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PARTNERSHIPS WITH CONSUMERS

good practice, good business, good policy

August 2016

INTRODUCTION

This report has been prepared by NAB Health to give some insight into the changing face of the health sector in Australia.

As Australia's leading financial institution for health, we have a large number of specialist health bankers spread across the country. Our aim is to truly support the health sector by enabling financial sustainability as well as ensuring a prosperous and healthy community.

This report looks into the growing trends of digitisation and how that is driving deeper partnerships with consumers. It is based on insights from industry experts, clients, NAB Health's analysts, plus key strategy executives representing practitioners, pharmacists, and corporate health.

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THE CHANGING *face of health*

Deeper partnerships with consumers

The extent to which the Medicare campaign resonated among voters during the recent Federal election highlights how important access to the health system is to Australians. However, 'the system' is not one giant monolith. It is made up of people – including consumers, practitioners, managers, and business owners – who interact with each other from within a variety of infrastructures. This makes assessing our health sector's challenges, and finding workable solutions, a very complex task.

Two related trends that are impacting treatment and business models across all areas of the sector are digitisation and consumer enablement. With people becoming more engaged with their health via wearable devices and easily accessible information, the relationship they want with their health practitioners and institutions is changing. The challenge for us as an industry is how to harness these newly engaged consumers to achieve better health outcomes cost effectively.

The economics of health – bottomless pit or mountain of opportunity?

NAB Chief Economist, Alan Oster, points out that the health system is often portrayed as a bottomless pit of expenditure. "The media latches onto the public system, which is taking around 25 percent of our national tax dollars. What isn't publicised is that our private health sector is outperforming in annual turnover and employment growth."

Oster adds that analysing where growth is occurring forms part of the health survey NAB is currently undertaking. "It should help break down where better outcomes are being generated and the areas taking up more of our resources."

"We also want to provide another 'voice' for the sector to help ensure areas of practitioner concern are given prominence and to help promote further growth in this critically important part of the economy."

NAB Health General Manager, Cameron Fuller, notes that we're going to have fewer people supporting more expenditure. "Unless there is a radical change in older Australians working longer, that imbalance is going to cause a problem in public health funding."

Fuller adds that the outlook for the private health sector is slightly different. "Personal health spending is growing faster than average incomes. This is telling us that health is a priority for people. If you've got a sick child, you'll mortgage your house to get them the treatment they need. People are also more committed to preventative health measures."

Oster agrees, adding that health operates differently to other spending sectors. "At the moment, while people are not willing to buy a new television, they will spend on what they think they need. And health is high on that list."

He adds that maintaining or growing that spend is a delicate balancing act. "If you charge them too much, whether doctors' fees or health insurance, they exit and go direct to the public sector."

Partnering for improved outcomes and reduced costs

Fuller notes that harnessing consumers' eagerness to be involved in their health outcomes is already impacting positively on care delivery and costs. "People increasingly want to work with their practitioners to improve their health outcomes and stay out of hospital – where incidentally, the major health costs occur," he explains. "With an asthmatic child, for example, the whole idea is to work with the patient and their family to keep the child out of the acute sector and living as normal a life as possible."

To work, this partnership implies a more equal relationship. "This is what we are starting to see," says Barbara Carney, Director and Health Policy Specialist at Canberra strategic advisory firm Carney Associates.

She explains that a benefit of this improved engagement between doctors and patients is increased transparency in the healthcare system, where the need of the patient is more clearly defined. "It requires broad consumer consultation with all participants if we are to create a more appropriate and flexible system going forward."

Carney points to the expanded services and interaction with patients that pharmacists now prioritise as positive examples. "These partnerships are driving further improvement to patients' lives and addressing the cost challenges of our current system." She further notes that creating a climate in which true patient partnering is possible has another huge benefit: "Having control is a really important part of people's mental and physical health."

Overcoming the challenges to better partnerships

The Commonwealth's share of spending on public hospitals has declined to just under 33 percent, down from about 40 percent over the past decade. The challenge for government has always been how to reconcile the interests of providers and patients – from a legal, cost and outcome perspective. "The plan going forward needs to address rising costs and deliver better health outcomes at the same time. It's a tough call for any government," admits Fuller. "But there are some obvious quick wins. Systems like My Health Record and the new Australian Digital Health Agency are already dismantling the information silos blocking effective partnering."

Fuller acknowledges that, as with any change, there are short-term barriers to overcome. "But digital innovators are breaking them down and creating what consumers and business are demanding. However, the un-connectedness of data remains a major problem," he says.

Acting CEO to the new Australian Digital Health Agency (ADHA), Richard Royle, is realistic about how better connectivity and, therefore, better partnerships with consumers can be achieved. He acknowledges that digitising the health system depends on government funding. "If you look at how the US rolled out hospital electronic medical records (EMRs), [President Barak] Obama's Meaningful Use legislation balanced financial carrots and sticks to encourage hospital operators to install them quickly. The US government gave financial carrots in the shape of capital grants to hospitals. The stick was that if you didn't install EMRs by a certain date, you would be penalised with reduced Medicare payments. And it worked," says Royle.

