The Health Advocate

Your voice in healthcare

Research in action

Perspectives from the 2017 Parliamentary Delegation on Mental Health

Reducing preventable hospitalisations due to heart failure

Beating blood-borne viruses

Disinvestment in low-value healthcare

+MORE INSIDE

The official magazine of the Australian Healthcare and Hospitals Association

ISSUE 45 / December 2017

PRINT POST APPROVED PP:100009739

HESTA

An Industry SuperFund

no butts about it

We've implemented a portfolio-wide tobacco exclusion.

Has your super fund?

hesta.com.au/no-butts

Supporter 2016

Contents

The Health Advocate

Issue 45 / December 2017

In depth

12. Immuno-oncology
16. Developing a Learning Health System platform to improve access, equity, and outcomes
24. Disinvestment in low-value healthcare
26. Privately practising nurse practitioners and Collaborative Arrangements
28. Dynamic simulation models forecast effect of public health interventions
30. Beyond the glass ceiling: co-creation of value in mental health
34. Patients first

Briefing

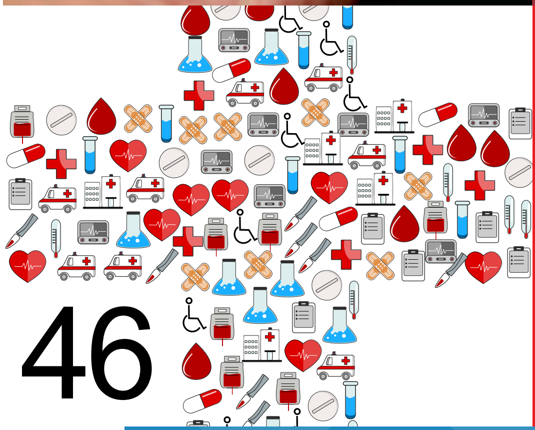
10. Perspectives from the 2017 Parliamentary Delegation on Mental Health
14. Reducing preventable hospitalisations due to heart failure
18. Are we Choosing Wisely?
20. A VHHITAL step
36. The Essentials website
38. Hospital pharmacists
40. Cardiopulmonary care—mobilisation is king!
42. Handling legal issues in the care sector
44. The Dealing with it myself research project
46. Private Health Insurance: A look under the bonnet
48. Experience-based co-design

From the AHHA desk

04. View from the Chair
05. Chief Executive update
06. AHHA in the news
50. Become an AHHA member
51. More about the AHHA

Advertorial

32. Hesta



Cover photo GraphicStock

DEBORAH COLE
Chair of the Australian Healthcare
and Hospitals Association (AHHA)

Actionable research requires alignment and accountability

Last month I presented at the World Health Congress in Taipei where I got to meet international health leaders and discuss Australia's move towards value-based healthcare. At the Congress, Barbara Anason, Senior Vice-President of the Vizient University Health Consortium identified emerging healthcare themes. These included the need to facilitate centres of excellence, foster environments for innovation and achieve alignment between the various pieces of the healthcare puzzle.

Alignment between researchers and practitioners is vital if we want a strong evidence base to support our move towards value-based healthcare. A culture of misalignment and a system of silos benefits no-one. Researchers end up unable to secure funding because their projects are not aligned to the health service's strategic goals. And practitioners end up with research that does nothing to improve health outcomes after taking an average of 17 years to reach clinical practice. It's for this reason that AHHA has invested in its Deeble Institute for Health Policy Research, bringing together clinicians, researchers and policy-makers to share their work towards a better health system.

On a broader scale, what we need are strategy-engaged researchers, research-engaged clinicians and leaders with a strong vision to improve health outcomes. We need clinicians to enhance research projects with their knowledge of the 'frontline', to participate in clinical trials and be passionate about building the evidence base that will affect change. We also need researchers who are engaged with the mission of the health service and tailor their projects accordingly. And we need health leaders who will invest in research projects that advance the move from volume to value.

AHHA staff attending the 2017 World Hospital Congress in Taipei

How do we achieve this alignment? We start by aligning governance structures, performance management systems and strategies. Some of this we are doing well. For example, when university medical and health science faculties start developing their strategic plans, it's common practice for them to engage with their key partners (i.e. the CEO of a health service). The new academic medical centres are taking this alignment further by developing governance frameworks that link research with health service operations. In Brussels the governance of the hospital, Universitair Ziekenhuis Brussel and the governance of the university, Vrije Universiteit Brussel, are aligned through a joint committee. This is progress, yes, but a step further would be one Board of Directors for the university's health faculty/research centre AND the hospital, with a robust performance management framework in place to ensure both are held accountable for achieving one set of strategic goals. No more silos. No more conflicting priorities and drivers. Rather a system where researchers and practitioners are engaged in a joint mission to improve health outcomes through innovation.

The need for alignment between research centres and health services is probably best illustrated by a recent interaction I had with a budding young researcher. He told me all about a research project he wanted to get off the ground and asked me to fund it. I told him it wasn't aligned to our strategic direction but if he tweaked it by doing XYZ, I would be prepared to support it. He refused to budge from his very set agenda and left my office in a huff and without a cent. He didn't get the outcome he needed and neither did I.

The move to value-based healthcare has the ability to transform the landscape and improve health outcomes for a population that is living longer and getting sicker. The research required by health services may not be flashy, it may not end up in an esteemed journal, but it will result in something far more powerful—action, disruption and change. ha

ALISON VERHOEVEN
Chief Executive
AHHA

Nice conclusion to 2017

Four things have brought a smile to my face as we approach the end of a successful 2017 for AHHA.

The first was the re-launch in National Carers Week (late October 2017) of our Palliative Care Online Training Portal. We have run this project for the last 5 years, with over 38,000 people using it. The feedback received over that time has been overwhelmingly positive, and we were very pleased that the Department of Health decided to extend the project for another 3 years as one component of a new $60 million palliative care services funding package. We are also pleased to have received 3 year funding to support Primary Health Networks and general practice in developing palliative care services. We'll have more news on this in early 2018.

The second piece of good news is the forthcoming release, on 18 December, of our 10-year blueprint for a post-2020 national health agreement, entitled *Healthy people, healthy systems*. It is the culmination of a year of engagement with members and stakeholders to develop a vision for Australia's health system for the next decade or more.

We will be advocating, as we have been in recent times, for reforms that put the patient at the centre of healthcare services rather than providers. We will advocate for funding to be based on value and outcomes, rather than volume or number of occasions of service, as happens now. We will advocate for a better integrated primary healthcare and hospital system, with better provision and coordination at the local level to ensure that care is provided in the right place, at the right time, by the right services. We will once again raise the importance of better national data, especially in primary health, so that we can finally and comprehensively track and measure value and outcomes in healthcare.

The third piece of good news was being passed the baton (figuratively) from the International Hospital Federation to run the next World Hospital Congress in Brisbane in October 2018, with our partner Queensland Health. This handover by International Hospital Federation President Dr Francisco Balestrin (Brazil) occurred at the conclusion of the excellent 2017 World Hospital Congress in Taipei. AHHA staff attending the conference made quite a splash in our Aussie-themed outfits!

Once back in Australia we hit the ground running in continuing our preparations, actively pursuing sponsorship and issuing the Call for Abstracts (see advertisement elsewhere in this issue).

> **"…it's uplifting to see that the overwhelming majority of Australians believe in everyone being given a 'fair go'…"**

Members and colleagues, this is a rare opportunity to showcase your products or your work in hospitals and healthcare to an international audience of your peers, on home soil. So, please consider our sponsorship opportunities and/or get your abstracts in (no more than 500 words) by 15 January 2018 at the latest—although we would love it if you were able to submit abstracts before 25 December 2017!

The final piece of good news was the result of the Marriage Law Postal Survey, which, to paraphrase the words of the ACT Chief Minister, showed just how decent, positive and inclusive Australians can be (the ACT had a 74% 'yes' response, the highest of all jurisdictions).

At AHHA we joined many other health organisations in welcoming the 'yes' result for marriage equality, which can only have positive effects on the mental and physical health of lesbian, gay, bisexual, transgender, intersex and queer people in Australia. We urged our politicians to get on with legislating the necessary change to the Marriage Act, and not to be derailed by any attempts to 'water down' current anti-discrimination protections. By the time you read this, hopefully that will have come to pass or just about be there.

Overall, it's uplifting to see that the overwhelming majority of Australians believe in everyone being given a 'fair go'—and have not been backward in coming forward to express that view. The near-to-80% participation rate in a voluntary survey, with 12.7 million people responding, must be an Australian record.

On our wish and resolution lists this holiday season is that 2018 will also see more action on addressing inequities experienced by Aboriginal and Torres Strait Islander people. AHHA has called upon the Government to support a voice for Australia First Nations' people in Parliament. We are proud to have launched our Reconciliation Action Plan in 2017, and are committed to providing leadership in the health sector to achieve better health outcomes for Aboriginal and Torres Strait Islander people, including through our continuing work on the Lighthouse Project, which aims to improve care for Aboriginal and Torres Strait Islander patients with acute coronary syndrome.

Thank you to all who have supported and worked with us during 2017. We look forward to another busy year working with you in 2018!

AHHA in the news

Photo: Robin Yang

Long acting reversible contraceptive methods can reduce unintended pregnancies in Australia

Behind much of the work being undertaken in Australia to improve the efficiency of our health services, and the quality of care they provide, is better use of linked data. This was highlighted in the August 2017 edition of *Australian Health Review* (AHR) in an open access article on the growth of linked hospital data use in Australia.

‘When done well, with appropriate privacy and confidentiality safeguards, linked hospital datasets can yield information that is very useful for health policy formulation, without the need, for example, to conduct new data collection activities or run surveys based on patient recall’, AHR’s editor-in-chief, Professor Gary Day said.

‘According to the article, from a University of Melbourne author team, Western Australia and New South Wales have easily outperformed the other states and territories over the last 20 years—over 80% of publications using linked hospital data were from these two states. The investment made by these states in developing data linkage capability to support health systems research is behind this.

The August edition of AHR also included an article on improving the accuracy of clinical costing for admitted sub-acute (in this case rehabilitation) patients. This was achieved through an ‘action research’ approach involving identifying current activity, finding gaps, revising the costing methodology, implementing changes and evaluating the effects of those changes.

Data issues and analysis were also at the centre of articles on the lack of data on periodontal disease in Indigenous adults, and using an outpatient scheduling database in investigating geographic clustering in chronic liver disease presentations within a health service district in Brisbane.

An open access article from Griffith University looked into what matters when operational decisions are made about emergency surgery queues. There are tensions surrounding such decisions, especially between surgeons and operating theatre managers, but also involving anaesthetists and nurses. Clinical precedence and logistical challenges are both important, and need to be appreciated and understood by all parties.

Also data-related, social participation as an indicator of successful ageing was considered in an article by a team of authors from Macquarie University. This study went further than most in looking at three different concepts of social participation, and how they are measured. The authors suggested that a measure of social participation segmented into each of the three concepts predicts variances in health outcomes more accurately than any of the measures on their own.

AHHA is proud to support research through AHR that contributes to the delivery of high quality, efficient and effective health services for all Australians.

Let’s not be stuck with the old and overwhelmed by the new in healthcare

AHHA released a Deeble Institute Issues Brief in early October, *Active disinvestment in low-value care in Australia will improve patient outcomes and reduce waste*, by 2017 Deeble Scholar, Victoria McCreanor.

‘Our current processes for government investment in health treatments and services have resulted in continued support for outmoded treatments and services while being overwhelmed by the new’, AHHA Chief Executive Alison Verhoeven said.

Ms McCreanor said ‘Australia does have good systems for ensuring that government funding decisions on new medical services, products or technologies are backed by evidence of cost-effectiveness and efficacy—and the current Medicare Benefits Schedule Review is a very positive step forward.

‘But many existing services, some funded a long time ago, may not ever have been subject to a thorough evaluation of their effectiveness or cost-effectiveness. And they are rarely routinely reviewed against the latest evidence.

‘Also, where old services are superseded by new technology, there isn’t a formal and ongoing process for coordinated, active disinvestment in the outdated services.’

GraphicStock

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

GraphicStock

Private health insurance shake up welcome, but should only be the beginning of reforms

'[The government's] announcement on measures to make private health insurance more transparent and affordable are welcome, but we still need a review of how we fund our health system—both public and private—to make sure all Australians benefit', said AHHA Chief Executive Alison Verhoeven on 12 October.

'With more than $6.4 billion of public money to be given to private health insurers through the Private Health Insurance Rebate in 2017–18, and only one-half of all Australians using private health insurance, the Commonwealth Government should establish a comprehensive Productivity Commission inquiry looking at the costs and benefits of private health insurance within the overall health sector.

'The Productivity Commission inquiry should also consider appropriate levels of profitability within the private health insurance sector, which has become increasingly for-profit driven, but is heavily subsidised and has government policy pushing the public into taking out health insurance policies.

'Today's announcement goes even further to significantly de-risk the insurers' revenue.

'Offering a discount of up to 10% off premiums will make private health insurance more attractive for people aged 18 to 29, while also decreasing the pooled risk of the overall insured population. By itself, this should reduce the rate at which premiums are increased because the pooled risk has been reduced.'

Government's taskforce on urgent after-hours primary care listens only to itself

'It's now almost certain that patients will have less access to care as the Government moves to restrict use of MBS items for urgent after-hours care to general practitioners working predominantly in the in-hours period', said Alison Verhoeven, Chief Executive of AHHA.

The AHHA was responding to the final report of the Medicare Benefits Schedule Review Taskforce on *Urgent after-hours primary care services funded by the MBS*.

'The preliminary report was released for public consultation for about 6 weeks over June and July. We put in a submission, along with many others—submissions were not made public.

'Now, months later, the Taskforce says they considered feedback from the public and have not made any changes. In fact the final report shows little recognition of interests and feedback other than from GPs.

'In other words this Taskforce is saying "We do not care about consumer expectations of needed access to MBS-funded after-hours primary healthcare, both urgent and non-urgent".'

'The Taskforce is saying "We do not care that many consumers, unable to afford care not subsidised by Medicare, will now go to already-stretched hospital emergency departments to seek the care they need".'

'The Taskforce, consisting of 10 GPs and only 1 consumer representative—nominated by the Government—is saying "We only care about ensuring funding is exclusively available to some GPs—although we have demonstrated we are unwilling or unable to provide sufficient services to meet demand".'

Pixabay

Pixabay

'Yes' to marriage equality, 'yes' to greater wellbeing for LGBTIQ people

'Today's marriage equality survey result shows Australians are committed to ending discrimination and supporting greater wellbeing for all Australians, and we now call on the Australian Government to pass the required legislation as quickly as possible', said Alison Verhoeven, Chief Executive of AHHA on 15 November.

'We also urge all politicians not to be distracted or bend to any pressure to water down current anti-discrimination protections.

'To do so will only replace one form of marginalisation of LGBTIQ people—the right to marry—with another.

'At AHHA we are pleased that our *Position Statement on Marriage Equality and Health*, which highlights the overall health benefits of all healthy, safe and respectful relationships, including marriage, is now closer to legal reality for same-sex couples who wish to take that step.'

AHHA in the news


Photo: Tran Mau Tri Tam

World Hospital Congress coming to Australia in 2018

‘We look forward to hospital and health leaders from around the world coming to Brisbane next October for the 42nd World Hospital Congress’, Dr Deborah Cole, Chair of the Board of the Australian Healthcare and Hospitals Association, said on 9 November.

Dr Cole made the announcement following an official handover of the hosting rights to Australia by International Hospital Federation President Dr Francisco Balestrin (Brazil) at the conclusion of this week’s 41st Congress in Taipei.

The official conference hosts in Australia will be the Australian Healthcare and Hospitals Association in partnership with Queensland Health.

Australian Health Minister Greg Hunt joined Australian health leaders in a recorded message inviting international health leaders ‘down under’, saying next year’s conference will be ‘both informative and enjoyable’.

‘We can learn from you, you can learn from us, and together we can help improve the standard of hospital care in each of our countries’, Minister Hunt said.

