's first peoples. This acknowledgement and respect are essential as a foundation to achieve equitable health and wellbeing outcomes—including oral health. ha

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Rethinking dental care in aged care facilities

The ResiDENTAL Care Program—a patient-first approach

The Australian population is ageing. Access to dental care for residents in aged care facilities is complicated by a lack of onsite dental facilities and the intricacies of transporting frail patients to external dental services.

To improve access, Hunter New England Local Health District (HNELHD) Oral Health Service developed and implemented the ResiDENTAL program. This program provides portable dental equipment for use on-site at aged care facilities, including a specifically-designed reclining wheelchair to address the work health and safety issues of dental practitioners when providing dental care away from their dental surgeries.

An instructional DVD assists participating dentists, covering setting and packing up of equipment, tips on treating the elderly, and background information on the Australian Government Department of Health's Better Oral Health in Residential Care education and training package.

A program coordinator liaises with the Residential Aged Care facility and participating dental practitioners to ensure all needs are met and the portable equipment is available and delivered on time as needed.

Public and private dental practitioners may use the equipment to carry out examinations, cleans, fillings and extractions. Some care is provided or funded publicly while private care using

private dental practitioners can be provided by arrangement with the practitioner.

By using both public and private dental practitioners the ResiDENTAL program maximises opportunities for residents to have timely access to dental care without the inconvenience and costs associated with attending external dental services.

A patient's experience

Mr Glynn Jenkins, an 81-year-old resident of Calvary Nazareth Retirement Community in Belmont North, New South Wales, presented to facility staff with a toothache caused by a decayed back molar. Mr Jenkins is a resident at Calvary Nazareth Retirement Community for four years,

A case for flexible delivery of dental care in an aged care setting

Centre for Oral Health Strategy, New South Wales Health

and also has advanced Alzheimer's.

Urgent dental care was required—however, due to his state of health, transporting Glynn to an external dental service was highly problematic. Due to his advanced dementia he cannot follow instructions, and unfamiliar surroundings can exacerbate his confusion.

Mr Jenkins was provided with dental care on-site at the facility by a private dental practitioner using the portable dental equipment supplied by HNELHD.

The on-site visit also enabled Mr Jenkins' wife to be present for the initial dental consultation, and the problem tooth was extracted on a subsequent visit, when a full course of dental care was also provided.

In addition to treating Mr Jenkins, all residents were offered dental care while the private dental practitioner was on-site.

BENEFITS

Before Glynn Jenkins' dental pain was treated at the residential facility, he rarely sat through meals. He would leave the meal table and attempts to bring him back to finish his meal angered him.

Mr Jenkins' dental pain made him unwilling or unable to chew food, resulting in subsequent weight loss. Since receiving dental care his weight has stabilised. He is now happy at meal times and does not leave the table before finishing his meal.

Facility staff noted that Mr Jenkins often walks around Calvary Nazareth Retirement Community with a day-long smile on his face—something staff had not seen for a long time.

Moving forward

Currently, 68 aged care facilities within the HNELHD boundaries have access to the award-winning ResiDENTAL Care Program and its benefits.

The program has won both Health New England and New South Wales Health Quality Awards, a New South Wales Health Director-General's Innovation Award and a Premier's Award since its inception in 2011.

This unique model of service delivery is often cited as an exemplar of collaboration among public and private dental providers. In a recent (April 2019) submission to the Royal Commission into Aged Care Quality and Safety, the Australian Dental Association NSW suggested that there is capacity for this program (among others) to be scaled up to provide needed dental services to older Australians. ha

More information: Karen Sleishman, Coordinator Community Aged Care Oral Health Programs, HNE Local Health District, tel.: 02 4016 4844, email: Karen.Sleishman@health.nsw.gov.au

Reflections of a consumer representative in the oral health sector

People want to feel invested in their experience and their health.
Sandra Anderson, Consumer Representative, Dental Health Services Victoria

Seven years ago, I saw an advertisement in the paper stating that Dental Health Services Victoria (DHSV) was looking for people to join their Community Advisory Committee. I had a strong association with the Royal Dental Hospital of Melbourne (RDHM) which is run by DHSV, so I was keen to get involved.

I used to take my children into the dental hospital and now my grandchildren are patients there. I have 16 grandkids so we're a big family. Two years ago, my 17-year-old granddaughter had to go into the hospital to have seven teeth out. I remember asking her how it went and she said, 'Oh grandma, they were so lovely. The nurse held my hand and made me feel like it would all be ok'.

We spoke a lot about her experience at the hospital because I love listening to things from the patient's perspective. We talked about how she had to travel three and a half hours from Wodonga to get to the hospital—these are things that organisations sometimes forget about, the practicalities patients face.

For example, someone might not have a car, or they might have a new baby plus a child that needs to be picked up from school. Often getting to a

Sandra Anderson

dental appointment is the last thing on their mind, especially if there's a big distance involved.

Since joining the CAC at DHSV, I've really flourished. I've joined the Safety and Quality Committee and been a consumer representative on the national dental directors group, comprising dental leaders from all states and territories.

I just really want to help wherever I can. I put my hand up to help develop a consumer registry for DHSV. Part of that was ensuring we had clear guidelines for consumers when they were asked to attend a workshop. It's important for people to know what's expected of them. It's also important that we fill the room with consumers who are >

"Over the last few years, I've been involved in the development of DHSV's value-based models of care. I love that it's about putting the patient at the centre of everything—finding out what matters to them and looking at the challenges they are facing."

genuinely interested in what are trying to achieve and feel comfortable contributing.

I really want to use my influence to get oral health messages out into the community. I also want to give DHSV valuable insights into how the community is thinking and feeling. My daughter is in charge of 100 childcare educators in Victoria, so I asked her, 'Why aren't parents accessing the $1,000 available to them through the Child Dental Benefits Scheme?' She asked her educators to ask the parents and a lot of them said they didn't realise that they were eligible. Or they worried their child would need more than $1,000 of dental work and they didn't have the money to pay extra. Through my role as a community representative, I was able to give that feedback to the management at DHSV and the dental directors group, and I felt really good about that.

Over the last few years, I've been involved in the development of DHSV's value-based models of care. I love that it's about putting the patient at the centre of everything—finding out what matters to them and looking at the challenges they are facing. DHSV started the consumer consultation with a blank page and they asked consumers, Where do we start? It was really refreshing because often people go in with a set idea of what they want the outcome to be, and they don't really listen.

At one of the DHSV workshops there was a man who was covered in tattoos, even on his face. Some people would be quick to judge him, but he was so impressive. He was experiencing homelessness and he gave such valuable insights into what it is like to live rough. He said that telling people on the street to come into the dental hospital for free treatment will never work. You need to go to them. And further than that, you need to speak to them about when and where they want you to visit. People who are living rough have busy routines—Wednesdays might be their washing day, Thursdays might be the day the mobile vet visits to clip their dog's nails. After chatting to him we realised that on Wednesday nights a lot of people experiencing homelessness visit the market down the road from the hospital and they would be receptive to a visit from the dental van then. Sometimes knowing what to do is as simple as asking the question. You don't know what people are going through unless you ask.

I'm so proud of the work I've done as a consumer representative at DHSV. Last year, I was invited to an awards ceremony where DHSV won a big award for their work in value-based health care. I sat there like a pony, I was so proud knowing I had played a part in it. The term 'value-based health care' might seem complicated to some, but it's just about another way of doing things to get a better outcome.

DHSV's new way of partnering with consumers is seeing such great results. Instead of feeling like just another number on a conveyor belt, consumers feel heard and empowered to take action in their own lives. They are invested in their own experience and invested in their own health. And it's all because they are at the centre of the process. They finally have a voice. ha

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DR SHALIKA HEGDE
Manager, Centre for Value-Based Health Care

DR MARTIN HALL
Chief Oral Health Advisor; Dental Health Services Victoria

Improving oral health outcomes

Oral health is important for overall health, wellbeing and quality of life. Poor oral health has been associated with cardiovascular disease, diabetes, respiratory diseases, adverse pregnancy outcomes, stomach ulcers, oral cancers and obesity.

While oral diseases can be one of the more costly disease groups to treat, most oral diseases such as dental caries and periodontal diseases are preventable. If prevention is offered early, better oral health outcomes are the likely result.

Public dental services are funded to treat disease rather than prevent them. But it is widely recognised that a prevention-focused system would be a more cost-effective way of delivering public dental services and, over time, will improve oral health outcomes and reduce the burden of oral disease.

Value-based health care at DHSV

Value-based health care aims to improve health outcomes that matter to consumers at an appropriate cost. To improve health outcomes and focus on the prevention of oral diseases, DHSV began exploring Value Based Health Care in 2016, and has rapidly mobilised to achieve strong results. We co-designed a Value-Based Health Care framework with our consumers, staff and key stakeholders and implemented it at the Royal Dental Hospital of Melbourne. DHSV also received a Gold Award from the International Hospital Federation (IHF) in 2018 for health system

Using integrated team-based delivery at Dental Health Services Victoria

transformation, and the Europe Value-Based Health Care Primary Care Award in 2019.

Improving health outcomes using an integrated oral health team at DHSV

To improve oral health outcomes at an appropriate cost, our oral health workforce must work as an integrated and coordinated team, prioritising prevention, eliminating all forms of siloing and working towards continuously improving the team capability. To create such a team environment, using the right workforce skill mix is essential to ensure that the right people, with the right skill sets, provide the right services at the right place and at the right time.

The oral health workforce in Victoria is predominantly made up of dentists. Using dentists, rather than other oral health professionals (for example dental assistants) is not a cost-effective method of delivering preventive programs such as oral health education and fluoride varnishes.

