Lorna O'Brien with her Mother Henrietta at the CHA National Awards.

"Live with Gusto"

Meet CHA *Nurse of the Year* 2018

by Kerie Hull

Lorna O'Brien's passion for caring for those with cancer or experiencing mental illness was nurtured at a young age. Raised in Sydney, her parents managed a home for young men with mental health disability, the nursery bed for her compassion. She hopes one day to see mental health treated justly. Her own battle with cancer has provided her rich insight into challenges faced by her patients. While an exemplary all-round practitioner of 30 years, Lorna has been recognised for her vision and transformative impact on hospital processes through a digital database at St John of God Richmond Hospital.

Lorna says the Award has given her a 'marvellous feeling', overwhelmed to be recognised by Catholic Health Australia and the executive of St John of God Health Care.

Brimming with positivity and an infectious enthusiasm, meet Lorna O'Brien...

Q Hm: Have you always been a nurse?

A *LOB: No, I have ventured into my own business, a ladies retail store. I had this business for 10 years in the 1990's before going to work for the Local Federal Member of Parliament.*

Q Hm: You were also at the Cancer Council?

A *LOB: I worked at the Cancer Council NSW for 13 years. My roles there ranged from fundraising to Cancer Support Manager – involved managing the cancer support programs – 13 11 20 Information and Support Line and peer support programs. I was also part of a research team that developed an online chat format as a mode of support.*

Q Hm: How does your faith influence your work and life?

A *LOB: My faith was developed at a very young age. I was very lucky to be able to attend Meriden School, a Church of England School for Girls, Sunday school, and fellowship was a large part of my young and adult life. Yes, my faith is reflected in my work and life. There are many times in my working day, when I ask myself... "if Jesus were here, what would he do?". This question aids my self-reflection and seems to guide me on how I will act or respond.*

At St John of God Hospital, we have guiding values of Hospitality, Respect, Compassion, Justice and Excellence. I do use these values daily, whether it be in my dealing with patients; and certainly, in my management role, I need and use these values. To me they are foundations that can encourage, and support Caregivers in how to provide compassionate care for our patients.

Q Hm: What attracted you to nursing?

A *LOB: Travel. Dad advised me to do nursing, 'you can go anywhere in the world and you can work anywhere'. He was right. Both my parents were nurses and I loved the way they cared for their friends and community. They were both great role models for great nursing, and had passion for their craft.*

Q Hm: You have a passion for caring for patients with cancer and those with mental illness – what drives this?

A *LOB: Yes, mental health has always intrigued me. I love hearing about people and their story and what makes them tick. When people are faced with adversity in both situations (cancer or mental illness), it is the human spirit and resilience that really shines through and gives hope. Stories of resilience and stamina and adversity have been a personal driver. I am totally addicted to reading biographies. I want to understand why, how and when people thrive, what makes a person leadership material. Kindness and caring are the two key drivers for me in talking with people who are experiencing mental health or cancer concerns.*

Q Hm: Why do you work in a Catholic setting?

A *LOB: The environment and the culture sits well with my spirit. I like to work in faith, not-for-profit based organisations.*

Q Hm: What do you think is different about care in a Catholic hospital?

A *LOB: The values and purpose are lived in work practice. The Leadership team upholds these values as indicators of care.*

Q Hm: What has been your greatest joy or reward in your work?

A *LOB: Many: all patient related.*
Helping cancer patients navigate their treatment and assisting them with an optimal care and health outcomes; assisting patients who feel they have no hope, to find hope; believing that a young woman who had drug issues could be free of her addiction – opening the door of recovery for her; supporting colleagues; and the lived experience of caring.

Q Hm: What motto/s do you live by?

A *LOB: You only get one go at life... live it with gusto, and to live, love and to laugh OUT LOUD every day!*

"It is the human spirit and resilience that really shines through and gives hope."
– Lorna O'Brien

Stephen Brooker, CEO of St John of God Hospital Richmond and Deb Morris, the Director of Mission Integration nominated Lorna for the Award.

Q Hm: What advice do you give or would you give to a graduate nurse?

A *LOB: Look your patients in the eye. Really, look at your patient. Remember to see them; they are more than a task that is required of you.*

Q Hm: What are the greatest challenges or obstacles that you have had to overcome?

A *LOB: Workplace bullying.*

Q Hm: What do you see are the greatest challenges for nurses of the future, or are these opportunities?

