TRANSCRIPT OF PROCEEDINGS

**The attached transcript, while an accurate recording of**

**of the day, is not proofread prior to circulation and thus may contain minor errors.**

2015/16 HAZELWOOD MINE FIRE INQUIRY

HEALTH IMPROVEMENT FORUMS

TRARALGON

MONDAY, 19 OCTOBER 2015

THE HONOURABLE BERNARD TEAGUE AO - Chairman

MRS ANITA ROPER - Board Member PROFESSOR JOHN CATFORD - Board Member MR PETER ROZEN - Counsel Assisting

|  |  |  |
| --- | --- | --- |
| DTI CORPORATION AUSTRALIA PTY LTD |  | |
| 4/190 Queen Street, Melbourne. | Telephone: | 8628 5555 |
|  | Facsimile: | 9642 5185 |

1 **GOVERNANCE, LEADERSHIP AND SUSTAINABILITY**

2 CHAIRMAN: Good morning and welcome to this, the fifth day

3 of our forums in the Latrobe Valley. Could I say that

4 I will be repeating some of the things that I said on

5 previous occasions, but that's because I know there are

6 significant numbers of new people, even though most of

7 you that I can see are very familiar faces.

8 I will at this stage acknowledge the traditional

9 owners of the land on which we're gathered, the

10 GunaiKurnai, and pay my respects to their elders past

11 and present.

12 I won't go into the detail of the terms of

13 reference 7, but this is very much focused on that term

14 of reference. What we are doing today is an

15 interesting variation of what has been in other

16 situations where we've had hearings rather than forums

17 of this kind, but so far they've been extremely

18 valuable. This is another Catford variation on the

19 theme, I might say. I give him all the credit, and so

20 far there really is only credit that's come from the

21 process that we've undertaken. It's a bringing

22 together of relevant people in a different kind of

23 format to a hearing which really is, in these

24 circumstances, I think, much more restrictive.

25 Apart from saying that we will be listening to

26 what emerges from the presentations that will be made

27 today, and taking an interest in the different

28 perspectives that are put together, I will really now

29 pass on to John and then Anita who will explain just

30 how we are intending to proceed this morning.

31 PROFESSOR CATFORD: Thank you very much, Bernie, and it's a

1 pleasure to be here again for our 13th Health

2 Improvement Forum. I am conscious that a number of you

3 have been to every forum and some of you are here for

4 the first time, so I'd just like to summarise some of

5 the key features.

6 Of course, we're very much focused today on

7 looking forwards at how to build and strengthen health

8 in the Latrobe Valley. We're looking at short, medium

9 and long-term proposals which we've been asked to by

10 the Victorian Government when they reopened the

11 Hazelwood Mine Fire Inquiry in May of this year.

12 We've conducted now 12 forums looking at a range

13 of very important issues. The first nine were what I

14 call deep dives. We looked on 29 December at chronic

15 disease management, health behaviours and mental

16 health - a very dynamic interactive set of forums.

17 The following day, 30 September, we looked at

18 early detection, high risk screening, health workforce

19 and children and ute.

20 Then, on the third of those deep dive days,

21 1 October, we looked at healthy workplaces, healthy

22 environments and social disadvantage. We also have had

23 a special encounter with the Aboriginal community here

24 in the Latrobe Valley on 13 October, and we had our

25 final set of Health Improvement Forums on that day

26 which looked at community engagement and communications

27 and the potential role of a Health Conservation Zone

28 and Health Advocate.

29 Today's forum is the last in this sequence of

30 forums where we're focusing on governance, leadership

31 and sustainability.

1 I think, it would be true to say, the Board has

2 been really pleased with the feedback and response

3 we've had through these forums; there's been a real

4 spirit of cooperation, people connecting, agencies

5 talking to each other, and a lot of help coming from

6 outside the Valley from NGOs working across Victoria.

7 There's been a very strong sense of pride of place

8 in the Latrobe Valley and very positive and

9 constructive orientation to the discussions and

10 proposals. I really think, and shared by Anita and

11 Bernie, a real genuine commitment to make things work

12 better.

13 We've heard of a wide range of possible

14 opportunities to improve the health of the Valley, from

15 for example 3-year-olds taking blood pressures of their

16 parents, we've heard about the need for a railway

17 station just outside this hotel; we've heard about the

18 needs for seating in walking areas to encourage people

19 to walk more; we've heard about kitchen gardens in

20 schools, community screening days - there's a whole

21 range, a host of interesting ideas; the role of

22 telehealth or telemarketing promoting the Valley more

23 broadly within the community and outside. We've heard

24 about the need for a quit smoking campaign, of

25 community nursing programs, of worker health checks,

26 and so the list goes on - more doctors living in the

27 Valley, advanced medical programs in the Valley, care

28 guidance pathways in primary care and I could go on for

29 a very long time, a myriad of suggestions.

30 I think, to me, a key theme has been the need to

31 build stronger integration between hospital, community

1 health, the primary care network and our council and

2 Government. We very much hope we can explore this

3 today and the issue of joined up leadership; agencies

4 engaging, co-designing with the community. That's very

5 much the theme of this last final forum, one of

6 governance, leadership and sustainability.

7 We're seeing the people of the Valley calling for

8 change, highlighting the need for doing things

9 differently. So what would improved governance look

10 like for collective action in the Valley?

11 We've also looked at the need for stronger

12 integrated leadership across the health systems in the

13 Valley, or how can this be brought forward.

14 And a recurring theme about sustainability, of

15 keeping the momentum going through political cycles -

16 how best can we ensure sustainability and commitment

17 and action to improving health in the Latrobe Valley?