To achieve a cost-effective system, the most resource-intensive components of the workforce (e.g. dentists) should focus on the most complex and difficult types of services. The less resource-intensive components of the workforce should be supported to carry out preventive services that they can be trained and upskilled to deliver safely and competently, within their respective scope of practice. An example is upskilling and training dental assistants to become oral health coaches and educators. >

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Trained dental assistants as oral health coaches and educators

Dental assistants form part of the non-registered health practitioner workforce and are not required to be registered with the Dental Board of Australia or any state or territory boards. The public health sector has historically faced challenges recruiting, retaining, and providing professional development for the dental assistant workforce.

As part of its value-based health care journey DHSV has invested in upskilling dental assistants through a Certificate IV program that enables them to undertake oral health promotion activities, take on the roles of oral health educators and coaches, and offer preventive services such as application of fluoride varnish. To permit Dental Assistants employed in the public sector to apply fluoride varnish (under the prescription of a registered practitioner), DHSV and the Victorian Department of Health and Human Services, along with key stakeholders and organisations, were successful in influencing necessary changes to the relevant legislation in Victoria.

Using an oral health behaviour change coaching model, and motivational interviewing techniques, trained dental assistants at DHSV work with consumers who have been assessed for their clinical, behavioural and psychosocial risk factors for current and future oral disease.

As trained coaches and educators the dental assistants explore the consumer's knowledge, attitudes, beliefs and challenges with oral health, examine their motivations to change behaviour, and co-design care plans with consumers based on their oral health needs.

DHSV is the first state in Australia to create a new pool of appropriately-trained dental assistants working as oral health coaches and educators. We are using this workforce in our School Dental Program and pre-school oral health programs.

In summary, the oral health team at DHSV is strengthening its relationships with consumers through providing individualised care plans, empowering and motivating consumers to self-care and manage their own oral health, and enabling their journeys toward improved health outcomes. ha

"As trained coaches and educators the dental assistants explore the consumer's knowledge, attitudes, beliefs and challenges with oral health, examine their motivations to change behaviour, and co-design care plans with consumers based on their oral health needs."

Dental Health Services Victoria (DHSV) is the leading public oral health agency in Victoria. It provides oral health services through the Royal Dental Hospital of Melbourne and by purchasing dental services for public patients from over 50 Community Dental Agencies across Victoria. DHSV implements statewide oral health promotion and prevention programs, invests in oral health research, advises the government on oral health policy and supports the education of future oral health professionals.

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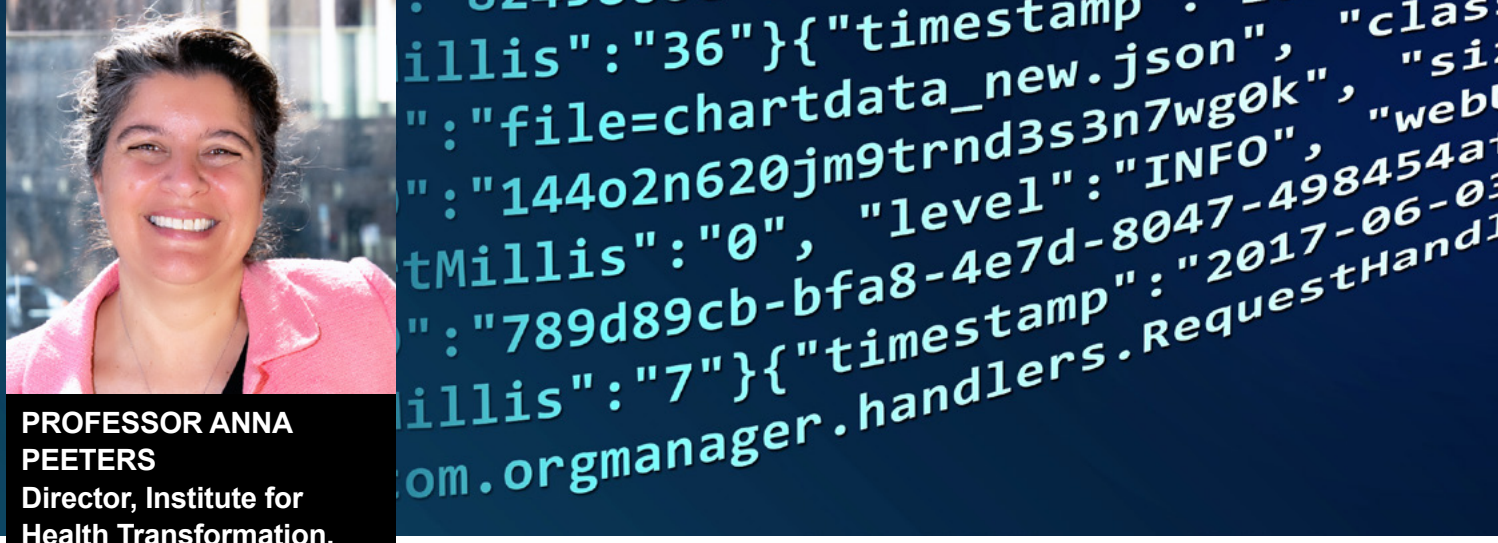

PROFESSOR ANNA PEETERS
Director, Institute for Health Transformation, Deakin University

Big data and health equity

Who is the master?

Big data is everywhere. In every facet of our lives we know that data is being collected, aggregated and analysed. In health, discussion abounds about big data analytics, electronic medical records and precision medicine.

Harnessing big data appears to offer us the opportunity to better tailor prevention and care to the individual, leading to more efficient investments in health, and better experience and outcomes for our citizens. For that reason, the rise of big data should provide a unique opportunity to improve health equity across our community. But will it?

It is well understood that there are many substantial and persistent health inequalities, in Australia, and globally. In Australia every year the Closing the Gap report is released. In the most recent release (2020), neither of two health-equity-related targets is on track, not for inequalities in child mortality nor life expectancy between Indigenous and non-Indigenous Australians. The gap in child mortality has widened, to more than double, while the life expectancy gap has not changed since 2006.

The National Atlas of Healthcare Variation, created to explore how healthcare use varies depending on where people live, also demonstrates year-on-year substantial inequalities in health in Australia. The most recent Atlas (2018) identified a number of themes related to our persistent regional inequalities in healthcare usage and health outcomes.

For example, they identify that 'despite higher rates of bowel cancer, people in areas of lower socioeconomic status (SES) have lower rates of colonoscopy than people living in areas of higher SES. Despite higher rates of cataract, Aboriginal and Torres Strait Islander Australians have lower rates of cataract surgery than other Australians. And, despite higher rates of heart disease, people living in regional areas have lower rates of cardiac stress

pixabay

tests and imaging than people in major cities.'

These reporting mechanisms demonstrate the utility of big data in highlighting these health inequalities, but can it support us to move from description to solutions? The Atlas identifies that an impact could be achieved with more intelligent, joined-up data, greater involvement of consumers, and more attention to prevention and systems factors.

Close the Gap for Vision is a good example of action on health inequalities that demonstrates these assertions. In 2011 they established a roadmap to tackle the largely preventable inequalities in eye disease between Indigenous and non-Indigenous Australians, with blindness rates in Indigenous adults then six times the rate for non-Indigenous Australians. In 2019 they reported a number of areas of progress, including a substantial decline in trachoma rates in Indigenous populations, tracking to meet the target of no difference in rates by 2020. Their approach harnessed the available data, brought together the many stakeholders involved—including consumers, Aboriginal and Torres Strait Islander health organisations, and primary health care and specialist eye health services—and addressed the system-level breakdowns in service delivery and prevention.

These examples reinforce the notion that big data can be useful for improving health inequalities—but it will never be the driver.

The same is true in precision medicine. There has been a surge in the use of big data to deliver genetically tailored prevention. One development has been new heart disease risk prediction scores, taking into account genetics as well as traditional risk factors such as smoking and high blood pressure. While we know that these new scores are better able to sort people according to their future risk of heart disease, we don't yet know the impact of their use on inequalities in heart disease.

A user-pays model for these tests would widen inequalities. Further, the increasing focus on the role of genetics could risk a lack of focus on our social, political, financial and environmental determinants of health. While the growth of big data analytics opens windows to being able to more finely tailor strategies based on a combination of an individual's genetics, health status, and social and physical environment, it will only do so if we ask it to, and provide the relevant data.

With the use of big data, we need to ensure that the wizardry does not distract us from what we know to be some of the key drivers of impactful research: who is involved and what is the health impact they are seeking? Too often we are retro-fitting our research to assess health equity impacts. There is increasing evidence that if we design our research and practice for health equity, the impact will be both effective and equitable.

It is clear that the rise and rise of big data is here to stay. It is possible to harness big data to improve health outcomes for all Australians. But to do this we will need to make health equity, and not big data, the master. ha

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Consensus frameworks

A platform to close the trust gap in health systems.

The world's health systems are extraordinarily diverse. As such, they face varied opportunities and obstacles in their mission to achieve the best patient outcomes. Despite these differences, each is confronted by a common and disturbing reality: a lack of trust among otherwise highly dependent, inter-connected stakeholders that enable our health systems to function. This trust gap is readily apparent in the medical device and biopharmaceutical sectors, where enterprises coordinate with payers and providers to develop and deliver therapies and technologies for patients. For these crucial stakeholders, it is obvious that more trust and collaboration, not less, would serve to improve patient outcomes.

Media headlines over the past decade paint a discouraging picture of ethical business conduct across the world's health systems. Public confidence has been shaken—in health industries, healthcare professionals and providers, governments, and other health organizations. While each of these stakeholders has made great advances in compliance with laws and adherence to high-standard codes of ethics, these efforts are generally isolated. Progress is siloed.