A *LOB: Self-care – being too busy to look after their own needs. Educating nurses about burnout and reflective practice needs to be factored into their work. There's an opportunity to provide CPD points about self-care and reflective practice.*

Q Hm: What is your greatest achievement?

A *LOB: Professionally – Winning the CHA Nurse of the year 2018. Can't get any better than that.*
Personally – a hole in one at my local golf course.
I play off a club handicap of 16.

Q Hm: What is on your bucket-list?

A *LOB: My Bucket list consists of playing golf in every continent. Mentoring up-and-coming nurse managers.*
Building a strong nursing workforce, nurses who are passionate about their patients' care.

Q Hm: What changes would you like to see achieved in health care?

A *LOB: Equity. That mental health care is treated as an equal for people with mental health issues. What I would really like to see in mental health nursing is for the stigma around psychiatric care to be removed. I know, through my work, that when people have cancer their loved ones visit with flowers and cards and embrace the patients, whereas when it comes to mental health, loved ones often stay away, and it can be a long recovery. I would love to see mental health treated equally.*

Hm

A vision for *birthing* on country

by Anthea Gellie / CHA Health Policy Project Officer

Imagine for a moment that you are a first time mother-to-be. You'll be separated from your partner and family 36 weeks into your pregnancy, flown away from your close-knit community to a city you are unfamiliar with, to give birth, not to return home for up to ten weeks? Now imagine you are the new father who will miss out on those crucial first weeks of your baby's life, unable to support your partner through the birth of your child.

Trish Farrant from Apunipima in training at a perinatal ultrasound course run by Mercy Health in Melbourne.

"Now I won't have to send patients to Cairns to get scans."

– Trish Farrant

This is sadly the reality facing Aboriginal and Torres Strait Islander families today living in remote Cape York communities. The nearest birthing suite is in Cairns, up to a thousand kilometres away from their homes and families. With no birthing facility in local communities, women over the age of 18 are obliged to fly down to Cairns at 36 weeks gestation, and are accommodated in motels for five weeks after they have their baby. These long periods of separation bring with them detrimental emotional, social, cultural, and financial costs[1,2]. Additionally, during the course of their pregnancy, Cape York women travel to Cairns for two to three days at a time for routine ultrasound scans.

Evacuation of antenatal patients to tertiary birth suites was put in place to ensure that labour complications could be managed safely. This has led to a decrease in mortality rate for infants of Aboriginal and Torres Strait Islander women. However, separation from family, financial stress while living in Cairns, and negotiating an unfamiliar urban environment are among the difficulties faced by women birthing away from community[3,4]. It has been suggested that this leads to lower rates of presentations for antenatal care, as this ultimately separates women from their support networks later in the pregnancy. Research conducted in Queensland showed that feelings of isolation and loneliness, poor social support and significant financial hardship have been reported among women giving birth pre-term in geographically distant sites from their homes[5].

1 Arnold, Joanna L., Caroline M. de Costa, and Paul W. Howat. "Timing of transfer for pregnant women from Queensland Cape York communities to Cairns for birthing." Medical Journal of Australia 190 (2009): 594-596.
2 Kruske, Sue, et al. "A retrospective, descriptive study of maternal and neonatal transfers, and clinical outcomes of a Primary Maternity Unit in rural Queensland, 2009–2011." Women and Birth 28.1 (2015): 30-39.
3 Arnold, de Costa and Howat, op.cit., pp. 594-596.
4 Chamberlain, M., Barclay, K., Kariminia, A., & Moyer, A. (2001). Aboriginal birth: psychosocial or physiological safety. Birth Issues.
5 Arnold, de Costa and Howat, op.cit., pp. 594-596.

In 2014-15, Apunipima Cape York Health Council[6] (Apunipima) developed and rolled out its 'Baby One' program (BOP) to improve access to consistent, culturally-safe maternal and child health services[7]. Apunipima has found that involving men in the early days of a child's life leads to greater father engagement. In research conducted in communities, supported by Apunipima, male focus group participants expressed concerns that the exclusion of the father at the birth of his child could establish an 'absent father' pattern. "Involvement from the start [will create] acknowledgement of family members... If [fathers are] involved, support will continue. Involve the man more." Comments from an Indigenous Health Worker participant included, "...the father's got to be a part of that thing from day one... it's like you want to be with your wife, your newborn, you've got to be a part of this child from the beginning"[8]. These findings have been supported elsewhere[9,10].

