Health reform in focus
The AHHA’s key health priorities for the upcoming election

Election special
How do we make coordinated care work in public and private practice?

The social determinants of health
Policy-makers understand SDH, but what’s the next step from there?

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## Contents

### In depth

8. **AHHA’s key health policy priorities**  
Australians need to send a strong message to both major parties in the lead-up to the federal election

10. **Social determinants of health**  
What’s the next step?

12. **Meaningful reform in community health**  
We must look at integration and coordination as the key

15. **The case for bundling of health payments**  
Are there better ways of determining efficiency?

18. **Investing in our oral health**  
Is the funding blitz for oral health programs sustainable?

20. **Coordinated care: the next step forward**  
The provision of health services must be transformed, but how do we do that without compromising quality?

22. **eHealth**  
Using technology to connect the points of care

25. **A brilliant career**  
The achievements of AHHA’s former CEO, Prue Power

27. **Integrated health research centres**  
Are they the key to transforming medicine in Australia?

28. **The demands of dementia**  
Ways we can improve hospital care for people with dementia

### Briefing

30. **The Deeble Institute**  
Universal healthcare and its challenges for the future

32. **Responding to hospital funding adjustments**  
Preparing for upcoming changes to public hospital funding

### Opinion

34. **Access? What a load of crap!**  
Improving access doesn’t mean improving quality of care

36. **The ‘Enough is Enough’ manifesto**  
A call to government to get nursing right

38. **It’s not all about the money**  
Reports of the health sector’s financial demise are premature

### From the AHHA desk

05. View from the Chair
06. AHHA in the news
40. Snippets and cartoon
41. Trade news
44. Who’s moving
45. Become an AHHA member
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A view towards the upcoming election

This issue of *The Health Advocate* is about reflecting on years past and looking forward to what we can do better in the future.

To do better, we need greater emphasis on producing a more effective, appropriate and coordinated healthcare system that values individual patients and providers. One of the key issues discussed in this election-themed edition of the magazine is the need for coordinated care across the system. This goes to the heart of what it means to have universal public healthcare in conjunction with a range of private services. To that end, it becomes clear that access, while important, is not the be all and end all of improving healthcare in Australia. More needs to be done to ensure that services and funding are well aligned such that the highest quality care is provided to those who need it most; that there is no duplication of effort; no unnecessary treatment and cost; and that there is greater understanding and transparency of responsibility around funding and service provision across all levels of government.

Another key issue is the need to place more emphasis on the patient/person experience instead of focusing solely on processes and outcomes. These points are made particularly clear in this edition from two different perspectives, one at the ‘end of the line’, so to speak: the aspirations and needs of palliative care patients; the other on the ‘front line’, the continued plight of nurses in this country.

Pressure on healthcare providers is ever-increasing, as the population continues to age, chronic disease becomes more entrenched, and co-morbidities consume available funds. As Australia’s disease burden continues to rise, we must rethink how we do things, not just in the context of individual patient and worker care experiences, but also how we finance and monitor that care.

As with any election, there are some real opportunities on September 14 for bringing about significant changes to healthcare that need to be taken seriously. Let’s hope that our post-September 14 government will not just aspire to move forward on healthcare reforms, but will see those reforms through to fruition. Politicians from across the political spectrum must listen to the concerns and suggestions if we are to have any real change at all levels of healthcare provision, and for those changes to be valued by the people who live with the consequences.

To discuss these and other policy issues, please take note of the AHHA and Deeble Institute events still to come this year.

<table>
<thead>
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<th>August</th>
<th>Arts in Health Policy Think Tank</th>
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<th>Canberra</th>
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<tbody>
<tr>
<td>Aug/September</td>
<td>Green and Healthy Sector Policy Think Tank</td>
<td>10am-4pm</td>
<td>Melbourne</td>
</tr>
<tr>
<td>24 September</td>
<td>Deeble Symposium</td>
<td>10am-4pm</td>
<td>Canberra</td>
</tr>
<tr>
<td>October</td>
<td>Oral and Dental Policy Think Tank</td>
<td>10am-4pm</td>
<td>TBA</td>
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AHHA in the news

New CEO for the AHHA

The AHHA has appointed Alison Verhoeven to the position of Chief Executive. Alison comes to AHHA after a distinguished career in the health sector, most recently in senior executive positions with the Australian Institute of Health and Welfare. She has a strong background in health and an excellent understanding of the issues impacting public healthcare today. We wish her well at this pivotal time for the health system with the implementation of the health reform agenda and an election looming.

A gala occasion

At the end of May, over 100 people attended a farewell dinner for retiring AHHA Chief Executive, Prue Power, and paid tribute to her lifetime of achievements. It was a great night attended by a who’s who of Australian healthcare leaders including, amongst others, three Presidents of the AMA and most of the CEOs of Canberra based national health organisations. Her good friend, Ged Kearney, President of the ACTU, couldn’t be there but recorded a lovely tribute.

NDIS funding plan welcomed

The AHHA welcomed the government’s plan to fund the National Disability Insurance Scheme and the commitment from the Coalition to fully support these measures. “The National Disability Insurance Scheme (NDIS) is a long-overdue measure which gives people with disabilities the independence and support they need to live productive and fulfilling lives,” said CEO Prue Power.

Strong primary & community health sector critical to avoiding hospital admissions

The reduction in potentially preventable hospital admissions reported by COAG was welcomed by the AHHA. The steady reduction in the rate of unnecessary admissions for people with chronic conditions is a great outcome for consumers and reflects a better performing health system and a more efficient use of resources. However, the ability to avoid admissions and provide suitable alternative care is dependent on the strength of the primary and community health sectors. Without appropriate community supports and a coordinated approach to the care of people with chronic conditions, these people will end up in hospital unnecessarily.

HAVE YOUR SAY...
We’d like to hear your opinion on these or any other healthcare issues. Write to us at admin@ahha.asn.au or PO Box 78, Deakin West, ACT, 2600

From the AHHA desk

This is the frontline for health care.
The AHHA is concerned that the improvements in emergency department waiting times will be lost when funding for sub-acute services ceases on 30 June 2013. Funding through the National Partnership Agreement on Hospital and Health Workforce Reform has allowed states and territories to implement effective and efficient alternatives to care in acute hospitals. These programs will cease unless new funding arrangements are established. This will place the pressure back onto acute hospitals, which will result in longer waiting times in emergency departments.

The AHHA has welcomed the National Disability Insurance Scheme.

The funding is there for a dental waiting list blitz, but will the Opposition support it?

Emergency department improvements at risk

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Health budget delivers gains but falls short

The AHHA acknowledges the balanced approach taken by the government in this year’s health budget, given the difficult fiscal environment, and welcomed the investment in the suite of initiatives comprising the new cancer package – World Leading Cancer Care – and the further investment in mental health. The government has claimed credit for reduced waiting times in emergency departments but with no ongoing commitment to the sub-acute programs, the gains achieved will quickly evaporate.

Coalition must support dental Budget initiative

Five national health organisations, including the AHHA, welcomed the government’s announcement of $515 million for public dental services in this year’s federal budget. This new funding follows through on the government’s promises in August last year and will significantly reduce the long waits for dental care endured by lower-income Australians. It is an important step towards a more equitable dental care system. The key question for the five organisations is now whether the Coalition will support this initiative. In his budget reply speech the leader of the Opposition has criticised the government’s approach but has not proposed any alternatives.

The AHHA has welcomed the National Disability Insurance Scheme.

