Jennifer Doggett reported on the 9th Health Services and Policy Research Conference in Melbourne, from December 7-9, 2015 for the Croakey Conference News Service.

Croakey is a public health blog based in Australia.  
http://croakey.org
On the importance of connecting health services research, policy and practice

Jennifer Doggett writes:

There are not many issues that the broad spectrum of health stakeholders agree on, but the need for health reform is one of them. In fact, even the Government appears to support the need for major changes to the way in which we fund and deliver health care.

In her recent National Press Club address, Health Minister Sussan Ley described Medicare as having “50 year old foundations” and stated that:

“...just pouring more money into the same inefficient system day-after-day; year-after-year; without complementary reform won't necessarily deliver the improved outcomes we want.”

In arguing the case for health system reform, the Minister posed the following question: “We continue to spend more on health care – but are we getting good value from this in terms of better health outcomes?”

Her Government’s response to this question thus far has been to set up numerous inquiries and consultation processes in key areas of the health system, including the MBS, private health insurance, mental health, therapeutic goods and aged care.

These processes have filled thousands of hours of stakeholders’ and bureaucrats’ time as they prepare and read submissions, as well as attend the associated meetings and roundtable discussions.

Consultation and review processes are always useful to some extent (even when they are limited and biased in their scope, as is the case with the private health insurance consumer survey).

However, their contribution is often limited by the various stakeholders simply pushing their own agendas and seeking to protect their “turf” rather than working collaboratively to develop the best reform options for the community as a whole.

On the need for robust research

If the Government is serious about finding workable and sustainable strategies to improve the efficiency and efficacy of Medicare, the current slew of consultation processes needs to be informed by robust research into the various options for reform.

This includes research that focuses on the delivery of health care and which compares the outcomes of various health systems around the world to assess which are the best options for Australia.
This is the sort of research that was presented by both Australian and international researchers at the 9th Health Services and Policy Research Conference, hosted by the Health Services Research Association of Australia and New Zealand (HSRAANZ).

The HSRAANZ conference was held in Melbourne from Monday 7 December to Wednesday 9 December 2015 and covered the broad spectrum of the health system, including a number of the issues on the current reform agenda, from a health services research perspective.

Health Services Research (HSR) is a multidisciplinary field of research that examines how people get access to health care, how much care costs, and what happens to people as a result of this care.

It is a relatively young discipline that brings together a number of different social science perspectives with the contributions of individuals and institutions engaged in delivering health services.

While biomedical research often grabs the newspaper headlines with stories of new ‘breakthrough’ discoveries and the promise of miracle cures, it is HSR that does the ‘heavy lifting’ of developing and implementing changes in health policies and programs.

However, despite its importance, HSR does not have the same profile in Australia as it does in some other countries.

For example, the United Kingdom invests in applied health research via the National Institute for Health Research, Canada has a specific Institute of Health Services and Policy Research, and the United States funds clinical effectiveness research through the Patient-Centered Outcomes Research Institute.

Australia has no comparable body. In fact, some key health services research bodies, such as the Australian Primary Healthcare Research Institute, have recently had their funding cut by the current Government. These bodies have been vital in providing information and support for researchers working in the area of health services research.

This is disappointing given the importance of HSR in helping Australia address the growing pressure on our health system from increasing health costs and rising rates of chronic disease.

This pressure will become even greater as our population ages and as our economy moves away from a mining and resources-fueled period of rapid growth.

HSR is also critical in addressing the rising rate of chronic diseases which currently affect around one in three Australians and, in many cases, could be prevented.
Current estimates suggest that up to 80% of heart disease, stroke and type 2 diabetes and more than one-third of cancers worldwide could be prevented by eliminating shared modifiable risk factors—mainly tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol.

Lifestyle-related risk factors for chronic diseases, such as these, are unlikely to be eliminated via breakthroughs in biomedical research but can be significantly impacted upon by changes to our health policies and services.

Examples of how this occurs in practice were showcased at the HSRAANZ conference in sessions which examined the data on the role of regular GP visits in managing diabetes and which showcased new innovations, such as TXT2BFit—a mobile phone administered app to reduce obesity.

**Influencing policy**

The keynote sessions, delivered by high profile Australian and international speakers, covered a broad range of topics, including the role of researchers in working within government to influence policy development.

This is an important issue for Australia but one which typically receives little attention within both government and academic circles. This is surprising given that the biggest reform in the history of our health system—the introduction of Medicare—was largely dependent upon the close engagement between the Government of the day and two academic health economists John Deeble and Dick Scotton.

Helping to fill this gap at the conference was keynote speaker Professor Sherry Glied from New York University. Professor Glied has had a distinguished record in advising the US government on health care, including as Senior Economist for health care and labor market policy on the President’s Council of Economic Advisers in 1992-1993, under both Presidents Bush and Clinton, and as a member of the Clinton Health Care Task Force.

She discussed the role of health policy research in informing the political process of achieving the health care reform in the USA and provide valuable advice for any researchers interested in hearing how they can influence policy development and implementation in the current health reform environment.

Another keynote speaker, Professor Libby Roughead, from the University of South Australia, focused on the use of data and development of data analytic systems to improve health care. Her work involves taking data from computerised health claims data and electronic medical records and using data analytics underpinned by behavioural theories.

This is an important issue for many areas of health care. Since the introduction of Medicare in 1983, the amount of data collected in the health system has exploded, along with technologies that allow access to this data. However, the data being collected is often not used to its best advantage (or not even used at all).
In her address, Professor Roughead presented examples of using this innovative approach to improve medicine use within the Australian veteran community and discussed the opportunities and potential for health services research using data analytics and distributed network approaches to improving Australian health care.

International perspectives on health care were well represented at the conference, including a number of presentations from experts in Canada and New Zealand who collaborate with Australian researchers on issues common to Indigenous peoples in these countries.

These include Tanya Hosch, the Joint Campaign Director for Recognise, Jill Gallagher, CEO, Victorian Aboriginal Community Controlled Health Organisations, Tanya Allport, Director of Research at Te Pou Matakana and Dr Graham Scott, a former Secretary to the New Zealand Treasury and Chair of the New Zealand Health Funding Authority.

### Profiling Canadian innovation

The Canadian health system is often described as the one most closely related to Australia’s, and the conference showcased some of the most recent and innovative Canadian research in areas directly relevant to Australia.

This includes Josée Lavoie from the University of Manitoba in Canada who presented a session on strategies to generate rural/remote relevant research evidence to support health service decision-making. Another important session was presented by Cathie Scott from the Alberta Centre for Child, Family and Community Research in Canada who compared the Australian and Canadian health systems on access and equity and discussed the learnings from her research in this area.

Another researcher with expertise in two countries is Dr Gary L. Freed from the University of Michigan and the University of Melbourne. He is an expert on child health policy and discussed why children aged 0-4 years make up the greatest number of Emergency Department (ED) presentations.

The consumer voice was central to the Conference with a strong presentation from Jen Morris from the University of Melbourne. She is a patient perspectives consultant, patient advocate, and healthcare quality and safety researcher who speaks and publishes extensively on issues relating to healthcare quality and safety, healthcare regulation, service improvement, and patient perspectives.

The role of government in health care was also well represented with Kym Peake, Acting Secretary, Victorian Department of Health and Human Services who will speak in the first plenary session.