Queensland Health Deputy Director-General for Clinical Excellence, Dr John Wakefield, congratulated Taiwan on an impressive 2017 congress, while indicating that the 2018 event will focus on ‘driving reliability and effecting transformational change in health to cope with challenges common to many nations around the world’.

Call for Abstracts: World Hospital Congress 2018

‘We are pleased to announce that the Call for Abstracts is now open for the 42nd World Hospital Congress to be held in Brisbane next October’, Alison Verhoeven, Chief Executive of AHHA said on 20 November.

Australian and international health sector leaders wishing to present their work, orally or as a poster, at the Congress are invited to submit abstracts of **no more than 500 words by 15 January 2018**, using the online submission form.

Abstracts for oral and poster presentations should respond to the overall Congress theme: **INNOVATE|INTEGRATE|INSPIRE — How can healthcare evolve to meet 21st century demands?**

eHealth and hospitals—wider vision, open minds and better research needed

‘Without the right vision, attitudes and research base, eHealth initiatives in hospitals can end up being extraordinarily expensive mistakes’, Alison Verhoeven, Chief Executive of AHHA, said today.

The Association’s Deeble Research Institute has released an evidence brief, The impact of eHealth upon hospital practice: synthesis of current literature.

‘In many quarters eHealth is seen in and of itself as a way to improve financial and clinical outcomes in hospitals through greater efficiency—but the available research shows mixed results’, Ms Verhoeven said on 27 October.

‘I think it’s fair to say that, in Australia, we have had variable success in our attempts to digitise and integrate health records, provider ordering, prescribing and decision support systems.

‘In many ways we should not be surprised.’

CALL FOR ABSTRACTS OPEN

PARTNER OR EXHIBIT NOW!

IFHE 2018

AUSTRALIA

IFHE 2018

BRISBANE, AUSTRALIA

BRISBANE CONVENTION & EXHIBITION CENTRE
6-11 OCTOBER 2018

25TH CONGRESS OF THE
INTERNATIONAL FEDERATION
OF HOSPITAL ENGINEERING

BROUGHT TO YOU BY

International Federation of Hospital Engineering

PROUDLY HOSTED BY

IHEA
INSTITUTE OF HEALTHCARE ENGINEERING, AUSTRALIA

INVITATION TO PARTICIPATE

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

PARTNERSHIP OPPORTUNITIES

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

Visit www.ifhe2018.com to submit an abstract, view partnership opportunities and to receive email updates.

Free Palliative Care Training Resource

Build skills in caring for people with a life-limiting illness—ideal for carers, clinicians, community and aged care workers and volunteers!

Evidence-based, interactive, easy to understand, and nationally recognised—over 35,000 people have completed the training and improved their practice. It is done completely online, can be completed in multiple sittings and requires no prior learning.

All modules are based on the PalliAGED evidence base, and may enable many participants to accrue Continuing Professional Development points.

The six training modules cover topics such as:

- needs of people and their families as they approach end-of-life
- end-of-life conversations
- pain management
- assessment skills
- self-care and building resilience
- recognising deteriorating patients.

PALLIATIVE CARE
Online Training
FREE

Get started NOW by visiting
www.pallcaretraining.com.au

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

SENATOR RACHEL SIEWERT
Australian Greens spokesperson
on mental health

Perspectives from the 2017 Parliamentary Delegation on Mental Health

THE DELEGATION

Mental ill-health touches everyone, if not directly then through a family member or a friend. In recent years we have made progress in addressing some of the stigma around mental ill-health, particularly depression and anxiety, although some of the more complex behaviour disorders have not been adequately addressed. We have also made progress in our understanding of preventive strategies and support for people living with mental ill-health but we have a long way to go.

In September I visited the United Kingdom, the Netherlands, Sweden and Canada as part of a parliamentary delegation on Mental Health to see what is being implemented around the world to address issues of mental health.

The trip was full of meetings, site visits, and lots of questions! I came away with a note book full of ideas and concepts. The trip was absolutely fascinating, I learnt a lot and it is abundantly clear that we are all facing many of the same challenges.

COMMON PROBLEMS AND STANDOUT SOLUTIONS

Funding remains a key concern everywhere—even in cases where there is more funding spent on mental health than in Australia. No country has what the UK refers to as 'parity of esteem'—meaning that mental and physical health funding is on par. Nowhere did the funding of the mental health budgets match the percentage of the burden of ill-health caused by mental illness. All of the countries we visited had deinstitutionalised mental health patients, but did not have sufficient community services in place, which resulted in poor mental health outcomes and homelessness in many cases.

It was fantastic to be exposed to so many programs and approaches that dealt with mental health in all aspects and stages of life—in fact far too many to mention here. There were some programs that particularly stood out such as early intervention, social inclusion, community care, and mental health in the workplace.

A standout for me is that local government was responsible for the delivery of social care to varying degrees. Local governments are responsible for social services, aged care, housing and disability services, enabling a much better delivery of wrap-around services and better opportunities for case management. Given that local government is more directly connected to community, I'm very attracted to this concept.

FOCUS ON COMMUNITY

A strong focus on participation in society and a network of support in the community for individuals came through strongly in many places, with a focus on increasing wellbeing. I was particularly impressed with a system in the Netherlands called FACT—Flexible, Assertive Community Treatment—where a multidisciplinary team provides individualised community-based care on a day-to-day needs basis.

We need to focus on increasing community wellbeing and working towards a more resilient community. We should be providing more case management and social services, and integrating a therapeutic approach, with more funding focused on prevention and early intervention and more attention paid to children and perinatal services. We could do better at integrating primary health, social care and the voluntary sector.

Many people dealing with mental ill health are also facing or dealing with homelessness and housing insecurity. There were several programs that focused on addressing these fundamental needs first, taking a housing-first approach as part of supporting people with mental health issues.

flickr.com/photos/evilerin

> “So often in Australia there are delays in agreement over provision of programs and services because of disputes over who pays.”

including a national standard for mental health in the workplace, with implementation tied to management performance. I was also interested in examples of successful employment programs that place people in jobs first and then provide the training after.

EARLY INTERVENTION

I was very impressed with some of the work being done in regards to early intervention with children and perinatal services. We saw examples of programs where there was a strong focus on infants and children, identifying risk factors, and offering a range of prevention and early intervention services targeted at the early years. In some instances there were excellent school initiatives with specific programs to help address mental health for young people, and extra funding given for support services in schools, such as those provided by nurses, GPs and psychologists. As part of this better approach to mental health was the building of better parent-teacher relationships to support young people.

MENTAL HEALTH IN THE WORKPLACE

We also heard about initiatives being developed around mental health and wellbeing in the workplace. Canada has approaches that are worth looking at,

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE AND MENTAL HEALTH

Central to any mental health approach in Australia has to be a focus on outcomes for Aboriginal and Torres Strait Islander people. Australia has, like many colonised countries, a poor track record in this regard. It is essential that decision-making is in the hands of Aboriginal and Torres Strait Islander people rather than a top-down approach that too often has been the default.

Governments should be working in partnership with Aboriginal and Torres Strait Islander peoples in creating and implementing services, particularly in addressing the social determinants of health such as housing. Culturally appropriate services are critical to the success of programs, while maintaining or rebuilding connection to culture is essential in addressing Aboriginal and Torres Strait Islander mental health. Australia has to date failed to address key injustices that have been perpetrated on Aboriginal and Torres Strait Islander peoples, lack of constitutional recognition, ignoring issues of sovereignty, failure to acknowledge and hear past injustices and truth telling. All this must be addressed as a matter of urgency.

THE WAY FORWARD

No country has a perfect system, and there is a lot we are doing right in Australia—but after visiting these countries it is also clear that we could be and need to be doing a lot better.

Funding arrangements can be a major barrier to people accessing the supports they need. So often in Australia there are delays in agreement over provision of programs and services because of disputes over who pays. This can be between the states and territories and the Commonwealth, and/or between government agencies. I was very interested in a concept called Jordan’s principle—where services are provided first and arguing about who pays for it happens later.

My head is teeming with ideas about how to improve our services, but clearest is that a stronger more connected community, with community-based services that support the individual with case management and wrap-around services, has to be the way to move forward. ha

DR LEORA HORN
Ingram Associate Professor of
Medicine and Clinical Director
Vanderbilt Ingram Cancer Center

> **“Immuno-oncology helps the patient’s body detect the cancer and build a response that is remembered by the immune system should the cancer cells re-appear.”**

Immuno-oncology

Clinical trials helping researchers and patients.

WHAT IS IMMUNO-ONCOLOGY AND WHAT DOES IT DO?

Immuno-oncology, which uses the patient’s immune system to fight cancer, is proving successful in patients and could herald a new era in treatment.

When I describe immuno-oncology to patients, I often start by explaining how cancer cells have a way of tricking your immune system. The cells can grow undetected and avoid attack from our body’s natural defence mechanisms. Immuno-oncology helps the patient’s body detect the cancer and build a response that is remembered by the immune system should the cancer cells re-appear.

Patients who respond to treatment often experience extended life. For example, 10 years ago, if you had all comers with lung cancer from stage I to stage IV, the overall survival rate [USA] was 15-16% at five years. The most recent data published this year shows stage IV patients—patients who have a life expectancy of one year or less—have an overall survival rate of 16%.

These survival statistics are significant, and those patients aren’t just living—they actually have a good quality of life. I have seen patients continue with their normal activities during and after treatment.

DETERMINING IF PATIENTS WILL RESPOND TO TREATMENT

But while this is an exciting time for cancer research, we are still learning, and the reality is these new drugs currently only work in a subset of patients. Immunotherapies do not work in everyone and so we need to focus on selecting patients who will respond and finding options for patients who do not.

Biomarkers, or genetic tests to determine if a patient will respond to treatment, help oncologists to determine if immuno-oncology therapy will be effective.

In advanced lung cancer, if a patient tests positive to what is called the PD-L1 protein (speculated to play a major role in suppressing the immune system), the response rate is 30-50%. If the patient is PD-L1 negative, there is still a 10% chance of them responding.

Other biomarkers are being explored, such as EGFR (epidermal growth factor receptor) and ALK (anaplastic lymphoma kinase), where patients have a 70% response rate to treatment with tyrosine kinase inhibitors, but research into these immune biomarkers is still in its early stages.

There is also interesting data that shows a high mutation burden is a potential predictor of response to immunotherapy drugs. But the problem with mutation burden is that it requires whole exome sequencing which is expensive and results don’t come back soon enough to help therapy selection.

So the main challenges in this space are finding the right biomarkers with a test that is effective, efficient and quick. This is why further research and clinical trials are vital.

AUSTRALIA AND IMMUNO-ONCOLOGY CLINICAL TRIALS

In Australia, you are lucky to have world-renowned oncologists who are at the forefront of immuno-oncology research. Their patients participate in clinical trials that are so important in our quest to find effective medicine and biomarkers that indicate

Pixabay

patient suitability. Clinical trials also play an important role in giving patients access to the very latest drugs if they are not responding to the ‘standard of care’ (diagnostic and treatment process that a clinician should follow) or may help them avoid ever having to have standard of care. Unfortunately the numbers are many.

Lung cancer alone accounts for 8,800 deaths in Australia every year, which is more deaths caused by lung cancer than by prostate cancer, breast cancer and melanoma combined. In the developed world we are seeing more ‘never smokers’ developing lung cancer, which might be attributed to pollution and the environment rather than cigarette smoke.

Many late-stage lung cancer patients have undergone surgery and chemotherapy but with limited success. The prospect of trying a new treatment on a clinical trial is often welcomed.

As a researcher, I have met some remarkable people on clinical trials from all walks of life, aged 18 to over 90. They are all individuals with friends and families who want their best health possible given their circumstances. The prospect of entering a clinical trial gives people hope and I have met many patients who have responded well in clinical trials and are still alive today because of access to drugs they would not otherwise have had access to.

The future of cancer medicine is bright and research in this space is moving quickly. But, as with any new medicine, we are still learning, which is why clinical trials and research are vital in bringing effective new treatments to patients as quickly and safely as possible. ha

Dr Leora Horn, Ingram Associate Professor of Medicine and Clinical Director, Thoracic Oncology Research Program, Vanderbilt Ingram Cancer Center, Nashville, USA.
Dr Horn spoke at the Medical Oncology Group of Australia Forum, Melbourne, August 2017.
Dr Leora Horn is studying how checkpoint inhibitors can potentially change the outlook for lung cancer patients.

GEOFFREY CHIN
Head
Health Care Systems,
Novartis Pharmaceuticals

Reducing preventable hospitalisations due to heart failure

THE PROBLEM

For patients with chronic heart failure, the risk of ending up in hospital due to acute exacerbations (experiencing symptoms such as shortness of breath, coughing and irregular heartbeat) is relatively high. Within months of being discharged from hospital with heart failure, up to one-half of these patients end up back in the hospital again.

Research shows that the majority of these re-hospitalisations occur due to limited coordination of care between healthcare providers across the hospital and primary care sectors. The presence of multiple chronic co-morbidities and increased prevalence in the elderly population compounds the complexity of the problem. Despite notable advances in medicines and technologies in heart failure management, the burden of preventable hospitalisations remains unacceptably high. It is clear that the potential for state and federal governments to reduce unnecessary costs and impacts on the lives of communities and individuals means that addressing potentially preventable hospitalisations continues to be a high priority.

THE APPROACH

In 2016, Novartis Australia set out to form a multi-stakeholder public-private partnership with the objective of reducing the burden of potentially preventable hospitalisations due to heart failure. With project coordination by the AHHA, the pilot was initiated with Primary Health Tasmania, Heart Foundation Tasmania, and the Tasmanian Department of Health and Human Services (DHHS). The partnership reflects on the need to adopt a community of practice approach to address gaps in the care of patients with heart failure. Specifically, the project focused on three areas: enhancing heart failure management of patients in enrolled general practices; increasing patient self-management; and optimising transfer-of-care processes.

Using DHHS data as a guide, the project invited practices in selected areas within

Solving a complex health problem in the real world: a pilot project.

Photo: Wesley Wilson

greater Hobart where, according to data from DHHS, rates of preventable hospitalisations were higher than expected. This allowed the project team to provide greater focus for service delivery to practices most likely treating patients with higher clinical needs, and at the same time ensured that the project stayed within budget and timeline.

Site visits and targeted education sessions were provided to support participating practices in optimising the clinical management of heart failure patients, as well as facilitating early detection of patients at risk of further hospital admissions. Education included information on the local area health profile, a collaborative model for improvement and clinical audit tools. Support and access to the Tasmanian HealthPathways web portal were also provided to the general practitioners to enhance patient care.

It is important for patients living in the community to be able recognise the symptoms of exacerbations early enough so that steps can be taken to avoid worsening of the condition that predisposes hospitalisations. To this end, the use of consumer resource booklets from the Heart Foundation on daily weight monitoring and limiting salt intake was encouraged.

Finally, the project also targeted system-level issues such as transfer-of-care across the hospital and primary sectors. Education sessions for hospital staff on optimising discharge summaries, better use of heart failure care plans for patients admitted under general physicians, and improving access to cardiac rehabilitation in primary care were among the key activities.

LESSONS AND EXPERIENCES

An interim report by the Deeble Institute for Health Policy Research on the progress of the project is available on the AHHA website at ahha.asn.au/primary_health under ‘Collaborative Projects’.

Early findings show that ordering and interpretation of echocardiograms is somewhat limited in general practice, as is patient interaction with practice nurses despite their potential for providing increased monitoring. Identification of patients with heart failure in general practice was not always straightforward, due to differences in the coding of the condition in practice software. Challenges in engaging medical practices and general practitioners also underscored the importance of clinical champions to drive uptake of best-practice initiatives.

The experiences to date further support the strength of a multidisciplinary approach to solving complex health problems such as preventable hospitalisations. The recognition that no single healthcare provider has the solution in either the public or private system means that a collaborative framework based on mutual trust, respect and accountability remains the enduring key to delivering better patient outcomes. In this regard, Novartis Australia is proud to be a partner in this research project.