18 We're very much hoping we're going to hear further

19 about this.

20 We've brought together at these forums leaders

21 from within the Valley as well as across Victoria, and

22 we've had the benefit of a very large number of public

23 written submissions, both before the forums and

24 afterwards, and our task now as a Board is to bring

25 these together to produce a report which we hope the

26 Government will look at, and I'm sure will look at

27 seriously and hopefully respond.

28 I've set the scene perhaps about the purpose of

29 this last final day of bringing together all the

30 various themes, and I'd now like to pass to Anita who

31 will actually talk through the process of the day.

1 MRS ROPER: Thanks, John. Well today, as John has said, is

2 the final day of our roundtable conversations that

3 we've had down here in the Valley and we've heard a lot

4 from the local folks about their concerns, and today

5 we're going to have a series of presentations from

6 senior health officials from right across the health

7 sector.

8 We have Kym Peake here today, the acting Secretary

9 of the Department of Health and Human Services; we have

10 Terry Symonds, the Director Sector Performance, Quality

11 and Rural Health of the Department of Health and Human

12 Services; Councillor Dale Harriman, the Mayor of the

13 Latrobe City Council; we have Kellie O'Callaghan, chair

14 of the Board of Latrobe Regional Hospital; John Guy,

15 the chair of the Board of Latrobe Community Health

16 Services; and Nola Maxfield, the chair of the Board of

17 the Gippsland Primary Health Network, and we certainly

18 thank all of you for making yourselves available today

19 to come down here and be with us for our last

20 conversation.

21 These presentations will run this morning from

22 about 9.45 to 12.30 pm with a 15 minute break in the

23 middle. The presentations will be about 20 to

24 30 minutes, and then we'll take some questions being

25 led from the Board and Counsel Assisting. We're going

26 to conclude today with a panel discussion with all the

27 presenters and that will be facilitated by Peter Rozen,

28 Counsel Assisting the Inquiry.

29 As per our previous days, transcripts of today

30 will be available on our website if you want to review

31 them and, as John said, at the conclusion of today we

1 have the task of reviewing everything we've heard

2 across all the forums, the submissions that we've

3 received both before the forum started and afterwards,

4 and just all the discussions and the immense richness

5 of the discussions that we've had and that will

6 contribute to helping us formulate our responses to

7 Term of Reference 7 and any recommendations we want to

8 make.

9 As we've said at each of the forums, the Board is

10 very, very conscious that this Inquiry has a limited

11 life and it's really up to those living and working in

12 the Valley to take this work forward in a meaningful

13 way.

14 I think it's very pleasing for us that, in the

15 past week or so we've already seen examples of this

16 happening, that local people have not waited for the

17 Board to make a report to the Inquiry and not waited

18 for the Government to make a response, but they've

19 taken that leadership that we've really hoped. There's

20 been a number of projects that have formed through our

21 forums that the group has said, "We're going to take

22 them forward now, we don't need anyone to tell us how

23 to do that", and this is what this has been all about.

24 So we hope that spirit of cooperation will

25 continue, not just with the local people living and

26 working in the Valley, but those from the health sector

27 outside the Valley will assist in carrying that

28 forward.

29 Some of the issues that we're discussing here are

30 clearly very, very specific to the Valley, but a number

31 of the issues that we've been discussing are not,

1 they're the same problems that other parts of the

2 Victorian community and even the Australian community

3 are facing. We also have an opportunity to not only

4 solve some issues here and move them forward, but

5 actually to show some leadership across Victoria, and

6 that again is up to the people that live and work in

7 the Valley to take that on as a goal.

8 As I hand over to Peter, thank you all for

9 attending, in particular our speakers who've travelled

10 today, and we really look forward to hearing what you

11 have to say during the course of today.

12 MR ROZEN: Thank you, Anita. As Anita indicated, my name's

13 Peter Rozen, I'm Counsel Assisting the Board, and I

14 would like to introduce our first speaker this morning,

15 Ms Kym Peake, acting Secretary of the Department of

16 Health and Human Services. Thank you, Kym.

17 MS PEAKE: Thank you very much for the opportunity to

18 present today. I did want to also start by paying my

19 respects to the traditional custodians of the land on

20 which we are meeting, and in particular pay my respects

21 to elders past and present.

22 I believe this forum is a really important

23 opportunity for us to reflect on the lessons that have

24 come from the Hazelwood Fire and this Inquiry to really

25 make sure that we understand those learnings and that

26 those learnings enable us to shape a healthcare system

27 that is better able to respond to such events and

28 provide the high standard of care that is expected of

29 Victorians wherever they live around the State.

30 Today I just want to cover off on a few matters,

31 in particular what the department has heard from the

1 community, early actions that we have taken, and then

2 some reflections on where we might go from here.

3 Following my presentation, Terry Symonds, the

4 Deputy Secretary responsible for strategy and reform in

5 our department, will then discuss in a bit more detail

6 some of the work underway to support health service

7 improvement in Victoria, as well as outlining some of

8 the opportunities presented by national reform to help

9 us get the best results from an improved and more

10 sustainable health system.

11 So, what have we heard? We have been actively

12 listening to what the community has been saying to us,

13 and there are a number of themes that I believe have

14 been very consistently put to us through the Health

15 Improvement Forums.

16 Firstly, this community has underlined the

17 importance of having a more coordinated person-centered

18 approach to healthcare.