### Providing breadth and depth

Break-out sessions over the three days of the conference covered a broad range of issues, including research translation, workforce and planning, rural and remote, use of evidence, general practice, data linkage, allied health, quality improvement and consumer and community engagement.
Some of the stand-out presentations from these sessions included:

- Hospital Nurse Attraction and Retention: A review of hospital workplace design characteristics by Lucio Naccarella, The University of Melbourne
- Data linkage and Australian health services research: Progress, challenges and opportunities by Philip Clarke, Centre for Health Policy, Australia
- How good is it really? An evaluation of New Zealand’s Population-Based Funding Formula by Erin Penno, Centre for Health Systems, University of Otago, New Zealand
- Improving population-based health through pay for performance by Verna Smith, ISCRR, Australia
- The Australian Burden of Disease Study: an important resource for health service planning and supporting policy by Lynelle Moon, Australian Institute of Health and Welfare, Australia
- Reciprocal Accountability: A mystery at the heart of Indigenous and government relations in primary care with presenters from Australia, New Zealand and Canada
- The benefits of public reporting of hospital performance: Does it deliver what consumers want? By Margaret Kelaher, Centre for Health Policy, Australia

Along with an extensive poster display, the conference also incorporated a number of interactive workshops, including one focused on early career fellowship funding for people completing their PhD as well as those embarking on their postdoctoral research career. This workshop provided practical tips for structuring career pathways and for completing grant applications.

Another seminar looked at population health and other data related to chronic diseases and their risk factors, and how this information can be used to influence policy and practice. The discussion used Australia’s progress with regard to World Health Organization (WHO) Noncommunicable Disease goals and targets as a starting point, and focused on initiatives that relate to these international policy directions.

There was also a pre-Conference Indigenous Workshop: Sharing successes, strengths and staying strong. This was held on Sunday 6 December and brought together international Indigenous researchers to share success stories and discuss emerging platforms to support Indigenous health service research and empower communities.

HSR may have a lower profile than biomedical research, but the scope and quality of the research presented at the HSRAANZ conference demonstrates how this field of research is making a difference every day in the lives of Australians. To ensure it continues to inform the development of future health policies and programs – particularly in the current reform environment – it is vital that HSR in Australia receives ongoing funding and support.

Professor Nick Zwar argued in Croakey recently that Australia needs a funding agency whose specific focus is applied health research. He suggested that such a body could be funded from the initial $1 billion investment in the Medical Research Future Fund and that research funded by this agency would contribute to identifying the savings in the health care system needed to grow the Future Fund over time.
The HSRAANZ conference in December might be the ideal place for researchers engaged in this field to explore this proposal further and to work together on strategies to promote the central role of HSR in informing current and future health system reforms.
Profiling an award-winning health services researcher and her vision for better health care

Jennifer Doggett writes:

Professor Kathy Eagar was probably the only person at #HSR15 surprised that she was chosen as the 2015 recipient of the Health Services Research Association of Australia & New Zealand (HSRAANZ) Professional Award.

This award is presented biennially to an individual who has made an outstanding contribution to the development of health services research in Australia and New Zealand.
In presenting the award, HSRAANZ President Professor Jon Karnon outlined the leading role that Eagar has played in the field in Australia and internationally over the last two decades, through both her own research and in her role as Director of the Australian Health Services Research Institute (AHSRI) at the University of Wollongong.

Eagar played down her academic achievements, however, and instead highlighted her ongoing commitment to improving health care as the main driver of her work. She encouraged other researchers in the field to concentrate on making a difference to the delivery of health care, rather than just adding to their list of publications.

Describing herself as “passionately committed to multi-disciplinary research that aims to improve population health,” Eagar is quick to dismiss complaints about the level of political interference in health care.

“We often complain about the politicisation of health, but it’s important to remember that health wouldn’t be so politicised if it wasn’t so important,” she said.

**The role of health services research**

Eagar has a broad vision for health services research as a major player in the health sector, but also points out the importance of understanding the other drivers of health policy.

“Health has to be influenced by evidence but it is not solely evidence-driven and it is important to understand the role and the limits of evidence,” she said.

Eagar identifies the audience for health services research as a defining feature of this field of research:

> **Unlike many areas, the target audience for health services research is not just academics also politicians, providers consumers.**

> **Another key feature of health services research is that we have blurred the distinctions between investigation-driven research and priority-driven research. The issues that drive researchers are also important to patients and the community more generally.**

> **This makes our research more relevant and because health services are important to people and have a high political profile, we can follow current trends by reading the media.”**

Eagar identified five perennial health issues of major concern to the community: quality, safety, accessibility, efficiency and better outcomes.

“They are all important,” she said, “but sometimes one of them will jump to the top of the list and receive the most media and community attention.”

Currently, she believes that there is a lot of concern in the community about the future of mental health and the lack of success we have had in building evidence-based systems that work. She said:

> **In the past we tended to assume that if everyone tried hard enough, patient outcomes would improve.**
Now we realise that we need to systematically assess the needs and outcomes of patients on a routine basis, especially patient reported outcomes, in order to assess the impact of health care.”

Impacts on health care

Throughout her career, Eagar has worked across many areas of the health system, but nominates three key areas in which health services research has had a major impact:

1. The development of Casemix classification funding models, which have moved health services from being paid on a historical basis to being paid on the basis of their activity.

2. Recognition of the importance of sub-acute care – 20 years ago the main components of the health system were seen as GPs and hospitals. Health services research has identified and supported the importance of sub-acute services such as palliative care, rehabilitation and geriatric care.

3. Recognition that patients are driven by more than their diagnosis, and the need to be systematic about how we measure patient needs and outcomes.

In urging early career researchers to get involved in the delivery of health care and to get to know how health services work – “you can’t make a difference if you’re not part of it” – Eagar has certainly practised what she preaches.

Health services research is in fact Eagar’s third career; she started out as a clinician and then worked as a health service manager in charge of service planning. It was in this role that she noticed the lack of available evidence on what worked and what was needed to improve health outcomes. She identified the need to develop an evidence base for health care and to put this in the hand of decision makers.

She now urges others working in the field to “go to a hospital, work in a health service, talk to a GP, and find out what drives people in this area. People working in the health system are partners in our work – not the subjects of it.”

Vision for the future

Eagar’s vision is for a health system where there is no distinction between academic, clinician and manager, with people in all three roles involved in evidence-informed management and practice-informed research.

She also believes that the assessment of researchers’ achievements should not just be about academic citations but should include consideration of what changes their research has achieved.

At AHSRI, she and her colleagues have developed an assessment mechanism which includes a measure of the impact that a project has achieved, both instrumental and conceptual. This reflects the aim of health services research to help improve health care, rather than as an end in itself.

In reflecting on the role of health services research internationally, Eagar says that the commitment to the field varies greatly by country, and also differs across the public and private health sectors.
She points out that Canada and the UK have a number of funding streams, which over time have focused on health services research, which is seen as a joint venture between academics and researchers. This differs from Australia, where typically researchers have to find themselves an industry partner.

Australia also lacks the tradition of funding by philanthropic organisations, which in both the UK and Canada commission research independent of government.

**Challenges**

Eagar would love health services research to get access to the research funding being provided by the proposed Medical Research Future Fund (MRFF) – but is concerned that thus far the fund has been conceptualised as focusing on traditional medical research.

She describes this as a good example of where the public conversation is still focused on a model of medical research, which has a direct pathway from discovery in the lab towards commercialisation.

This is despite the fact that health services research can directly influence the development of strategies targeting our major health problems, such as the gap in life expectancy between Indigenous and non-Indigenous people.

Influencing government to include health services research within the remit of the MRFF will be a major challenge for the sector, as will communicating its achievements to key stakeholders.

Eagar believes that the health services research community does a pretty good job of promoting research findings to academics and providers, but is less effective when it comes to communicating research findings to politicians and consumers. This is one reason for the lower profile of health services research relative to other research fields.

Eagar attributes this lower profile to the fact that it is a relatively new field that is small compared with other research sectors. She also believes that cross-disciplinary studies are intrinsically harder to understand, and that this makes it difficult to work out how to generalise their findings.

She said:

- “There is also an assumption that you can always get a good outcome and that you don’t have to make trade-offs.

- As in Australia, the USA is avoiding having a “hard” conversations about the value to the community of a universal health system or to undertake any consultation process on its underlying values.”