DR DAVID WHYATT
Senior Research Fellow, Faculty of Health and Medical Sciences, University of Western Australia

A/PROF. ALISTAIR VICKERY
Division of General Practice, Faculty of Health and Medical Sciences, University of Western Australia

Developing a Learning Health System platform to improve access, equity, and outcomes

Health systems around the world are confronted with ongoing and difficult challenges including providing access to appropriate care, avoiding over-utilisation of inappropriate care, and rising costs. Furthermore, there is increasing research examining what is effective in health care, yet there is an estimated 17-year lag between publication of research findings and translation into practice and/or policy.[1] Learning Health Systems (LHSs) have been proposed as a system-level innovation to help address these challenges. LHSs have already been developed both within and between institutions in the US, Europe, and Asia.[2]

DOES AN LHS WORK?

Within an LHS, the characteristics and experiences of every individual utilising the health system are securely available to improve knowledge. The rapid improvement in computing power and electronic health records have made this 'big data' feature more realisable. Best-practice knowledge from analysis of such data can then be available in a timely manner to support decision-making by service planners and policy-makers, as well as clinicians and other care providers.

LHSs support learning health cycles. This cycle includes a 'data to knowledge' step, which represents the standard research approach when investigating a problem of interest. However, there is also a 'knowledge to data' step that closes the learning health cycle, allowing research findings to be turned into policy and services, the impacts of which are monitored, enabling a new learning cycle to begin.

Developing an LHS requires infrastructure (access to data and analytical power) and links to policy and practice. Such infrastructure needs to be developed as a platform to support multiple learning health cycles, in order to maximize the return on investment.

Finally, stakeholders within an LHS should view the ongoing activity of an LHS as part of their culture, and for the process to be trusted and valued. LHSs have been described as cyber-social ecosystems involving large-scale, human-intensive, computer-supported information processing systems.[3]

> **"The rapid improvement in computing power and electronic health records have made this 'big data' feature more realisable."**

LHS AND THE COLLABORATIVE FOR HEALTHCARE ANALYSIS AND STATISTICAL MODELLING (CHASM)

In Western Australia, the Collaborative for Healthcare Analysis and Statistical Modelling (CHASM) at the University of Western Australia has developed the infrastructure and analytic power to support LHSs. This work is funded and sponsored by the WA Department of Health (DOHWA). CHASM's vision is to improve access to appropriate health care, improve equity in health, and optimise health outcomes. The CHASM group is a collaboration between the Schools of Medicine, Population Health, Earth and Environment, and Mathematics and Statistics, in order to ensure access to the necessary clinical, statistical, health economic, and geo-spatial modelling expertise. CHASM is actively improving and developing methods to analyse health care data, including better methods to calculate the impact of behaviours and risk factors on


GraphicStock

health outcomes[4] and to measure long-term health outcomes.[5]

CHASM relies on access to the comprehensive linked data from the WA Data Collections.[6] This includes access to clinical and demographic data on all hospital admissions, emergency department presentations, state-funded mental health service provision, cancer registrations, births, and deaths in WA since 2002. Access to this data is approved by both the WA Department of Health Human Research Ethics Committee and the WA Aboriginal Health Ethics Committee. Access to a whole-of-population dataset maximises the analytical power of the available data and allows CHASM to respond to the research and evaluation priorities of DOHWA as they arise.

CHASM's research activities are governed by a committee that includes Department of Health senior executive and clinical service planners, led by the WA Chief Medical Officer. Further, to allow for appropriate examination of specific Aboriginal health issues, there is also an Aboriginal Health Research translation group. These arrangements support the governance and tailoring of research outputs to implementation in clinical policy and service planning.

Finally, the computing power to do these analyses is provided by dedicated high end servers. All data are de-identified, encrypted, and access-restricted. To increase analytical capacity to allow more 'real-time' analysis, an exponential increase in computational power is being developed using secure cloud-based information processing options.

This LHS platform, which involves analytical expertise, population-based data, computing infrastructure, governance, and links to policy and planning, currently supports a number of learning health cycles. This includes predicting small geographical areas with statistically higher rates of potentially preventable hospitalisations many years into the future. This allows time for appropriate place-based interventions to be developed and implemented. Such interventions (both complex and simple) can be evaluated using techniques that can exploit large population-based datasets—for example matched control designs. As interventions and changes to service provision are enacted, the resulting outcomes can be monitored, refined and improved. This ensures clinical services are optimally placed and provide the right service at the right time, improving efficiency and patient outcomes. ha

If you have any comments or queries on the development of LHSs in WA, please contact the authors.

References

1. Morris ZS, Wooding S & Grant J 2011. The answer is 17 years, what is the question: understanding time lags in translational research. Journal of the Royal Society of Medicine 104(12):510–520. doi: 10.1258/jrsm.2011.110180.
2. Friedman CP, Allee NJ, Delaney BC, Flynn AJ, Silverstein JC, Sullivan K et al. 2017. The science of Learning Health Systems: Foundations for a new journal. Learning Health Systems 1:e10020. doi: 10.1002/lrh2.10020.
3. Friedman C, Rubin J, Brown J et al. 2014. Toward a science of learning systems: a research agenda for the high-functioning Learning Health System. Journal of the American Medical Informatics Association 22(1):43–50.
4. Tuson M, Turlach B, Vickery A & Whyatt D 2017. Reduction of Bruzzi's formula removes instability in the estimation of population attributable fraction for health outcomes. American Journal of Epidemiology. 8 June. doi: 10.1093/aje/kwx200.
5. Whyatt D, Tenneti R, Marsh J, Bolt SE, Kemp A, Firth L et al. 2014. The ecological fallacy of the role of age in chronic disease and hospital demand. Medical Care, 52(10):891–900.
6. Holman CD, Bass AJ, Rouse IL & Hobbs MS 1999. Population-based linkage of health records in Western Australia: development of a health services research linked database. Australian and New Zealand Journal of Public Health 23:453–459.

Are we Choosing Wisely?

Royal Brisbane and Women’s Hospital is challenging all facets of the organisation to think differently about the way healthcare is delivered.

RBWH Choosing Wisely Program Clinical Lead Jessica Toleman talks Choosing Wisely and how one simple question is changing the way we approach healthcare.

ONE SIMPLE QUESTION

'Why?' can be an empowering question for both a clinician and a patient. That's why Choosing Wisely Australia and the Royal Brisbane and Women's Hospital (RBWH) are together pushing for change, guided by those three little letters.

Choosing Wisely is an international healthcare movement designed to help clinicians and consumers start conversations regarding what tests, treatments and procedures are appropriate for a patient's individual needs and circumstances.[1, 2] It aims to reduce the use of 'low value care' interventions that may deliver only a marginal benefit to patients through overuse, misuse or waste.[2-6]

EMBRACING THE MOVEMENT

RBWH embraced this movement, becoming a *Choosing Wisely* partner in November 2016, and quickly sought to innovate 'outside the box'.

Relevant colleges and societies compiled a list of tests, treatments and procedures for clinicians to question, together with a set of five questions for the consumer to ask of their doctor or other healthcare provider.

Within the hospital itself, more specific, department-targeted initiatives began to gain momentum, and today RBWH is home to over 130 *Choosing Wisely* initiatives at various stages of development and implementation.

These include an outpatient accelerated discharge protocol program, which assists specialities to develop a discharge protocol for patients with conditions that would be better managed by their referring practitioner; and the digital meal management system, which has reduced food wastage from 13% to less than 2% per day.

The after-hours task manager for ward calls, which saw RBWH become the first hospital in Australia to implement an electronic task management system for its clinicians working all after-hours shifts, has also just started its journey through implementation.

Each initiative has enjoyed its own success, but one of the hospital's longest standing initiatives has been the 'fasting clock' for patients who need to fast for a blood test, operation or other medical procedure.

The simple, low cost but effective visual bedside aid has been championed by RBWH anaesthetist Dr Kate McCrossin. The initial pilot ran in January 2017 across two wards, and the results were promising enough to roll the clocks out to the remaining surgical areas of the hospital.

EMBEDDING THE PROGRAM

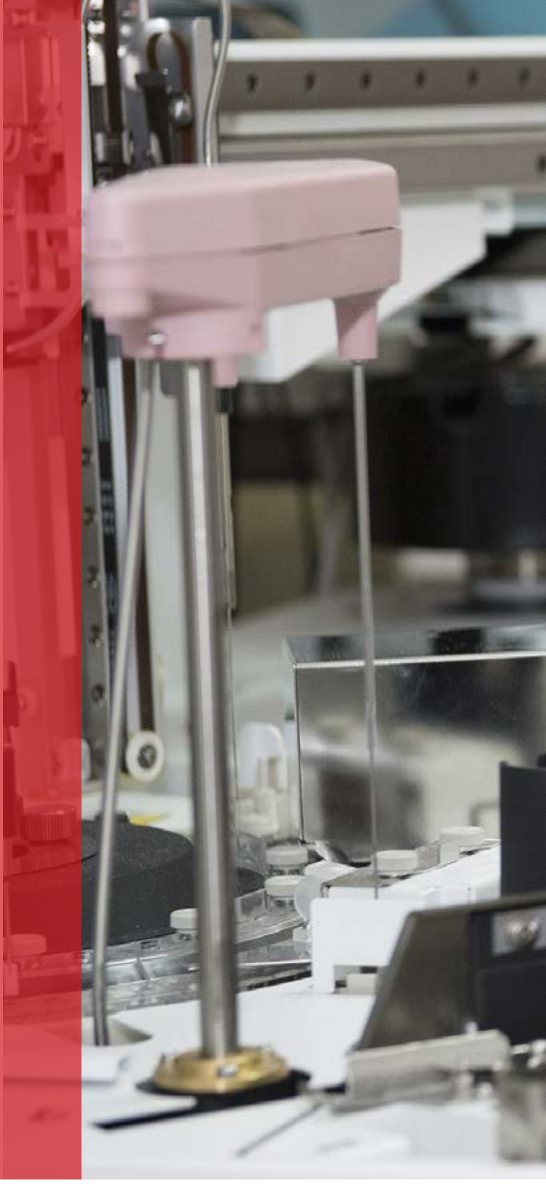
The *Choosing Wisely* program has been so strongly and openly embraced by RBWH that it has been embedded into 'the way we do things around here' through its inclusion in the facility's job description template, policy documents, orientation and hospital-wide approach to change.

RBWH plans to continue to work with Choosing Wisely Australia in order to highlight future success stories and communicating what we have learnt to other organisations.

References

1. Wolfson D & Suchman A 2016. Choosing Wisely®: A case study of constructive engagement in health policy. Healthcare (Amsterdam, Netherlands) 4(3):240-3.
2. Bhatia RS, Levinson W, Shortt S, Pendrith C, Fric-Shamji E, Kallewaard M et al. 2015. Measuring the effect of 'Choosing Wisely: an integrated framework to assess campaign impact on low-value care'. BMJ Quality & Safety 24(8):523.
3. Colla CH 2014. Swimming against the current—what might work to reduce low-value care? New England Journal of Medicine 371(14):1280–3.
4. Committee on Quality Health Care in America 2001. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academy Press.
5. Levinson W, Kallewaard M, Bhatia RS, Wolfson D, Shortt S & Kerr EA 2015. 'Choosing Wisely': a growing international campaign. BMJ Quality and Safety 24(2):167.
6. Elshaug AG, Watt AM, Mundy L & Willis CD 2012. Over 150 potentially low-value health care practices: an Australian study. Medical Journal of Australia 197(10):556–60.

JEREMY KENNETT
Communications Coordinator
North Western Melbourne Primary
Health Network (NWMPHN)



A VHHITAL step

A new training program is helping GPs and primary care professionals fight the spread of blood borne viruses.

VIRAL HEPATITIS PREVALENCE CONTINUES TO GROW

Diseases like smallpox, measles, polio and Hib (Haemophilus influenza type B), once considered widespread and deadly, have all been largely eradicated or greatly reduced thanks to vaccination.

But while a very effective vaccine exists for hepatitis B, and new treatments for hepatitis C are showing over 95% cure rates, the prevalence and impact of viral hepatitis continues to grow.

A new study shows that viral hepatitis is now the deadliest chronic infectious disease in the world, killing more than 1.3 million people every year. Around 500,000 people in Australia live with either hepatitis B or C, which are the main causes of liver cancer.

THE VHHITAL PROGRAM

Empowering primary care practitioners to take the lead in treatment and prevention is the key to turning these figures around, according to North Western Melbourne PHN CEO Adjunct Associate Professor Christopher Carter.

‘We have the tools to make viral hepatitis a thing of the past in Australia’, A/Prof Carter said. ‘It’s now a matter of increasing the skills and confidence of practitioners to apply these tools, and raising awareness among people living with or at risk of these diseases that they are available.’

Central to this push is the Victorian HIV and Viral Hepatitis Integrated Training and Learning (VHHITAL) program, which launched late last year. VHHITAL provides Section 100 (highly specialised drugs) HIV and hepatitis B prescriber training for GPs, as well as treatment education, training and support for all health professionals providing care to people living with HIV, hepatitis B and hepatitis C.

Early in 2017 there were only 60 HIV and 10 hepatitis B Section 100 prescribing GPs in Victoria, with the vast majority being based in Melbourne. Boosting these numbers will mean more people will be able to access the care they need, at a location and environment they are comfortable with.

The program is a joint effort between: NWMPHN; the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine; the Peter Doherty Institute for Infection and Immunity; Alfred Health; and the Victorian PHN Alliance. The program is funded by the Victorian Department of Health and Human Services.

With around 500,000 people living with either hepatitis B or C in Australia, as well as about 25,000 people living with HIV, the task facing the VHHITAL program is considerable. But recent successes in HIV treatment and prevention in Melbourne shows it is possible to reduce the impact of these blood-borne viruses.

FAST TRACK CITY

Melbourne became a ‘Fast Track City’ in 2016, joining a global network of cities committed to ending the global AIDS epidemic by 2030 through better awareness, prevention and access to treatment.

Early results are encouraging, showing Melbourne is meeting or exceeding Fast Track


static.pexels.com/photos

targets in all areas: 90% of people living with HIV know their HIV status; 94% of people with diagnosed HIV infection are receiving sustained antiretroviral therapy; and 93% of people receiving antiretroviral therapy have viral suppression.

A/Prof Carter said this success has been built on a coordinated approach between governments, services providers, health professionals and the community.

'We are seeing a similar level of commitment building around viral hepatitis', A/Prof Carter said. 'There's an acknowledgment that we have a potentially once-in-a-generation chance to greatly reduce or even eliminate a group of diseases that currently cause immense suffering.'

BEYOND VIRAL HEPATITIS AND HIV TO STIS

VHHITAL is also expanding into the prevention and treatment of sexually transmitted infections (STIs), leading two new projects that will help reduce their impact in the community.

Clinical pathways will be developed to guide health workers in best-practice care and management of STIs including chlamydia, gonorrhoea and syphilis. All six Victorian PHNs will be involved in developing their localised pathways while ensuring a consistent statewide approach.

The new pathways will be supported by improved provision of STI education to GPs and primary care practitioners, including the delivery of training for practitioners across Victoria.

A/Prof Carter said the new Victorian-Government-funded projects were a great opportunity to expand the focus of VHHITAL beyond viral hepatitis and HIV.

'Chlamydia, gonorrhoea and syphilis are all treatable if they are diagnosed in time, but many people have no idea they are living with these conditions," A/Prof Carter said.

'These two STI-focused projects will help GPs identify more people affected and get them the treatment they need.' **ha**

> **"A new study shows that viral hepatitis is now the deadliest chronic infectious disease in the world, killing more than 1.3 million people every year."**

More information about the VHHITAL program, including upcoming events and training sessions for GPs and other primary care practitioners, is available at nwmphn.org.au/vhhital.

North Western Melbourne Primary Health Network works to improve health outcomes for nearly 2 million people across Melbourne's inner, northern and western suburbs.

Improving equity of access to primary care in Australia

The Centre of Research Excellence in Rural and Remote Primary Health Care's *Index of Access*.

HISTORICAL (FLAWED) MEASURES OF ACCESS TO PRIMARY CARE

Australia is characterised as having substantial inequities in its health system, particularly with accessing primary care. Inequities of access are especially apparent for Australians living in its highly dispersed rural and remote areas. Improving access remains a key issue for rural residents, health service planners and policy-makers.

