The Health Advocate

Your voice in healthcare

Measuring what matters: Leading value-based health care reform in Australia

The pandemic may end, but the Pathway will continue

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Calls for a national revival of community health centres

Grassroots Healthcare

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The official magazine of the Australian Healthcare and Hospitals Association

ISSUE 67 / May 2022

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Cover photo: Nurse Priscilla Javni and Yr 12 student Angelina Trifunoski

The Health Advocate

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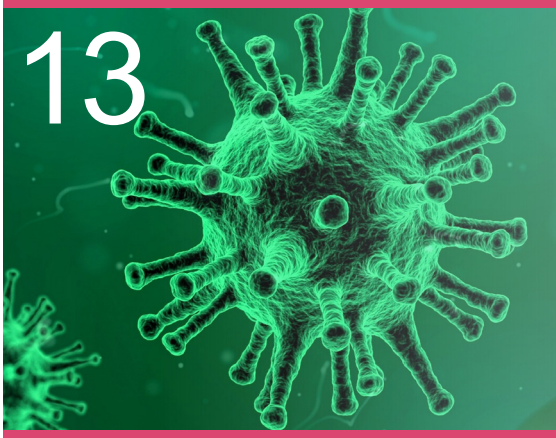


KYLIE WOOLCOCK
Acting Chief Executive
AHHA

Supporting our workforce

Matching and forecasting the needs, demands and supply of the health workforce are complex in any context. In the next five years, significant growth in the health and social sector is estimated to require an increase of over 300,000 skilled workers nationally. This is against a backdrop of the existing workforce being less willing to work than before.

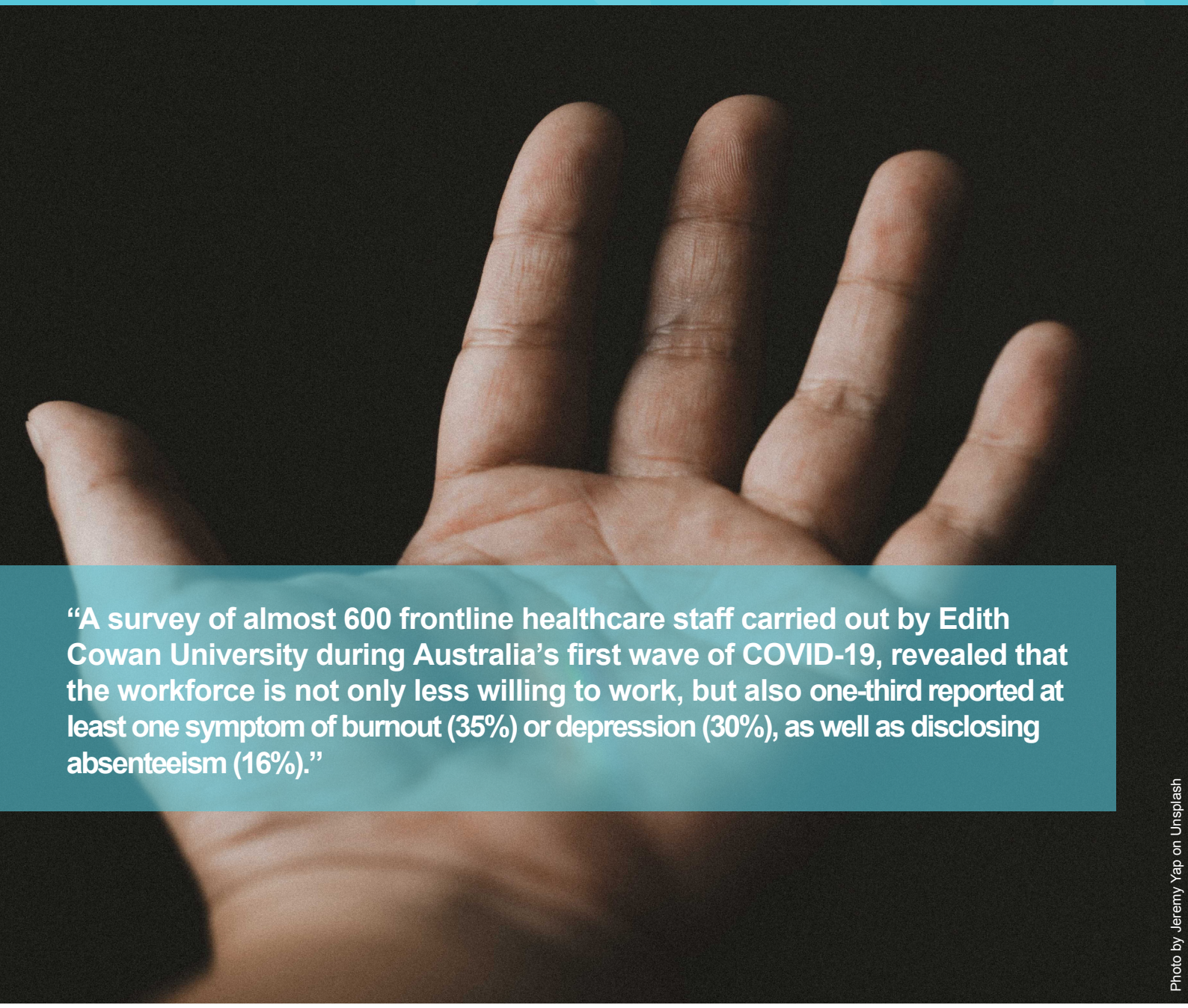
The pandemic has exacerbated the impact of burnout and its pervasiveness across the health workforce. A survey of almost 600 frontline healthcare staff carried out by Edith Cowan University during Australia's first wave of COVID-19, revealed that the workforce is not only less willing to work, but also one-third reported at least one symptom of burnout (35%) or depression (30%), as well as disclosing absenteeism (16%).