Overall, Eagar is optimistic about the future of health services research and its role in promoting the implementation of best practice care across the health system. She said:

- “If governments want to build a sustainable health services, they will need health services research.

- If we keep on doing high quality research and engaging with health stakeholders, it’s only a matter of time before health services research gets the high profile it deserves.”
You can track Croakey's coverage of the conference here.

A portrait of the complex factors affecting patients’ care, from Canada to Australia

#HSR15 Participants

Those tweeting the conference news, via #HSR15

Jennifer Doggett reports:

As well as having universal health systems, Australia and Canada have a shared history as Commonwealth nations with similar federal democratic political systems and many common cultural and geographical characteristics.

Given these similarities, it is not surprising that the Australian and Canadian health systems are facing similar challenges.

The role of health services research in meeting these challenges was explored at a symposium yesterday at #HSR15 that focused on comparing the performance of the Australian and Canadian health systems with respect to cost-related access and timeliness and equity for vulnerable populations.

Three researchers working in this area in both Australia and Canada presented their findings and discussed the lessons learnt from the research for both countries.

Grant Russell from Monash University discussed IMPACT, a five-year collaborative research program that brings communities in three Canadian and three Australian communities together with an international research team to focus on access issues within primary health care.

His Australian-based research took place in Sydney, Melbourne and Adelaide and involved working with local communities to develop priorities for primary health care access.

The barriers to access identified through the community consultation process included a lack of health literacy, affordability, cultural awareness on the part of service providers and difficulties in system navigation.
Each community identified a different strategy to address these access barriers, including the provision of mobile tele-health information (Sydney), a health broker to link consumers with an appropriate health service and a post-discharge model for people leaving hospital (Adelaide).

These strategies are now being implemented and evaluated to assess their impact on access to care.

Dr Jean-Frederic Levesque, from the University of NSW and CEO of the NSW Bureau of Health Information, discussed disparities in access to primary health care in Australia and Canada by analysing the Commonwealth Fund’s International Health Policy Survey 2013/14 using multiple logistic regression.

Dependent variables included in the analyses included: having a regular PHC doctor; skipping care due to cost; arrangement for follow-up care; providing clear explanations about treatment; and difficulty obtaining after-hours care.

The analysis found that while both Australia and Canada face access issues within their PHC sectors, the details of these issues varies between the countries.

Overall Australia performs better in relation to access to care but affordability problems are greater, which can have a specific impact on vulnerable groups. The main challenge facing Canada is to do with the appropriateness of care.

Common to both systems is the need to improve access for people with mental illnesses, in particular when they also have physical health problems. Levesque discussed the importance of understanding the specific barriers to accessing care within primary health care systems in order to address them effectively.
Associate Professor Jeannie Haggerty from McGill University also used Commonwealth Fund data to compare the Australian and Canadian health systems.

The Survey ranked Australia sixth out of the eleven countries surveyed on the timeliness of care (Canada was ranked eleventh) but on cost-related access Australia was ranked ninth and Canada fifth.

Heggarty discussed how the history of universal health care in Canada influences its performance today. In particular, she outlined how necessary compromises made to obtain the support of medical lobby groups affected the development of the health system in ways that are only today being addressed through the recent introduction of reform measures.

Overall, Heggarty’s analysis found that the Canadian system was performing well in relation to cost-barriers for necessary care, whereas the Australian system provided more timely access to care, but had significant cost barriers for disadvantaged groups.

Neither system was found to be providing equal access to care for vulnerable people, with Australia performing particularly poorly in ensuring access to care for people with mental illnesses.

While Levesque pointed out the limitations of this type of cross-systems research (including differences in interpretation of questions due to cultural factors), this symposium demonstrated its importance in highlighting the strengths and weaknesses of different health systems.

These findings need to be considered as part of the Government’s review processes in key areas of our health system (for example, private health insurance, primary health care, the MBS) to ensure that we learn from the successes of other health systems worldwide and avoid replicating their failures.
You can track Croakey’s coverage of the conference [here](#HSR15).

A portrait of the complex factors affecting patients’ care, from Canada to Australia

#HSR15

### Reports from the Twitterverse

**Jennifer Doggett** @JenniferDoggett · 50m
Aunty Georgina Nicholson welcoming delegates at #HSR15 to country.

**Jennifer Doggett** @JenniferDoggett · 42m
Awesome dancers and didgeridoo player as part of the opening of #HSR15

**Jennifer Doggett** @JenniferDoggett · 21m
Kym Peake A/V Secretary Vic Dept of Health “there is no better time to be a health researcher” #HSR15

**Covering #HSR15** @WePublicHealth · 25m
Jon Karmel great time to be a health service researcher, a chance for research to really make a difference to population health #hsr15 #HPM

*“Conference News Service”*
Dr Graham Scott, Director of the Sapere Research Group in New Zealand, spoke of the NZ experience in integrating health and social services.
Professor Andrew Wilson, Director of the Australian Prevention Partnership Centre, covered systems thinking.

Data linkage was a big theme at the conference.
Associate Professor Adam Elshaug spoke on low value interventions.

Another session heard about the burden of reporting on the Aboriginal community controlled health sector.

More #HSR15 snaps.
You can track Croakey’s coverage of the conference here.

A portrait of the complex factors affecting patients’ care, from Canada to Australia #HSR15

Reflections from Day One.

@elaine_hsr • 11m
Highlights were the data linkage session & the ECR #3MT session - more conferences should be doing this, such a good idea! #hsr15 @hsraanz

@elaine_hsr • 18m
Great first day at #hsr15. What stood out is the fact that everybody is having the same issues with data linkage!! #frustrating @hsraanz
And from “Croakey TV”
Some pointed advice for health services researchers from leaders in the field

The private health sector and many other areas of Australia’s health system are under-researched, and offer ripe pickings for health services researchers, according to presentations at the #HSR15 conference in Melbourne.

In addition to Professor Kathy Eagar’s advice that all early career health services researchers should “get out of your university and go and work in a health service”, other experienced researchers have plenty of pointed suggestions for the field.

Jennifer Doggett writes:

Health services researchers in Australia need a more rigorous training program, according to Professor Gary Freed from the Universities of Michigan and Melbourne.

This training should include a detailed study of how the health care system works and where the funds flow.

Freed is amazed how little some health services researchers in Australia know about how their health system works. He specifically recommends that all researchers make sure they understand the history of Medicare and how its various item numbers are reimbursed, before starting their research.

In addition, Freed suggested that all researchers should get out of their comfort zones and stop focusing on specific diseases or a single aspect of the health system.

He urged researchers to focus more on the health system as a whole, though he acknowledged that this can be difficult when grants are often structured along disease-specific lines.

He also identified a number of key under-researched issues in Australia, including the federal-state interface, the interplay of funding mechanisms for doctors and hospitals, the role of private health insurance in utilisation of health services and the impact of funding arrangements for outpatient care.

These are issues that he says researchers would be “all over” in the US but have not been systematically studied in Australia.

Overall, he believes that the private health care system in Australia is very under-researched and that it is important to build data systems that will enable researchers to examine it more robustly.
Call for greater systems focus

Keynote speaker Professor Sherry Glied from New York University agreed with Freed’s analysis, and added that there is an enormous amount of information lying around in “aggregates, averages and means” in Australia that hasn’t been analysed in more detail.

She also made the case for more research with a broad or systems focus, arguing that while research funding bodies tend to fund research on a disease or population specific basis, most health care policy has a provider focus and therefore research should reflect this perspective.

In general, Glied said that the supply side in health care is grossly under-studied, particularly in mixed public-private systems as there is typically no comprehensive data on the flow of funds throughout this system.

Echoing advice from Kathy Eagar to young researchers, Glied believes it is incredibly instructive for researchers to get into health services to talk to providers, patients and government, saying “when you talk to these people you often realise that you have the data and methods to answer questions they are asking, you just didn’t ever realise that they were questions.”