One reason for its lack of improvement may lie in Australia's historical reliance on flawed measures of access to primary care for workforce planning purposes. These include:

- *Provider-to-population ratios,* which have long been used, for example, to determine *districts of workforce shortage*, but which are constrained by the use of pre-defined geographical regions and no consideration of local need.
- *Proxy measures of access* commonly used in health policy, chiefly the *Australian Standard Geographical Classification-Remoteness Areas (ASGC-RA)* which is based on geographical remoteness and, more recently, the *Modified Monash Model* which is based on geographical remoteness and town population size. Being proxy measures, they do not directly measure any of the key dimensions of access.

None of these measures adequately takes into account factors additional to service supply which affect people's ability to access primary care, including how far people might have to travel to see a doctor, their willingness to do so and whether they are likely to have the necessary transport or personal mobility to do so.

Additionally, these measures do not take into account other important factors associated with population health needs, such as population age distribution, proportion of the population who are Aboriginal and Torres Strait Islanders, and the socioeconomic status of populations, each of which impact on whether available services are likely to be sufficient.

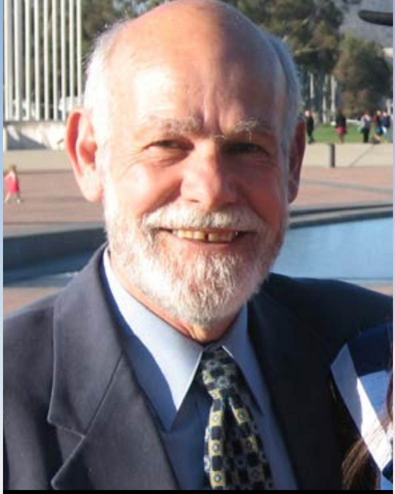
THE *INDEX OF ACCESS*

The *Index of Access* was developed as a key output of the Centre of Research Excellence in Rural and Remote Primary Health Care (www.crerrphc.org.au/), funded by the Australian Government through the Australian Primary Health Care Research Institute (APHCRI).

The *Index of Access* takes into account and overcomes the limitations outlined above. Additionally, it uses flexible boundaries when assessing population access to primary care. This means that all the different choices in doctors that are reasonably available to people in different locations can be factored in, thus enabling

MATTHEW MCGRAIL
Monash University School
of Rural Health

DEBORAH RUSSELL
Monash University School
of Rural Health



JOHN HUMPHREYS
Monash University School
of Rural Health

Photo: Mike Wilson

> **"Being able to accurately measure and compare levels of access to primary care using the fit-for-purpose *Index of Access* in and between different rural and remote towns, creates great potential for improving equity of access."**

an accurate measure of access for small areas.

Being able to accurately measure and compare levels of access to primary care using the fit-for-purpose *Index of Access* in and between different rural and remote towns, creates great potential for improving equity of access. Potential benefits include:

- Relatively under-serviced towns can be identified, an important first step for remediating a problem.
- Planners can investigate hypothetically how access might change, for example if a GP was to leave one town, or if one or more GPs were to move into another town.
- The *Index of Access* provides health workforce planners with key information needed so that they know where resources (including human resources) are most needed, the amount of additional resources needed—for example in order to achieve a specific or minimum level of primary care access—and what the likely effect of those resources will be in terms of access to primary care.
- Actual changes in access over time can be mapped, perhaps in response to longer term recruitment or retention strategies, or in response to other changes such as changing population demographics and associated changes in health needs.

To achieve improved access to primary care in rural Australia, governments should strongly consider adopting the *Index of Access* as an alternative 'fit-for-purpose' measure of access to primary care, to complement the limited information provided by other currently used measures. The *Index* has great potential for better identifying access inequities and guiding redistribution of primary healthcare services to correct such inequities.

Future developments of the *Index of Access* could include applying it to groups of primary healthcare professionals other than GPs, for example dentists and the various allied health professions—there is enormous inequity of access to these providers within Australia as well. ha

Further detailed information on decisions underpinning the development of the *Index of Access* is available at http://med.monash.edu.au/assets/docs/srh/cre/iofa-discussion-paper-19oct15.pdf.

More information is also available in our Open Access article published in Volume 41(5) (2017) of the *Australian Health Review*, 'Index of Access: a new innovative and dynamic tool for rural health service and workforce planning' (available online at www.publish.csiro.au/AH/AH16049).

VICTORIA MCCREANOR
PhD Candidate & Research Associate, Australian Centre for Health Services Innovation, Queensland University of Technology

Disinvestment in low-value healthcare

Healthcare sustainability and continuous quality improvement require active disinvestment from dated or less-effective practices.

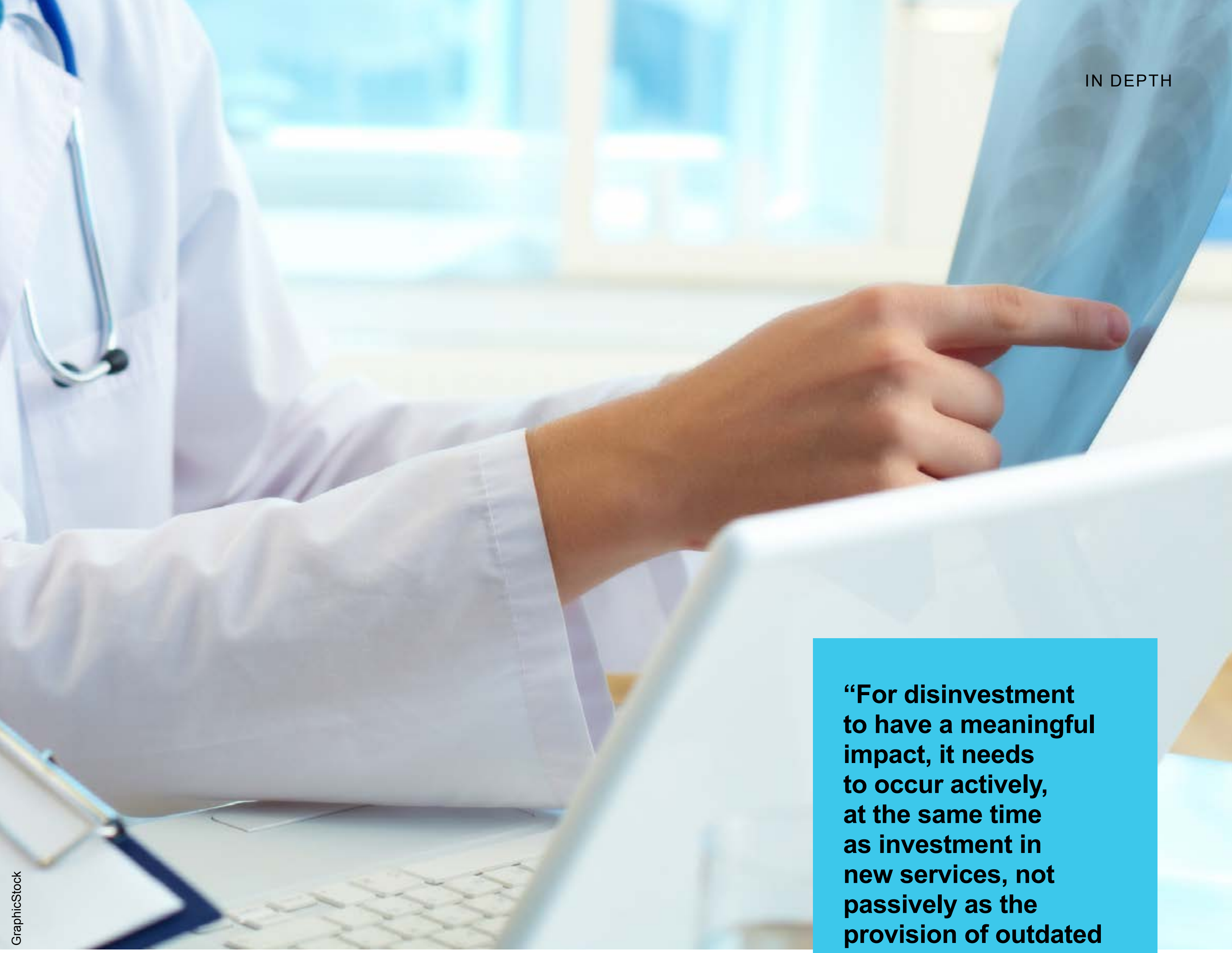
To make sure disinvestment activities are not seen simply as cost-cutting measures, strong leadership and involvement from all stakeholders is necessary—including clinicians, consumers, service providers and funding bodies.

In Australia, new medicines and medical services are subject to health technology assessment, a process which evaluates their cost-effectiveness prior to funding. However, when a new treatment or service is funded there is no formal process for disinvesting in old treatments or services which are superseded as a result. This inadvertently results in incentivising outdated, low-value care, when better options are available. Similarly, when new evidence shows that a treatment is less effective than previously thought, current mechanisms to limit or remove funding are unwieldly.

In light of this, there are several initiatives underway in Australia aiming to reduce use of low-value care. Choosing Wisely Australia and the Evolve campaigns promote awareness of low-value interventions and encourage patients and clinicians to discuss care options and expected outcomes. Consumer empowerment and choice are at the centre of these efforts.

More than 5,000 publicly-funded services on the Medicare Benefits Schedule (MBS) are also under review, to align the MBS with current practice. To date only obsolete items have had funding removed, resulting in zero impact on use of low-value care since items are no longer used anyway. For disinvestment to have a meaningful impact, it needs to occur actively, at the same time as investment in new services, not passively as the provision of outdated services gradually fades over time.

In Australia, the Medical Services Advisory Committee (MSAC) is tasked with making recommendations about which new medical services should be funded, while the Pharmaceutical Benefits Advisory Committee (PBAC) fulfils a similar role for funding of pharmaceuticals. Both committees use health technology assessment to make recommendations for funding. Both are also ideally placed to make parallel



GraphicStock

> **“For disinvestment to have a meaningful impact, it needs to occur actively, at the same time as investment in new services, not passively as the provision of outdated services gradually fades over time.”**

recommendations about de-funding superseded products or services.

Alongside formalising processes for disinvestment, Australia needs better collection, sharing and use of health data. Stakeholder consultation through the Australian Digital Health Agency has shown that the Australian public is indeed supportive of data sharing to evaluate and improve the quality of health services. To enhance our ability to assess the quality of health services, patient reported outcome measures (PROMs) should also be collected. PROMs give unique insight into patient outcomes, beyond traditional clinical indicators.

Collection and reporting of PROMs will better inform clinicians and service providers about which treatments are more effective and in return give patients more information about the likely health effects they may experience from different treatments. Improving access to information, where both patients and clinicians can see the potential benefits (or lack thereof) of different treatments, empowers patients to engage in informed shared-decision making with their healthcare providers, ultimately reducing the use of low-value care.

PROMs data could also feed into to the formal processes of MSAC and PBAC in assessing cost-effectiveness, and be used to align funding with outcomes. Our current funding arrangements relate solely to outputs, not health outcomes, creating perverse incentives to provide unnecessary care in some instances.

Australia’s health system should be setup to sustainably provide excellent health outcomes into the future. This requires strong leadership and community engagement. To avoid a health system that struggles to keep up with rapid advances and becomes overwhelmed with use of outdated care, we need to improve formal disinvestment processes, align funding with outcomes and enhance data collection and reporting to aid consumer empowerment.

AHHA has released a Deeble Institute Issues Brief, *Active disinvestment in low-value care in Australia will improve patient outcomes and reduce waste*, by Victoria McCreanor. Victoria was the 2017 Deeble Scholar, based at AHHA.

JANE CURRIE
Sydney Nursing School,
University of Sydney

PROF. MARY CHIARELLA
Sydney Nursing School,
University of Sydney

ASSOC. PROF. THOMAS BUCKLEY
Sydney Nursing School,
University of Sydney

Privately practising nurse practitioners and Collaborative Arrangements

INTRODUCTION

Nurse practitioners (NPs) are registered nurses with a Masters' degree education enabling them to assess, diagnose, and order and interpret investigations, as well as providing regulatory authorisation to prescribe medications. Nurse practitioners are therefore able to provide complete episodes of patient care.

The initial intent of introducing NPs to Australia was to increase patient access to care, particularly for under-served populations such as the homeless, people with mental illness, women (for women's health problems) and Aboriginal communities.

Before 2010, a lack of access to the MBS and PBS was identified as a major impediment to NPs working in community and primary care settings. Legislative changes in 2010 led to privately practicing nurse practitioners (PPNPs) being able to provide services subsidised through the MBS and PBS *(Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010)*. To access the MBS and PBS, PPNPs must: be working in a private capacity, have an MBS provider number and a PBS prescriber authorisation and a Collaborative Arrangement, either with a medical practitioner or an entity that employs/engages medical practitioners.

The Collaborative Arrangement provides for consultations, referrals and transfer of care between a PPNP and a medical practitioner *(National Health (Collaborative Arrangements for Nurse Practitioners) Determination 2010)*.

PPNPs are the only health professional group who must by law demonstrate a Collaborative Arrangement with a medical practitioner or medical practitioner entity in order to access the MBS and PBS.

Collaboration is beneficial to patient care because it provides opportunities to discuss patient treatment and diagnosis, and provides opportunities for additional learning.

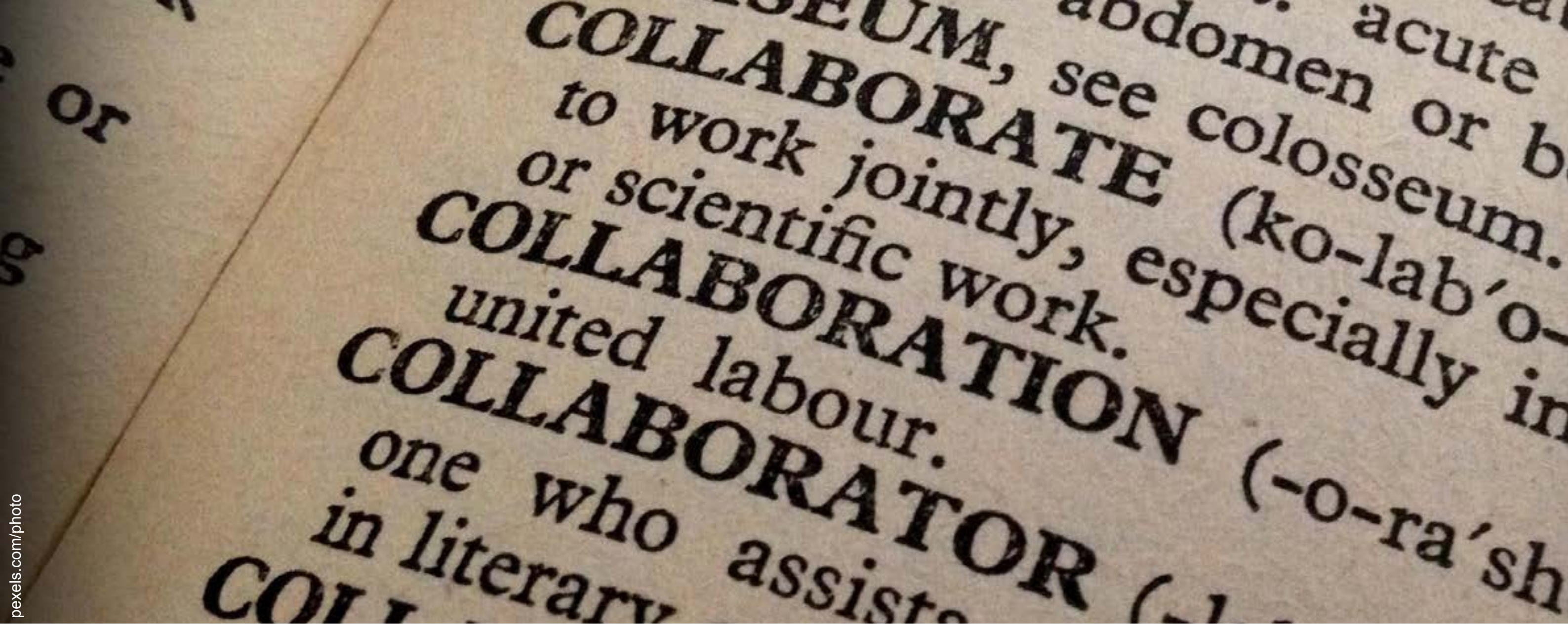
However, mandated collaboration can also be challenging for PPNPs, firstly because establishing a Collaborative Arrangement with a medical practitioner depends on practitioner willingness and availability to collaborate. If a PPNP cannot identify a medical practitioner or entity with whom to collaborate, lack of access to the MBS and PBS has the potential to reduce patient access to care.