The removal of COVID restrictions has since placed a further burden on healthcare workers due to furloughed staff. If not addressed, the decline of Australia's health workforce will be a major contributor to health system failure.

With the healthcare workforce still mobilised to deal with the pandemic, 2022 has seen the health system attempt to adapt to reduce the significant impacts of burnout on the mental health and wellbeing of an already outstretched workforce.

In this regard, value-based healthcare (VBHC) pioneer Elizabeth Teisberg has recommended reframing 'burnout' as a moral injury; defined as the damage done to one's conscience by a transgression of moral values. Teisberg further suggests that, 'system-level solutions that facilitate relationship-centred care and maximise healthcare workers (are) intrinsic motivation to heal. The approach to combat burnout is to align clinical work and experience with patient goals using value-based healthcare principles.'

At AHHA, reorienting our health system to one that is value-based means shifting our focus to the outcomes that matter to people and communities for the resources used. Combating burnout should be an essential component of the argument for making the transition to a



"A survey of almost 600 frontline healthcare staff carried out by Edith Cowan University during Australia's first wave of COVID-19, revealed that the workforce is not only less willing to work, but also one-third reported at least one symptom of burnout (35%) or depression (30%), as well as disclosing absenteeism (16%)."

Photo by Jeremy Yap on Unsplash

VBHC model. Positive workforce cultures help recruit and retain staff, as can well-resourced and supported teams. Going beyond alternative health models and scope of practice, VBHC can support the workforce and address the impact of moral injury by aligning clinicians around shared patients and care delivery goals.

This issue of The Health Advocate focuses on the innovation that is happening at the grassroots in health care and highlight that supporting the wellbeing of the health workforce is essential. ha

AHHA in the news

16 MARCH 2022

Welfare of healthcare workforce at stake in worsening climate crisis

'In the aftermath of the recent devastating flooding events in Queensland and New South Wales, we must continue to support our healthcare workforce who have already been stretched to their limits by the COVID pandemic,' says AHHA Acting Chief Executive, Kylie Woolcock.

Flooding in Queensland and New South Wales has had an unimaginable effect on communities, but also the healthcare workforce that serves them.

'We need to ensure that the mental and physical health needs of our healthcare workforce are continued to be looked after, particularly in the wake of yet another natural disaster,' says Ms Woolcock.

'This is a reminder of just how much our healthcare workforce is depended on by all Australians. Taking care of their welfare will be essential to ensure the continual delivery of health services during and after natural disasters like the recent floods.' ha

24 MARCH 2022

Supporting genomics workforce critical to ensure high value care

More than 1 million genetic and genomics related tests are performed in Australia each year and demand is increasing.

'Genomics is set to be an increasingly important tool for health care and offers much potential, but like the broader health workforce more generally, the Australian genomics workforce is under increased pressure,' says Australian Healthcare and Hospitals Association Acting CEO Kylie Woolcock.

Released by the Deeble Institute for Health Policy Research, a Perspectives Brief Transforming the genomics workforce to sustain high value care explores some of the challenges currently facing this rapidly evolving sector.

'A coordinated national genomics workforce strategy will ensure we have a workforce that is resilient and sustainable to support all Australians to benefit from genomics.

'As the application of genomics testing increases, the workforce will need to be reinforced to support increased demand for services.'

Read the Perspectives Brief Transforming the genomics workforce to sustain high value care on the AHHA website. ha

HAVE YOUR SAY...

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

29 MARCH 2022

2022 Budget: Australians looking for investment in their health

Over the past two years, the pandemic has disrupted health care. The health and financial impacts of missed opportunities for early diagnosis and treatment on the health system are likely to be long-term, and waiting lists have grown.

'In this budget, resources towards catching up on the high numbers of patient for whom care was delayed should have been a given. Funding as a one-off boost to capacity for breast cancer, cervical screening and colonoscopy triage is welcomed, yet this only addresses one element of delayed care, with nothing further reflected in public hospital funding beyond recurrent spending and planned growth,' says Australian Healthcare and Hospitals Association Acting CEO Kylie Woolcock.

'With widespread COVID infection across the Australian population, there is going to be a need for investment in Long COVID management and care services. The symptoms are diverse, but able to be managed in primary and community care. Enabling outcomes-focused, value-based care, provided by teams of general practitioners, nurses and allied health providers is critical in minimising the long-term burden.

'The pandemic has exposed and exacerbated inequities in Australia's health, and we know these gaps will only widen if investments are not made now.

Read our full response to the 2022–23 Budget here.

7 APRIL 2022

Health research could hold answers for approaching Federal Election

The April issue of the Australian Health Review, available online, features articles that, in the context the upcoming Federal Election, provide valuable insights on the current condition of Australia's healthcare system. This issue takes a closer look at health financing, improving health outcomes for First Nations Australians, digital health and the safety and quality of healthcare in Australia.

'As we head into this Federal Election, health and aged care is on forefront of many people's minds. While the 2022-23 budget announced record funding in these areas, it is yet to prove if it can provide value over volume when it comes to health spending,' says Australian Health Review Editor-in-Chief, Professor Sonj Hall.

Read this edition of the Australian Health Review on the CSIRO website.

AHHA in the news

12 APRIL 2022

Quality of life tools to improve outcomes for aged care residents

The provision of quality aged care continues to remain a concern for those older Australians who rely on community and aged care services to carry out their everyday activities.

A health policy brief, Quality of life tools to support measurement of aged care quality, published by the Australian Healthcare and Hospitals Association's Deeble Institute for Health Policy Research, in collaboration with researchers from Western Sydney and Macquarie Universities, examines the evidence for how tools assessing quality of life indicators in aged care settings can foster change in the system; and provide improved health and wellbeing outcomes for residents.

'Assessing quality of life accurately, and reporting the outcomes that matter is fundamental in improving the lives of Australians living in aged care,' says Australian Healthcare and Hospitals Association Acting CEO Kylie Woolcock.