Her advice to early career researchers is to “take a walk around the hospitals, talk to the clinicians and meet with consumers.”

She does not see traditional academic assessment mechanisms as a major barrier for researchers wanting to get involved in policy making and service delivery, pointing out that there are different ways in which researchers can build a career profile and that being involved in major policy changes can generate as much recognition and status as publications.

Empowering consumers

Glied also stressed the important role that health services research can play in empowering consumers and other under-represented groups in the policy debate by assisting them to combat the power of the vested interests that so often dominate the health system.

For example, she described how health services research had identified population groups who were under or uninsured, and were thus able to create a constituency who supported universal health insurance and were able to combat some of the opposing self-interested views of providers.

Glied also advised the health services research sector to be vigilant in looking for opportunities to contribute to policy debates.

She notes that the policy and political environment can “turn on a dime” and that researchers have to be ready with the relevant data and advice to take advantage of the opportunities when they arise.

In her keynote presentation, she described the long road to universal health care in the USA and showed how the political push for universal health care had occurred at least four times over the past 50 years in the US, with only the most recent attempt being successful.

Her experience in working on the development and implementation of “Obamacare” demonstrates how influential health services researchers can be when they understand and are able to work within the political sector.
Experienced public sector manager Graham Scott also urged researchers to focus on the “big picture” arguing that “we have to position what we do in a political environment.”

He suggests using data to stay “ahead of the game” by identifying issues likely to be of high priority to politicians and being pro-active in suggesting workable solutions and avoiding typical failures from uninformed ‘policy-on-the-run’.

He said that he believes that most politicians will listen to sensible advice from researchers with data to back up their position, as they do want ideas that work and don’t want to make stupid mistakes.

Citing examples from the UK, New Zealand and Australia, he nominated the setting of targets for emergency department waiting times as a particularly ill-informed policy that could have benefited from input from health services researchers.

He also urged researchers to keep in mind that health is a complex system and therefore cannot be controlled by the centre. He feels that politicians do not understand this and researchers should be clear about the limits of what politicians are able to influence and the limits of their power to drive change.

This advice is particularly salient in the current political climate in Australia.

With a number of key areas of the health system under review and the announcement yesterday of the Government’s $1.1b innovation fund, there are clearly opportunities available for health services researchers to get involved at the political level and influence the health policy agenda.

However, with lobbying from high profile interest groups on issues of self-interest and with health not even on the radar of the innovation fund (the PM’s statement launching the “ideas boom” did not mention “health” once), health services researchers will need all the advice and support they can get to ensure their work receives the attention and profile it deserves.

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From the Twitterverse

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You can track Croakey's coverage of the conference here.

Some pointed advice for health services researchers from leaders in the field #HSR15

Professor Sherry Glied - discusses the history of universal health care in the U.S. #HSR15

International Timeline of Universal Health Care

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Sherry Glied - International timelines of universal health care pic.twitter.com/reTkMrZDwg

Sherry Glied - pre-Watergate Nixon was a strong supporter of universal health care as he had a brother with TB #HSR15
You can track Croakey's coverage of the conference here.

Some pointed advice for health services researchers from leaders in the field

#HSR15

**Impact of Health Services Research**

- Process is slow and incremental – BUT:
- Research defines problems
- Research offers solutions when politics provides an opportunity
- Empirical estimates are critical to providing policymakers with a sense of feasibility and magnitude

AusHSI @AusHSI 2h

Friendly: HSR essential for #healthcare #reform. #HSR15 Preaching to the converted here! pic.twitter.com/VcnsNA1LzE
Are we making the best use of data to improve health care?

Jennifer Doggett reports:

Whether it’s big or small, linked or discrete, qualitative or quantitative – data is at the centre of all health services research and has been a key theme of the #HSR15 conference in Melbourne this week.

A number of presentations demonstrated new and innovative ways of using data to challenge commonly held assumptions about the health system and to generate solutions to challenging problems.

For example, Professor Gary Freed from the Universities of Michigan and Melbourne, demonstrated how he used hospital emergency department (ED) data to show that by far the greatest number of ED presentations are among children from 0-4 years old – and not (as is often thought) older age groups.

His research focused on understanding the drivers for parents to bring their children to the ED for lower urgency conditions.

Given that one of his findings was that parents believed that their children received better care at the ED than at their GP, Freed recommended exploring the idea of establishing specialist paediatric GP centres to provide children with high quality care for lower urgency conditions.
Professor Margaret Allman-Farinelli from the University of Sydney and her PhD student Stephanie Partridge also used data on changing obesity rates to show that young adults are the age group with the fastest growing rates of obesity, rather than children, as is commonly believed.

In response to this finding, they have developed the Text2BFIT initiative, which uses texting, blogs and social media to promote healthy lifestyles for the ‘Gen Y’ cohort.

Randomised trials of the initiative have resulted in sustained weight loss and lifestyle changes over a 12-month period among the target group, and the developers are now looking to see if these results can be achieved with a broader group of young people.

**Using ‘Big Data’**

Professor Libby Roughead from the University of South Australia showed how she used data from computerised health claims and electronic medical records, in conjunction with behavioural theories, to identify and address problems such as medication errors and preventable hospital admissions.

She described how she is working with doctors, pharmacists and veterans to improve medicine use and reduce hospitalisation among the veteran community.

A key take home message from her presentation is that research using ‘big data’ is not just ‘more of the same’, but can reveal important findings about health care that would not be discovered through clinical trials or other forms of research.

Data linkage was the focus of a number of presentations exploring both the potential for linking data sets to advance research and the barriers that often exist to doing so.

Professor Phillip Clarke from the Centre for Health Policy at the University of Melbourne chaired a ‘standing room only’ session dedicated to data linkage including three presentations on linking administrative health data with other information to improve health service delivery.

Clarke presented some case studies of the use of linked administrative health data to provide insights into the delivery of health care and described data linkage as a ‘powerful tool’ for understanding aspects of the Australian health system.

The case studies covered the use of linked data to estimate disease specific costs for people with diabetes, to understand associations between war-related service and war-related disability among veterans and to measure inequalities in access to care in people attending GP services.

He said that research using linked data was particularly important in developing policies and programs targeting people with chronic conditions and that there was significant scope within the Australian research environment to expand the availability and use of linked data to maximise health system performance.

**Differences between the States**

In her presentation at the data linkage session, Dr Kim Dalziel, also from the Centre for Health Policy at the University of Melbourne, reported the findings of a systematic review of publications involving linked hospital data in Australia.
She and her colleagues searched all journal articles available for the 15 years to December 2014 using individual patient-level data linked with hospital records. Specifically, they analysed these studies according to publication year, state(s) involved, type of data linkage, disease area and study purpose.

This review found that there has been significant growth in the publication of research involving hospital data linkage over the past 15 years. Fifty-one percent of these came from WA and 33 percent from NSW, representing an uneven pattern across the country, due primarily to access issues for researchers.

The review also revealed that over half of the studies identified (56 percent) involved linkage to state data bases and that only eight percent was linking health data to non-hospital databases.

Dalziel argued that her research demonstrates the unrealised potential for data linkage in states outside of WA and NSW, which could be used to improve health services.

She also demonstrated how the availability of linked data has resulted in increased research activity, leading to a growing ‘research gap’ between those jurisdictions which enable data linkage and those that don’t.

She concluded that this shows that there are underutilised opportunities for data linkage to add value in health services research and that the barriers to accessing linked datasets impedes efficient resource use and the potential gains in knowledge through accessing the wealth of useful data routinely collected in Australia’s hospital system.

(For more reading on data linkage, check this 2013 Croakey article).