6 Apunipima Cape York Health Council (Apunipima) is a membership-based, community controlled Aboriginal Health Organisation responsible for delivering high-quality, culturally appropriate, comprehensive primary health care to 11 communities in Cape York, Queensland. Apunipima has grown from a small advocacy organisation to one of the largest ACCHOs in Queensland. With over 230 staff, five health care centres located across Cape York and now four wellbeing centres, Apunipima adheres to a family centred model of comprehensive primary health care which sees clients as people embedded in families and communities.
7 Campbell, S., McCalman, J., Redman-MacLaren, M., Canuto, K., Vine, K., Sewter, J., & McDonald, M. (2018). Implementing the Baby One Program: a qualitative evaluation of family-centred child health promotion in remote Australian Aboriginal communities. BMC Pregnancy and Childbirth, 18, 73. http://doi.org/10.1186/s12884-018-1711-7
8 Ibid
9 Wise, S., Soriano, G., & Berlyn, C. (2008). Engaging Fathers in Child and Family Services: Participation, Perceptions and Good Practice. Commonwealth of Australia Occasional Paper no. 22
10 Makusha, T. and Richter, L. (2018). Fathers need to get involved in the first 1000 days of their kids' lives. [online] The Conversation. Available at: https://theconversation.com/fathers-need-to-get-involved-in-the-first-1000-days-of-their-kids-lives-100779 [Accessed 27 Aug. 2018].

BIRTHING ON COUNTRY

The cultural significance of birthing on country to Aboriginal and Torres Strait Islander women is substantial, as evidenced in this quote from Jilpia Jappaljari Jones, a Walmadjari Traditional Owner:

"I begin by quoting my mother's words when I met her again in 1977: You been born here in this country and this land owns you and you come back any time. In my mother's time birthing was carried out in one's own country with all the rituals and traditions such as squatting over a prepared hole in the ground covered with soft grass and leaves as well as soft red sand. The female midwives, such as my grandmothers and other designated women, attended to give physical and emotional support such as holding and massage; this relieved the discomfort of labour. More particularly it removed fear, and fear is responsible for so many prolonged and complicated labours. Birth in our traditional society was always 'Women's Business'[11]."

COMMUNITY CARE ESSENTIAL

The CHA-Apunipima partnership is working to alleviate stressors for Aboriginal and Torres Strait Islander families being shuttled to Cairns for antenatal scans. Equipping midwives with the skills to perform routine scans in home communities will reduce the time pregnant women need to spend apart from their families and older children.

In May 2018, Apunipima midwife Trish Farrant flew to Melbourne to attend a perinatal ultrasound course run by Mercy Health, which gave her the skills to perform late-term ultrasound scans.

Trish is a passionate advocate for the remote-living maternity patients and families she sees at the Apunipima clinic 'Atharpuch' in Kowanyama. She explains how connected they are to family and to country, and the negative impact evacuations to Cairns have on families. "Imagine being told your husband and other children can't come down with you and that you have to go by yourself. Cairns can be a very daunting environment for patients from community."

"They could be leaving five or six older children behind," she adds. "If there is no grandmother or other family member to look after their older children and if the partner is working, this really becomes an issue. If you want to have your partner and children stay with you, you generally have to pay out of your own pocket, which many families living in community cannot afford to do," Trish says.

Weipa, a mining town in the Cape York Peninsula, used to have a birthing suite at their hospital, but funding arrangements for this and other "bush hospitals" were withdrawn.

11 Jones, J. N. (2011, June). Birthing: Aboriginal women. In National Native Title Conference (pp. 1-3).

A Crana study reported that, "A widely held view in the provision of maternity care services in rural Australia is that maternity units must have 24-hour on-site surgical and anaesthetic capability to be considered safe. However, workforce shortages, and a trend towards centralising health services to regional centres, has resulted in many rural maternity units being unable to sustain such capability[12]." Despite the Queensland government announcing plans for birthing services to be returned to Weipa by 2016[13], this has not eventuated.

Trish is determined to enable as many women as she can to stay in the community longer. She can now achieve this by providing routine scans for her patients at the hometown clinic. "Now I won't have to send patients to Cairns to get scans", she beams. "Now if I think – or anybody thinks – a baby is breach, I can perform an ultrasound examination on the spot for the patient. Before attending this course, I had to send all my patients down to Cairns."