The AHHA has welcomed the National Disability Insurance Scheme.
AHHA’s election platform: Our key health policy priorities

In the lead-up to the federal election, Australians need to send a strong message to both major parties that near enough isn’t good enough when it comes to their health. Here are the five priority areas that, AHHA believes, require immediate attention if we are to really improve healthcare in this country.

Priority 1: Prevention
Recognition of the social determinants of health (discussed on page 10) is fundamental for the prevention of many diseases and other health issues. Greater research and action in this area is required from all levels of government for health issues to be addressed effectively and holistically. The recent Senate Committee Report provides a clear statement of actions that can be implemented.

Priority 2: Integration and coordination
Australia’s health system needs to better respond to patient needs and deliver the most appropriate services and care in the most appropriate setting.

The establishment of Medicare Locals was a direct response to the National Health and Hospitals Reform Commission’s recommendation for better service coordination and population health planning. Medicare Locals represent a new approach to primary care coordination and must be given time to develop and achieve their goals.

The National Partnership Agreement (NPA) on Hospital and Health Workforce Reform has supported investment in sub-acute services over recent years. This has contributed to a reduction in avoidable admissions to hospital and allowed transfer of patients from acute hospitals to more appropriate settings, helping reduce surgery and emergency department waiting times.

With the cessation of this funding as of 1 July 2013, the improvements achieved are likely to be lost. Therefore, a clear statement from all parties outlining their approach to the coordination, integration and funding of primary, community, sub-acute and acute care is essential.

Priority 3: Access and equity
The Labor Government, with the support of the Greens, has made significant commitments in oral health to reduce public waiting lists, provide Medicare funded dental care to children, and to increase services to low-income adults. These commitments reflect, in part, the recommendations of the National Health and Hospitals Reform Commission and the National Advisory Council of Dental Health. They are welcomed by the AHHA as a first step towards a universal dental scheme for all Australians. While the Coalition has indicated support for extending access to publicly funded dental care, it is yet to commit to honouring the reform program commenced by the Labor Government.

The health of Aboriginal and Torres Strait Islander people in Australia continues to lag behind the rest of the Australian community. While improvements have occurred, including a small reduction in the life expectancy gap, there remains much work to be done. The Labor Government has committed to the provision of $777 million to renew the NPA on Closing the Gap. The intention of the Coalition to honour the NPA or to provide a suitable alternative is required.

Timely access to emergency care is critical to improving health outcomes in the cases of acute coronary syndrome and other conditions. The current variable system of ambulance service funding across jurisdictions does not support equitable access to potentially lifesaving care. It is impossible to justify the fact that people suffering suspected heart attacks are delaying or avoiding calling an ambulance due to concerns about costs. With the evidence showing a clear socio-economic gradient influencing use of ambulance services, immediate action is
required by all areas of government to improve service access and to recognise the role of paramedics and the ambulance services in the provision of emergency health care.

**Priority 4: Safety and quality**

The AHHA urges immediate focus on improving the safety and delivery of healthcare, Australia-wide. In 2000, an estimated 11% of all admissions to hospitals experienced adverse effects in the provision of healthcare. Harm was permanent or severe in 2% of admissions and death was associated with 1/300 patients. Patients who experienced adverse events also stayed about 10 days longer and had over seven times the risk of in-hospital death than those without complications.

A 2004 study using patient-level costing data for major Victorian public hospitals found that the cost of adverse events represented 16% of the total expenditure on direct hospital costs, or an additional 19% of the total inpatient hospital budget. Estimates for total cost of iatrogenic harm across Australia are as much as $1 million per day.

Mostly, mistakes made in hospitals and health services are not the fault of individuals. They occur because of unrealistic demands placed on the system without sufficient resources to respond. Key activities to reduce error and improve safety and quality are the development and implementation of national clinical standards, practice guidelines and performance measures and electronic medication records.

**Priority 5: Research**

Australia is home to some of the best scientific researchers and medical pioneers in the world, supported by funding from the Commonwealth Government; by industry; by state governments; and to a lesser extent; by non-government organisations and through philanthropy.

Unfortunately, health policy research is rarely addressed as a specific category for grants by Australian funding institutions. Further, evaluation of the impact and effectiveness of government health policy and programs is extremely limited. Thus, research into health policy is fragmented in terms of both the intellectual traditions within which it takes place and the sources from which it is funded.

With health systems under increasing stress from constraints on funding, higher levels of chronic disease and costly technologies, it is essential that health policy research is recognised and funded appropriately. The implementation of new government health policies and programs should also be contingent on the development and implementation of robust evaluation processes which consider outputs, outcomes and cost-effectiveness.

**First 100 days**

The AHHA proposes the following plan for the next Commonwealth Government to implement in the first 100 days in office:

- Commit to the adoption of the Senate Committee recommendations relating to the Social Determinants of Health;
- Commit to the ongoing role of Medicare Locals;
- Commit to the current Labor Government’s Dental Reform program;
- Resolve outstanding issues with states and territories and implement a new NPA on Closing the Gap;
- Renew funding for sub-acute services to reduce pressure on acute service;
- Establish a taskforce of clinicians, experts and consumers to develop processes for implementing nationally consistent clinical practice guidelines and performance measures;
- Provide a specific infrastructure capital payment to public hospitals to enable them to upgrade ageing information management/technology infrastructure; and
- Consult with health stakeholders to develop and implement an electronic medication records system.

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Social determinants of health

Initiatives embodying an understanding of the social determinants of health have appeared in recent years, but what’s the next step in seeing real health outcomes from their approach?

Social determinants of health (SDH) have garnered significant international attention in the last five years. Key developments include: the 2008 report of the World Health Organisation’s (WHO) Commission on SDH; the 2010 Adelaide Statement on Health-in-All-Policies; the 2011 UN High-Level Meeting on Non-communicable Diseases (NCDs), the 2011 World Conference on SDH; and the 2013 Global Conference on Health Promotion, held in June this year.

Australian researchers and policymakers have known for some time – since the foundation of the Australian Community Health Program in the 1970s – that health is influenced by social, economic, environmental and cultural forces. The 2011 World Conference on SDH builds on this notion, calling for specific attention to governance (inter-agency partnerships); participation (involvement of civil society); health sector role (analytical lens and evidence); and monitoring and evaluation (for public accountability).

The appeal for inter-sectoral collaboration and community participation in areas such as these has been an integral part of contemporary Australian public health since the 1980s. The more recent operationalisation of the Health-in-All-Policies concept into a practical policy practice, as seen in South Australia, has even been featured globally as a key area of focus at the 2013 Global Conference on Health Promotion.

So what still needs to be done?
The Rudd Government initiated a series of national policies and programs embodying an understanding of SDH. These include: the Social Inclusion Board; Closing the Gap in Indigenous Disadvantage; Healthy Communities; and, potentially, Medicare Locals. The Senate Community Affairs References Committee has since released a report in March 2013, outlining Australia’s domestic response to the WHO’s Commission on SDH.

The Senate report highlights the submission from Catholic Health Australia which suggested that, by addressing the social determinants of many health problems, there could be: annual savings of $4 billion in welfare support payments; 170,000 extra Australians entering the workforce; 60,000 fewer people admitted to hospitals annually; and annual savings of $273 million in Medicare Benefits Schedule (MBS) and $184.5 million in the Pharmaceutical Benefit Scheme (PBS).

The five recommendations of the Senate report are: 1) adopt the WHO Report and commit to addressing the SDH relevant to Australia; 2) adopt administrative practices that ensure consideration of SDH in all relevant policy development activities, particularly in education, employment, housing, family and social security policy; 3) place responsibility for addressing SDH within one agency with a mandate to address issues across portfolios; 4) give the National Health and Medical Research Council (NHMRC) greater emphasis in its grant allocation priorities to research on public health and SDH; and 5) have the agency in charge of addressing SDH provide annual progress reports to parliament.