19 Secondly, it has been emphasised that we need to

20 take a "with us", not "to us" approach to designing new

21 services as the community wants to be involved and

22 empowered to co-design new initiatives collaboratively

23 with Government.

24 Third, the community wants long-term sustainable

25 solutions and actions that improve health outcomes for

26 the whole community.

27 Next, it's obvious we need to tackle the social

28 determinants of health in the Latrobe Valley if we are

29 to improve health outcomes in the long-term.

30 Finally, there's a need to build on the great

31 strengths of this community. There are

1 well-established trusted networks in the Latrobe Valley

2 and a strong sense of community that I think we've just

3 heard all members of the Inquiry reflect on.

4 The region has high rates of membership in

5 organised groups and high participation in community

6 events and these are strengths that we need to build on

7 for a healthier community.

8 But, as you can see from these charts, Gippsland

9 also has relatively high levels of chronic disease

10 which make the need to tackle this problem extremely

11 important to the general health and growth of the

12 region.

13 In addition, Gippsland also reports high barriers

14 to care. The barriers to equality and access to

15 services in producing the quality of health outcomes

16 will continue to be priorities for me and for this

17 Government.

18 That endeavour though will be assisted by the

19 region's great strengths in very healthy levels of

20 citizen engagement, strong social networks and an even

21 stronger sense of community that can be of great

22 service in helping to drive productive changes that

23 will lead to better services and healthier communities.

24 Over the past year the Government has been also

25 taking early steps, as this Inquiry has unfolded. If I

26 focus on one of these steps: during the Hazelwood Mine

27 Fire a small number of recognised community leaders

28 were brought together curing the response and relief

29 stage with support from DHHS. Many of those community

30 members have chosen to stay on this committee, now

31 known as the Community Recovery Committee.

1 The committee is currently chaired by Carolyne

2 Boothman and a local Councillor, Graham Middleton, as

3 deputy chair.

4 DHHS has provided funding to the Latrobe City

5 Council to support the community and to deliver on the

6 recovery activities for the community. The committee

7 comprises the Department, community members and local

8 community agencies. It has overseen a range of

9 recovery activities, including a number of community

10 events aimed at celebrating and advocating the

11 strengths of Morwell and highlighting key achievements,

12 for example a "thank you to emergency services" event.

13 From my perspective this committee has been a

14 really powerful voice for the community, advocating on

15 behalf of the needs of the community with Government

16 agencies.

17 Most recently, Latrobe City Council, in

18 partnership with the committee, has undertaken a local

19 door knock of 80 households in southern Morwell.

20 They've also run a number of planning meetings with

21 local residents, and I know that more are planned

22 across Morwell and across the region. These activities

23 have been designed to community building and inform

24 future planning and development of a resilience plan

25 for Morwell that will be linked into the municipal

26 public health and wellbeing plan. I think this is just

27 one example of the community leadership that you were

28 referring to earlier.

29 Of course, there are many aspects of life that

30 contribute to health and wellbeing, including access to

31 education, employment, secure housing, freedom from

1 violence, supportive social networks and services and

2 opportunities to participate in community life. Health

3 and wellbeing is everyone's responsibility.

4 As I mentioned, we've heard really strong feedback

5 that a long-term whole-of-community approach is

6 required to improve health and wellbeing, based on

7 governments and communities working together to improve

8 economic opportunities, social supports and to address

9 the drivers of both good and ill-health.

10 Looking ahead to 2025, across the State as a whole

11 and particularly in regional communities, the

12 Government is committing to a comprehensive jobs and

13 investment plan. Regional Development Australia and

14 Regional Management Forums will continue to work with

15 local businesses and community leaders to maximise

16 opportunities for this region.

17 In particular, State and regional approaches will

18 focus on creating an environment for jobs and

19 investment through boosting regional growth through

20 tourism and population patterns, enabling high growth

21 sectors to grow, export and employ; supporting

22 innovators and start ups to succeed and scale up;

23 seeking to attract more international students and

24 enticing them to live and work here; leveraging our

25 liveability and to complete globally for talent;

26 investing in planning and transport infrastructure to

27 enhance our productivity; and helping businesses and

28 communities right across the State to benefit from the

29 Asian century by Government leveraging its

30 inter-governmental partnerships and working with

31 industry to better integrate into global supply chains

1 so that we grow the ability of Victorian businesses to

2 design, package, market and brand products for Asian

3 preferences.

4 I actually sit on the Gippsland Regional

5 Management Forum and this has been one of the

6 continuing conversations that we've been having about

7 increasing opportunities here in Gippsland.

8 The most recent strategic plan for Gippsland which

9 has just been recently released identifies three major

10 opportunities for jobs and economic growth. The first

11 is about really leveraging the tourism potential of

12 both coastal and bushland locations. The second is

13 around expanding intensive and organic food production,

14 and the third is really about leading dairy innovation.

15 If we then turn to how we build strong and

16 resilient communities: looking out to 2025 it's likely

17 that all parts of Victoria will face challenges from

18 changes in where people choose to work and live and an

19 ageing population.

20 Maintaining opportunities and equitable access to

21 services, both where populations grow, but also where

22 they contract will be a particular challenge.

23 We also know that we face challenges with people

24 living longer, which is a good thing, with projections

25 suggesting that there will be around 40,000 centurions

26 in 2054-2055, almost nine times the number in 2014/15,

27 and that an ageing population, as we always hear, will

28 impact on spending, with 70 per cent of the total

29 burden of disease and injury likely to be attributed to

30 chronic disease by 2022.