Barriers to accessing data

This view was strongly supported by participants at the session who shared the difficulties they had experienced in accessing data, to the point that one participant described it as a ‘counselling session’ for disillusioned researchers.

Dalziel reported that the average waiting time for researchers to access the data they need is 18 months to two years in Australia. Some participants added that around half their research grant period was spent in attempting to gain ethics approval and access to data, leaving only half the time to do the actual research.

Other research reported at the session included a project led by Alison Hayes from the University of Sydney. This involved using linked data to analyse the healthcare costs of a cohort of children over the first five years of their life, which highlighted the cost-effectiveness of primary health care for this age group.

Another study by Gareth Goodier from Melbourne Health examined barriers to the effective use of linked hospital data within his organisation.

He found that there were particular difficulties in accessing cross-jurisdiction data, which creates inefficiencies between services and may adversely affect patient experience.

He recommended the development of a framework to enable the linking of data across the care continuum and investing in data linking infrastructure to fully utilise this resource.
The under-use of data

The under-use of existing data was also a theme of a number of presentations, with researchers highlighting examples of where data was being collected but not used to change existing health care practices.

Patient advocate Jen Morris presented data on consumer complaints about doctors to state health care complaints bodies, showing that 50 percent of the complaints relate to three percent of registered medical practitioners. However, this information has not been used to address the issues involved in the provision of care by the doctors involved.

Morris’s presentation also highlighted the range of data that needs to be considered in health services research, in particular the importance of consumer-generated data.

She described consumers as the ‘most under-utilised resource in the health system’, and argued that by asking questions, reporting problems and reflecting on health system performance consumers can play an important role in driving improvements in health care.

She argued strongly that the health system needs ‘constructive criticism’ and that consumers need to be supported to provide the ‘frank and fearless’ feedback to health services required to improve future delivery of care.

Mapping patient journeys

The complexity of obtaining data that reflects the experience of Aboriginal and Torres Strait Islanders in the health system was explored in a presentation by Janet Kelly from Flinders University.

She described developing a set of patient journey mapping tools that could be used to identify the barriers and enablers to equitable and responsive care for Aboriginal people.

She said that while health care is delivered in discrete and specialised segments, it mostly succeeds or fails as a package. She argued that tracking patients’ experiences or journeys through the system is an effective way to evaluate how and why the package as a whole works (or doesn’t).

Key features of patient journey maps are that they involve multiple perspectives, including those of the consumer, their family and carers, the community and health care providers.

This enables a richer and more relational picture of health service delivery to be developed which reflects the experience of Aboriginal people and can be used to improve coordination, communication, collaboration and cultural safety of health care.

Data literacy

Given the wide range of data being used in health services research and the increasing trend for collecting data sets across all areas of the health system, the advice from Professor Gary Freed that researchers need to become ‘data literate’ as well as ‘health literate’ is particularly salient.

From the presentations at #HSR15 it is clear that a ‘data literate’ health research workforce is the key to unlocking the potential that exists within our health databases in order to improve the future delivery of health care.
From the Twitterverse

Below are some of the tweets relating to the presentations mentioned above.

Professor Gary Freed’s presentation:

Covering #HSR15 @WePublicHealth · 8h
Hospitals in Australia seeing too many children in ED departments, most of these could be seen in primary care! #HSR15

Jon Karnon @jonkarnon · 8h
20% kids presenting at ED with low urgent condition do not have regular GP #HSR15 #freed

AusHSI @AusHSI · 8h
Freed: proportion and # of GP visits by children decreasing - our kids are being taken to EDs instead! #HSR15
Professor Libby Roughead's presentation:

- The database underpinning Veterans' MATES
  - Linked patient level data 2009 to present
  - Primary dispensing data
  - Medicare services
  - Allied health services
  - Public and Private hospitals
  - Community Nursing
  - Aged Care
  - Rehabilitation aids and appliances
  - Home care
  - Updated every month and covers 330,000 veterans at start, now 418,000 veterans now

Elaine Lum @ElaineLumx - 8h
Libby Roughead #HSR15: success of HMR uptake prior to funding rule changes @DRugby58 @the_cphs

CRE - Reducing HAI @CREducingHAI - 8h
Great example of the political window of opportunity closing from Libby Roughead - government changed rules for home med review #HSR15
You can track Croakey's coverage of the conference here.

Are we making the best use of data to improve health care? #HSR15

Jen Morris's presentation:

Jennifer Doggett @JenniferDoggett · 5h
Jen Morris: 3% of doctors attract 50% of consumer complaints to state bodies. This data shld be used to improve outcomes.
#HSR15

Jennifer Doggett @JenniferDoggett · 5h
Jen Morris: the health system needs constructive criticism, even if this is painful
#HSR15

Jennifer Doggett @JenniferDoggett · 5h
Patients are the most under-utilised resource in health care, according to Jen Morris #hsr15

Jon Karon @jonkaron · 5h
Jen Morris: consumers can ask not just answer questions #HSR15

IMPACT @IMPACT_PHC · 5h
To make healthcare systems trustworthy is to add patient’s voice - ongoing feedback and capitalising on their perspective. #HSR15

Peter O’Meara @omeara_p · 5h
Jen Morris #hsr15 Heaven forbid, patients and communities have a right to have expectations!

"Healthcare will only get better when we start talking about ‘patient expectations’ as though they are right to have them"
Are we making the best use of data to improve health care?

Janet Kelly's presentation:

- Benefits of mapping
  - Mapping journeys in a structured way:
    - Makes complex patient journeys visible
    - Identifies the services, settings and sectors involved
    - Highlights critical steps, transition points, gaps and responses
    - Enables local solutions and promotes wider systemic solutions

Janet Doggett: Janet Kelly: mapping patient journeys involves multiple perspectives: the patient, family, community, health care provider & others #HSR15

You can track Croakey's coverage of the conference here.
At a time of “reform fatigue”, some timely advice for improving primary healthcare

Address reform fatigue
Improve coordination of care
Develop strong relationships
Promote cross-sectoral leadership
Focus on change management & integrated information systems
Increase consumer input
Make the most of the available data

Researchers identified many challenges and opportunities for the never-ending cycles of primary healthcare reform at the recent Health Services and Policy Research Conference in Melbourne (#HSR15).

Jennifer Doggett reports:

“Reform fatigue” was how one delegate at #HSR15 described the syndrome affecting the Primary Health Care sector in Australia.

Moving from Divisions of General Practice to Medicare Locals to Primary Health Networks in the space of five years or less, this sector has experienced more than its fair share of change, as the organisation, governance arrangements and expectations of ‘primary health care meta-organisations’ have shifted in response to changing government priorities.

Some level of cynicism about the benefits of these changes was evident in the presentations at #HSR15 (one was titled ‘Old Wine in New Bottles’!).

However, there was also a degree of optimism about the future of the new Primary Health Networks (PHNs) and an interest in exploring the Australian and international evidence to support their role in improving outcomes in primary health care.

One popular session focused on PHN governance arrangements and provided a number of different perspectives on how these new organisations could benefit from the findings of recent research in this area.
Secrets to successful commissioning

Coming from the UK, Associate Professor Helen Dickinson of the University of Melbourne has extensive direct experience of the commissioning role of primary health care organisations in the National Health Service. She gave a presentation drawing on her UK-based experience and research, which focused on the role that these new organisations will have in commissioning health services.

Dickinson noted that unlike Medicare Locals and their predecessors (Divisions of General Practice), PHNs have been given an explicit commissioning role, with the goal of improving service efficiency and effectiveness, as well as improving coordination of care in particular for groups at risk of poor health outcomes.

She argued that in order to achieve these aims, PHNs will require a sound understanding of their role in commissioning health services and also the required knowledge and skills to undertake this role. Her international research into this issue suggests that there are no simple guidelines for commissioning in the health sector, a process that she described as ‘challenging’ and as ‘more art than science’.