Fuller says that the current payment system is another area that is very clunky, inefficient and costly. "Patients recognise it's extremely cumbersome. They can have three or more separate bills from a hospital procedure – the hospital, anaesthetist and surgeon to start with. Technology can improve that, and certainly the bank has ways to facilitate it. However, the real challenge is implementing an integrated payment system across Medicare."

Light at the end of the tunnel

Carney does not see competition for the government health dollar reducing. She also believes the economic changes that accompany digitisation will affect how practitioners work and earn their income. "I think the business model is going to have to change fairly rapidly and focus on the quality care provided by the doctor for the patient rather than 100 percent fee for service."

Carney looks to the way community pharmacies have proactively redefined their role. "Pharmacists now focus on their relationship with patients and how they can support their care."

She argues that doctors, particularly general practitioners (GPs), also need to switch their focus to the entire patient experience, thereby reducing the resulting costs. "The

way to constrain costs is to actually keep people out of the most expensive part of the system, which is the hospital system." However, to enable this we need to offer them an appropriate financial reward, says Carney. "Moving from providing a service against a number when someone is sick to rewarding doctors for keeping people well requires a different kind of payment system," she says.

She adds: "Many doctors see the Medicare fee freeze as an example of the way in which a government can reap easy savings from the system, without apparently giving thought to how that system can work better. This sends a message that there isn't a real desire to create the environment of trust that is essential for successful partnering," notes Carney.

"We need a rigorous, completely non-partisan consultation about what our payment and delivery system should look like going forward. It has to involve the whole industry, including doctors at all stages of their careers."

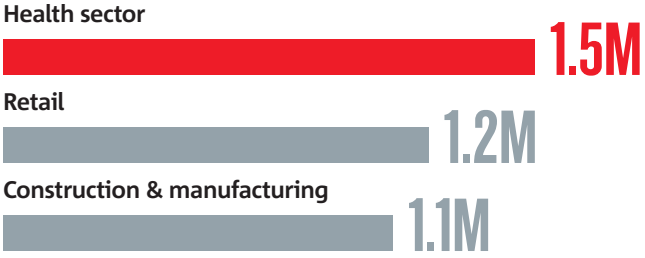
Fuller thinks that the positive health cycle of increasing consumer awareness, brought about by technological advances and the power of the internet and social media, has led to a dramatic shift in relationships that could also help contain soaring health costs. "Increases in diagnostic capabilities have led to earlier interventions and better clinical outcomes. Effective partnerships between clinicians and consumers have the potential to build on these advances to keep us living longer and staying actively engaged socially and economically for much longer. That can only be for the national good."

Australian jobs growth, March 2008-2016

Health and Social Services	**+458,000**
Manufacturing	-174,000

1.3 million jobs added nationally 2008-2016.
25% in health and social services.

Australian jobs in the health sector – compared to other key industry sectors 2016



Total Australian health expenditure as a proportion of GDP	1989-90	2013-14
Australian Institute of Health and Welfare (AIHW)	6.5% of GDP	9.7% of GDP

Source: Health expenditure includes: Australian, state and territory government expenditure; consumers; private health; insurers and accident compensation schemes.

Commonwealth health costs 2014-2015 FY*

Medicare	**$20.3 billion**
Pharmaceutical Benefits Scheme	**$9.1 billion**
Private Health Insurance rebate	**$5.6 billion**

Total Commonwealth health costs for the 2014-2015 FY represent **81%** of the **$43.3 billion budget** for the Department of Health and Ageing.

Source: Department of Health and Ageing, Annual Report for 2014-15, published October 2015

Pressures on Commonwealth health policy

1. **People aged 65+ cost the most**
2. **Fewer 15-65 year-olds working and paying tax**
3. **Corporations want to pay less tax**

Source: Intergenerational Report, Commonwealth Department of Treasury, 2015

MAXIMISING THE eHEALTH *revolution*

We are constantly encouraged to take more responsibility for our health and the rapidly increasing sophistication of wearable apps and digital technology in general is helping us do just that. Increasingly, the significant amounts of digital technology data already being provided to individuals is also being used by their doctors. People with chronic diseases such as asthma, diabetes and some cardiac conditions are already relying on wearable devices, at home monitoring and the national My Health Record platform to manage their conditions.

Although still cautious, practitioners generally welcome the fact that the digital health agenda is consumer driven. ADHA's Royle, formerly CEO of Hervey Bay's St Stephen's Digital Hospital, believes that eHealth will give consumers a lot more knowledge and power. "They will be better able to judge a doctor's quality of outcome and have access to their own data to understand what's driving their condition."

However, Royle emphasises that cultural change management for both practitioners and patients is critical to the adoption process. "Patients will become less passive, but they are going to have to be educated around what their data means. Clinicians, meanwhile, have to change how they respond to more informed patients," he says.