31 Breaking the cycle of disadvantage, particularly

1 in areas where it is particularly entrenched, is

2 therefore an absolutely key pillar of building an

3 inclusive and prosperous society.

4 For example, we know that there are lack of clear

5 pathways into work for young people, with 51 per cent

6 of 15-24-year-olds churning between periods of work and

7 unemployment. We know that our social services are

8 experiencing increasing client complexity. I spent

9 Friday talking with the Family Violence Royal

10 Commission about the growth in family violence and the

11 impact that has on families and communities, and social

12 service systems are not well equipped in their current

13 state to respond effectively.

14 Early intervention, integrated services and

15 services that are co-designed with communities can

16 empower communities and deliver tailored solutions to

17 local problems.

18 I would say that the early intervention argument

19 has been won, but the question of how to fund and how

20 to implement are central to making inroads. People

21 have families, people live in communities and people

22 are in very different circumstances and our services

23 need to account for this individuality. People have

24 existing strengths and motivations; we need to listen

25 and respond to these.

26 Of course, integrating service is a key part of

27 addressing complex multi-faceted issues such as family

28 violence, but integrating services requires

29 whole-of-Government social service system reform. We

30 have to find ways to empower workers to innovate and

31 deliver more personalised services, and place-based

1 localised responses are key to how we address the

2 particular needs of communities, and to do that we need

3 to entrust and empower those communities.

4 In particular, we will need to find new ways of

5 delivering services to vulnerable Victorians if we're

6 going to keep up with demand. That requires us to have

7 a much stronger focus on the achievement of outcomes.

8 Continuous improvement is possible if we measure and

9 track progress with rigor.

10 The system that sits behind all of our systems

11 needs to talk to each other and empower workers to make

12 a difference, and our interactions with clients need to

13 be both supportive and motivating, building confidence,

14 developing skills and capabilities and providing

15 opportunities for people to participate.

16 At our last regional management forum we agreed to

17 establish an education and community wellbeing

18 sub-committee here in Gippsland to progress this very

19 agenda.

20 If we move then through to how we best enhance our

21 health system. In many ways and in many areas

22 Victoria's health system performs well. We do have

23 some of the most efficient hospitals in Australia and

24 we are often referred to as having one of the better

25 health systems internationally.

26 However, there is no room for complacency.

27 Evidence from Gippsland and from across the State and

28 across the country shows there are areas where we can

29 do better.

30 Our current approaches do not work well for people

31 with chronic disease or complex needs. Care is often

1 not well coordinated to meet people's needs; we don't

2 have a strong enough focus on prevention, early

3 intervention and self-management; patients in

4 communities are not always treated as partners in care,

5 and there are variations in health outcomes across

6 different parts of our community.

7 With all of the forces of change continually

8 assailing the healthcare system, particularly the

9 rising levels of chronic disease and the needs of an

10 ageing population, there can be no time to rest if we

11 are going to continue to remain one of the best and

12 meet the demands of the future; in which case,

13 substantial and ongoing reform is of absolute

14 importance for the people of this region and Victoria.

15 So, what does this change agenda look like? The

16 health system is complex and can interconnected at

17 national, State and local levels. The Government and

18 its reform agenda is committed to creating a health

19 system that works well for all Victorians, no matter

20 where they live and work. This means Statewide

21 principles and approaches linked to national directions

22 but with the flexibility to meet and address local

23 needs. It means working with local communities in

24 close collaboration to co-design effective access and

25 provision of services. It means organising around

26 people, not providers, with a focus on individual and

27 population wellbeing, and it means developing new

28 models of access, service provision and flexible

29 funding that targets local priorities and needs.

30 The Government released Health 2040, a discussion

31 paper, in September to stimulate discussion about

1 directions for health reform. Alongside a call for

2 public views and submissions, the Minister for Health

3 recently held a health summit of leading clinicians,

4 administrators, academics and experts to discuss

5 opportunities to build an outcomes approach for the

6 health system, enable a more person-centered view of

7 healthcare, strengthen early intervention and

8 prevention, improve the way that health and social

9 service systems work together, and to promote a

10 stronger community voice and participation in the

11 design of the health system.

12 The summit's outcomes and submissions to the

13 Health 2040 discussion paper will inform the develop of

14 a detailed Government response later this year which

15 we'll be very happy to share with the Inquiry.

16 In parallel, the Travis Review reported to

17 Government in August. This review conducted a

18 Statewide census of hospital capacity and provided

19 recommendations about how to increase the capacity of

20 Victorian public hospitals.

21 The Government again is committed to implementing

22 all of the recommendations of that review which will

23 deliver benefits to regional areas of Victoria,

24 including ensuring that capacity and services are in

25 the right places to meet the needs of regional areas

26 and, importantly, ensuring that innovation is scaled up

27 and spread across the system so that the best ideas

28 have impact across the whole state.

29 A new framework for health planning will be

30 developed by 2017 to reform major infrastructure and

31 service planning and to ensure that in the future more

1 patients are treated more effectively in a timely way

2 as close to home as possible and in the most

3 cost-effective manner.

4 The Travis review also recommended the

5 establishment of a new body, Better Care Victoria,

6 which will be supported by Better Care Victoria

7 Innovation Fund and will have a key role in driving

8 innovation to increase the capacity of the public

9 health system, assess new health initiatives, scale up

10 proven initiatives, and improve the interface between

11 primary and acute care, as well as facilitating an

12 evidence-based approach to ensure long-term

13 sustainability. Again, we can provide more information

14 about the directions for Better Care Victoria.