One reason for the lack of clarity around the commissioning role was that the concept itself is often not clearly defined and often has different meanings for different stakeholders. Her current research with PHNs and stakeholders has found that this lack of clarity also exists within the Australian health sector. She argued that unless this is resolved it could result in confusion between and among PHNs and government about their roles and aims.

Dickinson recommended that agreeing on the precise definition of commissioning should be a first step, along with ensuring that the relevant PHN staff have the training and experience required to deal with the technical aspects of commissioning, such as contract management.

However, she also stressed the importance of not letting ‘process issues’ dominate and for PHNs to ensure they also focus on building strong relationships with providers.

Integrating care

The next presenter at this session, Dr Bernadette Ward from Monash University, also spoke about integrated primary health care in the context of a constantly changing primary health care sector.

Her presentation focused on a study on improving access to care undertaken by a team of researchers across NSW, Victoria and South Australia, including Dr Christine Walker from the Chronic Illness Alliance.

The research involved a comparative case study of six integrated primary health care centres in NSW and Victoria and included a range of models such as GP Super Clinics, community health centres and traditional GP practices. A major aim of this project was to identify the factors that have the greatest influence on the performance of this type of health service.
The research included looking at a range of elements of access, including availability, accommodation, approachability, affordability, acceptability and appropriateness. Ward reported that the study found significant variability between the models, and that these were influenced significantly by organisational and contextual factors, such as contractual arrangements, governance arrangements and GP supply.

Ward used these findings to demonstrate how policies can be developed to influence these factors and therefore support increased access. These could include increasing the supply of GPs in areas of need, supporting bulkbilling and including specific access requirements in contracts.

She also made the point that while there is extensive research demonstrating the benefits of high quality integrated primary healthcare for both identifying and treating chronic conditions, there is much less literature on how health services can achieve this aim. She argued for the need for more research into this issue in the Australian context in order to support PHNs to achieve their aim of improving access to care.

**Cross-sectoral leadership required**

Caroline Nicholson, Director of the Mater/UQ Centre for Primary Health Care Innovation, also reported on research she had undertaken on integrated primary and secondary health care governance, in conjunction with a group of colleagues, including past RACGP President Professor Claire Jackson.

She argued that the primary and secondary health care sectors need to be better integrated if the goals of health reform – such as improving outcomes for people with complex and chronic illness – are to be realised. This requires leadership from both sectors and her research focused on the views of board members and CEOs of PHNs as to how this can be achieved.

This project identified ten elements of successful primary/secondary care integration, including shared clinical priorities, joint planning, effective change management, integrated information systems and consumer engagement.

Her assessment of progress against these elements in the current reform environment was that while gains had been achieved in some areas, for example, in consumer engagement, there were other areas in which little progress had been made, such as in change management and integrated information systems. She argued that unless these areas were addressed they could undermine the capacity of the reforms to successfully achieve integrated care.

Some additional tips for those working in the primary health care sector came in the closing plenary session of the conference, with two of the visiting US experts reflecting on the main themes of the conference and providing some advice on future directions for HSR.

**Equity matters**

Dr Amal Trivedi from Brown University in the US noted that equity was a running theme of the conference, encompassing equity between different population groups, geographical areas and socio-economic levels.

He said it had become clear over the three days of the conference that it was impossible to evaluate quality or outcomes without also considering equity. This approach he described as ‘third generation’ equity studies, where equity is integrated into all aspects of a health service and program and considered in its broadest sense, as defined by consumers and the community (rather than by providers or managers).
He also described stakeholder engagement in Australia as more advanced than in the US, and specifically mentioned the multiple ways in which stakeholders are involved in health service planning, delivery and evaluation as a key strength of our health system.

In terms of a future direction for health services research in Australia, he highlighted the comments from patient advocate and consumer Jen Morris who described consumers as “the most under-utilised resource in the health system”, and supported her call for increased consumer input into health service delivery.

In her closing comments, Professor Sherry Glied, from New York University, reflected on three aspects of Australian culture that impressed her during her visit: the high Australian minimum wage (in comparison with that in the USA); the efficient public transport system (in Melbourne); and the respect shown to Aboriginal and Torres Strait Islander people.

While she did not elaborate on the health impacts of her observations, it is interesting to note that all three of these factors have significant implications for population health.

**Importance of relationships**

Glied also described a number of challenges in the Australian health system – in particular, she said it was tough to manage a system in which there were divisions in the responsibility for health care, for example Federal/State and public/private, with multiple points of interaction and a lack of transparency around funding arrangements.

She noted that this complexity can result in both gaps and duplication in services, and also uncertainty for consumers.

Her parting advice for health service researchers in Australia was to make the most of the data that is available to them. While it might be frustrating not to be able to use data that is being collected, she advised that there is often a great deal that can be achieved through de-identified and aggregate data.

In terms of dealing with governments, she reiterated her opening keynote address in encouraging researchers to be more pro-active in working with governments.

Glied advised researchers to develop relationships with bureaucrats and to listen to their priorities and concerns, saying that “it’s impossible to come up with the answers that governments need unless you know the questions that are being asked.”
At a time of "reform fatigue", some timely advice for improving primary healthcare #HSR15
You can track Croakey's coverage of the conference [here](#).

At a time of "reform fatigue", some timely advice for improving primary healthcare #HSR15

Jennifer Doggett @JenniferDoggett · 6h
While complex, commissioning offers a real opportunity for PHNs, esp in relation to consumer engagement - Helen Dickinson #HSR15

Jennifer Doggett @JenniferDoggett · 6h
Helen Dickinson: commissioning differs from purchasing as it involves ethics, values and consumer views. It is very hard to measure. #HSR15

Jennifer Doggett @JenniferDoggett · 6h
Helen Dickinson on commissioning for consumer outcomes and making sure the emperor has clothes #HSR15

PHCRIS @phcris · 13h
Find out more about Aust practice-based research networks here phcris.org.au /guides/pbrns... #PBRNs #HSR15

Niah N @Niah_nithi · 13h
McIntyre on researchtranslation: policy makers want relevant, timely research - short reports, problem & solutions identified #HSR15 @phcris

Kim Dalziel @KimCroatif · 13h
#hsr15 McIntyre: SA researchers collaboratively submitted tailored ideas and suggestions to Health Minister.

Abby Haynes @AbbyGHaynes · 13h
Great work bringing together research, policy and community. Ellen McIntyre and colleagues #HSR15
A global push to develop more effective funding models for Indigenous health services

Could “reciprocal accountability” – a concept based upon a more equitable distribution of power between governments and Indigenous peoples – help to liberate Indigenous health services globally from the red tape imposed by governments (as outlined in Australia in the 2011 publication, *The Overburden Report*)?

These and related discussions about new models for commissioning Indigenous health services were canvassed at the recent Health Services and Policy Research Conference in Melbourne (#HSR15).

**Jennifer Doggett reports:**

#HSR15 provided a unique opportunity for people working in the area of Indigenous health in different countries to come together to share their experiences and learnings. Researchers working in Indigenous communities in Australia, New Zealand, Canada and South America presented a diverse range of research into the delivery of health care in colonised countries.

While clearly all countries are unique and all Indigenous peoples have different cultures, experiences of colonisation and health care needs and priorities, many of the researchers reported that they valued the experience of sharing their work with others.

It was also clear from the sessions that the learnings from research into Indigenous health issues have broader implications for the way in which we approach mainstream health care.
An issue that was discussed in a number of sessions was the concept of “reciprocal accountability”, particularly relevant to Indigenous health in Australia, New Zealand and Canada.

Professor Judith Dwyer from Flinders University described reciprocal accountability as “a mystery at the heart of Indigenous and government relations in primary health care” and a “critical challenge” in the relationships between Indigenous health care providers and governments.