What is needed is collective action across the entire health system. No one stakeholder, not even government, is capable of doing this alone. But where does one start? We see promise in neutral and inclusive platforms—called 'consensus frameworks'—that allow stakeholders to work toward collective solutions.

Building the consensus framework platform

Conceived in 2014 through a ground-breaking Global Consensus Framework for Ethical Collaboration between Patients' Organizations, Healthcare Professionals and the Pharmaceutical Industry, consensus frameworks are voluntary, customisable, and inclusive platforms that enable cross-stakeholder collaboration to strengthen ethical business conduct and rebuild trust through:

1. facilitating the identification and communication of best practices;
2. undertaking cross-organisational capacity building for mutual benefit; and/or
3. shared monitoring and evaluation of changes in the ethical business environment.

A consensus framework is not a code of ethics—it is the table where diverse stakeholders agree to convene and set a common approach. This two-minute video (see link below) provides a short explanation. >

Building the first consensus framework platform at the global level was no easy feat. After several years of deliberation, the International Alliance of Patients' Organizations (IAPO), World Medical Association (WMA), International Council of Nurses (ICN), International Pharmaceutical Federation (FIP), and International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) agreed to continue developing their own policies while also committing to four overarching principles to guide their future cooperation:

1. Put patients first.
2. Support ethical research and innovation.
3. Ensure independence and ethical conduct.
4. Promote transparency and accountability.

The Global Consensus Framework then details key areas under each of these principles that should be considered by all partners to help guide ethical collaborations at the individual and organisational levels. A corresponding toolkit of resources for all partners to share was also released. In 2015, the International Hospital Federation (IHF) and International Generic and Biosimilar Medicines Association (IGBA) also joined as partners. For the first time, the world had a neutral and inclusive mechanism to work toward collective solutions.

This achievement coincided with the September 2014 launch of the APEC Nanjing Declaration on Promoting Ethical Environments in the Medical Device and Biopharmaceutical Sectors, calling for localised partnerships within APEC economies between industry, governments, healthcare professionals, and patients.

With support from APEC Ministers and the world's largest public-private partnership to strengthen ethical business practices in the medical device and biopharmaceutical sectors—the Business Ethics for APEC SMEs Initiative—we are now in the midst of an unprecedented race by economy-wide health systems to ink consensus frameworks.

As of today, nine consensus frameworks are in place, covering nearly 200 health organisations. Consensus frameworks are bringing about the collective action needed in Canada, Peru, Vietnam, Mexico, Philippines, China, Japan, Australia, and Chile. Brazil, Thailand, the United Arab Emirates and others are actively undertaking consultations.

Each consensus framework is unique. Australia's consensus framework, for example, enjoys support and engagement from the federal Minister for Health, state health ministers, and nearly every health system stakeholder—bringing 71 partners around the same table. In 2019, the consensus framework was reformed into the Australian Ethical Health Alliance (AEHA). AEHA serves as a model to improve health systems through the articulation and affirmation of ethical principles that promote the interests of patients and consumers, enhancing access to safe and effective healthcare, encouraging ethical collaboration in the healthcare sector, and building public trust.

Sustaining an impactful consensus framework platform

While building the consensus framework platform and convening key partners around the table has already proven a major feat, it is only the first step. As consensus frameworks are a new model, only time and continued collective action will prove their sustained impact.

In 2018, the Business Ethics for APEC SMEs Initiative released a *Guide to facilitate multi-stakeholder ethical collaborations in the medical device and biopharmaceutical sectors*, containing steps to form a consensus framework as well as concise strategies to realise sustainable and mutual benefits for the partners involved. In September

2019, the Initiative also released a *Status report on consensus frameworks in the APEC region* detailing the advances each collection of partners is making for the first time.

All consensus frameworks remain active in strengthening ethical business conduct in a variety of ways. Australia has developed an implementation guide to assist partners align their structure, policies, and processes with consensus framework principles, an external communications strategy to promote ethical healthcare across the system, and a template to report their individual activities.

While originally led by industry, Canada has elevated patient organisations to lead consensus framework deliberations, putting the patient voice at the centre of ethical business conduct for the first time. China's partners have completed the economy's first-ever biopharmaceutical industry association survey and report on code-of-ethics adoption while forging new industry-hospital collaboration on bioethical research. Japan is developing a joint-stakeholder ethics training curriculum. Mexico's partners are driving new linkages with the economy's anti-corruption system. Peru is conducting a self-assessment of every partner's code of ethics, building toward convergence of ethical practices in line with consensus framework principles and the legal system. The Philippines is leveraging the consensus framework to catalyse collection action to implement ethical business practices already recognised by the government. And Vietnam's partners are leveraging the consensus framework to rapidly propagate harmonised codes of ethics across different industry bodies where they previously did not exist. These advances are likely just the tip of the iceberg.

Left unaddressed, the trust gap that exists between crucial stakeholders as a result of unethical business conduct can hinder health system performance, cross-border trade, and economic growth.

Small and medium-sized health enterprises in health industries are particularly vulnerable where unethical business conduct is left unchecked and cross-stakeholder collaboration is stifled.

While the journey for consensus frameworks has only just begun and is likely to confront anticipated and unforeseen challenges, thus far the platform has demonstrated itself as an impactful approach in addressing the trust gap in our health systems. They are breaking down the silos in each stakeholder's work to strengthen ethical business conduct. In doing so, consensus frameworks are also leading each stakeholder to prioritise further work in this area—a true collection action that races to the top. ha

More information: To learn more about consensus frameworks and efforts around the world to strengthen ethical business practices, please reach out to us at ablasi@crowell.com.

Additional Media links:

10 September 2019—*Chile joins APEC efforts to bolster health ethics, support SMEs and patients:* https://www.apec.org/Press/News-Releases/2019/0910_SME

24 July 2018—*Ethics pacts provide timely boost to healthcare, trade:* https://www.apec.org/Press/News-Releases/2018/0723_health

27 September 2017—*Health coalition signs trade-boosting ethics agreement:* https://www.apec.org/Press/News-Releases/2017/0927_health

7 September 2016—*Health bodies unite against unethical conduct:* https://www.apec.org/Press/News-Releases/2016/0907_ethics.aspx

PROFESSOR NIGEL EDWARDS
Chief Executive, Nuffield Trust, UK

Strategies for improving health policy

Excerpts from the inaugural John Deeble Lecture 2019—part 2 (final)

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.

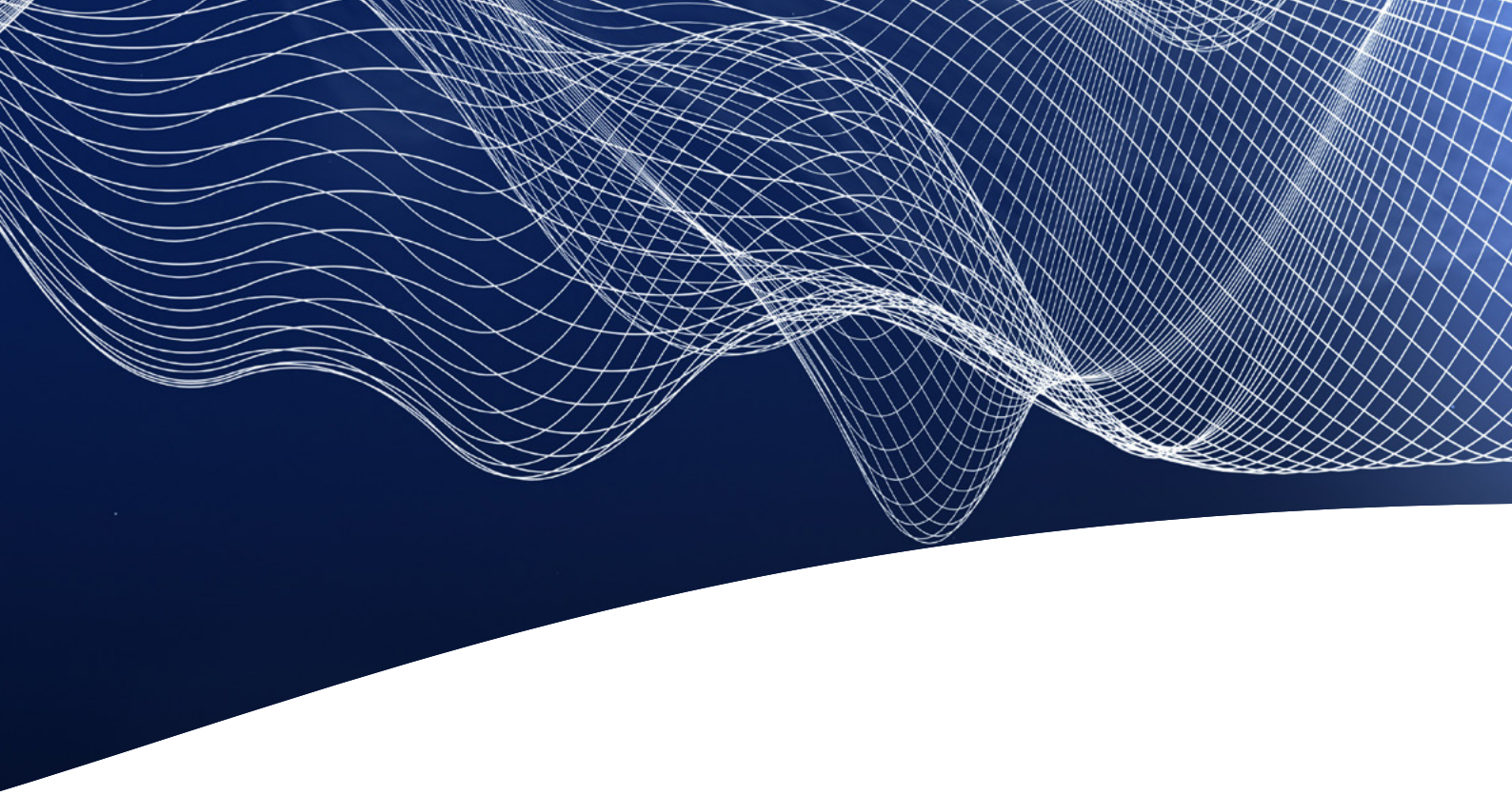
Excerpts from Part 2 of the lecture, on strategies for improving health policy, are published below. The focus in Part 1, published in the December 2019 edition of* The Health Advocate, *was on policy failings.