Head of the Primary Health Care Advisory Group (PHCAG) and ex-AMA President, Steve Hambleton, agrees. He points out that health is being hugely disrupted by information equalisation and distribution. Looking at how overseas systems have benefited from that disruption, Hambleton notes that nearly all high performance primary health care systems had patient engagement as their first initiative. "It's more than just keeping the patient informed. It's about recognising that engaging patients in their own care is an untapped opportunity to get better outcomes and reduce costs."

> "We need a lot of education and training for new and existing clinicians as well as patients. eHealth is a change management issue. Whatever happens in the digital space, successful adoption relies on how well you get practitioners on board."
>
> **Richard Royle, Acting CEO, Australian Digital Health Agency**

Managing Dr Google and information overload

As AMA president, Hambleton was continuously asked about patients using 'Dr Google'. "We know patients do it. They are not going to stop. I advise them to first get the diagnosis from their GP or specialist and then google all they like. But I direct them to sites that are trustworthy and informative."

Hambleton is also honest with his patients about his limitations as a GP – it is his job to know a little about a lot of things. He doesn't have a problem with patients attempting to know everything about their disease and is happy to talk about treatment options they may have found online. "I think there is a cultural change required. When I graduated there was still doctor knows best – a 'this is what you have and I'll tell you what to do' attitude. That's changed for the better."

Now, Hambleton finds that many of his IT-savvy patients, across all age groups, are already accessing their data on the national My Health Record platform. He encourages it and believes a wider use of My Health Record will lead to fertile ground for innovators to start making the information more patient friendly and useful in their condition management.

Royle agrees, adding that ADHA is setting up clinical and consumer engagement, and innovation and development, departments for that very reason. They want to encourage digital innovators in the health space to work in conjunction with doctors and patients on new digital health solutions. "My Health Record has the potential to become a great partnering tool between patients and practitioners. Every Australian already has a health identifying number. If they have an active My Health Record they will be able to go to their GP, specialist or emergency department and up will come their medical history, their current medications, hospital discharge information and soon their pathology results and X-rays. The more apps and measurement devices that can add data to it, the better."

Improving rural outcomes through patient enablement

The stage is set for eHealth, and My Health Record in particular, to revolutionise rural and remote health outcomes. Hambleton explains how it has worked for remote patients in the Northern Territory already. "Practices with high workloads of patients with chronic renal failure, such as Aboriginal Community Controlled Health Services, have been routinely measuring and weighing their patients for some time, and, with the patient's permission, uploading the information automatically at the end of the consultation," explains Royle.

"The advantage for a renal unit when assessing those same patients is in knowing immediately that there has been a significant change in their weight in a short period of time. For example, if you know they were five kilos lighter two weeks ago at their primary care practice, it is highly likely that they have fluid overload right now. That basic information can be the difference between treating someone quickly in the community or that patient ending up as an avoidable hospital admission."

> "Internationally, you see that the really successful health technology applications have been worked on in conjunction with recognised doctors who are respected in their professional disciplines."
>
> **Richard Royle, Acting CEO, Australian Digital Health Agency**

Opportunities and hurdles to eHealth implementation

Royle is pragmatic about funding the digitisation of the national health system. While the national eHealth agenda has guaranteed funding of around $160 million over the next two financial years, Royle understands there is a balancing act involved.

"On the one hand there is no time to waste, but to show this investment is worthwhile, we need to identify some quick wins for the Australian public and politicians. Remote monitoring of chronic conditions, for example, is growing. We have to get it into the main stream market and validate it as a health aid and in terms of costs and savings."

On the other hand, Royle's experience at St Stephen's taught him there is one issue that cannot be rushed – the time it takes to ensure the 100 percent accuracy of whatever you bring to market. "After all, you're talking about people's lives," he says.

Perhaps the most serious hurdle to eHealth implementation is information silos. "There is no agreement in this country on software interoperability. That means the systems, and data, don't talk to one another," says Royle. Fortunately, the new ADHA has the capacity to set and enforce standards for interoperability which will make more information available to more people – always with patient permission.

For Hambleton, the obvious place to start is engaging patients and getting them to use the technology available to them. They've already got their smart phones and wearable devices, he points out. "Why don't we bring them into the health system instead of having them set off to one side? I think that patient activation and ad-hoc opportunities are where innovation happens."

Hambleton is excited by the reforms to health care that digital technologies can bring. "Digitisation is a positive way to reduce the rate of increase in health spending – by cutting down on those avoidable hospital admissions (one every two minutes in Australia). It can improve information sharing and help with our ability to benchmark performance, which is particularly difficult in primary care in Australia."

> National infrastructure utilisation it really comes back to improved software that more easily integrates with the My Health Record while fitting into clinic workflow."
>
> **Steve Hambleton, Head of the Primary Health Care Advisory Group**

Government and practitioners agree that the primary beneficiary of eHealth is going to be the patient. However, Hambleton notes that with more and more data becoming available there is a risk of information overload, or chaos. That can be very daunting to both the providers and patients.

Nevertheless, with increasing computing power, innovators are becoming capable of distilling those large volumes of data. It will be possible to distil very useful information so practitioners can make better decisions and even represent the same information directly to the patient in a patient friendly way that will be empowering and doubly beneficial.