What are the gaps between the recommendations of Catholic Health Australia, the Senate report, and current government policies?
Federalism and inter-governmental financial relations dog the system, along with short political cycles. These short-term constraints serve to reinforce a culture of program silos, where it is easier for government departments
to maintain control and support their political masters. So, despite progress with the current policy and reform agenda, a programmatic management mentality still dominates. The Senate report is right to suggest that administrative practice changes are needed to embed consideration of cross-cutting issues in policy development, as the mere adoption of a report is insufficient basis for action.

However, if programs are the building blocks for realisation of policy objectives, then the challenge for the next Commonwealth Government, assuming a commitment to addressing Australia’s health inequalities, is to create synergies between programs and to scale-up program coverage to achieve health outcomes. Rather than more vertical programs about risk factors, particular population groups and micro-settings (such as schools and workplaces), we need expansion of place-based approaches that incorporate risk factors, population groups, and settings. Such an approach could incorporate inter-sectoral policy action on social determinants and secure partnership across levels of government, government departments, and between governments and civil society. The continuation of facilitation and reward payments, as per the current National Partnerships, would help focus activities on effective interventions. The obvious agency to provide strategic direction and stewardship for outcomes is the Australian National Preventive Health Agency (ANPHA). A stronger evidence base is needed to guide such interventions, as well as for policy learning and adaptation.

Given health is influenced by various factors, a whole-of-society approach is needed to accompany a whole-of-government approach.

Surveillance systems must ensure effective capture of inequalities and SDH to provide the information infrastructure for policy evaluation. The development of a mechanism for cross-jurisdictional policy learning would accelerate transfer and scaling up of current efforts. There is value in further research into tracking inter-sectoral policy processes and changes in SDH and social and health inequities. Such research would contribute to improved arrangements for horizontal governance, if not more effective policy interventions. But the NHMRC has yet to develop a track record in supporting policy and systems research.

Since hospital funding dominates political debates about healthcare, thereby shaping community perceptions of the key issues affecting our healthcare system, there is a need to improve awareness of SDH. This is true within government programs, health and community service providers, and the general public. The challenge in health financing is to create payment and other policy incentives that will support a shift to effective preventive practices and target key health issues and population groups. Without consideration of financing arrangements, MBS and PBS savings will not be realised, even if people are healthier and less likely to be admitted to hospital.

Given health is influenced by various factors, a whole-of-society approach is needed to accompany a whole-of-government approach. How Medicare Locals can become a truly effective actor and leader at the local level, where the programs are seamless and linked into the local social institutional landscape, is also an unfinished agenda.

Seedlings have been planted, but will the orchard be allowed to grow and bear fruit?
The current and growing challenges the Australian healthcare system face are well documented. Health spending now accounts for 19% of all Australian government (state, territory and Commonwealth) expenditure, an increase of 74% in real terms over the past decade. At a time of significant health funding reform by all levels of government, there is great potential for unintended consequences. To mitigate such effects, we need to ensure better coordination and integration of bilateral government reform agendas.

Strong primary healthcare systems have been associated with improved population health, decreased health costs, appropriate care and positive health outcomes. A priority of Australia’s First National Primary Health Care Strategy was to bring about changes in funding arrangements to further strengthen the delivery of care in the community. This was thought to make it easier for Australians to access the services they need in the most appropriate care setting.

In Victoria, community health services, traditionally funded by the Victorian and Commonwealth governments, have worked closely with local communities for over 30 years to deliver a diverse range of community-based health services. This experience and understanding of the broader primary healthcare system can provide invaluable expertise to policymakers in how to deliver locally responsive healthcare services to communities.

Reform agendas must be cognisant of the potential implications concurrent reforms may have. This is especially true for the current funding constructs to aged, disability, mental health, primary care and the broader health system. It is essential that funding reforms are integrated and coordinated, and that they are understood in the context of community health services and the broader primary healthcare sector. Without this, there is a risk that rather than improved integration and coordination of the sector, it will instead result in fragmentation. Some service providers may be forced or opt to withdraw from traditional services to focus only on more financially attractive aspects that the reforms will drive. If this occurs, the risk will be further fragmentation and reduced service delivery to some of the most complex vulnerable members of the community.

A reform agenda that does not ensure an integrated and coordinated approach across governments will not result in the much needed paradigm shift toward a more sustainable healthcare system. Reforms to the payment system need to be part of a wider program of reform. If healthcare systems require widespread structural changes, such as reconfiguration of hospital services and primary care, these will not be achieved by payment reform. They require a more systemic approach including service planning, capital funding and workforce redesign.

Public hospitals are encumbered by system inefficiencies. Clients often receive expensive emergency department and/or bed-based care when they could otherwise be treated in community settings. The community health sector, as part of the important role the entire primary healthcare sector plays, is vital in reducing this strain. It offers non bed-based treatment in local communities, reducing the need for hospital admission or entry into other institutional care.

Primary healthcare services are the most frequently used in the health system. However, they are not glamorous, rarely attract media attention, and hence there is little pressure for political action to improve them. To achieve a sustainable health system, government reform objectives must ensure an integrated and coordinated approach across the primary and acute care interface. This is what is needed to achieve a sustainable, high quality client/patient focused health system for the future.

In Victoria, community health services have worked closely with local communities for over 30 years to deliver a diverse range of community-based health services.

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3. Nuffield Trust (2012). Reforming payment for healthcare in Europe to achieve better value
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The case for bundling of health payments

Are there better ways of determining the efficiency of our health system?

After decades of health expenditure growing at a rate of around 6-9% per annum while state and territory economies are growing around 3% (with the exception of Western Australia), it is clear that Australia’s health system financing is unsustainable. It is only a matter of time before the inexorable ‘cliff’ occurs where the incremental approach to health system reform turns into a financial crisis. However, all experienced change managers know that there are opportunities during a crisis: change can be achieved that is not otherwise possible in a business-as-usual context. Nevertheless, it is incumbent on our health leaders to consider the inescapable reality that confronts Australia’s health system. We must seek to employ reform strategies in a measured way that best protects the integrity of the system and, in particular, the health and safety of our citizens.

The introduction of Activity Based Funding (ABF) to the health system is an enormous step forward for Australia. For the first time, we now have a ‘currency’ to measure the outputs of our health system. We know from experience that areas where the ABF has been introduced, first in Victoria and then South Australia, have seen improved technical efficiency for the delivery of healthcare. Moreover, the application of...
ABF provides, or attempts to provide, a direct comparison in the cost of outputs of healthcare across jurisdictions. This ability to count what we do in terms of volume and complexity is a great leap forward from where we were just a few decades ago. However, while casemix does provide an economic driver for ‘technical’ efficiency, it provides a disincentive for ‘allocative’ efficiency.

Technical efficiency measures the input to the output ratio; for example, the cost of an output (a standard episode of care) relative to the cost (dollars). Allocative efficiency, on the other hand, measures the outcome (a healthier patient) relative to the input (dollars). Where technical efficiency might improve the cost ratio of the admission, the allocative efficiency might drive to prevent the admission in the first place if it can occur at a lesser cost.

The problem often associated with price volume funding, such as that proposed by ABF, is that it can create an incentive to treat since treatment results in driving funding. The more admissions a hospital creates, the more revenue it receives. The cheaper the hospital can effect an admission, the more financially secure the hospital will be. The problem with activity-based funding is that it doesn’t reward the system for keeping people out of hospital. This is discussed in the Independent Hospital Pricing Authority (IHPA) activity-based funding Pricing Framework, and IHPA is conscious to not provide the economic disincentives for improved healthcare.