Elizabeth Murdoch, the Program Director Ambulatory, Community & Allied Health Services at Mercy Health, was one of nine CHA member representatives who recently joined a HESTA-sponsored community visit to Kowanyama. "We spoke about potential solutions in the future, such as the possibility of using telehealth for these kinds of procedures. Trish emphasised the invaluable benefit of ongoing learning in managing her caseload of new mums."

"When I got home I promptly arranged a place for Trish at Mercy's very popular 'Global Obstetric Update'[14] in November 2018. It is our aim to continue exploring ways of working together, through our partnership and CHA's partnership with Apunipima, to support services in isolated regions such as this. As a pre-eminent site for maternity services, research and training, Mercy Health is well placed to provide this kind of expert support in maternity care."

Ultimately, Trish says, the vision would be for Aboriginal and Torres Strait Islander women to be able to birth on homelands. However, the prevalence of high-risk Indigenous births, due to the socio-economic disadvantages in remote communities and the ongoing impacts of colonisation[15], present challenges. Trish's answer to this problem is simple. "We need to work towards improving the health and social-emotional wellbeing outcomes for Aboriginal and Torres Strait Islander communities, so that the number of births assessed to be at a high risk of complications is lowered, and eventually eliminated."

Therein lies the foundation of Apunipima, established by the people of Cape York, to create and lead a health system that would improve the health and wellbeing of Indigenous families and to provide a comprehensive primary health care service, from 'cradle to grave'.

The CHA members, through the CHA-Apunipima partnership are currently working towards strengthening the workforce exchange program to build capacity where gaps are identified by the communities themselves.

PARTNERSHIP ENQUIRIES

Please contact Stephanie Panchision, CHA Senior Health Policy Advisor, or the CHA office on 02 6203 2777.

Hm

Separation from family, financial stress while living in Cairns, and negotiating an unfamiliar urban environment are among the difficulties faced by women birthing away from community.

The CHA-Apunipima partnership is providing training for Cape York health workers.

12 Kruske, Sue, et al, op.cit., pp.30-39.
13 Bateman, D. (2018). Birthing services expected to return to Weipa and other points in the Far North. [online] Cairnspost.com.au. Available at: https://www.cairnspost.com.au/lifestyle/birthing shyservices-expected-to-return-to-weipa-and-other-points-in-the-far-north/news-story/7f2c0e4568a38ac6c56beb39a1628da3 [Accessed 27 Aug. 2018].
14 For more information on Mercy Perinatal's Global Obstetric Update, please see this website: https://mercyperinatal.com/event/global-obstetric-update-2018
15 Kruske, Sue, et al, op.cit., pp.30-39.

Women's Healthcare: *One size does not fit all*

by Stephanie Panchision / CHA Senior Policy Officer

While there are examples of excellent practice, the healthcare needs specific to women are too often overlooked. Historically, most medical research was conducted in men and the findings from such studies were assumed to be equally applicable to women.

CHA Senior Policy Officer Stephanie Panchision explores gender difference in health, bias in healthcare, and how a much greater understanding is needed to provide better treatment for all.

How we define women's health is fundamental to how women engage with the health system as both consumers (users) and producers (carers) of services. Women's health involves a patient-centred approach that addresses the physical, mental, and emotional health of women that also takes into account their social interactions and cultural environment. Women's health is separate from general health and centred on recognising the diversity in experiences and influence of social factors as well as the reproductive health of women[1]. To develop a system that responds to the full scope of health for women, an approach is required that encompasses the range of variables and lived-experiences of women and how they intersect in order to understand health needs, conditions, and outcomes[2].

Historically, research and clinical trials were conducted by men, often at the direction of men. This evidence was used to develop teachings and methodology that was based on the experiences of one particular sex and applied to all patients[3]. Traditionally, the health system was dictated by men and the doctor-patient interactions were based on domination and subordination as an extension of society that was male-dominated.

More recently, it has been uncovered that there are differences in how men and women experience health and wellness that directly influence treatment and practice. Even though men and women experience the same conditions, they can do so with more frequency, present different symptoms, and produce different outcomes as a result of different risks and barriers to healthcare. Gender bias in the medical system exists in the management of pain between men and women where women are half as likely to receive painkillers undergoing a coronary bypass surgery and wait significantly longer to receive an analgesic for acute pain when compared to men[4]. A study in The New England Journal of Medicine found that women are seven times more likely to be discharged from a hospital during a heart attack because their symptoms differ from men and screening methods for heart attacks are based on studies of male physiology[5].