Hambleton acknowledges that many practitioners are uncomfortable with the change in the balance of power that information access has and will generate. There is still anxiety around medical record access and ownership. "But when you look internationally at studies in organisations that routinely share their records with their patients, they have consistently found that patients being more involved in their care is a good thing."

Business models for patient enabled health care

The Primary Health Care Advisory Group (PHCAG) recently looked at the best practice models of chronic disease care in Australia and overseas. They discovered that Australia's fee for service model is actually in conflict with the 'enabled patient' model of chronic disease care.

Says Hambleton: "There is no rebate in Australia unless you actually see the doctor in real time. If you want to phone, email or Skype your doctor, or even just get advice from the practice nurse, you can't do it because there is no funding model for that type of interaction." There is also insufficient support to properly include allied health professionals in the health care team so there is underutilisation of their services.

The PHCAG would like to see a different funding model that also supports non-face-to-face care. "Patients should be able to call, text or email that they've seen the specialist and had the planned blood test," says Hambleton. "You could see that their blood tests were in range and the data uploaded from their health app showed that they were exercising and even that their home blood pressure and blood sugar readings were okay. That person really only needs a repeat script, not another visit."

Hambleton's frustration is clear when he describes how, at the moment, to get a rebate, patients have to book in face-to-face time for things like repeat prescriptions – maybe even days away – taking up precious time that could be better spent with someone who needed extra care. He points out that a text or email could help answer a simple health question without having to drag the person down to the surgery. In certain circumstances, it could even be enough to keep that person out of an emergency department.

Hambleton acknowledges that although Australia does spend a lot of money in primary health care, it is not where the major cost or the cost savings will occur. "What we are trying to do is utilise the digital technology to underpin a model of care to empower patients and practices in the primary care space and reduce the reliance on acute care. It is acute care – that is, 'in hospital care' – which costs the big money. That means anything primary care can do to lessen its occurrence by keeping people healthier is a win-win for everyone involved."

Royle agrees but warns that health care in Australia is way behind in terms of digital disruption. "We are going to have a sudden technical and cultural leap as a result, which means a lot of educating for all of us."

> "We need to engage patients and their carers and involve them in decisions around their health and wellbeing. With 15 million smartphones in use in Australia and 30% [of people] using or intending to use wearable devices, getting them to use the technology they've already got is one way to do that."
>
> **Steve Hambleton, Head of the Primary Health Care Advisory Group**

SUPPORTING BETTER PRACTITIONER RELATIONSHIPS *with patients*

For doctors, partnering with patients has always been a fundamental principal. "Good doctors are those who involve the patient in decisions about their management," says newly elected President of the Australian Medical Association (AMA) Michael Gannon. "Overall, access to information is a very healthy thing for patients and it has reduced the power imbalance that existed. But doctors still need to make time to explain things and answer questions."

Gannon admits, however, that many doctors do get frustrated when patients equate 20 minutes of Wikipedia research with the years of training and experience their doctor is drawing on. "It can be distressing when they decide to follow advice from those ill-informed sources," he adds. But more worrying still for Gannon and the AMA is that our health system is not set up to encourage the effective patient relationships that could help stop this occurring.

Time: the biggest hurdle to building an environment of trust

"Time and money are the really big issues around partnering with patients," Gannon notes. "Answering people's questions and explaining your reasons for electing a treatment option takes time. Doctors working within the public system have a few minutes to do what might need an hour if done thoroughly."

Lack of time to explain things properly means doctors are often unable to address another common issue with patients – fear. "Doctors could be better at understanding how afraid patients are when facing surgery, receiving a chronic disease diagnosis or having a series of investigations," says Gannon. "Because we do these things every day, we can underestimate how scared and concerned patients and their loved ones are. Fear is at the root of many of the questions patients ask and some of the decisions they make."

Lack of time is one of the issues that propels the AMA to advocate loudly and often for lifting the freeze on patient rebates. "A standard GP consultation is sitting at about half the AMA fee," explains Gannon. "If a GP chooses to accept the bulk billing rate, they need to see a certain number of patients in an hour to keep their business afloat. That reduces the time they have with patients to ten minutes or under. Sadly, that limits the ability to inform and answer questions. Basically, it stops an environment of trust from forming."

General Practitioners account for just 6% of Australia's total **health budget**

Gannon also cautions against the trend of fragmented care. "These ideas appeal to governments and allied health practitioners, but it often means the patient loses a totality of care," he says. "Doctors are trained to be diagnosticians and consider the whole suite of options. There are a lot of things that don't require prescriptions or pharmaceuticals. There are a lot of things that don't require anything more than reassurance."

Gannon argues that Australia has made a huge mistake in underinvesting in GPs over the last couple of decades. "They provide enormous value for money but only comprise 6 percent of the total health budget. A bigger investment in GPs would result in greater savings in hospital admissions."