Secondly, even if a Collaborative Arrangement is established, the medical practitioner's individual level of understanding of the legislation can have a marked impact on the PPNP's scope of practice.

STUDY FINDINGS

As part of an Australian study of PPNPs, we conducted a survey in February 2015 exploring the impact of PPNP activities on patient access to care, including the operation of Collaborative Arrangements between PPNPs and medical practitioners.

There were 73 responses from PPNPs, representing all states and territories except the Northern Territory.


pexels.com/photo

“However, mandated collaboration can also be challenging for PPNPs, firstly because establishing a Collaborative Arrangement with a medical practitioner depends on practitioner willingness and availability to collaborate.”

This study indicates that PPNPs are working in the under-served areas, as outlined earlier. However, they are experiencing challenges in relation to CAs.

Ninety-three per cent of participants reported that they have a Collaborative Arrangement in place. Sixty-two per cent reported that they collaborated with one or more specified medical practitioners and 30% with an entity that employed or engaged one or more specified medical practitioners. Frequency of communication ranged from daily (27%) to never (1%) and means of communication included face-to-face, telephone, email, letter, fax and Skype.

Topics discussed with collaborating medical practitioners included: advice on treatment (66%); prescribing advice (67%); and advice on diagnosis (64%). Asked how Collaborative Arrangements facilitate their practice, PPNPs believed they facilitated diagnosis and treatment (12%), helped to build relationships and promote the PPNP’s role (11%), enhanced patient care (8%) and promoted teamwork and interdisciplinary practice (7%).

Despite two-thirds of the 73 respondents believing that Collaborative Arrangements facilitated practice, only 19% considered that mandatory arrangements were necessary for PPNP access to the MBS and PBS. The concern was that mandating Collaborative Arrangements rendered the PPNPs subject to the willingness and availability of MPs to collaborate, otherwise they could not provide subsidised care to their client groups. PPNPs felt that mandating Collaborative Arrangements was unnecessary because collaboration is an inherent aspect of nursing practice, particularly in specialist roles, and they would want and need to collaborate anyway.

The level of understanding of the Collaborative Arrangement was variable among medical practitioners. Some medical practitioners perceived the Collaborative Arrangement to be a supervisory arrangement with concomitant legal responsibility for care provided by PPNPs, rather than a reciprocal working relationship. Such an erroneous interpretation may go some way to explaining the evidence of collaborative reluctance from medical practitioners. However, were the relationship to be established in this way, it would potentially limit PPNPs’ scopes of practice.

CONCLUSION

The main intent of enabling PPNPs to have access to the MBS and PBS was to increase patient access to care by fostering greater flexibility of the healthcare workforce. The data in the present study suggest that mandating Collaborative Arrangements can affect patients’ access to PPNP services, primarily as a result of the practical challenges of establishing and maintaining the arrangement. ha

More information is also available in our Open Access article published in Volume 41(5)(2017) of the *Australian Health Review* available online at www.publish.csiro.au/ah/ah16051.

HELEN SIGNY
Senior Communications Officer
Australian Prevention Partnership Centre

DR JO-AN ATKINSON
Director
Decision Analytics, Sax Institute

Dynamic simulation models forecast effect of public health interventions

THE CHRONIC DISEASE PREVENTION PROBLEM

As largely preventable chronic diseases threaten to overwhelm Australia's health system, policy-makers are struggling to find solutions they know will work to improve health and keep people out of hospital.

Yet chronic disease prevention is proving one of our most intractable problems. Despite a range of legislation, harm minimisation programs and education to address the risk factors for chronic disease, the problem is getting worse.

Prevention policy in Australia tends to focus on individual responsibility, but the lifestyle-related behaviours that cause chronic health problems are complex and embedded in everyday life.

Factors such as where people live, how they spend their day, who they interact with and what rules and regulations are in place can have just as much impact on lifetime health outcomes as the genes people were born with.

This means successful prevention requires a broader approach that moves beyond people's personal choices to one that helps people to lead healthier lives and reduce exposure to risk factors such as poor nutrition, physical inactivity and alcohol and tobacco consumption requires individual behaviour change.

Yet because no intervention works in isolation, it is very difficult to understand which policies are likely to have the most impact and what the unintended consequences might be.

A COMPUTER MODELLING APPROACH

Now, our team's research program at The Australian Prevention Partnership Centre is using an innovative computer modelling approach that is providing policy-makers with a rare insight into what policies or combinations of policies are likely to work at a population level over the short and long term.

Dynamic simulation modelling uses sophisticated computer technology to trial different interventions or combinations of interventions before they are launched in the real world. These models are a 'what if' tool that can test various policy scenarios over time to see which are likely to have the most effect—on different populations as well as on the system as a whole.

These models are set to transform health decision-making, providing answers about what will work in areas including childhood obesity, alcohol-related harm, diabetes in pregnancy, suicide prevention, tobacco consumption and lung disease. They mean that, for the first time, policy-makers have robust tool that brings together our best information and data in a way that allows decision makers to test different policies or prevention initiatives—before they invest time and funds.

HOW DYNAMIC SIMULATION MODELLING WORKS IN PUBLIC HEALTH

Dynamic simulation modelling has been used for decades in sectors such as business and engineering, but our team's research has adapted the process to engage diverse stakeholders from the outset, and improve transparency, increasing policy-makers' trust in the outputs.

It works like this. Dynamic simulation models are virtual worlds that recreate

Simulation model exercise in progress

human behaviour in all its complexity. Drawing on a variety of evidence sources such as research, expert knowledge, practice experience and data, they mimic the multitude of different influences that cause people to make decisions every day. The models then follow individuals throughout life, identifying how their influences and behaviours change, and how this impacts their health.

This virtual society reacts to different interventions in the same way as the real world. The policy-maker just turns on which policies they would like to test, and the model forecasts outcomes over future years.

The models can also map the cumulative effects of thousands of people operating as a complex system, following their interactions over time.

WHAT WE HAVE FOUND SO FAR

This work has already led to some interesting findings. For example, we have shown that interventions may take many years to show a significant public health impact, often much longer than the policy or political cycle. We have also found that combining different interventions can have unanticipated, synergistic effects—the impact of combining two policies can be greater than the sum of each policy modelled individually.

We have also found that some interventions can have unintended consequences. For example, we were surprised when our model of alcohol consumption behaviour and related harms in NSW showed an increase in consumption and violence if drink prices went up in licensed venues. The model was showing that this intervention would make people more likely to drink heavily and 'pre-load' at home before they go out.

Following on from the alcohol modelling project, we developed a model in partnership with the New South Wales Government to provide policy-makers, program planners and public health practitioners with a low-cost, low-risk way of planning interventions that will work to address the New South Wales Premier's priority on reducing childhood overweight and obesity.

The participatory nature of the modelling process has resulted in new networks and collaborations. For example, a dynamic simulation modelling project in the ACT has resulted in the development of a network of senior clinical experts, academics and dynamic systems modellers who are now working together to tackle diabetes in pregnancy.

Getting diverse people from different sectors to talk to each other has been perhaps the greatest win from our dynamic simulation modelling research. Providing evidence in this way to policy-makers that is relevant, timely and in which they can have confidence offers an exciting way forward in preventing chronic disease.

In fact, co-production of evidence—involving the end users of prevention research into projects right from the start—is at the heart of all the projects of the Prevention Centre. We have found that this is how to make evidence more relevant, which leads to action more quickly. ha

To read more about our other projects, visit www.preventioncentre.org.au.

Beyond the glass ceiling: co-creation of value in mental health

Pixabay

PROF. BRENDA HAPPELL
Synergy Nursing and Midwifery Research Centre, University of Canberra and ACT Health

DR BRETT SCHOLZ AND JULIA BOCKING
Synergy Nursing and Midwifery Research Centre, University of Canberra and ACT Health

THE GLASS CEILING, AND BENEFITS FOREGONE

Policies and standards require consumers to be involved in all aspects and all levels of mental health services planning, implementation, delivery and evaluation. It is encouraging that some organisations already employ and partner with consumers to improve their service offerings.

However, a 'glass ceiling' in such participation is apparent—few consumers are employed in positions with significant power or leadership in the upper echelons of the mental health sector[1]. Instead, consumer roles are often tokenistic, rather than facilitating influence, and have limited scope for decision making[2].

Several factors contribute to the under-representation of consumers in leadership roles, including:

- Mental ill health continues to be stigmatised, even among mental health professionals[3].
- There are power imbalances between consumers and other mental health professionals, and consumers need to work harder in mental health organisations to be seen as equals[1].
- There are no guidelines available on what mental health sector organisations can do to improve the way that they employ and partner with consumers.

The structural barriers to greater consumer leadership across the mental health sector inhibit the significant value consumers bring to organisations and services[3]. Examples of these benefits include:

- consumer experiences and understanding of treatments leading to improved efficacy and safety
- improved service innovation when consumers have power over service decision-making
- services becoming more accountable to their target populations.

Taken together, these benefits lead to services providing better consumer-focused mental health care.

VALUING CONSUMER CONTRIBUTIONS

To maximise benefits of consumer leadership, mental health organisations need to value the contributions that consumer leaders make[3]. An exploratory, descriptive study of mental health organisations in Canberra recently published in the *Australian Health Review* found that several mental health organisations allow opportunities for consumers' perspectives to be heard[4]. However, it is less common that organisations demonstrate valuing consumer leadership through capacity development or dedicated roles for consumers[4].

There are some key ways in which mental health organisations could consider creating space for consumer leadership. First, organisations can devise strategies to mitigate tokenism, such as creating dedicated positions for consumers. Second, although many mental health services have mechanisms in place to gain feedback from consumers, these opportunities can be strengthened for maximum impact. Thirdly, to be truly co-creative, consumer leaders should be partners in driving the focus of professional development opportunities, and be a part of the decision-making process about how such opportunities are established and delivered.

Finally, authentic co-creation with consumers requires a paradigm shift from the ways that mental health organisations have traditionally been run. Due to the barriers described above, this may take time and some health professionals may be professionally challenged by the movement. As with other social justice movements that seek to redress power imbalances, there is a potential role for allies to the consumer movement to assist with the paradigm shift[5]. Allies—non-consumers who are therefore not stigmatised in the same way, but who support consumer rights—are more able to challenge the status quo and champion consumer leadership within mental health organisations. Allies are therefore in a unique position to advocate for the establishment of more opportunities for genuine co-creation. ha

References

1. Scholz B, Bocking J & Happell B 2017. Breaking through the glass ceiling: consumers in mental health organisations' hierarchies. Issues in Mental Health Nursing 38(5):374-380.

2. Scholz B, Gordon S & Happell B 2016. Consumers in mental health service leadership: a systematic review. International Journal of Mental Health Nursing 26(1):20-31.

3. Scholz B, Bocking J & Happell B 2017 (early view available online). Improving exchange with consumers within mental health organisations: recognising mental ill health experiences as a 'sneaky, special degree'. International Journal of Mental Health Nursing.

4. Scholz B, Bocking J & Happell B 2017. How do consumer leaders co-create value in mental health organisations? Australian Health Review 41(5):505-510.

5. Happell B & Scholz B (in press). Doing what we can but knowing our place: being an ally to promote consumer leadership in mental health. International Journal of Mental Health.

No butts about it

“By excluding tobacco and signing the investor statement we aim to make a positive impact on the world our members will retire into.”

Tobacco use is a leading cause of disease and death globally, a fact many HESTA members confront daily in caring for our community. This is one of the reasons we’re proud to have excluded companies that produce cigarettes and tobacco products from our own investment portfolios since 2013.

And now we’re urging other investors to follow suit — for the health of our community and of your super — by signing a world-first Investor Statement on Tobacco.

“Many of our members work in hospitals and health settings across Australia, where tobacco-related illness clearly increases pressure on service availability and to the health system overall,” HESTA CEO Debby Blakey points out.

“As the national fund dedicated to health and community services, it’s vitally important that we raise awareness of this issue.

“We’re committed to responsibly investing our members’ super savings by being a careful long-term steward of their investments.”

“By excluding tobacco and signing the investor statement we aim to make a positive impact on the world our members will retire into.”

Released to mark 2017 World No Tobacco Day, the statement was supported by the United Nations-backed organisation Principles for Responsible Investment — a global leader in their field. ha

Flinders
UNIVERSITY

LEAD THE WAY IN HEALTH CARE MANAGEMENT

THE HEALTH ADMINISTRATION COURSES PREPARE YOU FOR THE CHALLENGES OF DELIVERING HEALTH AND AGED CARE IN A COMPLEX, CHANGING ENVIRONMENT.

The courses available at Flinders are:

- Graduate Certificate in Aged Care Administration
- Graduate Certificate in Health Administration
- Graduate Diploma in Health Administration
- Master of Health Administration and Master of Science (Health Administration)

TO LEAD THE WAY IN HEALTH, APPLY FOR ENTRY NOW:

08 8201 7755 | tiffany.carlin@flinders.edu.au
flinders.edu.au/fhcm

CRICOS No. 00114A

YOU CAN
CLOSETHEGAP

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

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

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

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

Photo: Jason Malouin/OxfamAUS

Support health equality for Alyssa,
support Indigenous health equality

oxfam.org.au/closethegapday

CLOSETHEGAP

DR NELI SLAVOVA-AZMANOVA
Associate Investigator

PROFESSOR CHRISTOBEL M SAUNDERS
Project Chief Investigator

DR NILOUFER J JOHANSEN
Research Officer

DR ANGELA IVES
Associate Investigator

Patients first

The Continuous Improvement in Care Cancer Project in Western Australia.

THE GLASS CEILING, AND BENEFITS FOREGONE

Globally, both a growing and ageing population contributes to the prevalence of cancer. A report by the Australian Institute of Health and Welfare in 2016 has highlighted that despite improved survival and prevalence rates, cancer is a leading cause of death and disease burden in Australia[1]. Between 2001 and 2014, there has been a 44% increase in the number of cancer-related hospitalisations, and expenditure on hospital-based cancer care has increased from around $2.2 billion in 2004–2005 to around $3 billion in 2012–20131.

While current national registries collect important data relating to cancer diagnoses, survival and overall healthcare costs, there is very little information on short- and long-term patient outcomes for cancer types or treatments delivered[1,2].

Several factors contribute to rising cancer-care-related costs. For example, the delivery of effective treatment is primarily dictated by short-term cost-saving cycles focused on the clinical absence of disease rather than bettering long-term patient outcomes[1,3]. Also, because cancer care requires a multi-disciplinary approach, the use of proprietary data-capturing platforms by different service providers in both public and private settings makes it difficult to access patient data and deliver effective treatment strategies in a timely manner[2]. Finally, the lack of a standardised dataset measuring long-term patient outcomes has made it difficult to compare and promote treatments in an evidence-based manner[2].

VALUE-BASED HEALTHCARE (VBH)

Comprehensive cancer care requires the coordination of multi-disciplinary specialties that is affordable, accessible and able to continually improve patient outcomes[1]. The goal of value-based healthcare (VBH) is to improve patient health outcomes while reducing the overall cost of healthcare[3]. It is therefore necessary to collect clinical outcome measures in conjunction with outcome measures important to patients, in order to monitor and improve both individual and system outcomes[2,3].

MEASURING PATIENT OUTCOMES

While many patient outcome measures exist, these are usually assessed independently from routinely-collected clinical outcome measures, and are not disease-specific, nor are they universally-applicable.

The International Consortium for Health Outcomes Measurement (ICHOM) has developed standardised datasets to measure clinical and patient-oriented VBH outcomes in cancers of the lung, breast, prostate and colon[4]. ICHOM is non-profit organisation comprised of leading health experts and patient stakeholders worldwide.