1 Johnstone, K., Brown, S., & Beaumont, M. (2001). Why Women's Health (rep.). Why Women's Health. Women's Health Victoria.
2 Sen, G., & Östlin, P. (2008). Gender inequity in health: why it exists and how we can change it. Global Public Health, 3(sup1), 1–12. http://doi.org/10.1080/17441690801900795
3 Miller, V. M., Rocca, W. A., & Faubion, S. S. (2015). Sex Differences Research, Precision Medicine, and the Future of Women's Health. Journal of Women's Health, 24(12), 969–971. http://doi.org/10.1089/jwh.2015.5498
4 Kiesel, L. (2017, October 7). Women and pain: Disparities in experience and treatment. Retrieved September 10, 2018, from https://www.health.harvard.edu/blog/women-and-pain-disparities-in-experience-and-treatment-2017100912562
5 Nabel, E. G. (2000). Coronary Heart Disease in Women – An Ounce of Prevention. New England Journal of Medicine, 343(8), 572–574. http://doi.org/10.1056/nejm200008243430809

Gender bias in the medical system exists in the management of pain.

Responding to the health needs of women requires a contemporary approach to address the complexities and experiences that impact on women's health. Researchers, policy-makers, and practitioners are recognising that women's health is not solely based on sex and gender, but is also influenced by socioeconomic status, education, age, geography, ethnicity, race, culture, and sexual orientation. Physical and economic barriers exist for women who may have less access to household resources or require more preventative reproductive services.

Often, women's health is used to encompass the physical health and status of reproductive functions and childrearing. While health programs and services are designed to address the very important and unique role that many women share in reproduction, they do not adequately address the many factors that disproportionately affect the health and wellbeing of women, such as violence, exploitation, and poverty[6]. Health experts are looking to broaden the definition of women's health to take into account the complexity of social life and environmental factors that impact the physical, mental, and emotional health. Intersectionality offers researchers and decision makers the opportunity to move beyond a singular approach to health by understanding the dynamics between multiple factors and engage in scholarship in a way that promotes an inclusive approach to reducing health disparities[7].

Health experts are looking to broaden the definition of women's health.

New research into systems of discrimination and disenfranchisement are helping to reshape conceptual frameworks to improve our understanding in how these systems overlap and influence each other. Intersectionality is an analytical framework that examines how multiple factors and identities overlap and are interwoven to illuminate the interacting social factors that create inequality and oppression. This approach is based on the premise that not all women share the same life experiences, and takes into account power dynamics that contribute to disparities[8]. While some criticize this approach as being too overly-complicated and relativistic to the point of being unachievable, some researchers and social scientists see this intersectional approach to women's health as an opportunity to analyse the complex nature of human interactions that expand our intellectual capacity for learning and building new methodologies.

Reproductive health and fertility rates can have enduring impacts on the future health of women and their families, as the UN recently reported that globally, women between the age of 20 and 34 are more likely to experience poverty than men.

This age disparity coincides with the peak reproductive age of women and can create lifelong impacts that limit a woman's education and earning potential that contribute to greater rates of disadvantage[9]. Extensive literature confirms that women's health is linked to long-term productivity and is associated with economic advantages and better societal development[10]. Countries that invest in comprehensive health services for women are more likely to have better health over-all and build a healthier more productive society.

Advances in new technologies are improving the ability to diagnose and treat conditions with the use of precision medicine using data about an individual's genetic and biochemical makeup. These predictive aspects allows tests and treatments to be targeted to a person's genes, lifestyle, and environment. This new form of individualized medicine has the potential to address conditions that are specific to women or manifest differently from men. Incorporating cross-sectoral specialities, new health programs are developing modalities that can identify cancers in women that are not normally detected using conventional methods. New precision techniques identify health disparities across minority groups and those at risk of certain conditions in order to institute preventative measures. The inclusion of sex chromosomes in genome-wide association studies will increase our understanding of the contributions human genetics has on health and disease. Sex-specific molecular pathways associated with age-related diseases help address the differences men and women face over time[11]. Whilst these new techniques often require a significant financial investment, using these innovative methods provides a more programmatic approach to understand how sex influences disease in the advancement of women's health.