Rewarding excellence of care

The AMA views blended payment systems as a solution to these pressures. "We have a system where you get paid more for seeing someone every week rather than making them sufficiently healthy so you only see them every six months," notes Gannon. While the AMA wants to reward doctors for their hard work, it also acknowledges that an open conversation is needed on the efficiency of the current primary care payment model. Gannon suggests looking at a range of health conditions that are more cost effectively managed in the private system. "There, part of a fee is based on excellence of care, another portion is fee for service. Blended payments, where we reward GPs for better outcomes, need closer examination. I view it as a priority," he says.

The future is digital

Gannon is adamant that My Health Record is the future. He believes it will enable partnering with patients and drive better health outcomes. Gannon points out that we have already invested well over $1 billion and the system is still not widely used – but it's worth it. "Although it is a long way from perfect, the current reality of individual paper records sitting in as many as six different hospitals is a worse scenario." He does add, however, that we need to get the interface working. "With test results communicated instantly, we'll soon start seeing a reduction in medication errors, complications and duplications."

Systematic acceptance and use of My Health Record involves getting GPs and hospitals on board. Gannon acknowledges that the AMA has had concerns over the patient controlled aspects of the record, specifically its ability to delete important clinical information. He points out that these privacy concerns need to be addressed to benefit everyone.

Experience has taught that the successful implementation of any digital health strategy relies on bringing practitioners along with it. "At Hervey Bay, we learnt that the only way to get eHealth universally accepted was by ensuring practitioners felt that they were part of the innovation, rather than it being imposed on them."

Royle emphasises that the implementation of any innovation – whether technology or patient driven – is a change management issue. Successful implementations around the world have always been developed in conjunction with recognised doctors who are respected in their professional disciplines. "The manner in which this occurs is just as important as the development of the technology itself."

He notes that it was such an approach that drove the successful transition to full medical record digitisation at Brisbane's Princess Alexandria Hospital. "Digitisation is a very big cultural leap; it's an enormous piece around education and training. We need to deal with it in tertiary settings where we formally train both new and existing health practitioners."

Managing the multi-faceted digitisation of health

CEO of Medfin and Head of Practitioner Segment, NAB Health Paul Freeman sees technology that provides a better interface between patients and practitioners as a growing area. "I think there is a great deal of potential for putting power in the hands of the consumer or patient."

While Freeman acknowledges that most recent innovations are confined to how people manage their fitness and diet objectives, he notes that there is a lot of strategic thinking around their development. "I think we're not far from having a much greater level of integration, including self-monitoring of key basic health markers like activity, diet, sleep and blood pressure."

What he hasn't seen yet, adds Freeman, is a working bridge that feeds app data directly to doctors. "Doctors need to capture that data and see it on a screen in front of them in a way that is useful. The patient handing over their phone isn't going to add a lot."

Trust, privacy and control of data between patient and practitioners

Like Gannon and Royle, Freeman recognises that there is work to do on the issue of trust around data sharing between a practitioner and patient. "It has to be sensitively managed. There is still some way to go, but most of the practitioners I speak to embrace digitisation. Ultimately, it makes delivering excellence of care a lot easier. You get much better patient outcomes when both partners know more and it's accurate," he explains.

> "There are interesting ethical questions around who owns the patient's data – patients, doctors or the app developers?"
>
> **Paul Freeman, CEO of Medfin and Head of Practitioner Segment, NAB Health**

Catering to patient demand: the rise of super clinics

In addition to app development and universal My Health Record implementation, Freeman is seeing the evolution of other innovations to support patient-practitioner relationships. "We're seeing more capable practice management systems that really help manage work flow, track patient data and foster better engagement with patients." Although the initial focus is around management efficiency, practitioners will start using the improved connectivity to build better patient relationships that foster loyalty and attract new clients through word of mouth.

The ongoing convergence and corporatisation of practices is also delivering more patient-centred care. "We are getting more and more corporate players in the clinician space. They are disciplined around business and operational efficiencies and are creating one-stop integrated medical centres, particularly in the outer suburbs of cities." Freeman notes that there are interesting corporate structures and partnership options emerging in this space. Practitioners who hadn't set eyes on a balance sheet until well after medical school have to increasingly manage sophisticated business structures – or join a corporate entity, such as a medical centre, that takes care of the business side for them.

"Everyone is time poor and we're not hearing stories of significant increases in remote consultations yet. So we still need a place to go. If that place has a range of clinicians in one convenient spot with good parking out the front, life is easier for everyone," he says.

Increasing competition is leading to some interesting entrepreneurial-style adaptations that focus on providing a better patient experience. "In the dental space, we're seeing practices that have done away with the conventional waiting room fitout. It's a more stylish, relaxing space with streamlined payment options to match. It transforms your experience of going to the dentist."

Meeting the challenges head on

Clinicians are responding to patient demands in a variety of ways. From addressing the practicalities of surviving as a business to adjusting to the changes brought about by technology, they are faced with a raft of challenges that are often not supported by the current systems.

Gannon reiterates that there is nothing for clinicians to fear from patients making informed decisions about their health and treatment options. What it does require are systems and infrastructure that support these new relationships. "When we have that, then partnering with patients will happen on a much more significant level."