Each medical-condition-specific dataset consists of previously validated clinical- and patient-based quality-of-life questionnaires, and measures of co-morbidity, survival and treatment-related complications. These data are intended to be collected routinely during clinical management and follow-up. Additionally, using a standardised dataset can provide a benchmark for patient outcomes that new treatments can be compared against for effectiveness and cost-benefit[4].

CONTINUALLY IMPROVING CANCER CARE IN WESTERN AUSTRALIA

We have recently been awarded funding to pursue an innovative program of research aimed at bringing VBH into cancer care in public and private settings in Western Australia. This project implements a co-design strategy involving consumers, clinicians, health services and researchers to measure outcomes important to patients. It identifies key deficits in care pathways, generates and trials new

GraphicStock

> **“A report by the Australian Institute of Health and Welfare in 2016 has highlighted that despite improved survival and prevalence rates, cancer is a leading cause of death and disease burden in Australia.”**

interventions, and will implement findings rapidly.

We will use ICHOM datasets for breast, prostate, colorectal and lung cancer (and develop similar datasets for two rare, poor-outlook cancers).

The project has five overlapping stages:

- **Stage 1** will focus on engaging key stakeholders (including consumers) to participate, and establishing champions in each tumour stream at each site.
- **Stage 2** will involve the identification and development of data-capturing tools to collect clinical data efficiently from different service providers. This clinical information will be combined with patient-reported outcomes data. Data will be made available to researchers to create hypotheses that evaluate new interventions aimed at improving care.
- **Stage 3** will pilot the implementation of the electronic platform developed in stage 2 to automatically capture and export relevant data required to determine patient outcomes for a given diagnosis and treatment. Automated reports assessing quality outcome measures relating to care will also be trialled during this stage to allow for quality assurance and performance-related analysis.
- **Stage 4** will involve incorporating feedback, and revision and review of the data captured and evaluated in stage 3. Based on feedback and subsequent refinement of electronic data capture and automated analysis, further integration with local and national programs and initiatives will be explored.
- **Stage 5** will involve developing a state/national initiative for benchmarking cancer outcome measures. Protocols for rolling out collection of both clinical and patient outcome measures will be shared with healthcare providers in metropolitan and regional areas to enable standardisation of collected data and rapid adoption of evidence-based treatments promoting best patient outcomes.

By identifying and promoting interventions that improve patient outcomes in a cancer setting, we hope to demonstrate a proof-of-principle in which good healthcare is affordable, accessible, continually-improving and evidence-based. This program also can provide a template for better long-term monitoring and treatment of other chronic medical conditions such as cardiovascular disease, asthma and diabetes. ha

Dr Neli Slavova-Azmanova,
Associate Investigator, Cancer and Palliative Care Research and Evaluation Unit, University of Western Australia

Dr Niloufer J Johansen,
Research Officer,
St John of God Subiaco Hospital

Professor Christobel M Saunders,
Project Chief Investigator, Consultant Surgeon (Royal Perth Hospital, Fiona Stanley Hospital, St John of God Subiaco Hospital),
Professor of Surgical Oncology at the University of Western Australia

Dr Angela Ives,
Associate Investigator, Cancer and Palliative Care Research and Evaluation Unit,
University of Western Australia

References

1. Australian Institute of Health and Welfare 2016. Australia’s health 2016. Australia’s health series no. 15. Cat. no. AUS 199. Canberra: AIHW.

2. Johansen NJ &Saunders CM 2017. Value-based care in the worldwide battle against cancer. Cureus 9(2):e1039. doi:10.7759/cureus.1039.

3. Porter ME & Teisberg EO: Redefining health care: creating value-based competition on results. Harvard Business School Press, Boston; 2006.

4. International Consortium for Health Outcomes Measurement 2017. Accessed 30 September 2017, https://www.ichom.org/.

The Essentials website

Building capability in NSW health services for people with intellectual disability.

THE CASE FOR CHANGE

Approximately 1.86% of the Australian population has intellectual disability, either as a primary disability or an associated condition. This equates to 328,000 people.

In all age groups, compared with the general population, people with intellectual disability and their carers have less favourable experiences with the healthcare system, with poorer health outcomes, shorter life expectancy and higher mortality rates.

COMPLEX NEEDS AND PEOPLE WITH INTELLECTUAL DISABILITY

A particular challenge for health services is ensuring that all people with intellectual disability, including those who have complex needs, are catered for by the mainstream health system.

This has implications in terms of the coordination of healthcare and the need to develop partnerships with the disability sector to support health care delivery and recognise the individual's need to navigate a range of healthcare specialties, along with disability, educational and social services.

NSW Health has placed particular emphasis on integrated care, the engagement of primary care providers/networks, and partnerships between providers, as well as with people with intellectual disability and their families.

BUILDING CAPABILITY—*THE ESSENTIALS*

The purpose of *The Essentials* is to help improve health services to people with intellectual disability. The website can be accessed at www.aci.health.nsw.gov.au/resources/intellectual-disability/id-essentials.

The Essentials has been shaped by, and with, people with intellectual disability. It guides health service sector staff and other service providers in better understanding and meeting the complex and multiple health needs of people with intellectual disability, and their carers.

The site was launched in July 2017 in Sydney after extensive consultation with people with intellectual disability, carers, health staff, advocacy groups, partners in a range of other agencies, and service providers.

Prominent among the links on the site's home page are 10 guiding principles that underpin the delivery of quality health services for people with intellectual disability, providing guidance around both what to do and how to do it.

The site includes case studies, videos, links to resources, and useful tools, templates and training supports that help health staff and others see the possibilities of how they can make a difference.

For most people, the starting point on the website has been the interactive self-assessment tool. In conjunction with colleagues, site visitors use the tool to see how they are performing on key actions for health services inclusive of people with intellectual disability.

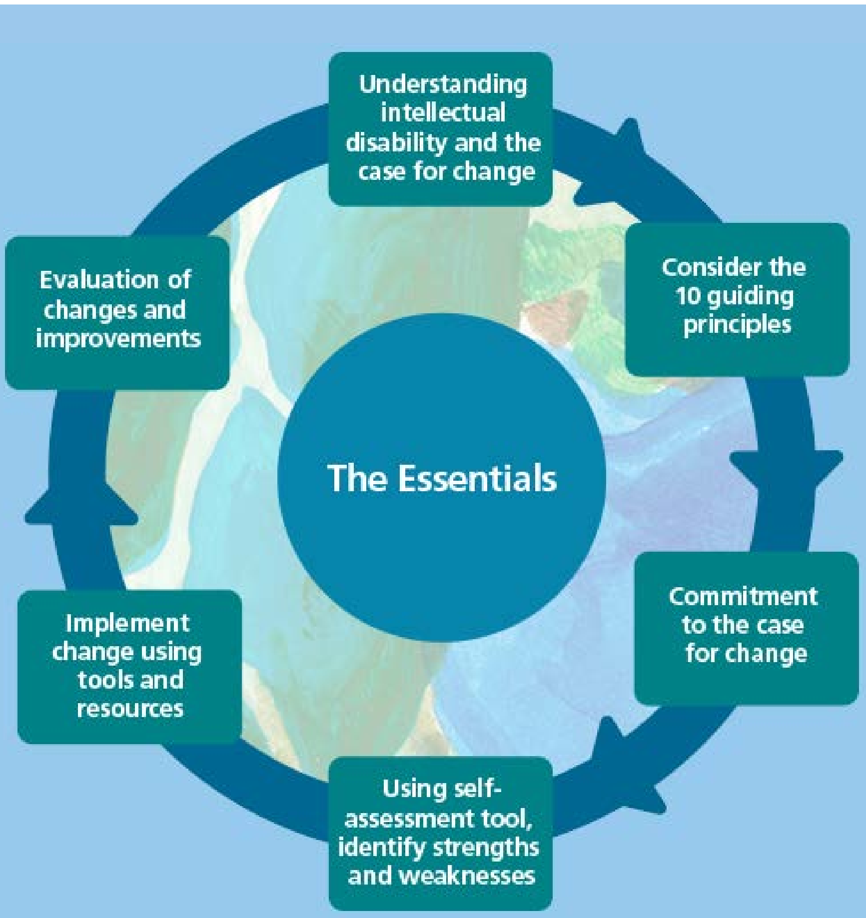
Once they have obtained a score and decided where they want to make changes, they can then use the extensive resources on the site to help implementation. There are plans to have patient experience measures available on the site in the near future to assist service evaluation.

COMMENTS FROM SITE USERS

'This has given me lots of ideas for things we can do in our team!'—Clinician

'This will help with our Disability Inclusion Action Plan!'—Health Manager

'We like the videos!'—Transition Coordinator



I am going to see the doctor.

I stand on the weigh scales.

The nurse puts a special cuff on my arm to measure my blood pressure.

Say less show more

An example of one resource developed in partnership with the Intellectual Disability Health Network is *Say less show more.* It is available at www.aci.health.nsw.gov.au/resources/intellectual-disability/childrens-services/say-less-show-more.

The *Say less show more* initiative seeks to support all children, including those with a disability, and their parents and carers, with a series of simple photo stories (visuals) that illustrate what will happen during a physical examination, a blood test and other common medical procedures. The visuals are supported by an e-learning package for health professionals and a variety of support materials.

The initiative has been well received, as shown in the comments below, and around 76% of clinicians surveyed said the training helped them to feel more confident in using the visuals in their clinical practice.

Say less show more was successfully trialled in a large hospital emergency department prior to release. Health professionals participating in the trial felt that similar resources could be applied to a wider population. Adult resources are currently being developed that will cover procedures such as going to the operating theatre and imaging.

Comments on *Say less show more*

'We cannulated a child presenting with behavioural issues who was stressed about the procedure. [Sedation]...had been planned and was not used due to the effectiveness of the tool'—Clinician

'I think the use of visuals is excellent and will make a positive improvement to the experience of anxious or disabled children in the department and in turn make it easy for parents and also staff doing procedures. The tools are really well designed and thought-out!'—Clinician

'My child would love to share "a story" with her nurse/doctor.'—Parent

'Thank you for helping make him understand the process. Very happy!"—Carer

'Great for the children to see the procedure and what will happen to them, especially when they ask what is going on. Easy language and easy for them to follow.' —Carer

The New South Wales Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better healthcare for NSW. The Intellectual Disability Health Network is one of the networks at ACI. It is managed by Tracey Szanto.

Hospital pharmacists

A missing link in managing mental illness.

GraphicStock

> **“Mental health pharmacy is well established internationally, but not yet in Australia. SHPA believes an advanced mental health pharmacy workforce would make substantial inroads into this void of high level care.”**

MEDICINES MISMANAGEMENT— A SILENT CONTRIBUTOR

Approximately 1.86% of the Australian Over the last decade, mental health has rightfully risen higher on the agenda of policy-makers, as advocates work tirelessly to increase the visibility and understanding of the impact of mental illness in our communities.

While important work is being done across healthcare disciplines, there is an urgent need to address a significant but silent contributor to poor physical health and mental health outcomes: medicines mismanagement.

Evidence shows that in the seriously mentally ill population, 50% of patients become non-adherent to their prescribed medicines in the first month following hospital discharge, despite understanding their medications would be helpful[1]. This figure rises to 65% for patients with bipolar affective disorder[2]. Patients who are non-adherent are 70% more likely to be hospitalised for medical reasons, with consequences including relapse, treatment failure, increased morbidity, hospitalisations, absenteeism and increased healthcare costs[3]. In the longer term, people with mental illness have a substantially shorter life expectancy due to their vulnerability, often caused by complex medicine regimens, to chronic conditions such as cancer, diabetes and cardiovascular disease[4].

The low adherence of patients with mental illness to medication regimes has been well-known for many years and is not surprising when the deleterious side-effects of many medicines are considered: weight gain, fatigue and mood change are common. However, medical practitioners now say these side-effects are not just ‘the cost of care’ for mental illness. And pharmacy experts agree; with good clinical pharmacy support, many of these issues can be addressed.

MENTAL HEALTH PHARMACY

Mental health pharmacy is well established internationally, but not yet in Australia. SHPA believes an advanced mental health pharmacy workforce would make substantial inroads into this void of high level care. Many pharmacists have both the clinical skills and pharmacological knowledge to support a range of effective interventions including:

- monitoring and managing medicine cessation
- the commencement, replacement or titration of therapies (in partnership with prescribers)
- reviewing blood tests for emerging chronic conditions
- counselling patients to support self-care with aids such as metabolic monitoring tools
- supporting adherence in outpatient clinics
- reviewing medicine interactions and counselling carers regarding medicines management.

Mental health pharmacists have often also completed Mental Health First Aid training to enable them to identify early relapse in medicines adherence or signs of suicidal tendencies.

When gaps emerge in transitions of care from hospitals and healthcare centres into the community, people with mental illness are especially vulnerable. The Australian pharmacy workforce provides a highly skilled and readily accessible means for cost-effective innovation, within their existing scope of practice.

SHPA is keen to work with other groups to translate known research into practical initiatives to improve how the broader health system protects, supports and cares for Australians with mental illness, especially in the transitions between acute and community services.

Let’s keep the conversation going, and ensure words result in actions.

Society of Hospital Pharmacists of Australia (SHPA)

References

1. Tomko JR, Ahmed N, Mukherjyy N, Roma RS, DiLucente D & Orchowski K 2013. Evaluation of a discharge medication service on an Acute Psychiatric Unit. Hospital Pharmacy 48(4):314-320

2. Lizer MH, Jawaid SAP, Marsh WA & Mogili L 2011. The impact of a pharmacist assisted clinic upon medication adherence and quality of life in mental health patients. Pharmacy Practice (internet) 9(3):122-127.

3. Gilmer T, Dolder CR, Lacro JP, Folsom DP, Lindamer L, Garcia P et. al. 2004. Adherence to treatment with antipsychotic medication and health care costs among Medicaid beneficiaries with schizophrenia. American Journal of Psychiatry 161:692-699.

4. Department of Health 2016. Fifth National Mental Health Plan: Draft for Consultation. Canberra: Department of Health.

DR NICOLE FREENE
Clinical Assistant Professor
Physiotherapy, Faculty of Health,
University of Canberra

DR BERNIE BISSETT
Assistant Professor
Physiotherapy, Faculty of Health,
University of Canberra

Cardiopulmonary care–mobilisation is king!

How the pendulum has swung across the continuum of care.

Within our professional lives we've noticed a huge change in the approach of physiotherapists managing cardiopulmonary patients—particularly our willingness to get our patients moving. It's safe to say that in our toolbox of patient-centred techniques in 2017, mobilisation is king!

EVIDENCE ON THE BENEFITS OF MOBILISING PATIENTS

Over the last decade there has been an explosion of evidence to support the benefits of mobilising our patients across the spectrum—from ICU to acute medical and surgical patients, through to cardiac rehabilitation and preventative care.

In ICU we've shifted from focusing on organ-level treatments, such as airway clearance, to a whole-body approach that includes mobilisation and rehabilitation, even for our sickest ventilator-dependent patients.

In a comprehensive review in 2013, Kathy Stiller pointed out that, given the effect of mobilisation on longer-term outcomes (including better quality of life and reduced mortality), we as a team should be focusing on mobilisation as our priority. Although we're still learning the best ways to do this, it's a telling sign that mobilisation has a big impact from the very earliest point in a patient's journey.

In other evidence, Kimberley Haines and colleagues (2013) identified that for each day a high-risk abdominal surgery patient doesn't mobilise away from the bed space, the patient is 3 times as likely to develop a post-operative pulmonary complication. Nothing like a bit of motivation to get our post-operative patients up and moving in the early days!

In 2016, in an article published in the *Journal of Physiotherapy*, Anderson José and team showed that for inpatients with community-acquired pneumonia, a whole-body exercise program, without any focus on specific respiratory techniques, resulted in better outcomes than a traditional treatment approach focused on airway clearance.

In the first half of 20th century, patients post-heart attack were required to stay in bed for 6 weeks and were forbidden to move or feed themselves in the first 2 weeks. In 2016, Julie Redfern outlined (in *Heart, Lung and Circulation* journal) changes in physical activity recommendations for patients with heart disease over the last 100 years, with the evidence now indicating that regular physical activity from very early on, and throughout life, can reduce cardiac mortality by 25-30% for these patients.