'This Evidence Brief looks at the viability of assessment tools used internationally and what this means for their application in the Australian Setting.'

Read the evidence brief Quality of life tools to support measurement of aged care quality on the AHHA website.

MARCH 2022

AHHA webinars and videos

Free webinars recently presented by AHHA covered the topics of Long COVID and value-based health care and environmental stewardship. Over 300 people registered to attend these webinars which are now available on our YouTube channel.

LONG COVID — MANAGING LONG TERM HEALTH CONSEQUENCES OF COVID-19

This webinar explores the hospital experience of Long COVID in Israel; examines the likely burden and health system impacts of Long COVID and post-COVID illness in Australia and discusses the development of Australian evidence-based clinical guidelines for Long COVID, watch the webinar here.

VALUE-BASED HEALTH CARE AND ENVIRONMENTAL STEWARDSHIP

In an Australian first, hear presentations delivered to a global audience of healthcare leaders at the World Hospital Congress in 2021 by Dr Arnagretta Hunter, Clinical Senior Lecturer and Human Futures Fellow at the Australian National University, and Vicki Bennett, Head of Metadata and Classifications Unit at the Australian Institute of Health and Welfare,

The webinar highlights the role of the health care system at the local, national and international level in climate change adaptation, mitigation, resilience, capacity building, monitoring, and measurement. It explores approaches to balancing the way health is delivered to ensure that improvements in health outcomes do not come from treatments which themselves cause poorer health outcomes because of their impact on the planet, watch the webinar here.

WHAT IS VALUE-BASED HEALTH CARE?

A video produced by the AHHA policy team look at what is valued-based health care? Learn basics of how value-based health care is defined in this informative video available to watch here.

Measuring what matters

Value-based health reform is a critical success factor in a system facing increasing pressures. All Health Ministers have signalled a commitment to value-based health reform in signing the 2020–25 National Health Reform Agreement. The associated Long term health reforms Roadmap provides a flexible approach for jurisdictions as they shift in key areas of reform.

What ties many of these areas of reform together is a focus on improving and measuring the outcomes that matter to people and communities.

Yet, what does it mean practically, to 'measure what matters'? And how is it different to, or the same as, what we already do? These are the questions that we continually hear from services and stakeholders across the health system pursuing the shift to value-based health care in Australia.

Why measurement matters

Health and health care information and reporting serves a number of purposes:

- For the public — patient-friendly and clinically-relevant statistical information can inform individuals and communities, promote transparency and support decision-making.
- At the point of care — it can inform shared decision-making and enable comparisons to drive service improvements.
- For regions — it can drive strategic directions, supports the allocation of funding and resources, and enable accountability for place-based solutions.
- For jurisdictions — it can inform policy and drives health system improvements (Nous Group 2016; AHHA 2021).

Yet despite the importance of information and reporting, and the substantial data currently being collected across the system, Australia has not implemented a long-term strategic plan to coordinate and direct national health information interests (AHHA 2021).

Linking outcomes to funding

Discussions around the use of outcomes data for sustainability in health system reform can quickly jump to how they can be linked to funding.

Linking outcomes with costs is not new in health care. Australia led the world in 1993 when a favourable cost-benefit analysis was introduced as a requirement for public funding of pharmaceuticals, in addition to the usual requirements of quality, safety and efficacy (Jackson 2007). We now have a national framework for health technology assessments that encompasses medical services, pharmaceutical benefits and prostheses.

The hospital sector also uses pricing and funding as levers to improve patient outcomes across three key areas:

- sentinel events;
- hospital acquired complications; and
- avoidable hospital readmissions.

Attention is now moving to whether pricing and funding could be used as levers in reducing avoidable and preventable hospitalisations (IHPA 2021), and this requires consideration of preventive health interventions and early disease management delivered outside the hospital setting, within primary and community care settings. >

The dominant funding model in Australian public hospitals is activity-based funding (ABF), which, since its introduction in 2012, has effectively contributed to the creation of a more equitable and transparent system of hospital funding. However, it has become evident that while ABF works well for predictable, one-off episodes of care, our system may benefit from the incorporation of alternate funding models (such as bundling and capitation) where health services are delivered across multiple care settings. It has been estimated that around 30% of the patients currently funded by ABF could benefit from an alternate funding approach (IHPA 2021).

Realising the potential of these alternate funding models in the public hospital system will require an engaged and coordinated primary and community care system. While much of primary care is also reliant on funding models that incentivise activity rather than outcomes, Primary Health Networks (PHNs) utilise commissioning to fund the delivery of services through a continual and iterative cycle involving needs assessment, co-design, procurement, monitoring and evaluation (DoH 2019). PHNs around Australia are adopting outcomes-based commissioning approaches to build local capacity and collaborative service arrangements that put people and communities at the centre of care (e.g., SNHN 2018; Murray PHN 2020).

"Across the Australian health system, but outside a national health information strategy, work is being done to adapt, develop and implement data collection and measurement approaches to better understand the impact of the care they provide."

Data-driven improvements

Importantly, funding is only one lever in the shift to outcome-driven, value-based health care. Data can, and should be used, to drive improvements at all levels of the system.

Clinical registries are a prime example, providing a mechanism to monitor outcomes and report on quality of care. Through collecting, aggregating, and reporting safety and quality data to institutions and clinicians, clinical registries provide a centralised mechanism for benchmarking, enable the identification of variation and incentivise improvements through comparison (Monash University 2020; ACSQHC 2020).

However, health data silos will continue to present a challenge to improving outcomes, throughout a person's care pathway and over time. When we measure what matters, this information should be accessible to individuals and available to share with their providers to support decisions about care. Our digital infrastructure must enable this.

Where to from here?