To address the full range of health concerns facing women, we will need to better leverage new advances in technology as well understand how social and environmental factors overlap to influence health. In the future, research into women's health and concepts of sex and gender will need to be embedded in the practices and teachings used to train scientists and health care providers. Innovative concepts, models, and systems need to be developed to tackle the health inequalities experienced by women and translate into better patient care.

Hm

6 Digiacomo, M., Green, A., Rodrigues, E., Mulligan, K., & Davidson, P. M. (2015). Developing a gender-based approach to chronic conditions and women's health: a qualitative investigation of community-dwelling women and service provider perspectives. BMC Womens Health, 15(1). http://doi.org/10.1186/s12905-015-0264-4

7 Hankivsky, O., Reid, C., Cormier, R., Varcoe, C., Clark, N., Benoit, C., & Brotman, S. (2010). Exploring the promises of intersectionality for advancing womens health research. International Journal for Equity in Health, 9(1), 5. http://doi.org/10.1186/1475-9276-9-5

8 Hankivsky, O., & Cormier, R. (2009). Intersectionality: Moving Women's Health Research and Policy Forward. Vancouver: Women's Health Research Network. https://www.researchgate.net/publication/238733273

9 UN Women and the World Bank unveil new data analysis on women and poverty. (2017, November 9). Retrieved September 11, 2018, from http://www.unwomen.org/en/news/stories/2017/11/news-un women-and-the-world-bank-unveil-new-data-analysis-on-women and-poverty

10 Onarheim, K. H., Iversen, J. H., & Bloom, D. E. (2016). Economic Benefits of Investing in Women's Health: A Systematic Review. Plos One, 11(3). http://doi.org/10.1371/journal.pone.0150120t

11 Williamson, R., Anderson, W., Duckett, S.J., Frazer, IH., Hillyard, C., Kowal, E., Mattick, JS., McLean CA., North, KN., Turner, A., Addison, C., (2018). The Future of Precision Medicine in Australia. Report for the Australian Council of Learned Academies, www.acola.org.au.

Dr Louise Schaper

"The best way to reduce preventable errors is through access to accurate information."

— Dr Louise Schaper

Q&A

with Dr Louise Schaper

Head of Health Informatics Society of Australia (HISA), Dr Louise Schaper, is determined to take health care into the digital age. Twenty years ago, as an Occupational Therapy student making home visits with a bootful of garbled handwritten patient file notes, Louise couldn't grasp why allied health wasn't using computers to manage patient information. Today, 20 years on, she's asking the same questions.

Q Hm: You have audacious plans – how do you believe you can fix the health space with digital technology?

A *LS: Simple. Getting information into the hands of clinicians and patients to make informed decisions. Technology is the vehicle to enable that to happen, but healthcare is not doing it fast enough. Information is the lifeblood of healthcare and clinicians need accurate, easily accessible and useful information in order to do their jobs. At present that's not what's happening in many health services. The good news though is that change is afoot.*

Q Hm: You never received a pay cheque as an Occupational Therapist, what happened?

Time and time again I couldn't believe that the information I needed wasn't available to make informed decisions during my training. Immediately on completion of my degree I was offered a three month research project in telehealth and soon after I began research into technology acceptance issues in allied health. A PhD ensued and a month after handing it in, I found myself applying for the CEO role at HISA. I think I would have been a good OT, but my skills are better placed working at a strategic level to transform healthcare. I've always felt a responsibility to do what I can to have a positive impact on a large scale, to help as many people as I can.

Q Hm: What is the most mind blowing data that keeps you motivated to the cause?

A *LS: Preventable medical error is the third leading cause of death. We've always known it was high, but a 2016 study in the BMJ confirmed that in the US, 250K people die every year due to medical error. While the numbers wouldn't be that high in Australia, the trend would be very similar. Utilising technology to manage the information of healthcare won't completely eliminate those errors of course, but it will go a long way to addressing the issues. This is certainly one statistic that continues to drive my own career motivations.*

Q Hm: What are your biggest frustrations at the moment?

A *LS: Change doesn't happen fast enough. The research evidence and lessons learned are not being translated into change as quickly as they should be. We know that it takes around 18 years for a new medical procedure to become common practice.*

Streptokinase (clot buster in heart attacks) took 18 years from the publication of the paper to 'normal' daily use. And it's not just the time delay in getting research into practice, we also have a problem in that widely practiced medical procedures may be useless or even cause harm. A study which examined 10 years of medical papers published in the New England Journal of Medicine found that 40 percent of articles concluded that medical practice was no better or even worse than no action/intervention and 20 percent were inconclusive.