15 If we move then through to how health is nested in

16 a broader approach to regional, economic and social

17 development. Earlier this year, John Brumby conducted

18 a review of regional planning and services, and one of

19 the key pieces of feedback he heard was that current

20 approaches for supporting regional strategic planning

21 would benefit from deeper engagement with local

22 communities and clearer feedback loops to inform and

23 influence State Government policy and investment

24 decisions.

25 The Government has committed to working with local

26 and Commonwealth governments to enhance partnership

27 models and ensure regional strategic planning covers

28 both Statewide and local priorities. This will build

29 on existing strategic plans - and I mentioned earlier

30 that there has just been a strategic plan finalised for

31 this region, but will, as I say, look to have much

1 deeper approaches to community engagement and clearer

2 feedback loops into Government.

3 I'm really confident that there will be

4 opportunities to develop stronger links between

5 Statewide, social and economic strategies, these

6 regional strategic plans, and then deeper dives into

7 local strategies to improve health and social service

8 systems.

9 As I said, the Government's response to that

10 review is due in the coming weeks and we'll make that

11 available to the Inquiry.

12 Cascading from whole-of-region planning to how the

13 health system develops in this region, I'm conscious

14 there's been lots of discussion through these Health

15 Improvement Forums on options to strengthen local

16 health planning and collaboration. There has been a

17 strong theme of adopting population health approaches

18 to focus prevention and early intervention on the

19 health issues that are the most relevant and important

20 to this community, and to adopt a community development

21 approach to health to strengthen health and broader

22 social outcomes. I would strongly endorse these

23 directions.

24 There is an opportunity to leverage national and

25 state reform efforts to maximise the impact of local

26 initiatives. Of particular note, in September the

27 Victorian Minister for Health released a new Public

28 Health and Wellbeing Plan. The vision of the plan is

29 for a Victoria free of the avoidable burden of disease

30 and injury, so that all Victorians can enjoy the

31 highest attainable standards of health and wellbeing at

1 every age.

2 The plan's priorities for 2015-2019: a healthier

3 eating and active living; tobacco-free living; reducing

4 harmful alcohol and drug use; improving mental health;

5 and preventing violence and injury. This is the second

6 of these Statewide health and wellbeing plans and is

7 stronger in its focus on health inequities.

8 The Government has also committed to deliver a new

9 10 year Victorian mental health strategy. The strategy

10 will focus on outcomes we want to see for people with a

11 mental illness, their families and carers, and the

12 broader community. It will have a strong recovery

13 focus and a strong focus on community-based support and

14 care.

15 Minister Foley has committed to a focus in the

16 plan on improving access to mental health services in

17 Regional Victoria.

18 These two plans, alongside the work of Better Care

19 Victoria and broader Commonwealth and State reform

20 discussions that Terry will discuss in a bit more

21 detail in a moment, provide a really valuable framework

22 for how regional services are planned and organised

23 going forward.

24 I also think that there is an opportunity to

25 leverage existing and emerging networks in this region

26 to drive planning and collaboration on prevention,

27 early intervention and more person-centered health and

28 social care.

29 I think it's critically important that the

30 approach to local improvement initiatives is

31 co-designed and co-produced through local leaders.

1 I know that the Commonwealth is interested in

2 kick-starting primary health networks, and I understand

3 that the Gippsland PHN is currently designing its local

4 subregional and regional level Government structures

5 and is kicking off work on strengthening care pathways.

6 Terry will talk more about the opportunities

7 presented by PHNs and other Commonwealth and State

8 processes.

9 But I in particular wanted to note local

10 leadership initiatives at the moment such as Carepoint,

11 which I think you've heard a bit about, and web-based

12 care pathways as really great examples of projects to

13 establish patient-centered care that is informed by

14 evidence and really helps to bring together different

15 professionals in a coordinated way.

16 In parallel, the Family Violence Royal Commission,

17 and reviews being led by Minister Mikakos and Minister

18 Foley, are very focused on strengthening social service

19 partnerships and networks to create simpler front doors

20 into social services, to integrate case management

21 services so that people don't have to re-tell their

22 story and navigate multiple services on their own, and

23 to keep building the evidence of effective

24 interventions to help people before problems escalate

25 and provide them with greater continuity of support.

26 I think there's a fabulous opportunity for the

27 Latrobe Valley to position itself to move first and be

28 the location to trial how these consolidating networks

29 can work together to achieve collective impact.

30 In further developing local services I'll just

31 finish with two reflections - I know this is a very

1 busy slide. The first is that I think there's great

2 merit in closely combining primary and community health

3 approaches to influence healthy behaviours and

4 strengthen screening, early prevention, early diagnosis

5 and treatment and management of chronic diseases.

6 For example, public health approaches can provide

7 knowledge about the prevalence of disease and public

8 health tools can enhance the planning of primary care

9 activities. Cooperation between these two sectors

10 could help to document unmet needs and the

11 identification of evidence-based health promotion

12 activities.

13 A health system based on a strong primary care

14 infrastructure and strong public health sector has the

15 greatest potential to optimise health of the population

16 as well as individual patients, and improving the

17 interaction between public health and primary care will

18 depend both on access to timely information about

19 regional and community health concerns and needs, but

20 also a deep commitment to cultural change and new ways

21 of working.

22 My second observation is that community health

23 services could provide a powerful platform for a

24 community development approach to health through strong

25 relationships with primary and social care services.

26 Community health services are, in my view, an excellent

27 vehicle for promoting healthy lifestyles and engaging

28 patients who may not otherwise be reached by other

29 services.