Implementation

There are a range of hazards that occur between designing a good policy and implementing it. The more 'transformational' it is, the more likely that these will create failure.

Perhaps the most significant issue for complex transformation programs in many health systems is the lack of a strong narrative which is well articulated in a compelling way…and lack [of] a theory of change—are we relying on professionalism and intrinsic motivation, managerial command and control, the invisible hand of the market or telepathy? It is not always clear.

One long-standing issue in some systems is the division of labour between purchasers/commissioners and providers in the design and implementation of policy. In England, unlike other countries with a purchaser/provider split, we have asked the commissioners to do too much of the detailed design of local implementation and to get overly involved in day-to-day issues. This is odd because the expertise about services and the management capacity to change them is located in providers. This has led to a long-standing disappointment with commissioners but indicates an important implementation lesson—put responsibility for change with the bodies that can make it happen, then use the commissioners to hold them to account and ensure that they do it. There is no point in having a dog and barking yourself.



The other areas to highlight resonate with much that is already in the business literature:

- poor process and unclear leadership
- timescale—policy makers are very prone to optimism bias. Complex change requires continual negotiation and often takes place in unpredictable ways and at varying speeds.
- insufficient resources, especially for double-running, organisational development and change management
- not enough attention to workforce, capital, IT or other infrastructure requirements
- payment systems and regulatory machinery that are misaligned
- policies and procedures being issued on top of a multiplicity of existing policies and procedures
- pilot projects that are hard to convert into sustainable change
- unintended consequences that are unhelpfully powerful and unexpected
- superficial attempts to change deep culture.

A particular aspect of this is the additional challenge introduced by having a large and powerful workforce with views and values that are often not aligned with those of management.

Evidence-based policy and the role of policy intermediaries

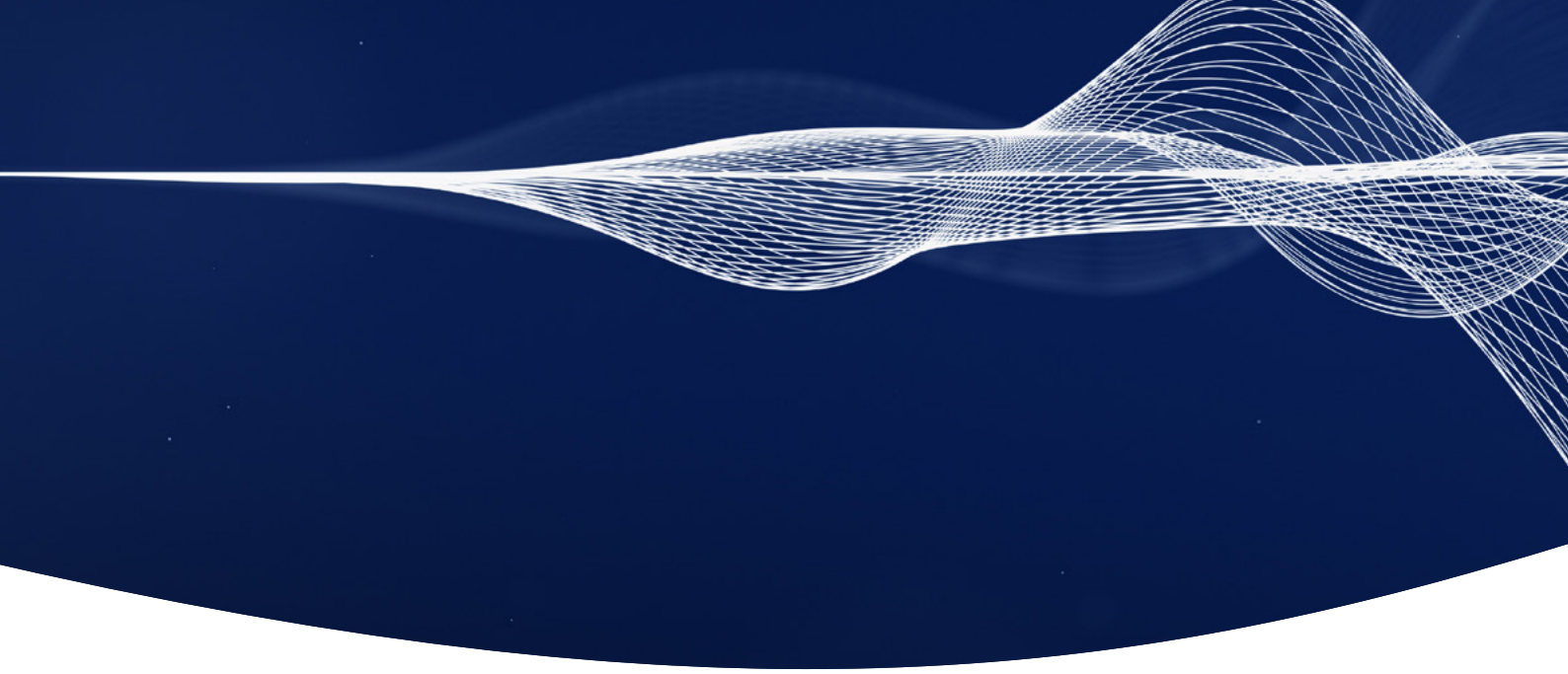
There has been a lot of handwringing over health policy and other failures in the UK. This has led to attempts to develop the idea of evidence-based policy and to get policy-makers to pay more attention to evidence when they are forming policy.

In a number of countries the use of evidence has improved, and organisations that sit between the worlds of research, policy-making and management practice play a key role in making the translation between these different domains.

But many studies have noted that knowledge use by administrators and politicians is a more complex, social and political process than rational models of policy-making allow for…and some of the evidence may be missing or not useful and in some cases there may only be indirect evidence.

This requires a number of strategies for those of us who are concerned with the creation of evidence for policy.

BETTER QUESTIONS. There needs to be more rigour in testing the questions being posed and, in particular, the easy emergence of group-think or ideas where the caveats and qualifications are being downplayed. >



MORE CRITICAL THINKING. Unfortunately, in the political arena, much simpler, less cerebral and more immediately arresting analysis is much more likely to be effective. 'Cutting bureaucrats and taking back control' [is] more immediate and impactful that the careful and qualified arguments that come from understanding the real complexities. When the debate is highly polarised, bound up with questions of identify, based on feelings rather than facts—which seems to be a feature of quite a lot of today's politics—the answers are not so easy.

DIVERSITY OF DISCIPLINES. There is more to do to bring ideas, analytical frameworks and methods from other disciplines such as sociology, political science, anthropology, organisational psychology, geography, etc. This means that there is an important role for skilled generalists who can span disciplines and methods—but who also know when to bring in a specialist.

DIVERSITY OF VIEWS. Getting the right balance between top-down and bottom-up in policy making is a perennial challenge. Policy-makers often need to connect to a wider range of views and voices from different levels of the health system, from different geographies, from patients, carers and stakeholders outside the system. Policy intermediaries can assist with this and reduce the risk of the usual suspects being brought in each time.

USING HISTORY AND COMPARATIVE STUDIES. Many policy ideas have been tried before or in other settings and countries. These require care in their interpretation. Better policy evaluation and learning needs to be a strong part of this—ministers are generally reluctant to fund this and so there is a key role for independent bodies.

MORE EXPERIMENTATION. The complexity challenge means that there is going to be more muddling through and experimentation. Many health systems, particularly in the UK, are littered with pilots that were never scaled up and so caution is necessary. Policy-makers need to get much better at the design and evaluation of experiments and being able to distinguish between processes that are about discovery and those that are meant to develop models for wider implementation.

BETTER APPROACHES TO THE PROBLEM OF CONTEXT. Mary Dixon Woods *[Professor of Medical Sociology, University of Leicester]* argues that in adapting quality improvement initiatives to their local context there is a need for a different type of knowledge than is usually deployed. She goes to Aristotle and others to identify four different types of knowledge:

"Many health systems, particularly in the UK, are littered with pilots that were never scaled up and so caution is necessary."

- *Episteme*: abstract generalisation, the kind of universal knowledge that is shared and circulated, taught and preserved. It can be seen as knowledge about things.
- *Techne*: the capability and capacity to accomplish tasks.
- *Phronesis*: practical and social wisdom, which is the result of experience and social practice.
- *Metis*: conjectural knowledge, which is unpredictable and intuitive. Metis is the form of ad hoc reasoning best suited to complex social tasks where the uncertainties are so daunting that intuition and 'feeling the way' is most likely to succeed.

SHORT DIGESTIBLE SYNTHESIS OF THE EVIDENCE. Generally, far too little effort is put into creating a hard-hitting short research summary that captures the key points in ways that will have an impact with policy-makers, managers and clinicians. Developing these is a key skill that policy intermediaries can bring. There is a particular role for communications experts who also have a good knowledge of the field rather than just being specialists on media, the web or public affairs.

Bringing these different approaches together will greatly increase the chances that policy will work better—and again policy intermediaries potentially occupy a key role.