80% of people, if asked at the time of a transition from curative to palliative care, indicate they would prefer to die at home.

In the particular case of palliative care, it is understood that approximately 80% of people, if asked at the time of a transition from curative to palliative care, indicate they would prefer to die at home. Nevertheless, it is common across Australia that approximately only 20–30% of people achieve that aspiration. To enable a palliative patient to achieve their aspiration to die at home takes a considerable investment in high quality community-based palliative care services. However, in an ABF regime, these may well be poorly funded even though they result in better patient outcomes and an increased allocative efficiency for the system. Because a high number of admissions occur in the last few months of a patient’s life, services that prevent the hospital admissions do not benefit from the resources that would otherwise have been used to fund service delivery.

If the actuarially calculated cost of the last three months of life was packaged into a bundle and given to a health service provider, that provider could substitute inpatient care costs for community care costs. This would enable better outcomes in terms of meeting patients’ aspirations. In such a model, the service provider would need to bear the risk of any admissions that did occur in the final three months of a life, thereby encouraging the service provider to provide such high quality care that it mitigated the need for inpatient admissions. Essentially, bundled payments for various classes of patients, such as those with respiratory disease, heart failure, renal failure and those in need of palliative care, put an incentive into the service delivery chain: to provide preventative healthcare and respect a patient’s choice to receive care at home, often at significantly less cost than the episodic inpatient equivalent.

The introduction of ABF is an important step on the way to achieving a better distributed health system, though not the completion of the journey. The data generated over coming years will provide the foundations for the IHPA to establish a more holistic approach to healthcare service delivery. That is, by funding extended bundles of care around a patient over time, they will allow service providers to be rewarded for improving allocative efficiency not just technical efficiency.
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Dr Lan Tran, Dream Dental - Holland Park QLD

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The past 12 months have seen an almost unprecedented level of direct investment in dental services by the Australian Government. The funding has had a particular focus on the provision of services to the most disadvantaged Australians, those reliant on public dental services and/or living in rural and remote areas, and on building the dental workforce where it is needed most.

The 2012-2013 Federal Budget included $515.3 million of additional funding for dental programs. This funding included:

- $345.9 million to treat people on public sector dental waiting lists;
- $35.7 million for an additional 50 places in the Voluntary Dental Graduate Year Program from 2016 and $45.2 million on 50 places for a Graduate Year Program for Oral Health Therapists from 2014;
- $77.7 million for relocation and infrastructure grants for up to 300 dentists who set up practices in regional, rural and remote areas;
- $10.5 million for dental health promotion; and
- $0.45 million for NGOs to coordinate pro-bono work by dentists.

This was followed by the announcement in August 2012 of the $4.1 billion Dental Reform package. This announcement included:

- the Medicare Grow Up Smiling program (GUS) which will provide basic dental services for children aged 2-17 in families who are in receipt of Family Tax Benefit Part A or other certain government payments;
- a further $1.3 billion for adult public dental services; and
- a grants program totalling $225 million for dental infrastructure.

All states and territories have signed up to a National Partnership Agreement for the first $345.9 million in public sector funding and are busy delivering additional services to their communities. Also, an expert committee, established under the leadership of Dr Clive Wright, has delivered their draft National Oral Health Promotion Plan to the Federal Minister. This plan will form the framework against which the $10 million in funding for oral health promotion activities will be delivered. Planning and associated consultation for all other programs is underway.

While those in the public sector unequivocally welcome the current commitment to funding dental care, reservations remain about the sustainability of the programs. Waiting list ‘blitzes’, while providing care to many disadvantaged Australians, tend to raise overall demand. States and territories will then struggle to manage this increased demand if and when the Commonwealth funding is withdrawn.

There is concern that a change of government may result in some programs not being delivered.

Of course, there is concern that a change of government may result in some of the announced programs not being delivered. The Liberal Party Plan Real Solutions for All Australians states in relation to dental services: ‘We aspire to improve and restore dental services through Medicare as soon as we responsibly can.’ Disadvantaged Australians will be hoping that whoever is in power after the election delivers more than just aspirations.
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In developed countries, the main drivers of change in healthcare are demography, technology, community expectations and the economy. In Australia, as in comparable countries, there is a consensus among clinicians, managers, policymakers and researchers that the trends in these parameters are threatening the sustainability of our health systems. The growth in chronic disease – complicated by comorbidities, frailty and social isolation among the aged – and growth in the cost of health service provision, indicates that we must transform how we provide care.

The policy response cannot be to reduce the quality (access, safety, appropriateness, effectiveness, acceptability) of healthcare; it must be to improve the performance of the system on all those dimensions of quality while improving cost-effectiveness. What part will an improvement in the coordination of care play?

From patients, carers and clinicians, we hear that chronic and complex conditions are often, or usually, not well managed. There are real problems created by: the separate funding programs for primary care, hospital care, domiciliary care and other care programs; the division of responsibility for programs among Commonwealth, state and local governments and a multitude of other authorities; the incentives created by different funding arrangements; and inconsistent or missing information about individual cases.

Current structures and processes are impediments to the coordination of care, both within and between health services. So, too, is the current culture that values autonomy of individual clinicians; the reputation and prestige of provider organisations; the protection of ‘turf’ by professions; ideological fixations about one ‘best’ way of doing things (e.g. private or public); and emphasis on the wrong measures (e.g. throughput instead of outcomes). In particular, the rhetoric about patient-centred care is rarely matched by the reality.

Around 15 years ago, Australia invested in Coordinated Care Trials, whereby funds from different programs were pooled, and clinical pathways and innovative arrangements were developed to coordinate care around the needs of patients. The trials improved access to services, enhanced patient satisfaction and knowledge of the system, and delivered more culturally appropriate services to Indigenous people. They did little to demonstrate improved financial sustainability but appeared to promote health awareness, timely diagnosis and self-management. They also led to some reductions in hospital admissions.

There were many lessons from the trials about how to improve coordination which are still relevant today. These include: the importance of primary care providers and clear roles; the availability of skilled clinicians and care planners; effective governance and management; and good information and communications systems.

We can also learn from a growing body of work about ‘ambulatory care sensitive conditions’ and projects such as the Victorian Hospital Admission Risk Program (HARP), which aims to provide care that is coordinated and more appropriate than hospital admission for patients with complex care needs.

All levels of government must remove or minimise the structural impediments (e.g. how performance is measured, funding, governance, and incentives) to the coordination of care. Governments also need to continue substantial investment in enablers of coordinated care, such as the eHealth record system and workforce reform.

Managers, governing bodies and clinical leaders need to create a culture in which there is strong leadership and clear expectations that providers listen to patients and carers; are truly committed to patient-centred care; and adopt an interdisciplinary approach to chronic and complex conditions. There must also be systems employing, where appropriate. This includes informed patient choices; evidence-based pathways; information and communications technology; and innovative workforce models. There have been many projects to improve coordination of care developed and led at local levels. The challenge is for governments to take some risks, learn from projects, and apply the lessons learnt across the nation.
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On 1 July 2012, the Australian Government’s eHealth record system became a reality. It is a key element of the national health reform agenda around making the health system more agile and sustainable.

Almost one year after the eHealth record system commenced operation, more than 150,000 Australians have now registered for an eHealth record and momentum is continuing to build. The adoption by GPs was given a boost through the requirement that general medical practices participating in the electronic health Practice Incentives Payment scheme (ePIP) must meet five eligibility criteria, including the ability to connect to the system.