30 Through co-location and referral pathways,

31 community health services can play a valuable role in

1 coordinating care particularly for people with more

2 complex needs.

3 So, to conclude, delivering a Statewide approach

4 with local flexibility that produces real improvement

5 to health outcomes and wellbeing means being guided by

6 a clear set of principles. The Government's approach

7 to health reform is still evolving and will of course

8 be informed both by this Inquiry and the various

9 reviews that I have referred to today, but there are

10 common themes that come through clearly and

11 consistently from the people of the Latrobe Valley, the

12 Statewide consultations on health reform, and the

13 experience and evidence coming from other health

14 systems.

15 Future approaches should be guided by principles

16 of patient-centered care, a long-term whole-of-system

17 perspective, community development approaches to

18 health, collaborative local leadership which leverages

19 the networks that exist here today, and community

20 engagement and consumer empowerment.

21 For mine, I look forward to continue to working

22 with people, institutions and community groups of

23 Latrobe and Gippsland on the big tasks that lie ahead.

24 I wanted to finish by acknowledging that I

25 appreciate the traumatic and difficult time that this

26 region has been through and make my own personal

27 commitment that we will continue to listen and learn as

28 reforms and changes are developed and rolled out.

29 We are united in our determination to deliver real

30 and sustainable improvements in wellbeing in this

31 region, and build on our capacity to tackle and reduce

1 inequality, disadvantage and illness in the Latrobe

2 Valley. Thank you.

3 MR ROZEN: Thank you very much, Kym, for that very

4 informative presentation.

5 Our second speaker is also from the Department of

6 Health and Human Services. Terry Symonds is the Deputy

7 Secretary of Portfolio, Strategy and Reform. Thanks,

8 Terry.

9 MR SYMONDS: Thanks very much, Peter. I'd like to also

10 acknowledge that we're meeting on Aboriginal land today

11 and pay my respects to their elders past and present

12 and elders from other communities that are here today.

13 I think where Kym's finished off by talking about

14 principles is a good place for me to pick up. I would

15 say, my overall assessment would be that we're in an

16 exciting time in health reform where the key principles

17 and the pieces, if you like, of the jigsaw are now

18 fairly well understood and agreed across jurisdictions,

19 both in Australia and internationally, and the

20 challenge we have, I think, is to put those together

21 into a working model that is sustained beyond

22 individual projects or pilots or programs or the life

23 of this or that Government and I think we are very

24 close to that point.

25 I guess it's important to begin by acknowledging

26 that Victoria has great experience on the ground to

27 build on as we approach that key next stage. If we

28 look across that continuum of key principles or

29 pillars, if you like, of health reform that Kym

30 outlined, if we think about outcomes, our new Public

31 Health and Wellbeing Plan will require us to develop

1 regional outcome frameworks and measures that will

2 include, not only rates of chronic disease, but also

3 risk and protective factors at a regional level, and

4 also broader enablers, measures of social capital,

5 public participation, et cetera, things that we now

6 know are fundamental to improving the health and

7 resilience of local communities.

8 So, the requirement and commitment by Government

9 to develop regional measures of those things, I think,

10 is a really good position for us to measure the

11 outcomes of our work, not just the outputs or the

12 activity that we're doing.

13 A population-based perspective has a long history

14 in Victoria of work in particular areas around cancer,

15 diabetes, et cetera, a range of chronic diseases. The

16 example I've pulled up here, Pathways to Good Health,

17 is a program that's actually based in community health

18 targeting prioritised healthcare for children in

19 out-of-home care, our most vulnerable cohort of

20 children in the community.

21 I raise it there because I think we sometimes

22 think about population approaches to health as being

23 about primary prevention or tackling very upstream risk

24 factors, but population health also involves

25 understanding particular segments of the community who

26 may be at greater risk, and this is an example of us

27 using a strong Victorian platform in our community

28 health services to target priority access, particularly

29 at primary healthcare, for a population that we know to

30 be at greater risk.

31 Integration has been picked up by John in your

1 opening comments and touched on by Kym as well; this is

2 a very exciting time for us in integrated care, and

3 I'll come back to opportunities that I think exist at a

4 national level. There's a couple of examples there in

5 the slide. Carepoint is an experiment going on, a

6 collaboration between private health insurers and the

7 State to see whether coordinated access in the

8 community to GPs and private healthcare might help

9 reduce avoidable admissions to hospital.

10 Healthlinks is an example of the State relaxing

11 our long-standing activity-based funding model for

12 hospitals to give hospitals flexibility to take that

13 investment and put it into the community to help keep

14 people out of hospital and give them care where they

15 need it, and primary care partnerships - again, we have

16 something like 600 different organisations that

17 participate in 28 PCPs around the State, and so a

18 strong tradition there of collaboration between

19 sectors. I'll come back to what I think are some of

20 the opportunities ahead of us in terms of integration.

21 Participation: I've picked up mental health as an

22 example here. We have two years now of experience of

23 dialogues for consumers and consumer advocates and

24 representatives of consumer organisations to come

25 together, agree on their advice to Government, ensure

26 that they're influencing Government policy around

27 mental health services. We have an equivalent dialogue

28 that exists for carers and carer organisations.

29 Victoria has a recognised strong and long history of

30 participation by clients, consumers, carers and

31 families in healthcare.

1 I think we have a challenge ahead of us in terms

2 of public participation and thinking about how we

3 engage broadly with communities as well, not just those

4 that directly access our services. The Auditor-General

5 released a guide earlier this year to public

6 participation and a call on agencies to do more around

7 how to directly engage with communities, not just the

8 individuals that access our services.