Independent bodies can speak truth to power or, perhaps less grandly, inject doubt into false certainty. They can remind people of the history, and test that the solutions fit the problems and have the requisite level of simplicity or complexity. They have a duty to speak up and avoid the temptation to be co-opted into the system—as well as helping to find new pathways to solutions. 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 https://ahha.asn.au/health-advocate-podcast.

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.

DR ROBYN CLAY-WILLIAMS
Senior Research Fellow, Australian Institute of Health Innovation, Macquarie University

Safety and speed in emergency departments

Is speed putting patients at risk?

Anyone who has visited a hospital emergency department (ED) will have experienced the anxious wait to be seen. New research from the Australian Institute of Health Innovation, Macquarie University, has found that judging the performance of an ED predominantly on how fast it can see people, however, could be putting patients at risk.

More than 8 million people presented to EDs across Australia last year; and this number is rising annually as the population grows and the proportion of older people increases. As we encounter new diseases such as the COVID-19 coronavirus, EDs will be relied upon even more to care for our population. This unrelenting demand puts EDs under enormous pressure.

We know that overcrowding in EDs results in care that is less safe, and can lead to errors. To help prevent this, Australian governments have set performance targets that are time-based, and provide guidance on the maximum time taken to be seen (depending on urgency of illness or injury), and the maximum time before admission to a hospital or discharge home.

There is evidence that time taken to be seen matters for some conditions, and that patients who stay longer than four hours in an ED have worse health outcomes. Each state and territory has therefore implemented hospital ED targets to ensure that patients are seen promptly and leave the ED for admission, referral or discharge home within four hours.

New research from some of Australia's largest hospitals, however, shows that hospitals that focus solely on moving patients though EDs faster are in danger of emphasising speed over safety. While strategies designed to keep patients safe are essential—1 in 10 people are harmed in hospital—focusing on speed alone risks punishing EDs that also value adherening to patient safety measures.

Safety and quality

The 'Deepening our Understanding of Quality in Australia' (DUQuA) study is a long-term Australia-wide in-depth study exploring how quality management systems, leadership and culture in Australian hospitals are related to care delivery

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and patient outcomes. The study included 32 large hospitals from New South Wales, Queensland, Victoria, South Australia, Tasmania, the Australian Capital Territory and the Northern Territory.

The Australia-first research has shown that proven policies and procedures that keep patients safe in EDs may result in slightly longer wait times and lengths of stay for patients—which is at odds with the government focus on time measures. In fact, there's an inverse relationship between the time measures we currently use to judge the performance of an ED, and ways of making an ED safer.

Safety and processes

Safety measures range from ensuring patients are given an identification bracelet, to emergency crash carts having a completed checklist of supplies, to appropriate reporting and investigation of poor instances of patient care.

Attending to safety like this, however, increases wait times. On a scale of 1–4, improving implementation of safety strategies by 1 point can mean 5 minutes extra waiting time to be seen, and an 18-minute longer stay in the ED per patient.

Safety and teamwork

Focusing on making sure people move into and out of ED quickly can also work against excellent clinical leadership and teamwork.

In order to achieve the safest patient care in an ED, our research confirmed excellent teamwork is needed. But strangely, we found that when communication and collaboration between doctors and nurses resulted in shorter wait times, a patient's subsequent length of stay increased.

This seems to indicate that when teams are working well together they are better able to cope with and see people arriving at ED promptly, but then spend more time assessing and treating patients once they are admitted to the ED.

Safety and organisational culture

When an ED has a high safety culture, such as where people feel empowered to follow guidelines and report errors, then wait times and lengths of stay both decrease significantly.

Good governance, and support for safety measures by senior managers, also resulted in shorter ED wait times and lengths of stay.

When hospital executives do not value quality and safety strategies, then the underlying message to the ED is that this shouldn't be their priority either. Tasks are then at risk of being performed more with time in mind rather than quality of care.

Safety and speed

While everyone deserves to be seen promptly when they come to an ED, hospital staff should be supported to provide care aligned with best practice, delivered in a respectful environment. In short, to provide the best service in EDs we need to measure and value safety as well as speed. ha

Dr Robyn Clay-Williams leads an internationally regarded research stream in the field of human factors and resilient healthcare.

DR JANET LONG
Senior Research Fellow, Keeping People out of Hospital Project, Australian Institute of Health Innovation, Macquarie University

Keeping people out of hospital

Coping with a long-term illness or recurring ill-health is a challenge faced by increasing numbers of Australians. While as a population we are living longer, it is often with more than one long-term health condition such as heart disease and diabetes.

If not carefully managed, and sometimes simply as a matter of course, recurrent hospitalisations can form part of the picture, causing greater pressure on hospital resources, and sometimes inappropriate care that could be better managed nearer to home.

The COVID-19 crisis has highlighted the importance of making high quality care available in the community, alleviating pressure on hospitals. Even without a pandemic, the key to better care for chronic and complex conditions lies in major improvements in the delivery of best practice care across the entire health system.

There is no lack of research, with solid evidence bases to guide high quality care. It is the translation of that research into best practice that is the hardest part—moving it from the laboratory bench to the bedside. The Medical Research Future Fund (MRFF) Keeping People out of Hospital Project, led by the Australian Institute of Health Innovation (AIHI) at Macquarie University, will develop a robust and detailed model of just how to do that.

The Project is being undertaken on the New South Wales Health Flagship program, Leading Better Value Care (LBVC), which has been rolled out across the State.

LBVC is seeking to provide the right care in the right place at the right time for all patients, recognising the impact of chronic diseases on the sustainability of our health system. The ultimate aim of the evidence- and value-based initiatives within the LBVC program is to improve the care people receive by:

- improving health outcomes
- improving patient experiences of receiving care

GraphicStock

- improving the experiences of health professionals providing care
- increasing effectiveness and efficiency of care.

The Keeping People out of Hospital Project is focused on the implementation of the LBVC program into the health system. AIHI will be working with several organisations that shape the delivery of healthcare in New South Wales (NSW), including the NSW Agency for Clinical Innovation, NSW Bureau of Health Information, Macquarie University Centre for the Health Economy, and the NSW Ministry of Health. The Project will complement existing health economic analyses, and formative and summative evaluations already being undertaken.

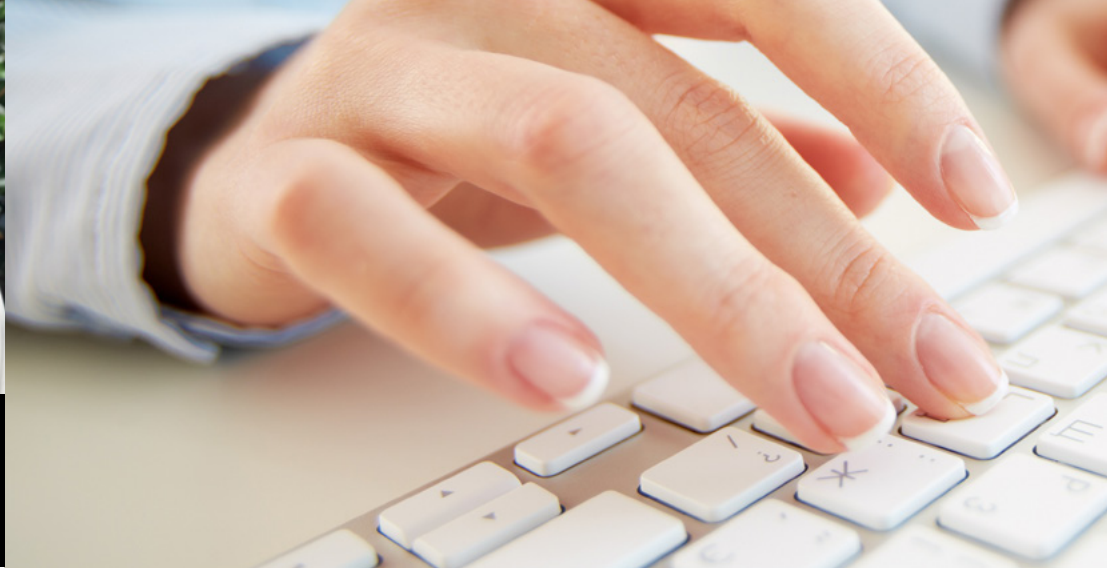
It is a complex project with a simple outcome—to identify implementation strategies that work well in one context, discover in detail why and how they work, and model how we can replicate that in other locations across NSW and Australia. It will focus on the leading causes of hospital admission—chronic heart failure, lung disease, diabetes, osteoarthritis and kidney disease. The research also aims to support the over 100,000 people in NSW Health working every day to improve experiences of care, and clinical outcomes.

A major challenge is trying to take into account all the complex contextual variables that implementation strategies must address—including differences in the nature of the various innovations, differences in sites and patient cohorts (e.g. rural, metropolitan), and differences in the resources available at each site.

The Macquarie University Centre for the Health Economy will concurrently develop an economic model that can be considered alongside the implementation model to identify benefits, risk-benefits, and how benefits are likely to change as the programs mature. ha

The *Keeping People out of Hospital Project* is funded by the Medical Research Future Fund (MRFF).

TESS VAN DER RIJT
Chief Executive Officer, Medinet Australia



The vital role of telehealth in supporting access to primary care during COVID-19

As patients adopt self-isolation measures in the context of COVID-19, presentations to GP medical practices have declined by at least 30%. While healthcare is considered an essential service and therefore is one of the few businesses in Australia that remains operational, medical practices are engaging in more novel ways to ensure continuity of business and continuity of care for their patients.

Telehealth has been recognised by the government as a critical tool in protecting the wellbeing of patients and doctors in response to the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic.

What is the policy around telehealth?