The system is now able to be written to and read from multiple GP, pharmacy, aged care and some hospital Clinical Information Systems (CIS). There is also the ability to gather and share information regardless of the CIS used, proving that joined-up patient care is an achievable goal.

Consumers are accessing a secure online portal and adding their own information to a consumer entered notes area of the record. They are also able to update information on their medications, allergies or adverse reactions. With the most recent release to the system in May, a child development function was added to the system. This allows parents and carers to track their children’s early health, growth and development information. The child development function has been modelled in part on the New South Wales paper-based ‘Blue Book’.

In addition, a mobile app will be available shortly to help parents view and monitor growth and development information in their children’s eHealth record. The My Child’s eHealth Record mobile app will be free to download from the Android and Apple stores.

It’s too simple to define eHealth by the complex technologies that will enable and support the future of connected care. This is ultimately not about technology – it’s about people. People like you and me, people who share the eHealth goal of safer, quality healthcare for all Australians.
direction for consumption. Similar information is also displayed in the new view of the eHealth record as medications are dispensed. The prescription and dispense view will build over time as more healthcare professionals connect to the system.

The National E-Health Transition Authority (NEHTA) is collaborating with all state and territory government health departments on a Rapid Integration Project that will see public hospitals start to transmit NEHTA compliant discharge summaries in the latter half of 2013. To get to this exciting point, where we can begin to achieve the benefits of a secure, interconnected health system, a number of critical components have been designed and developed. NEHTA has worked with all levels of government and a key group of delivery partners and stakeholders to develop and implement the technical foundations that will enable this national system to begin operation.

These technical achievements include:
- The Healthcare Identifiers (HI) Service – ensuring that only the right people have access to patient information and to ensure that newly acquired patient information is matched correctly with the existing patient records;
- Conformance and accreditation specifications for computer software used in health applications, working with the medical software vendors to develop and test software platforms to enable different medical computer systems to work with one another;
- eDischarge, eReferral and eSpecialist letters;
- National Clinical Terminology and Information Service including SNOMED CT-AU and the Australian Medicines Terminology (AMT) to ensure clear, unambiguous clinical communications;
- A world-leading approach to the supply chain for medicines, medical consumables and medical devices; and
- A National Authentication Service for Health (NASH) to ensure a robust and secure authentication system for the Australian healthcare sector.

All of this represents a turning point whereby our health system will no longer be reliant on pen, paper and human memory. A future where the points of care can finally start to be connected, meaning safer, better quality care with fewer errors, and ultimately, fewer lives lost.

It’s too simple to define eHealth by the complex technologies that will enable and support the future of connected care. This is ultimately not about technology – it’s about people. People like you and me, people who share the eHealth goal of safer, quality healthcare for all Australians.

If you’re a healthcare professional wanting to learn about using the new system, or if you want to register for an eHealth record, go to www.ehealth.gov.au.

The National E-Health Transition Authority has been tasked by the governments of Australia to develop better ways of electronically collecting and securely exchanging health information and is the lead organisation supporting the national vision for eHealth in Australia.

For further information on the Authority’s work, go to www.nehta.gov.au.
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A brilliant career

The AHHA looks back at the myriad of achievements of its former CEO, Prue Power, as she embarks on her next big adventures

Prue was born in Hobart on 15 May 1947, the first of four children to Desmond and Patricia Jackson. From her mother, an army nurse, Prue learnt compassion and caring for others; from her father, a soldier in the Australian Imperial Force, she learnt the importance of mateship, solidarity and strength in unity. It is with these sentiments that she chose to become a nurse, training at the Alfred Hospital in Melbourne and graduating in 1968.

Fast-forward to the 1980s when Prue moved to Canberra with her husband and three children. It was here that she became involved in union activities and was eventually elected secretary of the ACT branch of the Australian Nurses Federation (ANF). Alongside her co-workers, Prue was in the news headlines for weeks on end, picketing the Canberra Hospital about the dire state of nurses' pay and working conditions. In the end, the nurses won, and even today, ACT nurses are the best trained and highest paid in the country.

As a follow-up, Prue researched and presented a successful National Career Structure case before the Full Bench of the Australian Industrial Relations Commission, achieving significant increases in the terms and conditions for nurses in the ACT and other areas under federal jurisdiction. The ANF made her a life member in recognition of her work.

For three years from 1990, Prue was an adviser to the then Minister for Health and Deputy Prime Minister, Brian Howe. Here, she provided strategic health policy advice and oversaw national program management across a wide range of health issues.

After a brief stint as manager of the Nurse Education Transfer Assistance Program, which shifted responsibility for nurse education from the states to the Commonwealth, Prue joined the Australian Hospitals Association (the forerunner of the AHHA) as Deputy Director for three years.

She then took up a position at the Australian Medical Association (AMA) as director of its general practice and e-Health areas. One of her major achievements during this period was the establishment of the GP campaign, which created an extensive network of doctors throughout Australia for lobbying politicians in all electorates. She also developed, in consultation with stakeholder groups, a Rural Health Policy which influenced a range of Commonwealth initiatives in rural and remote Australia.

In 2002, she helped establish the Medical Informatics Forum. This allowed the whole medical profession to monitor the development and implementation of information management technologies in all areas affecting medical practice in Australia, including surgeries, hospitals and diagnostics.

In recognition of these achievements, the Royal Australian College of General Practitioners awarded her associate membership of the college – a rare honour for someone who is not a doctor. Then, on one auspicious day in July 2003, Prue took up the position of CEO of the AHHA.

In the 10 years since, Prue has turned the AHHA into a leader in healthcare that is respected and admired across the country. For all her hard work and wisdom, Prue is admired and respected by both sides of the political spectrum. Few people can claim to have worked effectively with organisations as diverse as a workers trade union and the AMA. On Australia Day last year, the nation recognised her contribution to public health and made her a member of the Order of Australia. She has made a major contribution to the improvement of public health in Australia and has contributed selflessly to community causes for over 30 years.

While the AHHA is sad to see her go, Prue will no doubt continue to devote her time to the betterment of others. We just hope she allows more time for herself, too!
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In April 2013, the final report of the panel of the Strategic Review of Health and Medical Research in Australia was released. It contains a range of recommendations which, if implemented, will have a major impact on translating medical research into healthcare outcomes in Australia.

One of the key recommendations for driving research activity in the health system is that integrated health research centres (IHRCs) be developed. This would involve clinicians, researchers and educators from hospital and community-care networks, universities and medical research institutes co-locating and collaborating with one another. The panel recommended that four to eight IHRCs initially be funded (in the amount of up to $10 million per annum each), depending on the centres’ satisfaction of funding criteria in a number of key areas. This could include funding existing centres, such as Victoria’s Monash Partners ASHC or Queensland’s Diamantina Health Partners.

The establishment of the centres would aim to ‘facilitate best-practice translation of research directly into healthcare delivery’.

Similar centres, sometimes known as Academic Health Science Centres, have already been established overseas (including in the UK, US and the Netherlands) and have been heralded as ‘transforming medicine’. The models employed for these centres vary, both between and within the various countries. Depending on how they are established, funded and governed in Australia, these centres could provide additional research opportunities for universities and research institutes, and significantly contribute to a more effective Australian healthcare system.