9 To help meet that challenge we've established in

10 my own division within the Department an engagement

11 branch that will start to pull together good evidence

12 from around the world of public participation in policy

13 making to ensure that our policies and programs are

14 well directed to the needs of communities.

15 And place and the importance of location and a

16 local approach to services, the example I've pulled up

17 there of Koolin Balit is our Aboriginal strategy for

18 the Department. More than half of the budget for

19 Koolin Balit is actually determined locally by local

20 committees, including in Gippsland all of the

21 Aboriginal controlled community health organisations

22 who come together, they decide on local priorities and

23 how to spend that money, and the fact that a majority

24 of that money is committed to local investments

25 reflects, I think, the Department's commitment to local

26 prioritisation of needs and local control of our work.

27 That's a good base, I think, for us to move

28 forward. I want to touch on a couple of examples in

29 particular. Kym's referred to them in passing.

30 Primary health networks are the latest iteration

31 of the Commonwealth ongoing deliberations about how

1 best to fund and commission and manage GPs and primary

2 healthcare; they replaced the former Medicare Locals.

3 There are six primary health networks in Victoria that

4 are slightly larger and the intention is for them to

5 align with hospital networks.

6 There's an explicit intention for the primary

7 health networks to be in a position to aggregate local

8 need, understand local need and then commission

9 services in primary care to respond to that need.

10 The Commonwealth has appointed Steve Hamilton,

11 former president of the AMA, to chair a primary

12 healthcare advisory group, who are currently conducting

13 consultations and will report back to Government, I

14 think in December of this year, on options for primary

15 healthcare reform.

16 They are suggesting that the primary health

17 networks might go - they haven't delivered their report

18 yet, but one of the options canvassed publically by

19 them in their discussion papers is that the primary

20 health networks might oversee population-based funding

21 models for GPs. So in addition to them being paid on a

22 fee-for-service basis for individual episodes, they

23 might be paid to actually improve the health of

24 communities in which they work, and that might be a key

25 role for PHNs to ensure that that actually occurs. I

26 think it's a really promising direction, it reflects

27 what I mentioned at the beginning which is the emerging

28 consensus I think internationally, that we have to

29 bring together the curative individual oriented

30 platforms of healthcare, both in primary care and

31 hospitals, and move towards population-based approaches

1 to healthcare. The Commonwealth's explicit, at least

2 endorsement of that option being considered, reflects I

3 think that appetite and it's a huge opportunity ahead

4 of us.

5 Victoria and Australia are reasonably well placed

6 in that, sometimes better placed than we assume.

7 Something like two-thirds of all Australians when

8 surveyed say they have had the same primary care

9 practitioner for at least five years, and almost all

10 Australians over the age of 65 years old can name a

11 nominated primary care provider. That's a very good

12 platform, very good basis on which to think about, if

13 that is the case, why we still only fund GPs based on

14 the individual episodes of activity for which they

15 present to a GP.

16 We have essentially a good platform for enrolled

17 populations and a good conversation with GPs or primary

18 health networks more importantly about how those needs

19 can be better understood, planned for in advance and

20 services commissioned. That's an option the

21 Commonwealth is considering and it's premature to

22 comment directly on it, but we think it reflects a kind

23 of emerging opportunity.

24 If we go to the next slide, Victoria has an

25 opportunity to directly influence some of the work

26 going on. The Council of Australian Governments, COAG,

27 met in Sydney in July and commissioned the latest round

28 of national health reform work under the banner of

29 Reform of the Federation.

30 Sometimes national health reform feels like a

31 chronic condition in itself, particularly for

1 bureaucrats. But there's reason I think to have

2 particular hope and optimism about the process we've

3 got now.

4 They have commissioned two essential planks of

5 work: one around hospital funding and, because of the

6 sheer scale of dollars invested in hospitals, that will

7 always be a focus for national health reform work; but

8 they've importantly commissioned another piece of work

9 around coordination of care for chronic disease.

10 What the COAG agreement reflects is that consensus

11 between State and Territory Governments responsibile

12 primarily for hospitals and the Commonwealth

13 responsible primarily for funding GPs and primary care,

14 that they need to move from their respective platforms

15 beyond paying for activity in whatever form they do, to

16 starting to pay for better health and how to better

17 coordinate their services and align their services to

18 ensure that that is delivered.

19 Victoria has been asked by COAG to put the

20 proposal together and bring it back into COAG

21 in December for how that might occur. We are very busy

22 in conversations with other States and Territories

23 about that. There's a couple of important features

24 about whatever will come out of that that are worth

25 pointing out and I'll finish here.

26 The first is that, there isn't clear evidence yet

27 for any one particular model that's going to be

28 implemented. We're not going to pull something off the

29 shelf here and say, this is the model for Gippsland,

30 this the model for Geelong, this is the model for

31 Sydney. Evidence is still emerging - internationally

1 evidence is still emerging, and everyone's interested

2 but no-one's kind of got the holy grail yet. And so,

3 whatever model, whatever proposal we come up with here,

4 there's going to be flexibility for different options

5 to get tested and trialled, and I think that is an

6 opportunity that is worth considering in the context of

7 the Valley and this process.

8 The other is that, needs are different in

9 different areas, and so, whatever model is developed

10 has to involve local commissioning based on local needs

11 and a shared understanding between acute hospital-based

12 providers and primary care providers about what those

13 needs are.