On 30 March 2020, the government released a fourth phase 'whole of population' telehealth policy, with the government making bulk-billed phone and video consults available to all Medicare cardholders in an effort to protect patients and healthcare workers from COVID-19. All citizens now have free access to medical practitioners via telehealth, including GPs, some medical specialists, mental health treatment and chronic disease management. Prime Minister Scott Morrison stated: 'We are asking Australians to stay home… and we want to ensure that they can continue to get access to healthcare and health advice and support from GPs.'

Doctors were elated at the telehealth expansion. Australian Medical Association President Dr Tony Bartone stated that the policy will allow 'the continuation of normal patient care' in primary health care and importantly, alleviate some of the pressure on public hospitals by reducing presentations that 'could have occurred without telehealth access'. Telehealth also protects doctors from infection and keeps them in the workforce.

How is telehealth used to manage and diagnose COVID-19 and also support business as usual?

A number of GP booking and telehealth platforms now offer online pre-consultation coronavirus assessments. The patient answers the national triage protocol criteria for suspected COVID-19 infection, which is provided as a health summary to the GP at the commencement of the consultation. If the GP determines it clinically appropriate, the GP can then generate a pathology referral which the patient can immediately access.

"All citizens now have free access to medical practitioners via telehealth, including GPs, some medical specialists, mental health treatment and chronic disease management."

GraphicStock

Patients are then supported by being provided with a list of dedicated collection centres and drive-through clinics in their state or territory.

The fact that the screening and consultation are online also mitigates the growing issue medical practices are facing, with some patients not divulging their full medical history before the consultation to ensure they can speak with a GP and are not turned away.

But telehealth demand has not simply increased for the purpose of screening COVID-19. Many patients are using telehealth for their regular medical needs, including accessing medications, medical certificates and general clinical advice for chronic conditions. Some medical practices are anticipating that 80% of their consultations will be conducted via telehealth during this isolation period.

How effective can telehealth be without the ability to physically examine the patient?

Unsurprisingly, demand for remote monitoring systems has increased. Integration of remote monitoring tools such as pulse oximeters, blood pressure cuffs and spirometers augment the effectiveness of remote health care.

It is also possible for doctors to teach patients how to conduct physical examinations on themselves to mitigate the risk of the health professional not being able to conduct a physical consultation themselves.

'Doctors are able to teach patients in simple steps how to measure, for example, pulse or respiratory rate. They can also ask the patient to use the video function on their smart device to show visible symptoms and encourage them to describe how touch or movement feels', says Dr Sumeena Qidwai, a GP and Clinical Expert at Medinet Australia, a GP telehealth platform.

Will telehealth make medical practices redundant?

While COVID-19 has forced both patients and healthcare professionals to adopt telehealth, whether they wanted to or not, it may result in both parties realising its ease of use and the new level of accessibility it provides to vital healthcare services.

But very few people would argue that the rise of telehealth will result in the redundancy of medical practices. There are many contexts where a physical examination is required to conduct effective health care and not every citizen is comfortable talking with a health practitioner online.

Dr Qidwai states that 'Even in the context of COVID-19, that's why GPs are still open for business as usual. There are, for example, patients who are pregnant who need regular check-ups, or babies who need their routine immunisations, and we obviously can't see or do those physical things over the phone.'

COVID-19 has forced both patients and practitioners alike to adopt more innovative means to access and provide healthcare. While telehealth won't replace face-to-face consultations, it is likely to remain as an effective complementary medium for accessing effective and convenient health care. ha

ANNA FLYNN
Executive Director, Australian Centre for Value-Based Health Care

The importance of strategic communication leadership in healthcare

"A strategic communications manager brings an impartial element to crisis talks."

Communication and COVID-19

One of the things that has struck me frequently during the progression of the COVID-19 pandemic is the way it has been communicated both internationally, and specifically in Australia. With a background in communication management myself, I can't help but think about the wealth of do's and don'ts we are creating for future communication leaders to draw on when aiming to provide clear messaging—especially about health issues.

As COVID-19 continues to play out in Australia, we can clearly see that effective healthcare messaging is vital, and in my opinion, this was initially a struggle. Governments are used to working with media managers that can turn a story around to fit with the political agenda or government staffers that can respond to questions with well-crafted pre-approved responses. However, the response to COVID-19 required and still requires a different type of messaging. It requires communication leaders with established relationships across all levels of government and access to subject matter experts, as well as the ability to translate complex information into plain understandable messages for the audience—in this case the entire nation. Most importantly it requires trust—the trust of other senior leaders in the communication leader to do their job.

For me, a prime example of a 'don't' was the messaging around hairdressing in one of the first press conferences held by the Prime Minister and the Chief Medical Officer at the end of March. The image presented of a hairdresser being timed to give a 30-minute haircut and to also practice social distancing seemed absurd in so many ways that I think the general public were left anxious and confused about whether the government really had this in hand. The next day almost led to a

coup with Premiers taking on their own messaging and the eventual backtracking on the hairdresser announcement.

Why are the messages so important?

The messages, and the way they are communicated under this particular scenario, are vital to the way a population acts. This is not like political messaging where you might influence 50% of the voters to support your policy—this is about ensuring the entire population understands what is happening and are able to follow some crucial instructions.

For the first time in many of our lives we want to hear from our Prime Minister and Premiers, we are dependent on their leadership. People need information—How long is this for? Can I go and see my family? Should I cancel my holiday? When will the schools be open again? Without clear messaging our mental health is tested.

Clear messaging extends beyond COVID-19. In looking to the future of healthcare delivery and options such as value-based health care (where the patient is at the centre of healthcare delivery) communication and messaging will be key success factors. Communication between clinical staff and patients is key to improving the patient experience, and 'losing the jargon' will be one of the many factors vital to success.

The need for strategic communications leadership

Communications has for many organisations become a 'functional' role. Often outsourced, communications staff make things look good, manage social media and websites and run some specific campaigns. However, it will often take a crisis such as a pandemic to highlight a lack of investment in genuine strategic communication at the leadership level.

A strategic communications manager brings an impartial element to crisis talks. A good strategic communications manager will have developed strong relationships with people at senior levels across all levels of government, and departments. They are trusted, and most importantly knowledgeable about subject topics, and who the most trusted subject experts are. Their primary skill is to translate complicated information into clear, concise messaging that can be understood by the audience. A strategic communications manager must be part of the leadership team and engaged at the highest level of decision-making. My practical experience is that even if comms managers are included at those levels, they are often relegated to observer status rather than providing a genuine contribution to decisions.

Organisations can learn a lot from the 'hairdressers' press conference. The government turned this around in the following week. Clearly a better conversation was had with the Premiers, and the incorporation of better spokespeople has certainly helped with delivering more accessible and understandable messages in subsequent press conferences.

An ongoing need for communications leadership in health

Going forward into life after COVID-19, I see good strategic communication being crucial in managing the nation's mental health—a problem that, despite being quite high on the government's agenda, will surely be one of the biggest health challenges of the next decade. ha

phn NORTHERN SYDNEY
An Australian Government Initiative

SYDNEY NORTH Health Network

Improving health and wellbeing through person-centred care

Our experience
Sydney North Health Network

Person-centred care may well be the future of general practice in Australia—and it's here now in Sydney's north. A person-centred care model, sometimes referred to as a person-centred medical home (PCMH), combines the traditional core values of a family-focused medical practice with a team-based approach to care and an ongoing, active relationship between the person and their healthcare team.

'Person-centred care focuses on the patient, their needs, and their goals to achieve better health outcomes. It is a team-based approach to healthcare, where the GP works with a team to look after a patient's welfare and health. This allows health professionals to focus on their individual skill sets to deliver a better quality of care to patients,' says Sydney local northside GP, Dr Kiril Siebert.

Sydney North Health Network (SNHN) provides support and education to healthcare teams to help enhance patient experience of coordinated care, improve systems and data collection, optimise health and wellbeing, and improve the work life of healthcare clinicians.

'This shared or team approach not only provides additional value for patients, it can help prevent burnout of our medical professionals', says Sue Barry, Primary Care Coordinator/Program Lead at SNHN.

Practice nurse Kathleen Chapman said she was in a very fortunate position in that she was able to spend time with the patient. 'We work out what they need and what is important to them. I get to do a full health assessment which can take up to an hour depending on complexity, then we go and talk to the GP together. We like to make sure they keep the same doctor and nurse, and work towards their healthcare goals as a team.

> **“This shared or team approach not only provides additional value for patients, it can help prevent burnout of our medical professionals.”**

It’s about connecting with and continually following up with the patient. We also connect them to services around the local community to help them in getting well and staying healthy.’

Local GP Dr Mehrnoosh Alian emphasised the ongoing and preventative approach to care. ‘You don’t have to be sick in order to seek and receive care. It can all be a part of your preventative healthcare program. When a person is involved in their own care, they have a better understanding of their own needs,’ says Dr Alian.

Dietitian Lisa Mesiti said that through the PCMH model, patients who were previously isolated in the community ‘now have a place to come and build health-based relationships with our healthcare team and other patients. This is really rewarding. Whether they are struggling with several chronic conditions at once or are reasonably healthy, we regularly check in with patients to help them stay on track in achieving their health goals.’ >

SUE BARRY
Primary Care Coordinator/ Program Lead, SNHN

KATHLEEN CHAPMAN
Practice Nurse

DR MEHRNOOSH ALIAN
Local GP

LISA MESITI
Dietitian

Bec Lewis Imaging (http://blimaging.com.au/aboutus/)

PCMH IN ACTION

Northern beaches patient Meg Parsons has Chronic Obstructive Pulmonary Disease (COPD) Her condition was progressively getting worse and her quality of life was deteriorating.

The moment Meg stepped into a north Sydney Person-Centred Medical Home (PCMH) practice, the receptionist recognised her distress, enabling Meg to be promptly seen by the practice nurse and GP.