In addition, moving more after a heart attack (safely!) may not only reduce a number of risk factors for heart disease and improve quality of life, it can also reduce hospital admissions and help patients live longer.

PHYSICAL ACTIVITY GUIDELINES AND HEALTH

It is only since the 1990s that we have had public health physical activity guidelines for healthy individuals. Research evidence has been used to make recommendations about the level of movement required to prevent a number of diseases and conditions, and dying from any cause. *Australia's physical activity and sedentary behaviour guidelines* (2014) advise us to move more and sit less, aiming for greater than 150 minutes of moderate-to-vigorous physical activity per week, including some strengthening exercises. Meeting these

GraphicStock

guidelines has been found to improve our health, both physically and mentally.

Physical inactivity and sedentary behaviour (sitting time) are independent risk factors for cardiovascular disease and all-cause mortality in healthy and non-healthy individuals. The research has shown us that the more we move, the less likely we are to end up with poor health outcomes. So the message we want to be getting to ALL our patients, wherever they present, is that movement and mobility are the keys to a long and healthy life.

MOBILISATION BENEFITS APPLY ACROSS CONTINUUM OF CARE

In 2017 our treatment decisions should be evidence-based, and as we have seen, the benefits of mobilisation are found across the continuum of care, from the healthy to the very unwell. Consequently, it's exciting to see the physiotherapy profession evolving in response to the evidence.

Of course, there will always be patients who can't mobilise—for example due to low blood pressure or when bed rest is required for healing of a fractured pelvis—so we can't dispense with the rest of our toolkit. But we should be helping and inspiring our patients to get moving as much as possible, as the research clearly tells us that mobilisation is king! ha

References

Stiller K 2013. Physiotherapy in intensive care: an updated systematic review. Chest 144(3):825–47.

Haines K, Berney S & Skinner EH 2013. Association of postoperative pulmonary complications with delayed mobilisation following major abdominal surgery: an observational cohort study. Physiotherapy 99(2):119–25.

Jose A & Dal Corso S 2016. Inpatient rehabilitation improves functional capacity, peripheral muscle strength and quality of life in patients with community-acquired pneumonia: a randomised trial. Journal of Physiotherapy 62(2):96-102.

Redfern J 2016. The Evolution of Physical Activity and Recommendations for Patients with Coronary Heart Disease. Heart Lung and Circulation 25(8): 759-764.

Department of Health 2014. Australia's physical activity and sedentary behaviour guidelines. Available from: http://www.health.gov.au/internet/main/publishing.nsf/content/health-pubhlth-strateg-phys-act-guidelines.

MARY ANNE IRELAND
Partner, Salvos Legal

Handling legal issues in the care sector

Tips for obtaining legal advice with the 'right' outcome in mind.

Person-centred care' and an 'enabling approach' have become holy grails for health and aged care providers. But what happens when a provider is faced with a legal issue involving a client or patient?

Research tells us that 66% of aged care providers are not-for-profits and 78% of community care places are delivered by not-for-profit providers[1]—so it's not surprising that these organisations feel conflicted when faced with legal matters involving clients or patients. How can they deliver on their purpose and values while also protecting their organisation financially and legally, and their reputation?

Through our experience advising the community and aged care sectors, we have learnt that there are three steps care providers can take to achieve the 'right' outcome when obtaining legal advice:

1. Be proactive
2. Put yourself in your stakeholders' shoes
3. Take a longer-term view

BE PROACTIVE

Let's start with being proactive.

Ideally, all providers would have a great complaints handling process to help sort out any problems before they become a legal matter. However, legal issues still arise from time to time and it's important to seek legal advice early. This could be as simple as an informal conversation with your lawyer to flag a potential issue and gain an understanding of the legal framework that applies.

Australia has rigorous federal and state legislation that governs the operation of health, aged care and retirement facilities. Sometimes we are contacted by providers who have tried to resolve an issue with a client without legal advice, only to discover that their solution does not comply with the law. An early conversation with a legal adviser can put you on the right track and help resolve the issue in a way that does not put the provider or the rights of the client at risk.

PUT YOURSELF IN YOUR STAKEHOLDERS' SHOES

Empathy is essential to effective health and aged care services, and it's equally important when dealing with legal issues.

Ultimately you are dealing with people—and very often they are in a vulnerable position because of their age, lack of mobility, health or mental health issues, impaired cognition or a disability.

Listening to the concerns of your patients/clients and their families can often reveal a subtext to a complaint. For example, a patient's complaint about a lack of service or care could expose a deeper problem with your staffing, management or organisational culture.

Even though it might make you uncomfortable, listen to and learn from the complaints of family members or other patient advocates. Showing empathy in this way can often defuse a situation and help all parties to better understand it.

In the same way as a just legal system provides representation for all parties, the best outcomes are achieved when patients have someone in their corner. Indeed, some of our clients provide external support for patients and their families who have raised or are involved in legal issues. This shows a level of care beyond what might ordinarily be expected.

An empathetic approach can also guide the approach a provider takes to implementing changes. For example, last year the media reported on residents of a retirement village in Sydney who felt unfairly treated when they were notified that they would have 12 months to move to make way for a redevelopment of the village. Faced with a similar situation, one of our clients took a values-based approach. They made sure their plans had very long time frames that would reduce distress for very elderly residents by enabling

pixabay

them to remain in their homes for life. More mobile residents were provided with options to relocate to a nearby village. The solution was one that worked for both residents and the provider.

TAKE A LONGER-TERM VIEW

When providers approach a legal issue with a longer-term view, they are not only seeking to resolve the issue at hand, but also taking into account the long-term relationship they may need to have with a patient or family, and the impact of the issue on other patients/residents and staff.

By taking this approach, providers can also use legal interactions as learning opportunities. Questions that could be asked are:

- What can we learn from this situation?
- How can we better equip staff to deal with this kind of issue in the future?
- Would staff benefit from legal training on their rights and responsibilities under the relevant legislation, or training on listening skills and empathy?
- Can we improve our policies, procedures or complaints handling process to avoid the same situation happening in the future?
- Is this situation a symptom of a larger issue we need to address?

WHICH LEGAL APPROACH IS RIGHT FOR YOU?

Understanding your organisation's values and communicating them to your legal adviser is key to achieving the 'right' legal outcome. Your lawyer can advise you on the relevant Commonwealth or state and territory legislation, and how it applies to your situation.

It's important to remember, however, that sometimes the 'right' outcome involves a compromise to ensure that you have a positive and ongoing relationship with a patient or staff member, and protect and enhance the reputation of your organisation.

Mary-Anne Ireland is a Partner in the Property practice at Salvos Legal, a social purpose law firm that undertakes commercial work to fund its life-changing free humanitarian legal services. The firm was named 'Professional Services Innovator of the Year—Australia' in the 2017 Social Care Awards. Contact Mary Anne at: maryanne.ireland@salvoslegal.com.au or phone: 02 8202 1555

References

1. SGS Economics & Planning 2014. Not-for-profit sector in the aged care industry 2014. Report for Aged and Community Services Australia. October.

The Dealing with it myself research project

Supporting immigrant and refugee carers.

GraphicStock

ROSI ARYAL LEES
Equality@Work Project Officer, Multicultural Centre for Women's Health, Victoria

Informal carers support family members or friends who are frail elderly, and/or living with a disability, chronic illness or mental illness. Demand for informal carers in Australia is rising as our population ages, particularly within immigrant and refugee families, who have an older age structure than the Australian-born population.

The 2016 Census showed that nearly one-half (49%) of Australia's population were either born overseas or have one or more parents who were born overseas. Unfortunately the cultural diversity of our population is not reflected in mainstream modes of service delivery, and navigating the complex Australian health system can be daunting for immigrant and refugee families. Many older people experience substantial barriers in accessing services, due to intersecting factors such as limited English proficiency, social expectations about family-based elder care, and little understanding among service providers about culturally appropriate aged care.

With limited ability to navigate the aged care system, and personal preferences for 'ageing at home', older migrants rely more heavily on family members than the Australian-born elderly. Similar issues exist for families attempting to access disability and mental health services, and we know there is a pressing need to improve support to informal carers from immigrant and refugee backgrounds.

Between 2015 and 2017, the Multicultural Centre for Women's Health (MCWH) conducted *Dealing with it myself*, a community-based, multilingual health promotion and research project with carers and families from Arabic, Burmese, Chinese, former Yugoslavian, Hakha Chin, Indian, Karen and Punjabi backgrounds.

During the project we conducted focus groups and interviews with carers, and used our findings to develop and deliver culturally-tailored multilingual health education about carer support. The project was funded by the Australian Government under the Aged Care Service Improvement and Healthy Ageing Grants program.

GENDER, MIGRATION AND CARING

Caring is highly gendered across all cultural contexts, informing both policymakers' and families' expectations about *who* in our community is available and willing to care. Australia is currently experiencing a trend away from institutionalised care towards community-based care. Coupled with our ageing population, this trend is increasing demand for informal family carers. Women (whether Australian- or overseas-born) are overwhelmingly meeting this rising demand. Indeed, the tacit assumption underlying current policy trends towards community-based care is that women will be available to care. Immigrant and refugee women are layered with additional stereotypes, including the assumption that they will be more willing to care for cultural reasons. This is concerning because policies that reinforce stereotypical gender roles have a known negative impact on women's health, particularly for immigrant women who are often undertaking unpaid caring work with smaller family networks and less social support than in their home countries.

Australia's restrictive visa system, with increasingly tighter residency requirements and controls on family reunion, can isolate women further and limit families' access to preventative health services. For instance, people on temporary visas who legitimately qualified for support under the HACC program do not qualify for the NDIS, which can only be accessed by citizens, permanent residents or those holding a Protected Special Category Visa.

The removal of support from care recipients will have a negative impact on immigrant and refugee caring families, creating inequitable outcomes between permanent and temporary visa holders, and compounding health problems and increasing costs when people are granted permanent visas but have been excluded from timely and cost-effective early intervention measures.

The downward economic pressure on immigrant families, exacerbated by discrimination in the job market and lack of recognition of overseas qualifications, means that carers are often also negotiating precarious, casualised and low-paid employment, further limiting their access to high-quality preventative healthcare.

RESEARCH FNDINGS

Our community research highlighted key structural barriers immigrant and refugee caring families experience in Australia, including marginalisation from mainstream services, lack of multilingual resources and culturally-tailored services, and social isolation. Newly-arrived families in particular face many challenges:

> *When we first arrived it was a very difficult time for me and my husband. We did not have any friends or extended family to support us. English language was the hardest thing to understand and learn. After just one year of coming to Australia my husband got very sick, and it was up to me to take care of him as is customary. (Serbian female carer interviewed for Dealing with it myself)*

Keeping such structural barriers in mind, we caution against the assumption that immigrant and refugee families resist external help because of a supposed 'cultural' understanding that caring duties are part of daily (female) life and should be kept internal to the family. Certainly, many carers mentioned that their family members resisted outside help, but this was often due to lack of awareness about services, or concerns (whether real or perceived) that services would be discriminatory and culturally inappropriate.

However, during our community health education sessions, all participants showed keen interest in accessing carer support services. Our project findings have therefore highlighted an opportunity to better support immigrant and refugee families in their caring journey by removing barriers, facilitating access and offering culturally-tailored support.

For more information on supporting immigrant and refugee carers, please visit our website: www.mcwh.com.au/

MARGARET FAUX
Founder and CEO
Synapse Medical

Private Health Insurance: A look under the bonnet

AN IMAGE PROBLEM

Australian private health insurers (PHI) have an image problem. They are never out of the headlines for long, are criticised for inappropriately profiteering from a $6 billion government handout and still their products seem to offer poor value and satisfy no one. And despite an ongoing debate about whether Australia should continue to support our current blended public/private health financing arrangements, a recent raft of PHI reforms has signalled the government's intention to maintain the status quo for now—albeit with a bit of fine tuning and finessing here and there to see if we can hang on a little longer. But is it sustainable?

Australia's health system is still widely regarded as one of the best in the world and given our GDP spend on health at 10% compares favourably with other OECD countries, it is not surprising that major reform seems unlikely from either side of politics. So, if one accepts that, for now, we are going to continue to have PHI, then it is reasonable to suggest that creating the necessary conditions to allow the PHI market to succeed is a sensible debate to be having.

Since the 1950s Australian PHI has been community-rated, which means PHIs cannot charge more for higher risk individuals. Every insured Australian pays the same rate for the same PHI product regardless of expected claims costs.

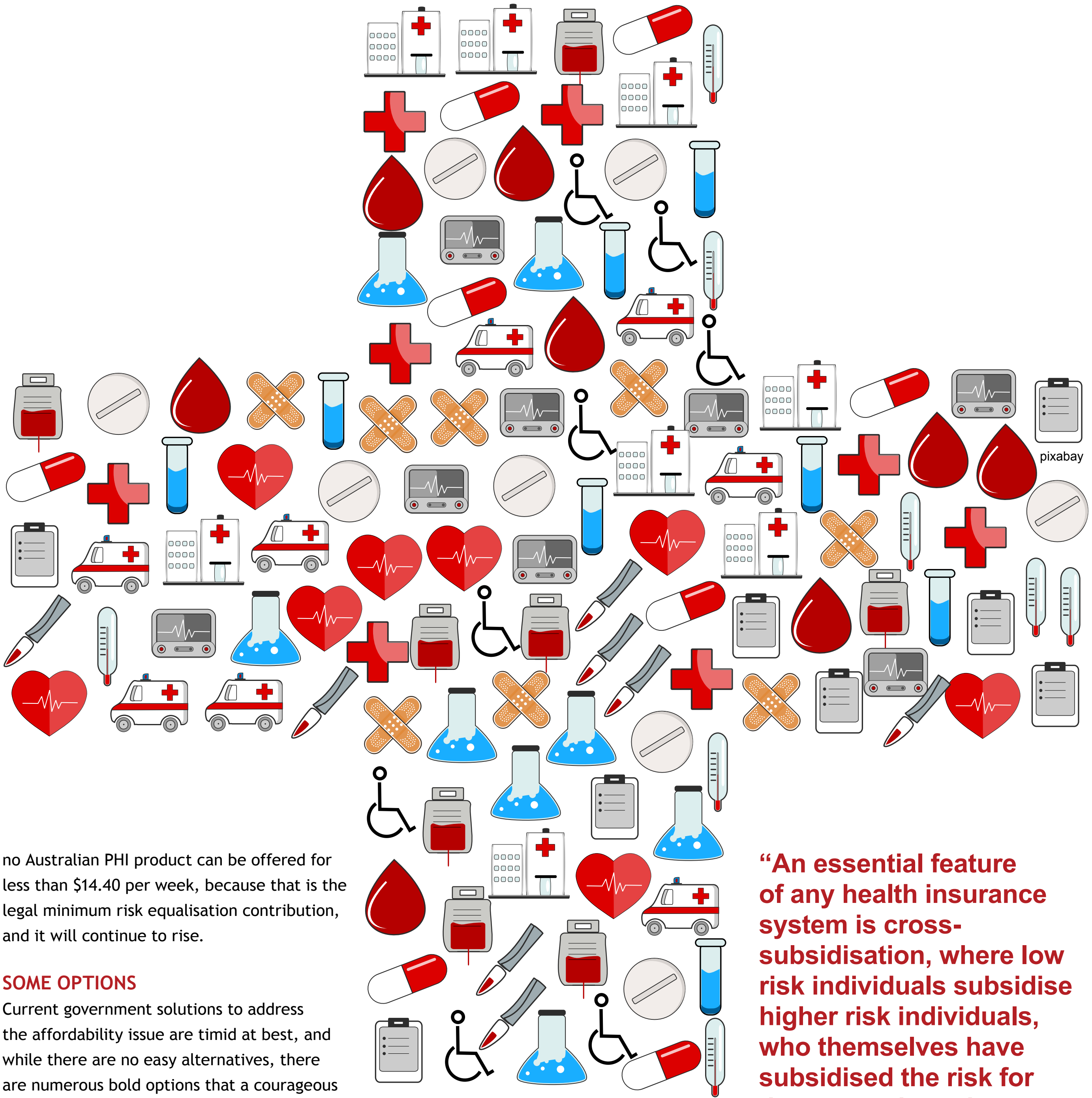
An essential feature of any health insurance system is cross-subsidisation, where low risk individuals subsidise higher risk individuals, who themselves have subsidised the risk for the generations that came before them. Put simply, the healthy subsidise the sick.