If this recommendation is adopted, key issues to be considered in its implementation include:

- Whether the centres are established as stand-alone entities with an independent governing body, or, through collaborations governed by representatives of the various stakeholders. The panel recognised that different governance models may be successful;
- What level of funding is provided; what it can be used for (including how it interacts with existing funding sources available to the participants, to avoid any unwanted cross-subsidisation between activities); whether co-contributions are required from the organisations involved; and whether the funding is milestone driven or provided as block funding (on the latter point, the panel recommended that block funding be provided to IHRCs, alongside unrestricted access to competitive research funding);
- How the objectives of each of the stakeholders (which are not always aligned) will be integrated into the overall objectives of the centre, and how alignment can be maximised (including by employing financial systems and incentives); and
- How criteria to assess the performance of the centres will be developed and employed, taking into account the range of clinical, research and education activities that will be undertaken by ISHCs.

Because Australia lags behind other countries in this area, there is a range of overseas centres that can provide valuable lessons when seeking to resolve these issues. However, overseas experience has shown that centres must be designed to take into account the particular goals they seek to achieve. Centres also need to remain flexible and adaptable in order to accommodate environmental changes, such as changes in the economic environment, information technology and the healthcare needs of the community.

* Kylie Diwell is a partner at Minter Ellison
† Nicole Reid is a senior associate at Minter Ellison

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Integrated health research centres

Are they the key to transforming medicine in Australia? Kylie Diwell* and Nicole Reid† of Minter Ellison Lawyers discuss some key issues
Hospitals can be confusing and dangerous places for people with dementia. The unfamiliar environment of a hospital can cause confusion and distress and may lead to a worsening of cognitive and behavioural symptoms. People with dementia have a much higher rate of complications and adverse events in hospital. This is not a small issue, as recent estimates suggest that as many as 30% of adults who enter hospital may have some form of cognitive impairment.

Alzheimer’s Australia recently commissioned a report from the Australian Institute of Health and Welfare (AIHW) entitled Dementia Care in Hospitals: Costs and Strategies. This report found that nearly half of people with dementia who were hospitalised did not have dementia recorded as one of their diagnoses. Lack of identification can lead to poor quality care and increased risk of complications and longer stays in hospital. The AIHW report also found that the average cost of care for a person with dementia is approximately 50% higher than for a person without dementia ($7,720 and $5,010 respectively). This is driven by a longer length of stay and higher likelihood of re-admission. The report can be found at www.aihw.gov.au/publication-detail/?id=60129542746.

Dementia has recently been identified as the ninth National Health Priority Area. It is imperative that we work to improve hospital care for people with dementia, as well as finding ways to reduce unnecessary hospitalisations. The Tackling Dementia package which was announced as part of the Living Longer Living Better aged care reforms includes funding to promote better hospital care over the next three years.

Consumers often tell us about their experiences when hospital care was poor and the person did not receive adequate support. But it is just as important to recognise the initiatives being taken to ensure good hospital care for people with dementia. The AIHW report suggested a range of multifaceted strategies that could be used to improve hospital care for people with dementia. It also recognised that a number of local initiatives are already in place.

In the city of Ballarat in Victoria, Associate Professor Mark Yates and his colleagues have implemented a bed-side cognitive impairment identifier accompanied by a training program in over 20 hospitals in order to improve both identification and care.

A separate program has been implemented in New South Wales hospitals called ‘Top Five’. This project involves recording tips from family carers about effective communication and care for the person with dementia. This information is used to develop five personalised strategies to promote better care and communication which are then recorded in the patient’s notes. This project has been implemented in over 20 hospitals in New South Wales and is currently being evaluated.

As part of our work to improve dementia care in hospitals, Alzheimer’s Australia would like to identify other local initiatives and programs in place to improve dementia care in hospitals. We welcome your feedback on this issue by completing an online survey: www.surveymonkey.com/s/H85HL6R.
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Ever since Gough Whitlam introduced Medibank, Australia’s first iteration of universal healthcare, in 1974, people of all political stripes and professional backgrounds have debated its place in the fabric of Australian society and questioned its long-term viability. Almost 40 years later, and a number of fundamental policy shifts and name changes along the way, Australians today see Medicare as the guarantor of public and universal healthcare. Under this system, access to health services is considered freely available, regardless of a person’s ability to pay.

Fast-forward to the 2000s when a series of sensational scandals, brought to prominence by the media, shook the public’s confidence in Australia’s universal healthcare system. Additional pressures of an ageing population, a pronounced increase in chronic disease, and diminishing financial resources exacerbated the debate between the Commonwealth, state and territory governments about how to fix healthcare.

The current Labor Government assumed office in 2007 promising large-scale health reforms. It vowed to end the blame game around healthcare through a cooperative and systematic national reform process that would improve services, reduce costs and halt the incessant finger pointing. True to the Government’s word, *National Health Reform: A Better Deal for all Australians* achieved buy-in from all states and territories at the February 2011 Council of Australian Governments meeting. Unfortunately, the blame game continues to this day, and Australia’s public healthcare system is still under pressure.

In an effort to better inform the current policy debate, and cut through the political rhetoric, the Deeble Institute is holding its inaugural symposium on universal healthcare in Australia and its challenges for the future. Taking place in Canberra on 24 September, prominent health policymakers, service providers, academics and advocates will join Saul Eslake, chief economist at the Bank of America Merrill Lynch in Australia and former ANZ Bank chief economist, to debate:

- **Is it realistic to expect universal healthcare into the future?**
- **What are the fundamental policy challenges to ensuring universal healthcare?**
- **What reform options are there to improve universal healthcare?**

As part of the inaugural Deeble Institute symposium, Dr Anne-marie Boxall, director of the Deeble Institute, and Associate Professor James Gillespie, deputy director of the Menzies Centre for Health Policy at the University of Sydney, will launch their book, *Making Medicare: the politics of universal health care in Australia.*

**Contact**
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Since the 1980s, Australians have had a system of universal health care that we largely take for granted. But the road there wasn’t easy. *Making Medicare* is a comprehensive account of Australia’s long, tortuous and unconventional path towards universal health care – as it was established, abolished and introduced again – and of the reforms that brought it into being.

With its detailed investigation of the policy debates that have determined the shape of health care in Australia, this book is the most thorough survey of Medicare’s history published to date. But it is not just about the past. The authors offer a timely overview of further reforms needed to address the challenges facing our health care system: new technologies, the ageing population and the rising tide of chronic disease.

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In 2011, the Council of Australian Governments (COAG) endorsed a policy, under National Activity Based Funding, of applying a single quantum of payment for each patient in a public hospital. The Independent Hospital Pricing Authority since announced that a discount will be applied to the Commonwealth contribution to a patient’s care, if that patient attracts a source of funding other than the national funding pool or state/territory contribution.

In recent years, states and territories have successfully focused on capturing third party sources of income. Most large public hospitals now identify up to 20% of their inpatients as private or compensable. Additionally, an increasing number of outpatient services have attracted Medicare payments.

It remains to be seen how each jurisdiction will respond to the elimination of this practice of ‘double dipping’ and cost shifting for these patients from 1 July Next year. Clearly, though, a reduction in available finances is inevitable; and hospital CEOs must take the following actions to mitigate the risks posed by these changes:

1. **Know the costs and revenues.** A thorough understanding of the cost structures, sources of revenue and how they relate in terms of productivity is essential. CEOs and CFOs must accurately model the financial impact of any funding changes.

2. **Invest in productivity.** It is possible that the states and territories may convince COAG to overturn its 2011 decision. Alternatively, they may choose to offset the reduced Commonwealth funding. The more likely reality is that they will pass on the funding reduction to the hospitals, as some did in 2012. To avoid short-term measures like redundancies, service reductions or deficits, CEOs should be implementing plans that result in cash capture in the medium to long term resulting from productivity improvements.