Meg was adamant she did not want to go to a hospital emergency department. The practice team listened to her concerns and undertook an immediate course of treatment. They placed Meg on oxygen, which her greatly improved her breathing and alleviated her distress.

The practice nurse, Kath Chapman, became Meg's primary contact. Kath referred Meg to the best health services able to assist her in better managing her condition.

Local GP Dr Mehrnoosh Alian now provides a compassionate, ongoing and preventative approach to Meg's care.

The PCMH team empowered Meg to be at the centre of her own care and encouraged her to take proactive steps to manage her condition.

Meg was referred to a local hospital to undertake exercise rehabilitation and sent to a specialist physiotherapist who focused on her breathing techniques.

The team also arranged for an aged care assessment, which provided Meg with a home cleaning service. Her home was regularly cleared of dust, and she could breathe more easily. Meg was now able to focus on her exercise regime and, using a pedometer, she could track her steps and improve her fitness.

'I was blown away with how the person-centred care practice helped me. Suddenly my whole world and health improved. I had choices, I was connected to the services I needed. They make you feel very important and worthwhile', she said.

Sydney northside GP Dr Kiril Siebert

PERSON-CENTRED MEDICAL HOMES IN THE US

Dr Kiril Siebert recently undertook a study tour of general medical practices in the USA that were using the PCMH model of care. He says general practice teams in the American healthcare system are generally much bigger than those in Australia.

'In the US practice system there are often doctors, nurses, behavioural therapists, pharmacists, medical assistants and care coordinators all in the one practice.

'I also noticed that the practices in America rely heavily on their data as benchmarks to improve standards, and to proactively improve quality of care. American practices are also not shy to share their data within practices or beyond. They were very upfront and proud about sharing their de-identified data which I think is great and something we could do better here in Australia.'

Dr Siebert was also impressed by one practice that had a 'Patient and Family Advisory Committee' (PFAC). The PFAC was a committee of 10 patients with whom the practice consults on health campaigns and potential practice improvements.

'Members of the committee were really enthusiastic and empowered about the part they played in their own healthcare. I would love to introduce PFACs here in Australia', Dr Siebert said. ha

SNHN Person Centred Medical Home

SUE MURRAY
Managing Director, Zero Suicide Institute of Australasia; Co-author, *Crisis Now* International Declaration

Crisis Now: transforming mental health crisis services

A systemic alternative to emergency department presentations

In January 2020 the world witnessed unprecedented fire storms across Australia. We also saw an unprecedented response of generosity from across the globe. Millions of dollars have been pledged, as has ongoing resource support. What lies ahead now is how to most effectively support the mental health and wellbeing of those who were left in the wake of this tragedy—both directly and indirectly.

This month (May 2020) Australia was among the first countries to launch the International Declaration for crisis mental health care. With input from more than 60 experts across 10 countries the document provides key elements required for *everyone, everywhere, every time*, to receive optimal care.

Like a physical health crisis, a mental health crisis can be devastating for individuals, families and communities. While a crisis cannot be planned, we can plan how we organise services to meet the needs of those individuals who experience a mental health crisis. Too often that experience is met with delay, detainment and even denial of service.

Impact of poor mental health crisis care

With non-existent or inadequate crisis care, costs go up because of hospital readmissions, overuse of law enforcement, and human tragedies.

In too many communities, the 'crisis system' has been unofficially handed over to police, sometimes with devastating outcomes.

The current approach to crisis care is patchwork, delivering minimal care for some people while others (often those who have not been engaged in care) fall through the cracks, resulting in multiple readmissions, life in the criminal justice system or death by suicide. >

"A comprehensive and integrated crisis network is the first line of defence in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources."

Photo by Toa Heftiba

There is a better way

A comprehensive and integrated crisis network is the first line of defence in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources.

There is a better way. Effective crisis care that saves lives and dollars requires a systemic approach. Piecemeal solutions are unacceptable. According to the National Association of State Mental Health Program Directors in the US, research has demonstrated the effectiveness of the core elements of systemic quality crisis care as being:

1. A Crisis Call Centre Hub that connects people in crisis with health professionals to ensure timely access and maintains a detailed data collection.

These programs use technology for real-time coordination across a system of care, and leverage big data for performance improvement and accountability across systems every minute of every day.

2. Mobile crisis workers who can be deployed to the location of the person to de-escalate the crisis and connect the person and family or carers to ongoing community-based services.

Mobile crisis services are typically comprised of a two-person (licensed clinician and peer partnerships are common) crisis response team that offers outreach and support where people in crisis are either in the person's home or a location in the community (not a healthcare facility).

3. A stabilisation unit where the mobile crisis worker can take the person for more comprehensive support and assessment of the need for inpatient services.

Design of these facility-based programs may vary, but ideally will include a medically staffed flexible observation/stabilisation area (often limited to 24 hours of care) that implements a no-referral-refused process in which walk-ins, police and other first responder referrals are immediately accepted without requiring any form of screening prior to acceptance.

4. Evidence-based treatments and supports available 24 hours per day.

Standard practice involves: implementing universal screening; asking directly about suicidal behaviours; and delivering evidence-based treatments for suicidality, along with safety planning and post-care follow-up.

These quality crisis systems are further enhanced by harnessing data and technology, drawing on the expertise of those with lived experience, delivering services where the person is and providing evidence-based suicide prevention.

Everyone, everywhere, every time

The Victorian Royal Commission, the Productivity Commission Draft Report into Mental Health, and the voices of those with lived experience all call for non-hospital based mental health care to be available at all times. The *Crisis Now* model which operates in several US states has demonstrated a 40–45% reduction in costs to hospitals and to demands on partner services such as the police. Most importantly, *Crisis Now* is delivering improved outcomes for the people it serves.

A recovery-oriented approach to crisis care is integral to transforming a broken system. Crisis Now presents a proven model to rebuild Australia's mental health services with clinical care fit to need. While there will always be a need for some hospital-based care, it does not have to be the norm.

The latest Australian Institute of Health and Welfare report on mental health services noted that 6 out of every 10 people who present to emergency with a mental ill-health condition are not admitted to hospital. Providing alternative care pathways will help individuals, families, workplaces and whole communities recover from a mental health crisis.

We know from experience that *immediate* access to help, hope and healing saves lives. ha

MS CHRIS KANE
General Manager—Strategy and Engagement, Western Australian Primary Health Alliance

Rainbow tick for health equity

Although many lesbian, gay, bisexual, transgender and intersex (LGBTI) Australians live healthy and happy lives, research has shown that a disproportionate number have significantly worse mental and physical health outcomes when compared to the wider community. Evidence shows that the social exclusion, discrimination, stigma and marginalisation experienced by LGBTI people increases the risk of adverse impact on their health and mental health, and creates barriers to accessing health and social care services.

Western Australian Primary Health Alliance (WAPHA) is actively involved in advocating for and facilitating safe, inclusive, and culturally appropriate primary care services for LGBTI people. As part of our efforts to improve health equity, we have started a conversation about what inclusive and culturally competent primary care services should look like in Western Australia.

On a practical level, we undertook and achieved Rainbow Tick Accreditation, the first Primary Health Network in Australia to do so. This accreditation recognises our ongoing commitment to ensuring people of diverse sexuality and/or gender have access to safe, inclusive and culturally appropriate healthcare.

WA LGBTI Health Strategy 2019–2024

The WA LGBTI Health Strategy for 2019-2024 was released in August 2019 by the WA Department of Health. The first of its kind in WA, the strategy sets out to improve health outcomes for Western Australians who identify as LGBTI.

As part of the WA LGBTI Health Strategy Reference Group, WAPHA helped develop the strategy, along with extensive input from local LGBTI community members and health service providers to better address LGBTI physical and mental health care needs. During the development process, more than 600 submissions were received, detailing the priorities individuals from the LGBTI communities would like to see addressed.

As a result, six priority areas were identified in the strategy which will help lead to better health

AGPAL Group CEO Dr Stephen Clark presents WA Primary Health Alliance CEO Learne Durrington and Board Chair Dr Richard Choong with their Rainbow Tick organisation accreditation certificate.

outcomes for LGBTI people over a five-year period. These include promoting accessible and inclusive health services, leadership, affirmative practices, access to LGBTI-specific resources and services, research, education and training.

Engaging with our LGBTI communities has, of course, been fundamental. They told us they want to be treated as 'substantively equal' to their heterosexual counterparts and they seek health providers who are inclusive, non-judgmental and informed about issues related to LGBTI health.

This input is already informing our health service planning, helping to ensure the health services we fund are safe, and the general practices they visit are welcoming and inclusive of the needs of LGBTI people.

Our Rainbow Tick journey

The Rainbow Tick was developed in response to the growing number of requests from the LGBTI community seeking LGBTI-inclusive health professionals and services, and health and human services organisations wanting to understand how they could improve the quality of care they provide to this group.

Our accreditation journey commenced in 2018, where we began working towards meeting six national standards of LGBTI-inclusive practices.

These include:

- organisational capability
- workforce development
- consumer participation
- a welcoming and accessible organisation
- disclosure and documentation
- culturally safe and acceptable services.

Achieving Rainbow Tick accreditation aligns with who we are as an organisation and what we're all about—shaping, strengthening and sustaining a health system that works for everyone.

Our Board and Executive were (and continue to be) committed to building our capacity to work inclusively with our LGBTI communities and enable the cultural change required to truly embed LGBTI-inclusive practice within WAPHA and our partner organisations. >

"The Rainbow Tick accreditation report provides us with recommendations for improvement as we strive for excellence in diversity and inclusion."