She outlined the evolution in the relationship between governments and Indigenous health organisations, starting with a system in which governments impose requirements for funding, contracting and performance on the Indigenous health sector (see this previous Croakey piece for further background).

This system has not met the needs of either governments or Indigenous communities for a number of reasons, including the fact that it constrains service providers by overly restricting the use of funding and imposing onerous reporting and administrative burdens on them.

The end result of this is an Indigenous health sector which in many areas does not perform as well as it could due to the constraints placed on it by governments, resulting in high transaction costs, poor responsiveness to communities and challenging relationships with professional staff.

Professor Dwyer described “reciprocal accountability” as a new approach to contracting and funding which is based on a more relational approach to improving Indigenous health that recognises the complex accountabilities of both governments and Indigenous health service providers.

This approach moves away from a hierarchical concept of accountability towards an approach that reflects a more equitable distribution of power between governments and indigenous peoples.

She identified that at the heart of this concept is the dual role that Indigenous health services play, as services providers (accountable to government for their funding) and advocates for their communities (holding the government to account).

While her research has found that there is broad acceptance of a term such as “reciprocal accountability” to describe this relationship, she also found that there was a lack of confidence in its ability to change current accountability regimes. Key barriers identified to this were the technical issues involved with measuring a more complex form of accountability and systemic racism throughout government and the health system.

Lack of trust a critical issue

These barriers were discussed in more detail in presentations from Derek Kornelsen, from the University of Manitoba and Kim O’Donnell from the Lowitja Institute and Flinders University.

Mr Kornelsen explored in more detail how a workable framework could be developed which reflects both Indigenous and Western concepts of reciprocal accountability. He found that this can be informed by using a fiduciary frame to clarify the nature of this relationship, as this entails a consideration of Indigenous perspectives on a legitimate relationship with the state.

In her presentation based on Australian research, Dr O’Donnell highlighted the importance of building strong working relationships between government departments and Aboriginal Community Controlled Health Organisations, but pointed out that there is a lack of national strategic direction to support engagement with Indigenous leaders and peak bodies.
In her consultation with stakeholders she found that there was a lack of trust between stakeholders involved in funding relationships and a lack of agreed understanding about their respective roles.

Dr O’Donnell argued that underpinning this situation is a failure among some people in a position to influence the Indigenous health sector, such as those within the bureaucracy, to admit or fully explore the reality of Australia as a colonised nation.

The presentation by Associate Professor Josée Lavoie on her work with Associate Professor Lloy Wylie in Canada expanded on the concept of “reciprocal accountability” in the context of recent changes to the funding arrangements for First Nations health services in British Colombia (BC), Canada.

A/Professor Lavoie described how in 2013 the First Nations Health Authority (FNHA) took over the responsibility for funding and service provision to all BC First Nation communities. A key component of the agreement between the FNHA and the Canadian Government was a commitment to reciprocal accountability, although this was not clearly defined.

Through stakeholder interviews and an analysis of key documents, Professor Lavoie and A/Professor Wylie found that while the details of reciprocal accountability have yet to be fully articulated, there is a shared understanding between stakeholders of a shift away from a traditional principal-agent contractual arrangement towards a more equitable partnership which paves the way towards health self-governance for First Nations people in Canada.

**Commissioning services for Māori**

A New Zealand perspective was provided in the closing plenary session by Dr Tanya Allport from Te Pou Matakana.

Dr Allport described the concept of ‘whānau ora’ as being central to the provision of Māori health services in New Zealand. This term can be loosely translated into English as ‘family and community well-being’ but has a much broader and more powerful sense of ‘strength in connectedness and culture’ that is fundamental to the concept of health care within Māori culture.

The words of the Pou (patron) of Te Pou Matakana, Dame Tariana Turia, encapsulate the richness of this term:

- **Whānau Ora is a source of comfort, of motivation, of encouragement.**

- **Whānau Ora is about whānau being empowered to develop a plan for our future; and to trust in our own solutions.**

- **It is about restoring to ourselves, our confidence in our own capacity to provide for our own – to take collective responsibility to support those who need it most.**

Dr Allport outlined the approach taken by Te Pou Matakana to commissioning services for Māori which reflect this concept of ‘whānau ora’. She described how Te Pou Matakana is responsible for commissioning initiatives that will drive whānau health and wellbeing by building on the strengths and assets of Māori communities in the region.

The aims of these initiatives are defined in a broad sense as enabling Māori to enjoy good health, experience economic wellbeing, be knowledgeable and well informed, be culturally secure, resilient, self-managing and able to participate fully in te ao Māori (Māori culture) and in wider society.
This involves both receiving and distributing government funding and includes active engagement with Whānau Ora Partners to help them build capacity to achieve positive outcomes as well as advocating for policy change that will benefit whānau to government and central agencies.

These presentations, along with a number of others at #HSR15 and some of the poster presentations, provided delegates with a broad picture of research being undertaken in a number of countries on Indigenous health issues.

They included both “experts’ who are well established leaders in this field, such as Professor Judith Dwyer, and younger early career researchers, such as PhD student Angelique Ferdinand, who presented her research on the approach taken by two health services in Chile to the traditional healing practices used in their communities.

These presentations reflected the depth and diversity of this field of health services research, and highlighted both the challenges and opportunities being addressed.

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**Reporting via the Twittersphere**

From the First Nations Health Authority, Canada (@fnha)

From VACCHO’s Jimi Peters (@VACCHO_org)
You can track Croakey's coverage of the conference here.

A global push to develop more effective funding models for Indigenous health services

From Te Pou Matakana (@TePouMatakana)

#HSR15
Further reading in this report from The Lowitja Institute, *A Reciprocal Relationship: Accountability for public value in the Aboriginal community sector.*

**Photo credit:** the feature image is taken from a clip on the website of Te Pou Matakana, which is responsible for commissioning initiatives to drive North Island whānau health and wellbeing by building on the strengths and assets of whānau and Māori communities.
Some helpful tips for making better use of “the most underused resource in healthcare”

Health services have been given much useful advice about how to make better use of the knowledge of patients and community members.

In a plenary address to the recent Health Services and Policy Research Conference in Melbourne (#HSR15), Jen Morris, a patient perspectives consultant, advocate and researcher, made a powerful argument for patient engagement as a critical tool for improving the safety and quality of healthcare.

Amongst other things, she said that patients can introduce a “constructive unease” into the culture, methods, processes and structures that comprise the healthcare system.
Jennifer Doggett reports:

Patient advocate and researcher Jen Morris’s keynote address at #HSR15 was enthusiastically received by delegates and the Twittersphere. Her insights into the role of consumers in healthcare were also picked up by a number of speakers at the conference, who repeated and reinforced many of her points.

Her address was titled “Patient innovators: tapping the most underused resource in healthcare” and focused on how consumers can play a greater role in influencing the delivery of healthcare.

In defining the role of consumers, Morris described how the media regularly features stories on a shortage of healthcare resources – be it time, money, beds, equipment, specialists, or anything else.

She argued that under this perpetual headline, patients are described, at worst, as a drain on resources – for example, through unnecessary attendance at the emergency department – or, at best, as vulnerable victims of resource shortage. She said that consumer or patient engagement is similarly viewed as a resources drain.

Morris challenged delegates to reconsider the way in which the relationship between patients and healthcare resources is framed under this constant headline.

Respect and support

She argued that patients are both users of resources within the health system and are themselves also resources who can help to address some of the problems within the health system, when they are respected and supported.

This is because patients are ultimately motivated to ensure healthcare is the best it can be, as they are the ones who reap the greatest rewards or suffer the greatest personal cost, depending on the quality of their healthcare.