Across the Australian health system, but outside a national health information strategy, work is being done to adapt, develop and implement data collection and measurement approaches to better understand the impact of the care they provide. Yet what is missing in the Australian context is a shared understanding of how we draw all these elements together to enable value-based reform.

The Measuring what matters event series seeks to address this. In June, AHHA is exclusively bringing leading international experts Elizabeth Teisberg and colleagues from the Value Institute for Health & Care (virtually) to Australia. They will work with health leaders from around the country to understand the 'how to' of outcomes measurement, including where to start, what measures to use, how to calculate associated costs and how to use the tools currently available. It is a must-attend event for anyone involved in measuring outcomes to achieve high-value health care.

Following this, a roundtable will explore what this means in the Australian context. With decision-makers across the system, we will explore how systems and services can better support each other to create a health system that is delivering value and improving outcomes for all Australians.

More information is available here. ha

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Measuring what matters

Leading Value-Based Health Care reform in Australia

AN EVENT SERIES

ABOUT THE EVENT SERIES

The goal of health care is to create value by improving the outcomes that matter to people and communities for the costs of achieving those outcomes.

Join Value-Based Health Care (VBHC) pioneer Elizabeth Teisberg and the team from the Value Institute for Health & Care. Together with health care leaders from around Australia, learn to measure the outcomes that matter, including where to start, what measures to use, and how to begin using available tools for data collection. Participants will get to know the Capability, Comfort, and Calm[tm] framework, which simplifies and streamlines outcome measurement and evaluation.

Then, through facilitated discussion with leading government decision-makers in Australia, improve your understanding about the approaches to VBHC implementation being pursued in the Australian context, and contribute to the policy reform required to enable Value-Based Health Care in Australia.

View Preliminary Program, speaker line-up and supporting partners **here**.

LEARNING AND POLICY OBJECTIVES

By the end of this event series, health leaders should:

- Know where to start, what to measure and how to calculate associated costs
- Understand and know how to use the tools available for outcome measurement, cost calculation and data allocation
- Understand how clinical registries can be used in outcome measurement
- Explain the Capability, Comfort and Calm framework for outcomes measurement
- Discuss how VBHC measurement is similar to, and different from, approaches already used in Australia
- Consider how VBHC outcomes measurement integrates with the work of government agencies and departments and make recommendations for action in the system.

Health Transformation Leadership Intensives:
Measuring what matters

LOCATION: virtual
TIME: 9am - 1pm AEST
DATES: 2 June 2022
9 June 2022

Roundtable for reform:
The Australian VBHC Agenda

LOCATION: virtual
TIME: 9am - 1pm AEST
DATE: 23 June 2022

COST

AHHA members
$2,000, plus GST
(Group discounts apply)

Non AHHA members
$2,200, plus GST

Register here

Group discounts are available
please contact admin@ahha.asn.au

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Australian Centre for Value-Based Health Care

ahha australian healthcare & hospitals association

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

TAC Transport Accident Commission

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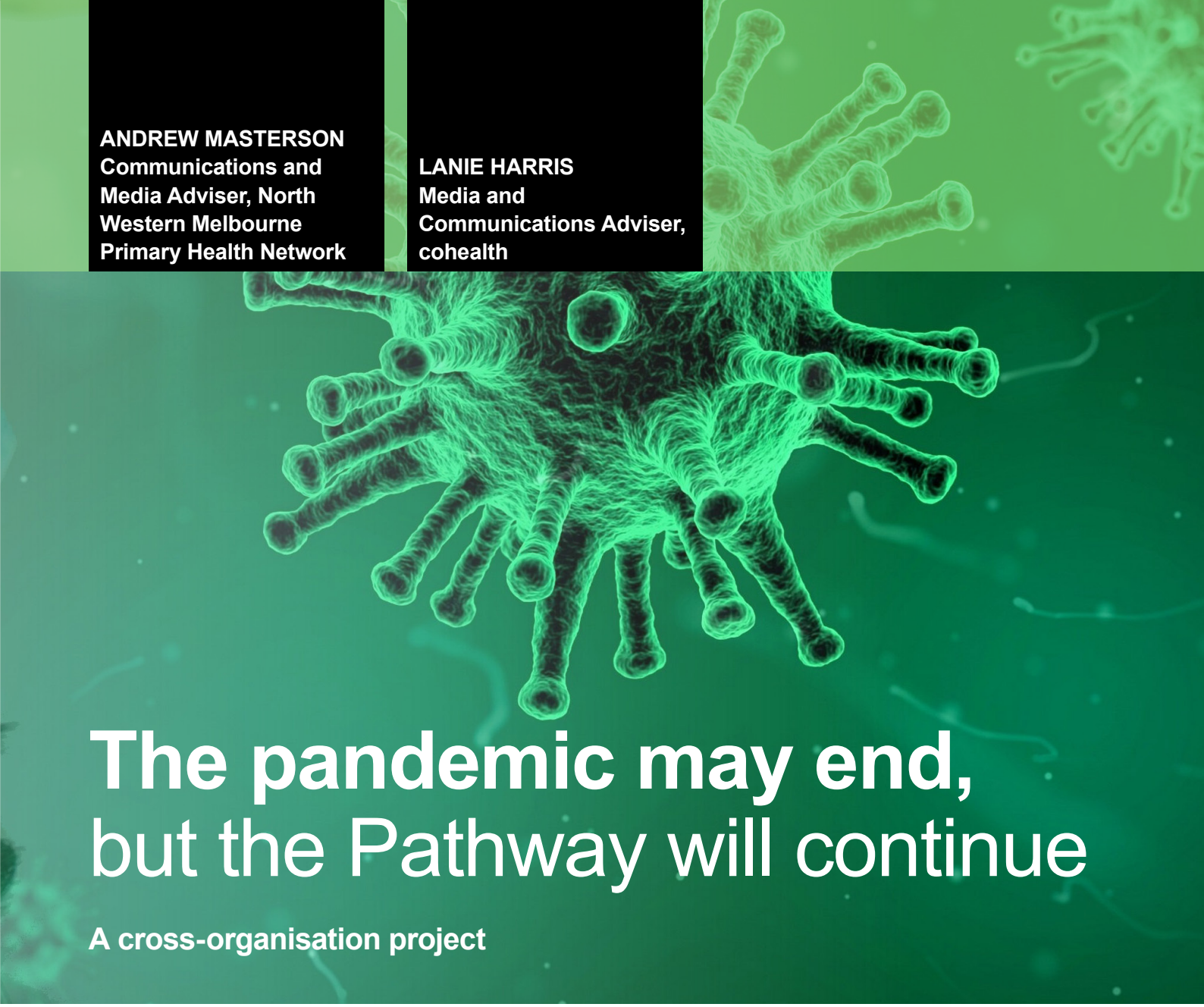