COMMUNITY PHARMACISTS AT THE CENTRE OF *consumer-centred care*

The role of the pharmacist is changing rapidly. Driven by the government focus on a better use of allied health professionals to deliver consumer-centred care that improves health outcomes and delivers health savings, pharmacists have found themselves at the cutting edge of a new way of delivering care – and it's one they are embracing.

Pharmaceutical Society of Australia CEO Lance Emerson views the community pharmacy network, which we tend to take for granted, as a real gem of the Australian health system, partly because of its dedication to consumer-centred care.

"I think partnering with consumers is well understood by pharmacists. It's really about us being responsive and understanding the consumer's needs." Emerson notes that while pharmacists have to ensure their service is empathetic and respectful, "they also provide the health information the consumer, their carers, and family require to assist the consumer manage their condition."

Head of NAB Health Pharmacy Division, Paul Littleton, agrees that pharmacists play a critical, frontline role in health care. "People spend more time going to their pharmacist than their doctors. That places community pharmacists at the centre of Australian health care."

Evidence-based models from overseas and within Australia

While partnering with consumers is new to the Australian health scene, it has been successfully implemented internationally for some time. The upside of this is that there is a lot of evidence around the outcomes of different systems. That makes it easier for Australia to create its own best practice model. Explains Emerson: "We know that partnering with consumers is better for consumer health. We've also seen how it results in better medication management and safety – which, as well as dramatically improving consumer health, also reduces costs for the health system."

The PSA has been running its own Health Destination Pharmacy program for a number of years. It helps community pharmacies adjust their service and business model to provide consumer-centred care.

In addition, the PSA has been working on placement of pharmacists in General Practice surgeries, with around 30 pharmacists placed within surgeries in Australia to date. Emerson explains that the UK's local council funded My Care Pharmacy model has significantly improved a number of consumer outcomes in diabetes, asthma and medication management, among others. "We also see improvements in relationships and collaboration between local health practitioners and community pharmacies. This model is a win for consumers, for general practices, for community pharmacies and for the health system."

Littleton describes how he had the importance of this care model driven home to him quite recently. "Australia is faced with a lot of emerging health challenges that pharmacies are really well positioned to support – obesity, mental health, bone density and smoking are all examples."

Littleton experienced the system first hand on a very personal level when one of his daughters was diagnosed with Type 1 diabetes. He found the relationship with their pharmacist to be critical. "The support offered to my daughter by our local medical community was first class. However, the relationship with our local community pharmacist has been the most regular and plays a central role in her day-to-day care."

Adds Littleton: "The trust involved – and how comfortable my daughter feels knowing she gets that regular support about medication, her new pump, how she's feeling emotionally – it just epitomises the role of community pharmacies."

Creating a real-time national My Health Record platform

Pharmacists are strong supporters of the My Health Record. As the medication experts in the health system, they have an important and collaborative role to play in its development, implementation and effectiveness. "We know the incidence of death and harm resulting from inappropriate use of medications, both prescription and over the counter, has increased," says Emerson. "That's why the PSA has called for a real-time nation-wide recording of drugs of dependence to be included on the platform." Emerson emphasises the fact that this is supported by coroners, doctors and consumers alike.

However, he is at pains to point out that no one wants it to be a punitive approach. "A real time recording and reporting system shouldn't be a barrier to the legitimate use of analgesics and other medications. The system needs to involve a real partnership with consumers to ensure their reasons for taking medications are clear on the system."

Emerson is adamant that any technology – whether apps, personal monitors or the My Health Record platform – has to be supported by evidence-based guidelines and protocols that improve consumers' health outcomes. This includes building in triggers that alert the consumer that they need to see their doctor or pharmacist. "With the right protocols in place, I think new technologies could be very useful as part of an agreed plan between the GP, consumer and pharmacist. What's more, the pharmacist can be very helpful in providing information and advice so the consumer maximises the technology's benefits."

> "Pharmacists can be very useful in brokering information and advice about technology recommended by other practitioners."
>
> **Lance Emerson, CEO, Pharmaceutical Society of Australia (PSA)**

Changing to service-based business models

Emerson reminds us that pharmacists are the only registered health professionals who do not receive funding through the Medicare Benefits Schedule (MBS). "It is generally agreed that there needs to be a broadening of the funding model to include a range of pharmacy services proven to result in better health outcomes," he says. This includes a payment model that rewards pharmacists working with consumers and doctors to deliver collaborative and integrated care. Adds Emerson: "We would quickly start to see an improvement in effective and correct medication use indicators for starters."

The current community pharmacy payment model is based on volume of medications dispensed. At the moment, a consumer who has been stable on the same medication for 20 years often needs little assistance from their pharmacist, whereas someone commencing a complex cancer therapy may need a lot of extra assistance and advice – yet the pharmacy is basically paid the same dispense fee, even though the hours involved are very different. "We need to move towards a model that encourages evidence and needs based quality care and moves away from a straight medication volume model, to ensure consumers' health is optimised," argues Emerson.