Health data challenges

Data on LGBTI health trends is needed to ensure WAPHA-commissioned services and existing primary care services meet the needs of the LGBTI community. However, the scarcity and inconsistency of data for the LGBTI community poses a real challenge. Without robust data, we don't have the full picture of health needs and service utilisation required to help our funded service providers and general practice meet the needs of the LGBTI community.

To overcome this, WAPHA and our funded service providers have improved the way we capture data on service provision and outcomes for the LGBTI community. For example, we are working to include data elements that adequately capture sexual preference and gender identity in our outcome indicators.

More widely, we've sought to influence data sets to include sexual preference and gender identity and made it clear that the collection, analysis and interpretation of data and trends should be formulated in consultation with the LGBTI community to avoid inadvertently causing additional stigmatisation.

LGBTI inclusiveness in the data collection represents, at a system level, the first step towards breaking down barriers to service access for LGBTI people.

Where to from here?

Our journey doesn't end with achieving Rainbow Tick accreditation. WAPHA recognises the leadership role we have as an advocate for LGBTI pride, diversity and inclusion in the primary and social care sectors in WA.

The Rainbow Tick accreditation report provides us with recommendations for improvement as we strive for excellence in diversity and inclusion. Our forward-looking Quality Improvement Plan will guide our work in this area and is based on three key objectives that emerged during our accreditation assessment.

Going forward, WAPHA will:

- continue to work with stakeholders to embed LGBTI cultural safety and inclusive practice across commissioned services and the primary healthcare sector;
- ensure continuous improvement and maturation of LGBTI training and development for staff to meet operational needs; and
- consolidate and integrate relevant systems to ensure LGBTI-inclusive practice is embedded and consistently applied, reviewed, developed and demonstrated across WAPHA. ha

NIGEL FIDGEON
Chief Executive Officer, Australian and New Zealand College of Anaesthetists

Beyond medical advocacy

How a specialist medical college is working to reduce health inequities in Australia and New Zealand and the broader global community.

photo by Cristian Newman

Representing 9,000 anaesthesia and pain medicine fellows and trainees, the Australian and New Zealand College of Anaesthetists (ANZCA) is one of Australia's largest specialist medical colleges.

The college takes its role as a trusted and respected organisation in society seriously and recently released its 'Statement on the role of ANZCA in advocating for the health and wellbeing of all people' (see www.anzca.edu.au/documents/statement-on-the-role-advocating-for-health-and-we.pdf) outlining its responsibility to advocate on behalf of the health of all members of society.

The statement is a strong and public commitment by the college that we:

- Support access to healthcare as a basic human right.
- Oppose all forms of discrimination, given the potential for this to negatively impact on the health and wellbeing of our trainees, fellows, staff, patients and the wider community.
- Endorse the principles that (i) health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity; and (ii) the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, or economic or social condition. >

"Since the launch of the strategy, ANZCA has commenced dozens of initiatives across every area of the college designed to reduce health inequities."

The college is working hard to improve equity in healthcare across a range of activities within the college, for Australians and New Zealanders, and for peoples living in the Asia-Pacific.

ANZCA's commitment to addressing inequities was evident in its 2015 statement supporting the health of people seeking asylum. More recently, the college established the ANZCA Health Equities Projects Fund to support Indigenous and overseas development projects.

Indigenous health

In 2018, ANZCA launched an Indigenous health strategy to address the significant inequities in health outcomes that exist between Indigenous and non-Indigenous people in Australia and New Zealand.

The strategy is accompanied by a 2018–2022 action plan that frames our work towards health equity for Aboriginal and Torres Strait Islander people in Australia, and Māori in New Zealand. ANZCA's work in Indigenous health can be found at www.anzca.edu.au/fellows/community-development/Indigenous-health.

Since the launch of the strategy, ANZCA has commenced dozens of initiatives across every area of the college designed to reduce health inequities. Highlights include:

- A doubling of the number of Aboriginal and Torres Strait Islander trainees.
- The establishment of a career and professional advice service for Indigenous medical students and prevocational doctors.
- A new project group to review Indigenous culture and health learning outcomes in the anaesthesia and pain medicine training program curricula.

Global health

Health inequities between people living in high- and low-income countries are evident across a range of measures. ANZCA has been involved in global development activities since its foundation and an Overseas Aid Committee was established in 2010 to co-ordinate this work, guided by a five-year strategic plan.

Health workforce represents a major challenge in many of Australia's Asia-Pacific neighbours, and teaching and vocational training is at the core of our activities. Through scholarships, in-country anaesthesia and pain medicine training, examinations support, and professional development, we aim to foster and develop a sustainable, local health workforce.

Of note is Essential Pain Management (EPM), a multidisciplinary and cost-effective training program designed to improve pain management across all local health workers. The program was developed by ANZCA fellows Associate Professor Roger Goucke and Dr Wayne Morriss. Since being piloted in 2010, EPM workshops have been delivered in more than 60 countries.

The Overseas Aid Committee also supports the donation of medical and educational equipment, and undertakes advocacy and evaluation activities to support global health. Some of the Committee's work can be seen at www.anzca.edu.au/fellows/community-development/overseas-aid.

Gender equity

Gender inequity affects people from all sectors, negatively impacting on quality of care and health outcomes for patients. About one in three anaesthesia fellows and one in four pain medicine fellows are women—however the

proportion of female trainees in both specialities is approaching 50%.

ANZCA strongly supports gender equity because of the ethical, social and economic benefits to its members and the broader community. In 2017 the college established a Gender Equity Working Group to achieve equal opportunities for all genders. Some of their work is summarised here—www.anzca.edu.au/about-anzca/gender-equity.

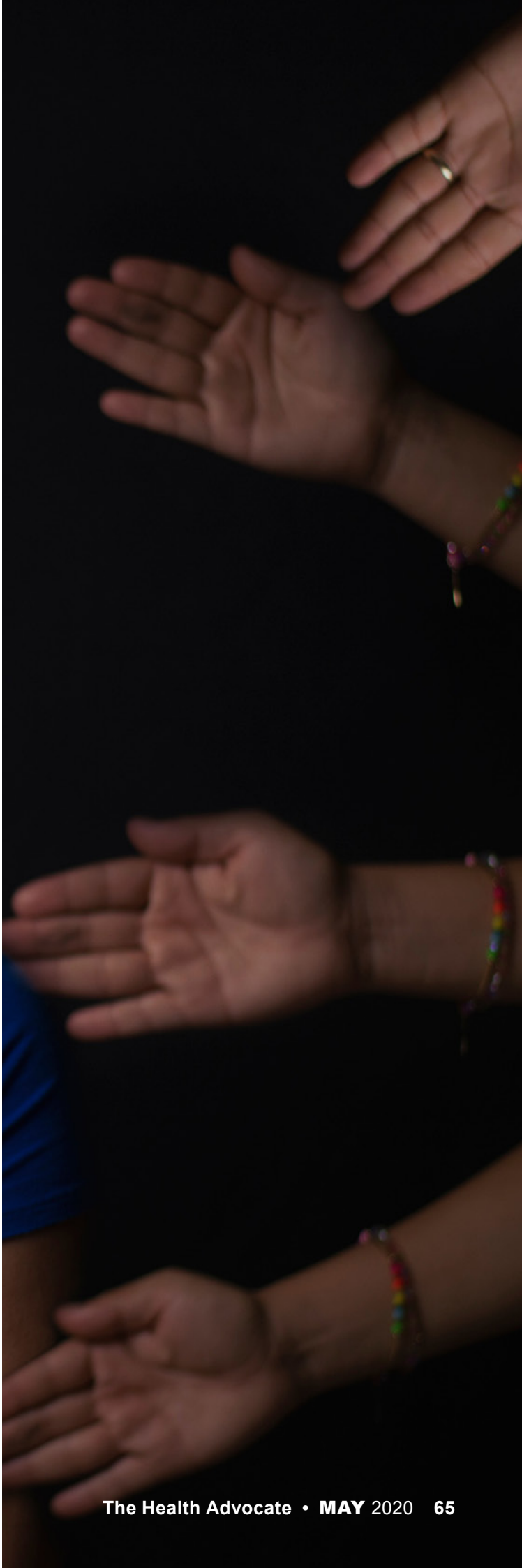
The first task of the Working Group was to develop a Gender Equity Position Statement articulating the college's enduring commitment to gender equity. The group has now expanded its scope to include inequities associated with LGBTQI and pride, multiculturalism, Indigeneity, ability and the disadvantages of geography, financial hardship and health systems.

Inequitable access to healthcare for rural and regional Australians

Access to healthcare is one of the key factors responsible for inequities in health outcomes between people living in urban and non-urban areas of Australia and New Zealand.

A focus in ANZCA's current strategic plan is to address these inequities through government advocacy and involvement in workforce planning, developing a rural GP anaesthesia qualification and rural training pathways, and promoting the benefits and rewards to fellows of working in regional and rural areas.

ANZCA—along with other specialist medical colleges—continues to advocate on a range of issues that affect peoples' health and wellbeing. The highest attainable standard of health for every human being is a formidable challenge—however it is one that all members of the college community are committed to working towards in everything we do. 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 Joy Savage
Cairns Health and Hospital Service

Prof. Wendy Moyle
Griffith University

Ms Yasmin King
SkillsIQ

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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AHHA's JustHealth Consultants provides affordable consultancy services that support Australian healthcare organisations at national, state, regional, hospital and community levels by delivering products and services that help our clients meet the demands of an ever-changing, complex healthcare environment.

JHC is ISO9001 accredited and has access to a pool of highly experienced and talented experts with skills across the spectrum of clinical, managerial, policy, administration, research, analysis and communication expertise.

If you are looking for consultants with a deep understanding of and connections to the Australian health sector and a focus on quality, reliability and cost-effectiveness, look no further than JustHealth Consultants.

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