The pandemic may end, but the Pathway will continue

A cross-organisation project

'Infectious diseases,' wrote Melbourne's Nobel Laureate and national treasure Peter Doherty in 2013, 'are no respecters of wealth, power or personal merit.'

In mid-2020, when the first wave of COVID-19 infections broke across Victoria, there was reason to disagree — a difference of opinion that led, rapidly, to a collaboration between community health, general practice and hospital care that came to define the state's response to the pandemic.

Professor Doherty is correct, of course, in implying that a virus can physically enter anyone it encounters. However, plentiful data exist to show that such encounters are far more likely among populations characterised by low incomes, high-density housing, unstable work and high mobility.

Influenza can infect a CEO or a part-time forklift driver, but it's the person in the high-vis gear who is much more likely to meet it.

It was therefore not much of a gamble, back in 2020, to bet that the same grim pattern would manifest with SARS-CoV-2 — a disease for which at that time there was neither treatment nor vaccine.

This unappealing prospect prompted an urgent collaboration between the Royal Melbourne Hospital, community health organisation cohealth and North Western Melbourne Primary Health Network (NWMPHN)—three agencies with >

"The significance of the first Pathway has now been recognised in a major peer-reviewed paper published in the Medical Journal of Australia. Lead authors are three of the original architects: Dr Seok Ming Lim from the Royal Melbourne, Dr Nicole Allard from cohealth, and Janelle Devereux from North Western Melbourne Primary Health Network."

catchments that covered many of Melbourne's most under-resourced suburbs.

The collaboration sought an effective way to combine the resources, expertise and social connections of three levels of health care. The aims were multiple but linked: to prevent an influx of cases into hospitals, to allow GPs to monitor and manage patients with mild symptoms, and to make sure that financial and psycho-social factors were addressed so that those patients could isolate at home without hardship.

The result was a set of protocols that became known as the COVID Positive Pathway. Launched in August 2020, it was quickly bolstered by other health services, and, almost as quickly, adopted and adapted by regions across the city and the state.

COVID Positive Pathways are now the standard model used for the management of the pandemic for the whole of Victoria. The significance of the first Pathway has now been recognised in a major peer-reviewed paper published in the Medical Journal of Australia. Lead authors are three of the original architects: Dr Seok Ming Lim from the Royal Melbourne, Dr Nicole Allard from cohealth, and Janelle Devereux from North Western Melbourne Primary Health Network.

'In the design and delivery of the program we recognised the importance of incorporating social and mental health supports for people, recognising that people's social circumstances may limit their ability to isolate,' says Dr Allard.

'We developed a model that supported the complex needs of people who had to isolate at home for 14 days. Our teams assisted with complex care navigation — meeting people's health needs beyond COVID-19, and social support for them to stay at home safely.'

Following triage by cohealth, COVID-positive participants were allocated to low, medium, or high tiers of care according to their symptoms and

disease risk factors. Low risk participants isolated in their own homes, in most cases, monitored every two days via telehealth, where possible by their regular GP. If a patient deteriorated, treatment escalated rapidly.

People at risk of severe disease and those with moderate symptoms were referred to hospital outreach services. Those already seriously ill were placed in wards or ICU.

By December 2021, around 35,000 people had been referred to the program, equivalent to about one in six Australians who had contracted COVID-19 at that time.

'The aim of Australia's first COVID Positive Pathway was to provide universal care,' says NWMPHN's Janelle Devereux.

'This was a big ask in the rapidly evolving and sometimes chaotic environment of the first coronavirus wave, but nevertheless it captured and treated 83 per cent of diagnosed eligible people.'

Of course, methods for managing coronavirus also evolved, as vaccines and, later, treatments became available. New variants also changed the picture. Throughout the pandemic, however, the Pathway model has proven robust and adaptable.

In Victoria, it remains the bedrock management tool.

Indeed, Drs Lim and Allard, and Ms Devereux, are already looking at its usefulness for treating other conditions, a long way removed from SARS-CoV-2.

Work is underway investigating how the Pathway model can be deployed, suitably tweaked, for the management of certain chronic conditions, including heart disease, lung disease and mental health challenges.

Because these too, as Professor Doherty might note, are no respecters of wealth, power, personal merit — or postcode. ha

Building the Healthcare system Australia deserves

The establishment of Medicare revolutionised health care in Australia, with a focus on providing universal access to the care that people need, when they need it. But almost four decades has passed since then and health policy has not kept pace with change.

A lot has shifted in both the conditions that people are managing, and the way care can be delivered. The COVID-19 pandemic has also exposed and exacerbated inequities in Australia's healthcare system, with vulnerable Australians being disproportionately affected.

Health services have faced inconsistent communication from governments during the pandemic, with the healthcare workforce experiencing greater administrative burden and escalating workloads, often without timely support and resources. Expectations of reverting to 'business as usual' as we start to 'live' with COVID are unrealistic if health outcomes and inequities are to be improved.