When change doesn't happen fast enough, people die. That's my biggest frustration.

Q Hm: What will we look back on and think 'I can't believe we argued or were so concerned about that?

A *LS: It's a common misconception that giving patients access to their own healthcare information will not be good for patients, and could lead to anxiety, therefore medical professionals need to 'curate' the process. However, research shows that being able to access their own information improves engagement and reduces anxiety, and that the majority of people feel informed and empowered. It also enhances the relationship and communication between the clinician and the patient. It surprises me that despite this being well known and published, a paternalistic view still often prevails that we should 'protect' patients, rather than engage them with their information.*

'OpenNotes' in the U.S started out as a research experiment giving patients full access to their healthcare records, not just a summary. Well, that experiment has turned into a movement, with 27.5 million people having full access to their clinical notes – and everyone loves it, the healthcare professionals and the patients. This is the way of the future and can't arrive soon enough!

Q Hm: What does the future of health look like in a digital context?

A *LS: Firstly, there will likely be vastly different funding models. The status quo doesn't work for patients or clinicians and it certainly doesn't work for the national budget. It is unsustainable to continue with the status quo of healthcare funding, but the future doesn't mean less or poorer quality healthcare as a result. Eliminating the waste, the duplicate tests, the unnecessary procedures that don't provide any evidence of benefit will save the system millions.*

Other changes I foresee – significant changes will be made to enable people to stay in their own homes for longer, and more money will be provided for prevention.

"Change doesn't happen fast enough... it takes around 18 years for a new medical procedure to become common practice."

— Dr Louise Schaper

New players will enter the market place. Technology companies will emerge and morph themselves into healthcare companies. Companies such as Google are priming for this. An example is that instead of just giving us search results when we look up symptoms for diabetes, Google could suggest we speak with a diabetes educator via video chat with a Google clinician, probably for free. We could see in the not too distant future where healthcare professionals are employed by tech companies, and while that could be great news for patients who could have 24/7 access to clinicians, and clinicians who could work from home providing online care, this would be a challenge for traditional healthcare providers who will face even more competition for staff.

There will also be a shift in power dynamics towards the patient. Developments around genomic sequencing, personalised healthcare and precision medicine will also radically change how we practice healthcare – it's going to be fascinating!

Q Hm: What main areas do healthcare providers need to open their minds to?

A *LS: My best advice is not to have a closed mind about any opportunities to change healthcare for the better. Scepticism and applying critical (and clinical) reasoning are important skills healthcare providers have, which when applied to opportunities for change, enables healthcare providers to be leaders in the change process. Change leadership is important for all clinicians to ensure they are out in front of change, bringing others along for the journey and also ensuring that the problems we're trying to solve are paramount ie you should be sceptical of anyone who has a technology looking for a problem. Always start with the problem you're trying to solve to work out the best solutions for addressing it.*

Q Hm: Where can the biggest gains be made in quality and safety and patient centred care?

A *LS: To have medical error taken off the list of top 10 causes of death. It's not simple, but something worthwhile never is. The best way to reduce preventable errors is through access to accurate information. Not a single reader of Health Matters would not be motivated by improving quality of life and care.*

Looking back with Richard Gray

by Richard Gray / CHA Senior Aged Care Advisor

"On looking back over my 27 years in aged care with 22 of them being with CHA, I have been impressed with the quality and commitment of the Catholic aged care sector to the reforms."

— Richard Gray

Catholic Health Australia's Richard Gray, at 80 years of age, retired at the end of August having dedicated more than 22 years with CHA, firstly as Director Aged Care Services and in latter years, Senior Aged Care Advisor. Here he has penned his last article for Health Matters and takes the opportunity to look back at his 27 years immersed in peak body aged care advocacy in Canberra.

In the Spring of 1991, I strolled into the office of Aged Care Australia (now ACSA) as the organisation's first fulltime CEO to join two other employees. One of the first peak body colleagues I met was Chris Rigby, the CEO of ACHA, the Australian Catholic Healthcare Association (now CHA).

Chris and I shared concerns over the then Minister for Aged Care's plans to legislate for the introduction of a compulsory residents' agreement in nursing homes. The agreement was to force nursing homes to allow residents their doctor of choice. CHA members were concerned about the consequences of euthanasia becoming legalised. Together with ACSA we succeeded in removing the mandate from the agreement.