> Better health outcomes is just one of the benefits of pharmacist-based consumer care. There are also reforms and efficiencies to the health system itself. Community pharmacists giving influenza injections is a recent example of how it can take the burden off GPs."
>
> **Paul Littleton, Manager, NAB Health Pharmacy Division**

One model that has proven successful in the UK is funding through National Health Service (NHS) Care Trusts and Clinical Commissioning Groups to provide pharmacist support in general practices. Pharmacist professional services within GP surgeries in the UK has not only reduced inappropriate hospital visits but has improved inter-profession relationships with a better understanding of mutual skills and capabilities. Littleton agrees with this approach but points out that although pharmacists in Australia are encouraged to take on more collaborative management of chronic disease, particularly diabetes and asthma, "our current funding model doesn't reward or encourage it".

One exception Littleton cites is the Home Medicine Review program. Now that more and more people over the age of 50 are taking medicines, one of the biggest preventable health issues is people not taking their medicine correctly. He points out that pharmacy services such as the Home Medicine Review are demonstrating that consumer partnering significantly improves consumer health and wellbeing, and reduces costs through fewer hospital visits and better use of GPs' time.

The digital age in hospital pharmacies has arrived

Medication errors are a major problem in hospitals as well as at home. St Stephen's at Hervey Bay is the only 'closed loop electronic medication system' in the country that delivers every drug in single dose blister packs that are barcoded for the specific consumer. They are delivered out of finger-print controlled dispensing cabinets around the hospital.

Richard Royle, former CEO of Uniting Care Health (the organisation responsible for St Stephen's), points out that they had to change Federal and state legislation to be able to do this. While the prescribing and billing is entirely electronic it is still reliant on the clinical practitioners entering the correct information in the system. There are safeguards in place however. "Doctors use a screen with a lot of quality indicators built into it. So if the doctor orders a drug that has an ingredient you are allergic to, then the system refuses the prescription. Dosages are built into the system as well."

The system has been operating for 18 months and the 80 percent reduction in medication errors is a significant benefit for the consumer. "The government currently spends billions in hospital admissions or extended length of stays as a result of medication errors. So this system is hugely beneficial – it has implications for home care as well," says Royle.

Pro-active in implementing consumer-partnering care

Pharmacists' role in collaborative and integrated care for patients is making a difference to consumer outcomes. For the pharmacist, it's not just about dispensing medicine any more. It's about advising and providing complimentary services. For the client, it's not just about getting medication at the cheapest price. "Client loyalty will develop because of the connection, support and reassurance of dealing with a clinician who knows you," explains Littleton. "The industry is in a reformation period. Fortunately, pharmacists are very proactive about their growing role in consumer partnering and community care."

CORPORATE *health*

Competing and collaborating for sector innovation and growth

Technological advancements, increased consumer awareness and the introduction of new funding models mean the healthcare sector is now as competitive as any other.

To win the discretional health dollar and grow multiple income streams, organisations need to uncover how they can better connect with consumers and communities. “It’s not just about getting ‘people in beds’ anymore”, explains NAB Health’s Head of Corporate Health, John McCarthy. “Health businesses need to create better customer outcomes. That means continuous research into what customers really want and implementing services that meet those needs.”

To win the consumer’s trust, and dollars, some areas in the health sector are already entering into more intensive and equal partnerships with consumers and the people involved in their care. For these organisations, partnerships are providing a mine of information about how to improve and expand their services. However, McCarthy cautions that most areas, from primary acute to residential aged care, still do not co-ordinate or talk to each other, or their consumers, nearly enough. “It’s a lost opportunity for everyone. I’m regularly being told that when it comes to the existing health funding mechanisms, it doesn’t really matter if consumers come back into the system again and again – or if their outcomes are improved. Moreover, it’s this out-of-control spiral of costs that forces governments sometimes to take drastic action.”

Aged care providers collaborate for research and better outcomes

The aged care sector in South Australia has embraced partnering with consumers to improve their treatment outcomes and set up formal research structures.

The national Consumer Directed Care (CDC) Reform in Aged Care’s recommendations were based on a productivity commission report that proposed working with customers so they could return to more independent living. Aged care providers in South Australia have used the directive to set up a collaborative organisation, known as The South Australian Innovation Hub, with long-term research projects built around customer input.

“Older people now have more control over what they spend their care dollars on and, like any other business in a competitive environment, aged care providers have had to look at what will attract customers and broaden their revenue streams,” explains McCarthy. “That means research."

> “Some operators have leapt on the changing trends and have already implemented partnership-based solutions that are producing additional revenue streams.”
>
> **John McCarthy, Head of Corporate Health, NAB Health**

Changing systems to serve the individual

ACH Group is one of The Hub participants that has put partnering with customers at the centre of its business model. The business has successfully expanded its traditional aged care offering with services that address the issues customers have said were a priority.

ACH Group CEO Mike Rungie believes our society's ageist attitudes mean we are not driving aged care improvements as a matter of urgency. As a result, we have a low level of innovation. "Opening up the market is clearly one way of doing this – so you get a bit more choice and control. But the other way that absolutely has to sit in parallel with competition is co-design and co-invention with our customers and health provider colleagues."