While the pandemic has driven many changes in the way care is delivered and provided opportunities for innovation, transitioning the healthcare workforce and services to new and different ways of working remains an ongoing challenge. Understanding what matters to people, and how the Australian healthcare system can innovatively and sustainably respond are essential for health system reform.

Approaches should be introduced that focus on the value of healthcare, rather than the volume. We need to consider the population's health, while ensuring that people and communities, including our most vulnerable, are placed at the centre of care. To achieve meaningful reform, we need to consider the sustainability and resilience of our workforce. This is particularly important in the wake of the pandemic and more recent natural disasters, including bushfires and flooding. It will be essential in supporting universal health care in a post-pandemic era.

In shifting to more outcomes-focused, value-based health care, it will also be crucial to measure and report what matters. Health data should accurately reflect care outcomes, support decisions within care relationships and inform improvements in performance across all levels of the health system. A long-term strategic plan to coordinate and direct national health information interests will be essential to underpin this collection, linking and reporting of data.

1

Measure and report what matters

2

Build a sustainable and resilient health workforce

3

Provide stewardship and support that enables regional innovation and reform

4

Use funding models that incentivise improved health outcomes

Funding models must then incentivise the achievement of these outcomes. Security and certainty in health care funding will be necessary to attract and retain an appropriate workforce for care delivery; and for service providers and communities to trust and invest in the co-design of pathways of care. Mixed, flexible funding models in health, if properly utilised, can adequately compensate for activity while protecting equity and incentivising agreed performance standards and outcomes that reward high value care.

Focusing on measuring what matters, building a resilient workforce and securing health funding that is fit for purpose is key to addressing the reforms urgently needed. By taking this step, we can begin to move towards a system that people, communities and the health workforce of Australia deserves.

This upcoming Federal Election, the Australian Healthcare and Hospitals and Association is calling parties to act in these key areas of reform urgently needed. To read our full 2022 Election Statement visit the AHHA website.

ANDREW MASTERSON
Communications and Media Adviser, North Western Melbourne Primary Health Network

Health care in high schools is class all the way

NWMPHN Doctors in Secondary Schools Program

Dr Jenni Lyne sits at a table in the medical centre at Reservoir High School.

'I've only been doing this for a couple of months, but I think from the different variety of presentations that I've seen so far, to me it seems like a good idea to have doctors in secondary schools,' she reflects.

'Access to health care can be very difficult for young people. They are at school when clinics are open — many of which don't have after hours appointments. And if they do manage to book a time outside of school hours, getting themselves physically there can be challenging.'

Dr Lyne is part of a Doctors in Secondary Schools (DiSS) team. She works part-time at two clinics — Reservoir Medical Group, and IPC Health in Deer Park. She spends one day a week at the local high school as an extension of the first residency, and another at Laverton College P-12 as part of the second.

The work, she says, adds an extra dimension to her professional life as a GP.

'The main benefit to me with these roles is really just being able to feel like you are providing a service that is of need,' she says.

PHOTO BY LEIGH HENNINGHAM

Dr Jenni Lyne
Reservoir High School,
DiSS Program

'A lot of these young people don't normally access health care — or don't even realise that they need to access health care until you start asking all the questions.'

Doctors in Secondary Schools is a program funded by the Victorian Government's Department of Education and Training and administered through Primary Health Networks. Running since 2017, it seeks to place a GP and a nurse on campus for one day every week during term time at 100 schools in the state's most under-resourced metropolitan and regional areas.

The program has been a significant success, but it is not without its challenges.

Working with young people as they emerge from childhood into adulthood is rewarding, DiSS participants agree. Practices are expected to sign up to the project for a year, but most stay for at least two.

Nevertheless, from time to time vacancies arise.

For this reason, the North Western Melbourne Primary Health Network (NWMPHN) — the lead agency in the DiSS project — has kicked off a rolling Expressions of Interest scheme, inviting >

PHOTO BY LEIGH HENNINGHAM

“Many families are under significant pressure and for a variety of reasons sometimes this makes it difficult for young people to get the attention they need.”

eligible general practices to register their availability, ahead of possible opportunities.

‘It’s an important matter of equity and access to medical care,’ explains NWMPHN’s Marie-Louise Neary, who heads the recruitment drive.

‘Many families are under significant pressure and for a variety of reasons sometimes this makes it difficult for young people to get the attention they need. Missing out on care has lots of knock-on effects, not only for health but also for education and social connection.’

And sometimes, even with parents happy and willing to ferry a young person to a medical clinic, having access to care on campus is still the best option.

‘It gives them the opportunity to come and see us confidentially,’ says Priscilla Javni, a nurse at Reservoir Medical Group who does DiSS duty with Dr Lyne.

‘A lot of the problems they are having are school problems, or they might be home problems, but in either case they are things they need to talk about but they don’t want their parents knowing.’

(Teenagers have certain age-dependent legal rights around health care and confidentiality; DiSS personnel, as well as school principals, fulltime school nurses and wellbeing officers, are trained to navigate and respect these.)

Andrew McNeil, Principal at Reservoir High, is quick to acknowledge the value of the program.

‘It provides a safe space for our students to see the doctor,’ he says. ‘Our students are very comfortable at school. It is something they are very familiar with. They don’t have to go to a new clinic. They don’t have to do anything different.’

It’s interesting, though, that doing something different is a prime motivation for some GPs and nurses to enrol in DiSS.

Dr Hannah Walker, for example, provides DiSS care at Mt Rowan Secondary School in the Victorian regional city of Ballarat.

She decided to join the project in 2021 — in part, to keep her own professional life fresh.

‘I wanted to keep my practice varied,’ she says. ‘I wanted to challenge myself and do something different to my speciality — which is palliative care.’