Morris outlined different areas where consumer input could help, including:

- Research – direction, design, communication
- Design – of services, communications and systems
- Provision – support groups, peer education
- Evaluation – research participation, examining performance
- Improvement – ideas for change, trials of changes
- Reform – input into large-scale overhauls
- Conclusion – dealing with loss or restructure of services or programs.
She also described the different target groups for consultation and engagement process, which can include the following:

- Non-users of the service
- Individuals using service
- Those connected with individuals using service
- Specific group or community members (such as Aboriginal and Torres Strait Islander people, transgender people, teenage parents)
- General community members
- Experts in non-health disciplines.

Morris said the different types of input sought from consumers included asking questions, evaluating suggestions and identifying needs, barriers and enablers to help them achieve their goals.

She outlined a broad range of benefits arising from consumer engagement in healthcare. This includes introducing what she termed “constructive unease” into the culture, methods, processes and structures that comprise the healthcare system.

Morris argued that the healthcare system desperately needs an injection of what one might call “transformation by transparency”.

She described this as “a sense that learning about one’s faults – like having somebody quietly tap you on the shoulder and mention the toilet paper on your shoe – might be momentarily painful, but it is far more helpful in the long term. Because you can do something about it.”

**Overcoming blind spots**

Health services use many great initiatives, both compulsory and voluntary, to gather data on patient experience in an organised fashion, such as standardised patient experience questionnaires and surveys and clinical data on readmission rates and waiting times. While these are highly valuable, Morris argued that they are not sufficient.

She said that in healthcare, as in life, the worst kind of blind spot is the one you don’t realise you have, because then there is no hope of fixing it or even making an informed decision about whether to fix it.

This means that even health services that show real commitment to measuring patient experience, or care quality and safety will only really collect and analyse data on factors and patterns they are already looking for – the things that they think are important.

The result of this is that a health service’s greatest weakness becomes such not because of deliberate neglect of the issue, but because the issue has not even entered their scope of awareness, much less been pegged as something important.

One counter measure to this is to encourage freer-form patient input, released from the constraints of forms and random surveys and structured feedback schedules, as this can shine a light on the blind spots that health services don’t even realise they have.
Morris also argued that patient engagement is a vital measure in improving the safety of care. She said that every instance of preventable harm in healthcare provides an opportunity to learn, improve and to prevent similar events in the future.

These benefits can extend all the way from individual practitioners, through teams, departments, hospitals, services, and the health system as a whole and they are maximised by directly and proactively involving patients in a culture of safety in healthcare.

Patients can make a unique contribution to healthcare safety because they are uniquely placed to observe risks in care. They can offer crucial clues and information on factors that contribute to clinical risk and adverse events, which might never otherwise come to light, and even come up with ideas about how to reduce them.

Unlike any other participant in the healthcare process, patients are there for every test, consult, procedure, treatment, handover and other component of the delivery of healthcare.

In particular, patients are best placed to provide perspectives on contributing factors leading to adverse events, such as those relating specifically to patient experiences. These may go unnoticed if investigations focus only on practitioner-centred issues, such as inadequate staffing or poor consultant handwriting.

**Hear the canary**

Morris pointed out that there is powerful evidence that, when taken collectively, patient voices can be a very effective “canary in the coalmine” to detect struggling or problematic practitioners.

She gave the example of complaints against doctors as one area in which patients could play an important role in ensuring the quality and safety of the health workforce and in detecting practitioners who are in difficulty.

Morris went on to discuss patient expectations, stating that “healthcare will only get better when we start talking about ‘patient expectations’ as though they are right to have them.”

She argued that patient expectations do not arise from nowhere and that the healthcare system has to take responsibility for its role in creating them.

She also made a case for seeing healthcare as a social contract between providers and consumers, and said healthcare must match consumers’ trust with trustworthiness in order to deliver on its side of the contract.

Patient engagement is one way in which healthcare services can ensure that practices within healthcare better match up to community standards. This can be achieved through involving consumers in a number of areas including:

- Quality and safety governance
- Hiring processes
- Training and education
- Enforcement of transparency and accountability (committees that ask questions, not just answer them)
- Investigations and disciplinary proceedings (including consumers on medical and other health professional boards).
Morris discussed a common approach to patient engagement whereby health services identify problems to solve and then seek consumer input on a specific solution they have already devised. She argued that this approach can miss much of the potential contribution consumers can make to service improvement.

**Useful questions to ask**

Instead of ‘narrow’ consultation with consumers, Morris advised services to regularly ask the most open questions possible, such as:

- *How could our service be improved?*
- *What is good about our service?*
- *What could be better about our service?*
- *What do you wish was different about our service?*
- *If you could give one piece of advice to the service, what would it be?*

She also stressed the importance of fostering consumer engagement and creating an environment in which consumers can ask questions and raise their own issues of concern.

Morris concluded her presentation by stating that there is so much to be gained from recognising the value of patients, consumers and members of the public in shaping, driving and delivering health services.

She reiterated the importance of seeing patients as a precious but tragically under-utilised resource in healthcare and said that while a common newspaper headline was ‘Patient saved by medical breakthrough’, her work would not be done until another headline was at least as common: ‘*Healthcare saved by patient breakthrough*’.

On Twitter, follow [@JenWords](https://twitter.com/JenWords)
You can track Croakey's coverage of the conference here.

Some helpful tips for making better use of "the most underused resource in healthcare"

From Twitter

Jen Morris @JenWords • Dec 6
Looking forward to delivering a plenary about patient engagement as exciting & underutilised resource in healthcare

Karen O'Leary @kmoi62
Follow #hsr15 - hope speaker @JenWords shares some insights twitter.com/wrightdmc/sta...

Jen Morris and 2 others Retweeted

IMPACT @IMPACT_PHC • 5h

To make healthcare systems trustworthy is to add patient’s voice - ongoing feedback and capitalising on their perspective. #HSR15

Peter O'Meara @omeara_p • 5h
Jen Morris #hsr15 Heaven forbid, patients and communities have a right to have expectations!

Pegging practice to community expectations

"Healthcare will only get better when we start talking about ‘patient expectations’ as though they are right to have them"

Elaine Lum @ElaineLmx • 6h
Jen Morris #HSR15: 3% of registered Drs in Australia accountable for 50% of formal healthcare complaints

Complaints clustering – a canary in the coal mine

Dicky Knee @UBS9 • 5h
#HSR15 patients as canaries in the coal mine for dangerous practice. We all need to listen to the songs
You can track Croakey's coverage of the conference here.

Some helpful tips for making better use of "the most underused resource in healthcare" #HSR15

Jon Karmen @jonkarmen · 5h
Jen Morris: consumers can ask not just answer questions #HSR15

Jennifer Doggett @JenniferDoggett · 5h
Jen Morris: 3% of doctors attract 50% of consumer complaints to state bodies. This data shld be used to improve outcomes. #HSR15

Jennifer Doggett @JenniferDoggett · 5h
Jen Morris: the health system needs constructive criticism, even if this is painful #HSR15

Jennifer Doggett @JenniferDoggett · 5h
Patients are the most underutilised resource in health care, according to Jen Morris #hsr15

Jan Morris Retweeted
Lynsey Brown @Lyns_Brown · Dec 7
'Healthcare saved by patient breakthrough' - Thanks @JenWords for a fantastic keynote presentation #engagement #advocacy #KE #hsr15

Jan Morris Retweeted
Lynsey Brown @Lyns_Brown · Dec 7
We don't educate patients about health systems @JenWords #healthliteracy #hsr15
As this is our final article from the #HSR15 conference coverage, below are the Twitter analytics covering the period 22 Nov to 24 December.

The #HSR15 Influencers

The Numbers

6,894,007 impressions
1,819 Tweets
319 Participants
2 Mentions
6 Retweets

Plus you can read the entire Twitter transcript for #HSR15 over that period.

And here is a grab of the #HSR15 Twitter participants:

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Croakey Conference News Service

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- Editing by Melissa Sweet
- Layout and design by Mitchell Ward

Some helpful tips for making better use of “the most underused resource in healthcare” #HSR15