3. **Implement a strategy for recruitment and retention of staff specialists, independent of third party income.** States and territories have become increasingly reliant on third party income to pay specialists to work in public hospitals, because of the ability of the doctor to bill Medicare and/or an insurer for private inpatients or certain outpatients. Visiting Medical Officers can also gain income from private patients in public hospitals, and the extent of this income may not be visible to hospital management.

   Although patients could still ‘elect’ to be private patients when visiting public hospitals, the reduced incentive for hospitals to proactively identify these patients may result in significant changes to income for many specialists. This carries the risk of these doctors increasing their time in the private sector which, in turn, presents a workforce management issue for hospitals. CEOs should develop a comprehensive workforce plan to mitigate this risk.

4. **Model waiting list impact.** Hospital CEOs continue to face external pressures on waiting lists. If jurisdictions pass on the funding reduction to public hospitals, resulting in less aggregate financing for public hospitals, there will likely be capacity reduction and waiting list expansion. This will be made even more acute should medical staff increase their time spent in the private sector relative to the public sector. Well-considered scenario plans focused on achieving access targets in a variety of environments should be developed.

5. **Build partnerships with the private sector.** While it is likely that the funding changes will result in a shift from the public to private hospitals, it is unclear as to whether or not the private sector has the capacity to absorb any such shift. Public hospitals should foster productive partnerships with private sector providers to capture the potential benefits of the changes and mitigate the risks, especially those posed to the workforce.

Regardless how the final funding model looks, hospitals will be significantly affected. It is imperative they undertake these ‘no regrets’ actions in order to prepare.
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I wish it were trite to say that we should be focusing on health outcomes rather than health processes. The accountability juggernaut, realised (after Donabedian) that it is often easier, and equally effective, to measure processes where there is evidence that these processes lead to outcomes. Then it lost sight of the need for evidence and the possibility that outcomes are sometimes better measures. Now processes are all too frequently used and incentivised as performance measures without due regard to whether they make a difference.

Access is a potentially important process measure. Unfortunately, the ease with which it can be measured has turned it into fetish object for politicians, the media and hence, perhaps, the community. International comparisons show that Australians enjoy relatively good access to health services. However, access to healthcare appears to be price sensitive. This, and an increasing mismatch between need and availability as one moves away from the GPO, means that healthcare tends to be less accessible to those who need it most. Why is this not an issue in the marginal electorates of rural areas and the more inland parts of our cities?

The access drum bangs on about emergency and surgical services. The adage is ‘cheap, quick or high quality – choose two’. It’s easy to measure timeliness and cost, harder to measure quality. Easier, if you like, for providers to get away with an indifference to quality. If performance management is thought to work – and why else would one use it? – then, when resources are fixed, a focus on, and improvement in, one area will inevitably result in a deficit in another. Quality is sacrificed to timeliness of care.

An aside: I believe that getting patients out of the emergency department (ED) and onto the wards is associated with better patient outcomes. I am certainly working hard on this premise in my institution! Like the association between hospital accreditation and improved patient outcomes, there is a risk that causality is mis-attributed. Those hospitals which have engaged together around reducing length of stay in the ED and better planning the patient’s journey through things like MAUs are, in my view, likely to be engaged in other practices to improve patient outcomes. Early transfer from the ED is part of the package, but will not make a difference alone. Attitude is probably more important than the process, at least in the longer term.

Care needs to be taken to ensure that one is not providing too much access. The Dartmouth data demonstrate a two-fold difference in the median per capita spending on health between the lowest and highest expenditure quintiles across the US. This expenditure correlates positively with the availability of healthcare services – numbers of physicians and hospital beds, the requisites for better access – but negatively with health outcomes. The UK program to improve access to surgery led to unnecessary cataract operations.

This should not surprise. It is known that, in Australia, around 1:6 patients are harmed as a result of their hospitalisation. We have triage processes in place to ensure that the most urgent patients are treated first. The most urgent patients are likely to be sickest and therefore to get the most benefit from treatment. As increasingly less sick patients are treated, the benefit of treatment diminishes, but the risk is constant. The more treatment we provide, the less beneficial it is, even without taking dollar cost into account. Unconditioned access is not a good thing.
With a general election looming, we will soon have a ‘new’ Commonwealth Government of some political persuasion. What will not change is the view that ‘reorganising’ healthcare is a politician’s plaything; ‘occupational therapy for failed bureaucrats the world over with a pathological need to be seen to “do something”’. Another transient health minister will be appointed to deal with problems and systems that may well be older than they are, while health professionals sigh and think, ‘here we go again’.

There will be no shortage of advice coming the new government’s way about what they should do. My five cents’ worth for nursing is: Get nursing right and everything else like safety, quality, patient experience will follow. Get nursing wrong, and you are doomed. Here, future health minister, is nursing’s ‘Enough is Enough’ manifesto:

Enough of thuggery masquerading as ‘strong management’ corrupting our care systems while we wonder why compassion and empathy do not thrive in the wards.

Enough of mindless ‘auditing’ that equates quality with box-ticking and reduces nurses to little more than a pen with a warm body attached.

Enough of endless documentation where the volume of such documentation becomes a hollow proxy for actual nursing care.

Enough of mediocrity and low expectations that are regularly met.

Enough of being embarrassed and ashamed by reports of poor care and being afraid to even discuss or confront them.

Enough of clinical nurse leaders being held responsible for ‘excellence’ that they are powerless to demand or enforce.

Enough of ‘dumbing down’ nursing by imagining that something called ‘skillmix’ makes it okay to believe that healthcare assistants and registered nurses are interchangeable.

Enough of going home after every shift unable to remember why you came into nursing in the first place.

Enough of a nursing position being a job for life regardless of ability or performance.

Enough of management ADHD and flitting from one transient organisational fad to another.

Enough of expecting that our nursing leaders’ first loyalty should be to the organisation and not to the patient/person.

Enough of being pigeonholed as either caring or intelligent.

Enough of ‘advanced practice’ and ‘extended roles’ for nurses if this means ‘mini-doctoring’ while skilled fundamental care withers on the vine.

Enough of ‘employing a qualification’ rather than a person.

Enough of managers allowing dangerously inadequate staffing levels while simultaneously telling nurses that ‘working smarter, not harder’ will solve the problem.

Enough of being embarrassed and ashamed by reports of poor care and being afraid to even discuss or confront them.

Enough of the ‘any nurse is better than no nurse’ recruitment philosophy.

Enough of ‘dumbing down’ nursing by imagining that something called ‘skillmix’ makes it okay to believe that healthcare assistants and registered nurses are interchangeable.

Enough of ‘employing a qualification’ rather than a person.

Enough of managers allowing dangerously inadequate staffing levels while simultaneously telling nurses that ‘working smarter, not harder’ will solve the problem.

Enough of nurses being the only professionals in healthcare who apparently don’t need a university education.

Enough of the systemic overlooking and trivialisation of the great nursing that transforms lives.

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Funding is critical, of course. But let’s not get hysterical about the money. The sky is not falling, and claims that the system is ‘unsustainable’ are exaggerated, although we could make things unsustainable over the coming decade if we did a lot of the wrong things. But let’s keep this in perspective: we’re doing well on international comparisons of both overall health and managing costs (according to the Organisation for Economic Co-operation and Development).

Life as we know it will continue. Serious work to find the best ways to deliver needed care within available resources, and to reduce wasteful practices, will continue to preoccupy armies of health economists, lobbyists, consumer organisations, professional colleges and public servants. Governments will continue to set health budgets, which will continue to be not big enough. Chief Executive Officers will get sacked from time to time, and governments will change.