‘I’m a GP at UFS Medical in Ballarat. I think you can be very cushioned in your exposure to the community, so it’s important to expose yourself to different environments. To keep going, you have to push yourself and change things around.’ ha

General practices interested in exploring the Doctors in Secondary Schools program can check out the online expression of interest form here.

Nurse Priscilla Javni and Yr 12 student Angelina Trifunoski

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"The recent COVID-19 pandemic experience has reiterated the importance of simulated learning opportunities in the tertiary education sector."

Virtual reality to help **boost health student placements in rural areas**

At The University of Queensland (UQ) Rural Clinical School, a series of projects are underway that tap into extended reality to ultimately enhance healthcare delivery and healthcare training programs in rural Australia. Extended reality encompasses augmented reality (AR) and virtual reality (VR) which are technologies that enhance or replicate a real-world environment with a simulated one. Extended reality is increasingly being incorporated into the educational sector, both in schools and at the tertiary level, with reports of enhanced learning in areas like problem-solving, collaboration, and creation to better prepare students for the future. The recent COVID-19 pandemic experience has reiterated the importance of simulated learning opportunities in the tertiary education sector. Furthermore, extended reality is one way to augment limitations in resources, in areas such as rural Australia.

Challenges with rural placements

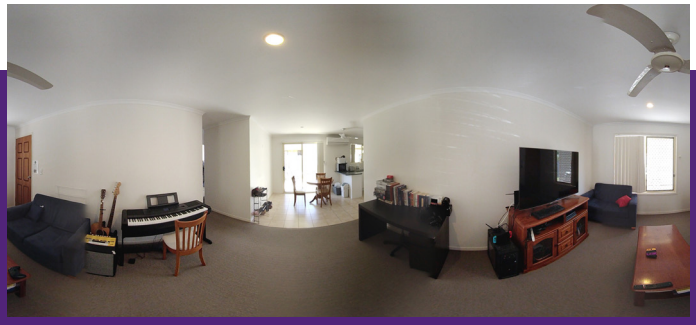
Whilst both AR and VR projects are underway, in response to a range of learning (i.e. academic sector) and healthcare delivery (i.e. healthcare sector) needs, This particular VR project focuses on healthcare students undertaking placements in rural areas. It is a well-acknowledged issue that attracting healthcare students to regional, rural, and remote areas in Australia to undertake placements can be challenging. Although healthcare services and settings offer a number of student

ICT Support Officer Chris Camilleri demonstrating the VR program.

placements, not all of these are filled. This is not only because of the physical and social isolation students can experience whilst on rural placements, but also because students often have to give up part-time jobs they hold closer to their university, thereby disrupting their financial independence. Isolation is an issue especially for students that have to travel great distances from their families and social support networks to attend a placement.

At times, placements are terminated part-way so that students can return to their home bases.

Several strategies have been trialled to enhance the uptake of rural student placements, as they play an integral role in the recruitment of future healthcare professionals. Research has shown that students who have an enjoyable and positive placement experience in a rural area, are likely to return to work in that area. This is vital in ensuring high-quality and equitable access to healthcare in these disadvantaged areas. To ensure a positive placement experience, both the healthcare and academic sectors continue to partner to rollout a number of initiatives such as sending out student pairs or groups of students to rural areas (rather than a single student), providing financial incentives such as subsidised or free accommodation, providing innovative placement models such as the Rural Interprofessional and Supervision (RIPES) model (Martin et al. 2021), and utilising local buddy and mentoring systems. Whilst these strategies have >



Students can tour accommodation and surrounding areas using the VR program.

been devised to provide a positive placement experience in rural areas, the issue remains of getting students to embrace the opportunity to undertake these placements.

VR as a proposed solution

Using VR, we have been able to promote student accommodation options in places such as Blackbutt, Charleville, Chinchilla, Goondiwindi, Hervey Bay, Kingaroy, Roma, St George, and Toowoomba in Queensland. The VR resource provides medical, nursing, midwifery, and allied health students from several universities an opportunity to view and familiarise themselves with the accommodation options, and at times, the neighbourhood, in the given regional, rural, or remote location, that they may not have visited before. The VR of accommodation options, tied to the Rural Clinical School (Faculty of Medicine, UQ) and Southern Queensland Rural Health (SQRH; Health and Behavioural Sciences, UQ), play a key role in making these rural placement options appealing to students. Building the VR starts with taking photos of the accommodation using two types of cameras, a 3D 360 degree camera (consisting of eight built-in cameras) and a 2D 360 degrees camera (consisting of two built-in cameras). Subsequently, videos of the neighbourhood or township are filmed if necessary. These photos and/or videos are then uploaded to VR cloud-hosting software to create a 360-degree environment. This software enables the addition of text and buttons in the VR environment. A link to this VR is created and shared on the web (e.g. SQRH accommodation webpage) and with relevant stakeholders. This innovative work has been made possible through intra and intersectoral collaborations involving administrative, marketing, and information and communication technology staff, academics, clinicians, and researchers. Whilst anecdotal accounts are available of the positive impact of the accommodation VR resource and its role in attracting students to rural areas for placement, as with any new initiative, a formal evaluation is needed to document and learn from the user perspective. ha