RISK EQUALISATION

In a competitive health insurance market, some form of regulatory intervention is required to ensure health insurance remains affordable for low income, high risk individuals because without it, these people would be priced out of the market. And as a matter of public policy we accept that everyone should have access to proper health care irrespective of their ability to pay.

The preferred solution employed in many countries, including Australia, is risk equalisation. It is basically a method whereby instead of making high risk individuals pay more, the risk is adjusted beneath the surface between the insurers. It's a bit like the way server hosts load balance when one server has too much data. Cloud platforms like Facebook and Drop Box balance data loads without our knowledge, by shifting data to and fro across many servers to prevent system crashes. Similarly, when one PHI is burdened with too much risk and high claims costs, the load is balanced by sharing the risk across other PHIs to prevent the industry crashing. When risk equalisation is perfectly optimised health economists believe it balances affordability, insurer efficiency, and minimises 'cream skimming' behaviours (where insurers select low risk individuals). But achieving optimal risk equalisation is hard, and no country can yet claim victory in achieving a perfect balance.

Risk equalisation in Australia is one of many moving parts under the PHI bonnet supporting community rating. Together with the PHI rebate, Lifetime Health Cover loading and Medicare Levy Surcharge, it is the linchpin keeping the entire PHI industry afloat. Without it the industry would collapse. But the entry point into PHI has become too expensive over time, particularly for young people. Currently



pixabay

no Australian PHI product can be offered for less than $14.40 per week, because that is the legal minimum risk equalisation contribution, and it will continue to rise.

SOME OPTIONS

Current government solutions to address the affordability issue are timid at best, and while there are no easy alternatives, there are numerous bold options that a courageous government might consider.

Firstly, there are too many PHIs—38 for 24 million Australians. Many are small not-for-profits running very expensive boards, and a consolidation would save considerable administration costs.

A more contentious suggestion would be risk rating like the New Zealand health system, with inbuilt regulatory safeguards to protect vulnerable groups and ensure affordability.

Less contentious would be partial community rating, like our current compulsory third party (CTP) motor insurance, where premiums are varied based on expected claims costs, but the full risk is not loaded onto premiums. Implementing this would require care to avoid the problems the UK motor insurance industry suffers. The UK's risk-rated car insurance system means the cost of car insurance for a young male driver is often more than the car.

There are many other options, such as the prospective risk equalisation system used in the Netherlands (rather than our retrospective system)—this improves PHI efficiency, but depends on reliable data to succeed. In time, the government's My Health Record could facilitate consideration of this option, but until then, we will continue to tinker—because currently our government does not seem to have a clear plan for PHI and its role in the health of our nation. ha

"An essential feature of any health insurance system is cross-subsidisation, where low risk individuals subsidise higher risk individuals, who themselves have subsidised the risk for the generations that came before them. Put simply, the healthy subsidise the sick."

ADJUNCT PROFESSOR PARESH DAWDA
Director, Prestantia Health

Experience-based co-design

An Australian toolkit.

INTRODUCTION

Healthcare systems around the world are striving towards achieving a quadruple aim:

- improving clinical outcomes;
- improving the unit cost of delivery;
- improving staff experience; and
- improving patient experience.

Achieving this quadruple aim requires good design of healthcare service delivery. Good design considers three aspects: *performance*, *engineering* and *usability*.

- ***Performance***, or the quality of care and outcomes, has always been a focus of healthcare organisations.
- ***Engineering***, or safety, has been gaining tremendous momentum over the last 15 years or so.
- ***Usability***—the feelings and emotions associated with the use and experience of health services—are now beginning to be considered.

To truly achieve an improved experience requires going beyond the usual approaches of seeking patient influence to an approach that gathers the very essence of the experience and then improves it together with patients.

> *'Happenings become experiences when they are digested, when they are reflected on, related to general patterns and synthesised'* (Saul Alinsky. Rules for radicals, 1971)

WHAT IS EBCD?

Experience Based Co-Design (EBCD) is a methodology that goes beyond user views, attitudes, needs and perceptions to a focus on designing experiences through bringing together a 'user-centred orientation' (experience base) and a collaborative change process (co-design).

These concepts have been used in other industries for many years, and particularly in technology organisations. Application to healthcare is still relatively young, having originated in the UK in 2005. EBCD has gained increasing popularity since then, with projects reported in countries such as Australia, Canada, England, the Netherlands, New Zealand, Sweden, and the United States. They have addressed a broad range of clinical areas, including emergency medicine, drug and alcohol services, cancer services, paediatric diabetes care and mental healthcare.

WHY A TOOLKIT?

Use of EBCD to date demonstrates flexibility in application, which is a strength. However, some health services can underutilise useful tools such as observation, while finding other aspects challenging—such as co-design, which is integral to the methodology.

The toolkit aims to bring together existing influential international material, together with Australian case studies of EBCD, into a freely available practical resource that Australian health services can use in projects aimed at improving the patient experience.

WHAT'S IN THE TOOLKIT?

Following an introduction and background, the principles of EBCD are explored.

A fundamental concept of EBCD is a focus on patient and staff experiences and emotions, rather than attitudes or opinions. Therefore, qualitative methods play a central role, with ethnographic methods such as narrative-based approaches, and in-depth observations, being used. These emotions and experiences are mapped to key 'touchpoints' along the patient journey. A co-design process is used right across the methodology from the outset, but particularly in understanding experiences and then translating them into meaningful improvements.

The toolkit divides the methodology into five key stages:

1. Setting up for success
2. Gather the experience
3. Understand the experience
4. Improve the experience
5. Sustain the experience

There is a repository of EBCD tools together with seven case studies. The case studies are from diverse Australian settings including

GraphicStock

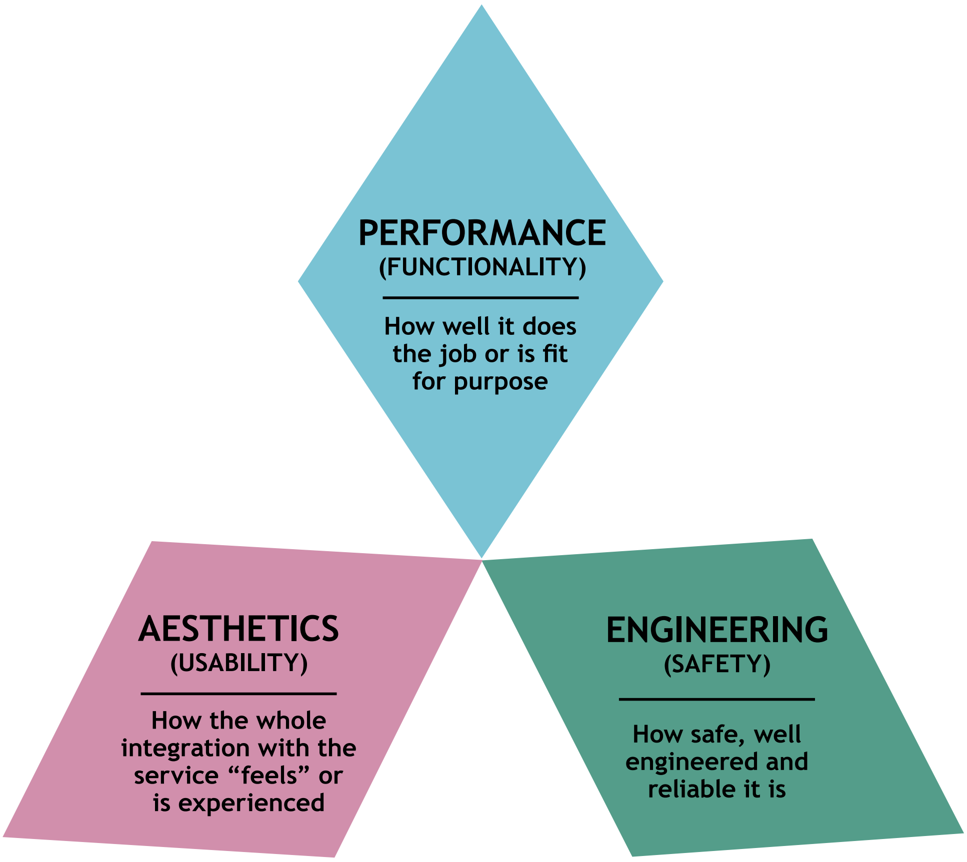
acute care services, rehabilitation services, and mental health and primary care.

Tools and inspiring examples are interweaved throughout the description of the five stages. Where a service in the case study found a particular tool valuable, or had insightful reflections, then these are shared. The tools themselves are designed to make it easier for services to undertake EBCD projects, e.g. there are template agendas, interactive PDF forms with signposting to useful websites, and resources, including videos.

NEXT STEPS

The toolkit will be available online in coming weeks from the Consumers Health Forum and the Australian Healthcare and Hospitals Association. It will also be available as a PDF document.

A recent *Harvard Business Review* article concluded 'It's every healthcare leader's mission to improve patient experiences. Design thinking is a useful process for doing so, as it requires decision-makers to empathise with patients, think creatively, prototype, and continually test solutions to these problems'. The Australian EBCD toolkit will support health service leaders and providers to make a positive difference in their efforts to improve the experience of consumers. **ha**



Become an AHHA member

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

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

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

By becoming a member of the AHHA, you will gain access to AHHA's knowledge and expertise through a range of research and business services.

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

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

In partnership with the LEI Group, the AHHA also provides training in "Lean" healthcare which delivers direct savings to service provider and better outcomes for customers and patients.

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

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

More about the AHHA

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

AHHA Board

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

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

Dr Michael Brydon
Sydney Children's Hospital Network

Dr Paul Burgess
NT Health

Ms Gaylene Coulton
Capital Health Network

Ms Jill Davidson
CEO SHine South Australia

Dr Paul Dugdale
ACT Health

Mr Nigel Fidgeon
Merri Community Services, Vic

Mr Walter Kmet
WentWest, NSW

Mr Adrian Pennington
Wide Bay Health and Hospital Service, Qld

AHHA National Council

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

Secretariat

Ms Alison Verhoeven
Chief Executive

Mr Murray Mansell
Chief Operating Officer

Dr Linc Thurecht
Research Director, Acting
Deeble Institute Director

Mr Krister Partel
Advocacy Director

Ms Lisa Robey
Engagement and Business Director

Ms Kylie Woolcock
Policy Director

Dr Chris Bourke
Strategic Programs Director

Dr Rebecca Haddock
Deeble Institute Manager

Ms Claire Bekema
Engagement and Business Development Manager

Mr Nigel Harding
Public Affairs Manager

Ms Kate Silk
Integration and Innovation Manager

Ms Sue Wright
Office Manager

Mr Daniel Holloway
Web/Project Officer

Ms Freda Lu
Assistant Accountant

Ms Suhi Sudhakar
Administration Officer

Mr Matthew Tabur
Executive Officer

Ms Odette Fuller
Administration Officer

Australian Health Review

Australian Health Review is the journal of the AHHA. It explores healthcare delivery, financing and policy. Those involved in the publication of the AHR are:

Prof Gary Day
Editor in Chief

Dr Simon Barraclough
Associate Editor, Policy

Prof Christian Gericke
Associate Editor, Models of Care

Prof Sonj Hall
Associate Editor, Health Systems

Dr Linc Thurecht
Associate Editor, Financing and Utilisation

Ms Danielle Zigomanis
Production Editor (CSIRO Publishing)

AHHA Sponsors

The AHHA is grateful for the support of the following companies:

- HESTA Super Fund
- Good Health Care
- Novartis Australia
- Price Waterhouse Cooper

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

Contact details

AHHA Office
Unit 8, 2 Phipps Close
Deakin ACT 2600

Postal address
PO Box 78
Deakin West ACT 2600

Membership enquiries
T: 02 6162 0780
F: 02 6162 0779
E: admin@ahha.asn.au
W: www.ahha.asn.au

Editorial enquiries
Nigel Harding
T: 02 6180 2808
E: nharding@ahha.asn.au

Advertising enquiries
Lisa Robey
T: 02 6180 2802
E: lrobey@ahha.asn.au

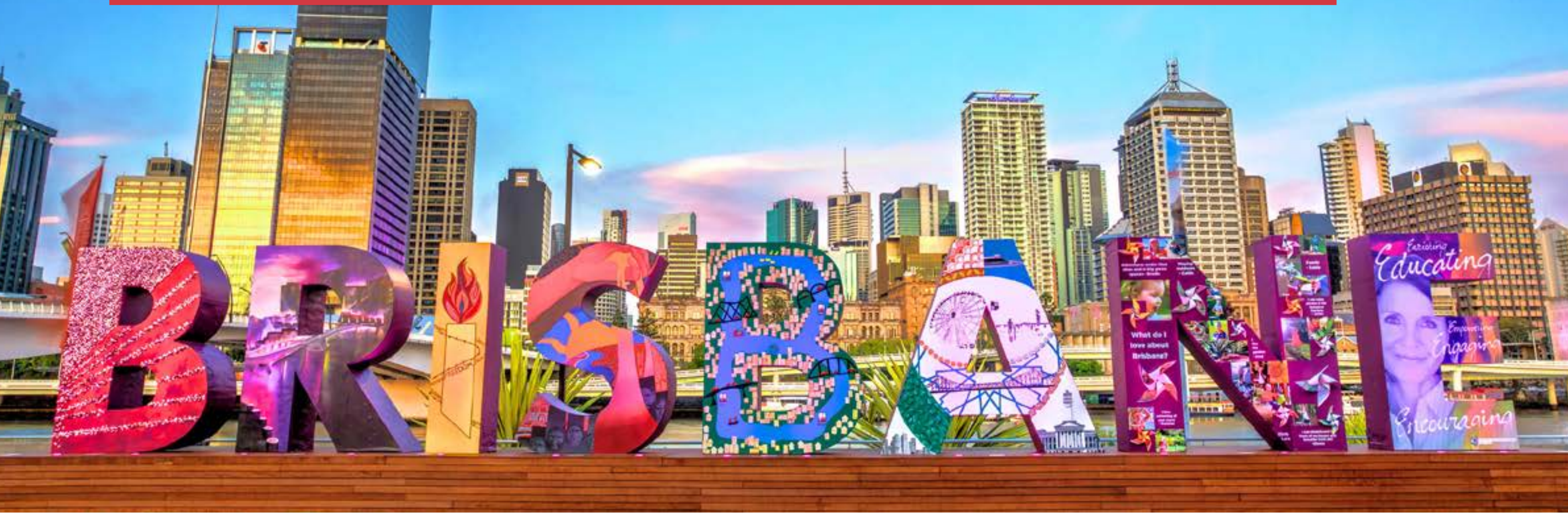
General media enquiries
E: communications@ahha.asn.au

The Health Advocate

ISSN 2200-8632

Call For Abstracts Now Open

2018 IHF BRISBANE
42nd World Hospital Congress
10–12 OCTOBER 2018 BRISBANE AUSTRALIA



INNOVATE | INTEGRATE | INSPIRE
How can healthcare evolve to meet 21st century demands?

The call for abstracts for the 42nd World Hospital Congress is now open.

Abstracts for oral and poster presentations are being called for in response to the overarching Congress theme: How can healthcare evolve to meet 21st century demands? against the following tracks:

- From volume to value
- From four walls to the neighbourhood
- From information to intelligence

Further information on the overarching theme, tracks and how to submit your abstract is available from the Congress website at www.hospitalcongress2018.com.

Important Dates

Call for abstract closes
15 January 2018

Notification to authors
15 March 2018

Earlybird registration closes
30 June 2018

World Hospital Congress
10-12 October 2018

Presented by

International Hospital Federation

ahha
australian healthcare & hospitals association
the voice of public healthcare®

Host Partner

Clinical Excellence Division
Queensland Government

Platinum Sponsor

NOVARTIS