This is not to trivialise the human cost of unmet demand, long waiting periods for many kinds for treatment, staff redundancies and unnecessary suffering; nor to downplay the need for continuous innovation. But it won’t be fancy financing methods or various approaches to rationing (like the ‘social insurance’ and ‘savings accounts’ we heard a lot about during the run up to the National Health and Hospitals Reform Commission’s report) that give us the breakthroughs we need.

As I and my age cohort enter our expensive years, and staff in chemotherapy units move into permanent panic, the aged care industry looks for ways to keep ahead of tight policy settings. At these times, it’s the healthcare that matters. The financing arrangements come second, third (after the workforce challenges), or fourth (after the technology issues).

Big changes in the actual care people need are happening already, but many are subterranean. I am old enough to feel the difference in relationships when the care is working well – consumers know what’s going on, teams coordinate their work, and there is some management of what we now call ‘the patient journey’.

Watch this concept over the next few years. Even if the language changes, the idea of being able to ‘see’ (and therefore manage) the processes of care from the point of view of the patient and their support people is a subversive and powerful one. And there are implications for almost everything the system does.

The ‘new oldies’ may well end up getting a lot of their cardiac rehabilitation online, and talking to their care coordinators on Skype. All of those technological fixes (importantly including our personal electronic health records) will be transformative when they start to work. We’ll still need skilled staff, guides and supporters; and we’ll really need to make active end-of-life choices. It may well be mostly good for the budget, but that won’t be the reason we do it. So let’s not forget the difference between means and ends as we watch the big scares and the big promises of the election show.

No matter what happens with technology, we’ll still need skilled carers for the ‘new oldies’.
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In June, five bills were passed in the House of Representatives in a major step forward for the $3.7 billion Living Longer Living Better aged care reforms. Then Minister for Ageing Mark Butler said at the time the changes to the Aged Care Act 1997 are part of a 10-year plan to build a better, fairer, sustainable and nationally consistent aged care system to meet the challenges of the nation’s ageing population.

The federal Coalition will formally review the structure of Medicare Locals if elected in September, saying its priority is to ensure Commonwealth health funding is used as productively as possible. It says it is committed to reducing waste and expenditure on administration and bureaucracy, so greater investment can be made in services that directly benefit patients and support clinicians.

The Mason Review of Australian Government Health Workforce Programs has made 87 recommendations. Federal health minister Tanya Plibersek said she had accepted the report’s recommendations to provide a more advanced system for classifying rural locations and areas of workforce need to determine eligibility for support and funding through many Commonwealth workforce programs.

The number of Australians who are obese has reached ‘staggering’ numbers, according to a COAG report. It shows that 63% of Australians were overweight or obese – an increase of 2% in the past four years – with 35% of people overweight and 28% obese. The report says seven in every 10 men and more than half of all women are above their healthy body weight.

More Australians are covered by private hospital insurance now than at any other time since reporting began 42 years ago, with almost 10.8 million Australians now covered. The March 2013 quarter figures reveal that almost 1.4 million additional people have taken out hospital cover since the government took office.

The National Disability Insurance Scheme (NDIS), now known as DisabilityCare, has been guaranteed through the budget, the budget reply speech and through bi-partisan legislation to create a levy to fund the NDIS. The NDIS is now part of Australia’s future.

Bulk billing rates for GP services reached a new record high of 82.4% in the March quarter – the highest rate in Australia’s history. Minister Plibersek welcomed the new record, saying that this figure contrasted sharply with only 67% when Tony Abbott was health minister.

Health is one of the biggest spending areas of the Federal Government, accounting for $61 billion or 16% of the budget.

Australians living in rural and remote areas will have better access to essential medical services, thanks to a $179 million investment from the Australian Government that will bring more health professionals to areas that have found it hard to attract them.
Peter Mott moves from St John of God Murdoch and Regional Hospitals to take up his appointment as Chief Executive Officer at Hollywood Private Hospital in Perth.

Shane Kelly is also on the move, this time from St John of God Subiaco where he was Chief Executive Officer, to assume the position of Chief Executive Officer at North Metropolitan Health Service in Perth.

Rejoining the movers and shakers in the west is Di Jones, who joins Joondalup Health Campus after spending several years based in Sydney as National Director of Clinical Services at Little Company of Mary Healthcare.

Jane Orr is moving to Mundipharma as their new Managing Director.

In another gain for Mundipharma, Jagdish Ghadge – formerly Senior Project Manager, Regulatory Affairs at Janssen Cilag – has joined as Regulatory Affairs Manager.

Janet Compton is changing direction: formerly at Eastern Health, she moves to Northern Health as Chief Executive Officer.

Matthew Mackay, former Director of Clinical Services at Surgery Centres Australasia, is now with Pulse Health as Chief Operating Officer.

Memo Musa, the former Chief Executive of Whanganui District Health Board, has been appointed chief executive of the New Zealand Nurses Organisation (NZNO).

Professor Gary Smith has been appointed Deputy Vice-Chancellor (global engagement) at Deakin University. Professor Smith is currently the Pro Vice-Chancellor (engagement and international) at the University of Western Sydney. Baker & McKenzie has recruited life sciences partner Amanda Turnill from DLA Piper. Amanda will co-chair Bakers’ Australian life sciences group with partner Ben McLaughlin.

Leading international medical researcher Professor Stephen Smith has been appointed Dean of Medicine, Dentistry and Health Sciences at the University of Melbourne. He is currently Vice-President (Research) at Nanyang Technological University and takes up his Melbourne position in September this year.

In other offshore appointment, Dr David McGiffin is arriving to head up cardiothoracic surgery at Alfred Health. He was previously Chief, Section of Cardiopulmonary Transplantation and Deputy Director, Division of Cardiothoracic Surgery with the School of Medicine, University of Alabama, Birmingham, where he had a busy job and very big business card.

Robert Morton, Director of the National Ambulance Service, Ireland, is winging his way to Adelaide as Chief Executive Officer of the South Australian Ambulance Service.

Maryanne Hambrecht, former Chief Executive of Family Planning Queensland is off to Queensland Eye Hospital as Chief Executive Officer.

Gerry Wynn, from Queensland Health, is moving to Townsville as Chief Executive Officer of Mater Health Services North Queensland.

Steve Zappia, State Manager of Queensland Imaging for Primary Healthcare, joins Virtus Health’s Queensland Fertility Group as State Managing Director.
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The Health Advocate
August 2013

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As a member, you will have access to the association’s regular professional development activities and to networking opportunities with colleagues across Australia through our stimulating networks and innovative events.

You will also receive the Australian Health Review, Australia’s foremost journal for health policy, management and delivery systems (print and online), as well as our magazine The Health Advocate, up-to-the-minute email news bulletins and other professional information.

AHHA values your knowledge and experience
Whether you are a student, clinician, academic, policy-maker or administrator, the AHHA values your skills and expertise.

The AHHA reflects your views and gives them a voice. Your ideas will help shape the AHHA’s policy positions and our highly influential advocacy program.

Our focus is on improving safety and quality for patients and consumers in all healthcare settings. To do this we are working to achieve care delivery in appropriate settings through better service integration; enhanced information management systems; efficient financing models; targeted performance measures and benchmarking; environmental sustainability and a flexible workforce.

Your knowledge and expertise in these areas are valuable and you can have direct input to our policy development. Join our think tanks or participate in our national seminars or conferences.

Our voice is authoritative and influential. It is heard via our high-level advocacy program and extensive media exposure.

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*Fee includes GST - valid from 3 June 2013 to 30 June 2014.

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