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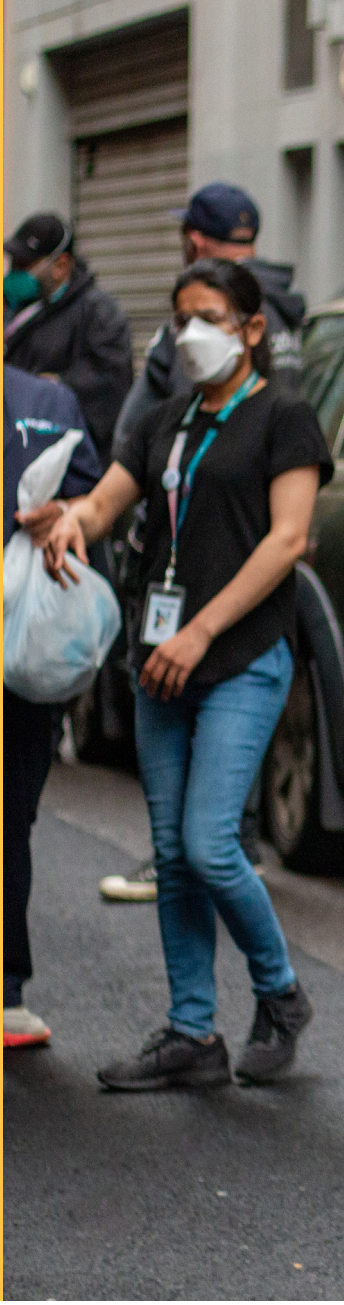

Calls for a national revival of community health centres

This article was supported by cohealth, a Health Equity Champion member of Croakey's Health Media Funding Consortium.

If you are over 50 and grew up in Australia, there is a good chance that your first experience of health care was in a community health centre (CHC).

Now almost invisible on the Federal health policy landscape, CHCs once played an important role in Australia's health system, providing locally accessible health and social care to millions of Australians.

With their focus on addressing the environmental and social determinants of health, and a model which emphasises community ownership of healthcare, CHCs differ significantly from traditional general practice despite offering many of the same services.

Other key attributes of CHCs include the use of multi-disciplinary, team-based primary care; integration of primary care with other health services; and responsibility for a defined local population.

However, awareness of community health — outside of Victoria at least — is now so low among policy makers that it has been almost completely omitted from the Federal Government's current plans for the future of primary health care.

The recently released Australia's Primary Health Care 10 Year Plan 2022-2032 contains only four mentions of community health, and not one mention of community health centres, apart

cohealth peer worker at a vaccine-pop-up

from recognising the significant contribution of Aboriginal Controlled Community Health Centres (ACCHOs).

A brief history of Community Health Centres

Community health centres became common in the 1960s as a way of addressing community concerns about the cost of healthcare (prior to Medibank there was no universal subsidy for GP services).

Initially CHCs were isolated services, established in an ad hoc manner around the country, but in 1972 the Whitlam Government made CHCs part of its winning pre-election policy platform.

When the Coalition came to power in 1975, funding was cut to several Whitlam-era health programs. Eventually funding for the hospital and CHC programs were absorbed into general revenue sharing arrangements with the states.

This resulted in responsibility for community health services (apart from ACCHOs) being devolved to the states, most of which have absorbed this sector into the acute care system or other health programs run by state governments. >

cohealth nurse at Braybrook Temple

cohealth vaccination pop-up van

Community health model still strong in Victoria

While some individual CHCs still exist around the country, Victoria was the only jurisdiction to retain a comprehensive network of community health services. Today the state has 26 independently managed, registered community health centres, which deliver a broad range of health and social programs, such as drug and alcohol, primary medical care (general practice), disability, dental and mental health services.

These services leverage both state and federal funding streams and fill gaps in our current health system, with a particular focus on vulnerable and marginalised communities.

The case for community health centres

International evidence supports the health benefits of the CHC model and the increased efficiencies that result from moving ambulatory care out of hospitals and into the community.

A clear example of the benefits of the CHC model is provided by cohealth, a CHC operating across the north and west Melbourne.

Throughout the COVID-19 pandemic, cohealth has built on its strong relationships with the community to play a crucial role in responding to some of the largest outbreaks in the country, including disseminating health information to hard-to-reach populations and providing vaccines to people who have difficulties accessing mainstream services.

cohealth partnered with Royal Melbourne Hospital and the local PHN to deliver the COVID Positive Pathways program which provided medical, social and mental health supports for people who tested positive in the west of Melbourne, reducing the burden on hospitals and allowing people to safely isolate at home.

Dr Richard Di Natale is a public health specialist, GP and former leader and health spokesperson for the Australian Greens. He now works as a public health advisor for cohealth and is a strong supporter of the CHC model of care.

Di Natale says cohealth's response to COVID illustrates the potential of CHCs in addressing local health challenges and highlights the contribution that the CHC sector can make to Australia's primary health care sector.

cohealth Collingwood Towers community vaccination pop-up

Nikol Tap from cohealth's Health Concierge team
PHOTO: THE AGE

'cohealth was able to provide support for people with COVID because it has deep roots in the communities it serves... People were supported at home, with access to advice and care from experts across a range of areas.'

Reviving the national community health model

Dr Di Natale believes that the current environment provides some promising opportunities to revive the CHC model of care.

He points out that many of the factors that prompted the CHC program in the 1970s still exist, such as concerns about the costs and inequity of private models of primary health care, and a growing awareness that private, stand-alone, fee for service general practice is unable to meet the needs of many vulnerable people.

Additional factors supporting a future role for CHCs in Australia are our ageing population, rising rates of chronic disease, and new developments in treatments and technologies which allow increasingly more health and medical services to be provided safely in the community rather in hospital.

So where to from here?

An obvious first goal is to embed CHCs into Australia's Primary Health Care 10 Year Plan 2022-2032, says Di Natale, extending Commonwealth support for the model beyond ACCHOs

This would represent a shift in the policy direction of the Commonwealth which, since the CHC program was abolished in the 1970s, has largely seen its role in primary health care as supporting private GP services, either directly via Medicare or indirectly through programs to supplement or support GPs.

However, Di Natale warns that without a unity of purpose and significant commitment from the sector it will be difficult to reverse the decades of policy and funding neglect which have prevented CHCs from realising their potential within the Australian health system.

'CHCs provide a critical and important service, and the challenge is to make sure policy makers understand it and see CHCs as central to meeting the current health needs of a rapidly growing, and increasingly diverse, population.' ha

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  -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.

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