Residential aged care comprised nursing homes and hostels. Each had distinctly different policy origins. Nursing homes came from a health policy perspective with Commonwealth funding commencing with the introduction of nursing home benefits in 1963.

Hostels came from a welfare policy approach with the first federal government foray into aged care being the *Aged Persons Homes Act 1954*, which allowed for a capital subsidy for approved not-for-profit organisations to provide self-contained hostel accommodation[1].

IN HOME SUPPORT

In 1992, the Commonwealth Government funded more intensive care services for older people living at home through the introduction of Community Aged Care Packages (CACPs) and again in 1998 with Extended Aged Care at Home (EACH) and EACH Dementia packages.

The policy and funding arrangements for nursing home and hostels created inequalities. Hostel buildings were newer and of reasonable quality, owing to the availability of capital funding through capital subsidies, variable fees and entry contributions. In contrast nursing home buildings were generally older and of lower quality, due mainly to constraints on nursing home income that limited the ability of providers to invest in new building stock and in capital regeneration[2].

In 1994, ANU Professor Bob Gregory highlighted the existence of the capital problem in the nursing home industry in his report, *Review of the Structure of Nursing Home Funding Arrangements Stage 2*. He identified a large backlog of capital expenditure requirements due to deferment of refurbishment expenditures in the past.

As nursing homes were not allowed to charge variable fees nor entry contributions, and the CAM and SAM funding arrangements did not provide an adequate return on investment for capital regeneration, over the 10 years of the aged care reform strategy there was a continuing decline in the quality of nursing home stock. The aged care reform strategy had basically run its course when there was a change in government from Labor to the Coalition in March 1996.

In the year leading up to that election, I had been arguing for a change in the way residential aged care was funded. I advised the Shadow Minister for Health and Aged Care, Michael Woodridge that nursing homes and hostels should be treated equally, as residential aged care, under the same subsidy and fee arrangements. Also that there was a need for independent quality management oversight to replace the discredited Standards Monitoring System.

AGED CARE BILL 1997

Coinciding with the change in Government I left ACSA and joined CHA which meant that I was able to represent CHA on the Government's consultative committees for the implementation of the new aged care policies including the drawing up of the *Aged Care Bill 1997* (the Bill) and the creation of the Aged Care Standards and Accreditation Agency.

The Bill was stalled in the Democrat controlled Senate at the last week in June 1997, the last opportunity to pass the legislation in time for its October 1 commencement. CHA CEO, Francis Sullivan, myself and Uniting Care Australia CEO, Libby Davies, spent that last weekend of June negotiating final amendments to the Bill with Aged Care Minister, Judi Moylan, Prime Minister Howard's office, and the Democrats. The amended Bill was duly passed in both Houses during that final week.

The second wave of reform commenced through the introduction of the *Aged Care Act 1997* (the Act). This brought nursing homes and hostels together under the same Act with a single Resident Classification Scale (RCS) determining the government subsidy for residents in either high or low care. In March 2008 the RCS was replaced by the Aged Care Funding Instrument (ACFI).

The Act also introduced;

- income testing of recurrent subsidies thus requiring those with means to contribute to the cost of their care;
- accreditation of residential services based on legislated standards;
- improved complaints resolution processes; and
- certification of building standards.

Entry payments, subject to an assets test, were also permitted for persons entering all residential care, for the first time allowing providers to charge an entry contribution for access to nursing home care.

LUMP SUM ENTRY ABANDONED

CHA led a sustained media campaign that exposed a move by the Federal Government to introduce a 'contribution' for entry into a nursing home, which would require the pensioner to sell the family home. The Government abandoned the 'lump sum' entry contribution for a high care nursing home and substituted it with a daily accommodation charge (still subject to an assets test) of up to $12 per day.

Accreditation of residential services replaced the former Standards Monitoring of nursing homes and commenced late 1999. All 3,050 residential aged care services were required to be accredited for one to three years by 1 January 2001 to be able to retain care subsidy payments.

Richard Gray retires after 27 years of advocacy for providers and consumers of aged care services.

1 Gibson, Diane, 1998. Aged care: old policies, new problems. Cambridge University Press.

2 Gray, Richard, 1999. The Third Wave of Aged Care Reform, Health Matters, October & December 1999.