Rungie explains how partnering with customers has resulted in a re-evaluation of how the sector can deliver better customer, and therefore financial, outcomes. "The sector has had quite high quality consumer engagement in aged care for a long time. But it centres around quality of care, not quality of life," he says. "What we're discovering is that older people know there is not a correlation from very high quality of care and a high quality of life."

Rungie points out that the dynamics driving a low quality of life for older people are the same as for any other age group. "If you start to lose your social roles, sense of purpose, investment in learning and anticipation, your pets, your hobbies, life starts to get very ordinary. The aged care sector has tended to focus on good care but not on helping people reinvent and live good lives – even if they are quite frail. We're now working to invent things together. This sector has never really done that before."

Customer-led innovations

Even in these early days, delivering what customers want is making a lot of business sense for ACH Group and other aged care providers in The Hub. They work with older people, collect data and share information around what exactly needs to change to increase their customers' quality of life.

Rungie is adamant that trusting the market to develop everything won't work entirely. "It's going to need quite a bit of consumer-led innovation that sits alongside the market," he says.

The Hub is partnering with local people in their 70s, 80s and 90s to research three main areas:

1. Assessing current 'whole care' models and ensuring best CDC practices
2. Examining how staff sit down with individuals to find out how they want to grow
3. Enabling older people to exchange ideas and solutions among themselves.

Collaboration between customers is also important for Rungie. Outside The Hub, ACH has set up The Exchange, an online forum for older people in South Australia. It currently has about 200 members which it is slowly increasing through word of mouth. "There is a huge acceptance of this kind of low level technology to connect people and let them learn from one another," he says. "Members share ideas that have improved their lives and ask their providers to help them achieve similar changes."

Rungie knows of a woman in her 80s who decided she was going to learn Italian. Her care provider found home care workers who would speak Italian when at her home. "It's a simple, cheap idea that adds interest to the customer's daily life. Having choice and control are very important markers for quality of life and resilience and we know that learning a foreign language is a very good way of challenging your brain."

New revenue streams through collaborative research

ACH Group and The Hub are uncovering new income streams in the aged care sector through their investment in collaborative research. These include:

A. Resilience training
As people age, bouncing back from setbacks and loss often becomes more difficult. As a result, people can decline earlier than they would otherwise and therefore need a higher levels of care. This is why, with The Hub's guidance, the South Australian Health and Medical Research Institute (SAHMRI) has set up a joint venture with three Adelaide universities to look at how resilience training can be applied to older people. If it is proved to slow the rate of decline, then the savings for government could be enormous. Resilience training could also become another service providers can use to attract clients.

B. Living laboratory testing
The Hub is also setting up a living laboratory where the Tonsley Campus for Technology Innovation at Flinders University will engage from 500 to 1,000 older people to trial products and services. In return for their input, participants get a lot of information and a sense of social purpose.

C. Combining education, health care and research
On top of their projects within The Hub and The Exchange, ACH Group has also recently opened ViTA, a progressive partnership between ACH Group, SA Health, Flinders University and the Australian government. This $46 million facility for advanced learning and aged care offers innovative services that deliver restorative aged care and wellness to patients so they can return home or to a lower level of care.

Rungie uses frailty as a typical example. "Frailty is an avoidable and reversible condition. Yet working with people to prevent or reverse the condition isn't encouraged. "The funding doesn't pay you to do it, and the system isn't set up so that if you reverse frailty, you could have someone stay short term in an aged care facility and then move home. Even with CDC in place, the system hasn't shifted to encourage the re-enablement it is supposed to. ViTA is our attempt to deliver on that."

D. Research led re-enablement
ACH Group and Flinders University have also recently jointly appointed a chair of re-enablement at Flinders University. Professor Susan Gordon is researching the effectiveness of person-centred, inter-professionally delivered aged care. Rungie notes that it's not hard for a provider like ACH Group to create research capacity, "And the data and learning coming back to us is fantastic," he adds.

Ways forward

With the government intent on promoting competition between providers, the experimentation and innovation taking place in South Australia is an important model of collaboration among people dedicated to creating major improvements in aged care.

Like Rungie, McCarthy hopes collaborative hubs throughout Australia will uncover more ways to improve the health outcomes of all Australians. They would drive a stronger focus and rewards for generating positive CDC results, including keeping patients from re-admission. "The South Australian initiatives prove there is a lot that can be done in the current system, without it costing more than current practices."

However, to enable better partnering with older people across the board, the sector needs a lot more technological innovation, says McCarthy. "If you think about what's happened with glucose and blood pressure self-monitoring – patients can pick up changes before they become serious. This means they shouldn't reach a point where they end up back in hospital for four or five days. If we achieve that for more chronic conditions, then a lot of our current health service problems would be reduced."

> "Across the sector quality of care and improving quality of life will win out at the end of the day because that's how you get to build your reputation and ensure you have a business-viable model."
>
> **John McCarthy, Head of Corporate Health, NAB Health**

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