14 The form that takes is not yet clear. Primary

15 health networks are an exciting opportunity, but they

16 have yet to deliver on commissioning primary care, let

17 alone commissioning broader spectrums of care, but I

18 think that's an interesting question for us to ask, is

19 what form that will take. But, regardless of the form,

20 alignment of the existing investment is an implicit

21 commitment, I think, now from State and Territory and

22 Commonwealth Governments, which is an historic

23 opportunity and goes beyond just making hospitals more

24 efficient.

25 We are now talking about putting together combined

26 resources of the Australian healthcare system to

27 improve population health on the basis of local needs,

28 determined by local bodies, and that I think is an

29 historic opportunity and we're at key stage in terms of

30 timing for this Inquiry, because I think the interest

31 and recommendations that you make will land at a time

1 when Governments, in particular the State Government,

2 are considering models and how best to actually

3 prosecute this discussion.

4 It's a good time for fresh ideas and a good time

5 to think about how best to apply locally some of the

6 emerging concerns that we've got. I'll leave it there,

7 thank you.

8 MR ROZEN: Thank you very much, Terry.

9 In the next little while we have some time set

10 aside for questions from myself and also from Members

11 of the Board of the two speakers that we've just heard

12 from. If we could invite both of you up to the stage,

13 if you don't mind.

14 Perhaps if I could kick off, and maybe just a

15 question for Kym. I'm just looking at your first slide

16 and you I think identified something which we've heard

17 a lot about during the forums, and that is the need for

18 long-term sustainable solutions to improving health

19 outcomes.

20 One of the particular themes that's come through -

21 one of the questions we've had from the community and a

22 lot of the submissions the Inquiry has received has

23 been the design of solutions and systems that can

24 outlive the short-term political cycle and the

25 challenge that that presents to Government; I was

26 wondering if that's something you are able to address.

27 MS PEAKE: Yeah, and I think the opportunity that presents

28 itself, both through the public health and wellbeing

29 plan that goes beyond the cycle of any one term of

30 Government, and that regional planning process that I

31 described, is what assists with durability.

1 The strategic plans that have been in place

2 regionally have cut across political cycles, have been

3 continued and built on. Of course, every Government of

4 the day is going to have particular priorities, and

5 that is why they're elected, but that sort of planning

6 process which is more deeply embedded in community,

7 thinks about the relationship between things like town

8 planning and land use planning and our health outcomes

9 I think is a fantastic vehicle for durability of

10 planning and solutions.

11 The third point I would make is that, as Terry's

12 just described, if we can get the relationships right

13 between primary health networks, the community health

14 platform and our hospital networks, then that local

15 leadership to maintain relationships and initiatives is

16 incredibly powerful.

17 MR ROZEN: If I could ask a follow-up question. Are there

18 things that local communities, and in particular the

19 community of the Latrobe Valley, can do as a community

20 to ensure that reforms are longer lasting beyond

21 political cycles?

22 MS PEAKE: Again, I would come back to that point about the

23 participation and collaboration of local leaders

24 through those service networks and those strategic

25 planning processes is important. Good ideas endure.

26 Good programs, they might be tweaked, slightly

27 repositioned, but at their heart, if they're having

28 outcomes, they have got a much more powerful case for

29 re-investment.

30 One of the things that we haven't done very well

31 right across the public sector is have really good

1 outcomes measures, and that, combined with an evidence

2 base on the efficacy of interventions, are the two most

3 powerful ways of convincing incoming governments to

4 stay the course on a health direction. Measuring of

5 outcomes relies at its heart on the data that is

6 collected through our services, measuring the efficacy

7 of our services again is importantly influenced and

8 supported by all of the clinicians in our system as

9 well as our public health professionals.

10 I think our local leaders are incredibly important

11 in setting their own destiny.

12 PROFESSOR CATFORD: I wonder if I could follow with a

13 supplementary, Kym. I absolutely agree that the public

14 health and wellbeing plan is a very useful sort of

15 platform. Of course, there's also an Act, and I just

16 wondered if you felt the Act was also a vehicle for

17 maintaining this continuity?

18 We heard at a previous forum the possibility of a

19 consultative council which is enshrined in the Act. Is

20 that another mechanism, do you think, that might be

21 suitable for advancing things in the Latrobe Valley?

22 MS PEAKE: Certainly, there are already consultative

23 arrangements that are both facilitated and required

24 through various legislation. I think that you also

25 want to make sure that you leave enough dynamism so

26 that, as contexts change over time, the focus of

27 consultative arrangements, and even the composition of

28 consultative arrangements can change as well; so,

29 there's always a balance between durability and

30 flexibility I think. I don't know if you want to add

31 anything to that, Terry?

1 MR SYMONDS: I would say the Act requires local governments

2 to develop public health and wellbeing plans. They are

3 variable across the State. As with all planning

4 exercises as to how well and how collaboratively

5 they're done; I'd commend the process that has been

6 followed here locally, I think there's been a lot of

7 consultation going on locally to ensure the plan is

8 reflective of advice that the council and the

9 stakeholders have received.

10 But I'm optimistic, I suppose, that if we put

11 council and acute health services and primary health

12 network and other groups together, and they all have a

13 requirement to understand local needs, they wouldn't be

14 doing it separately, the public health and wellbeing

15 plans locally in the Act, without any change in

16 legislation, would be informed by a consensus amongst

17 those groups about what those needs and priorities are.

18 PROFESSOR CATFORD: Could I just follow up also the comment

19 about outcomes, and I'm sure you're absolutely right,

20 we need to be much better at monitoring and tracking

21 outcomes. Of course, another development is actually

22 paying by outcomes, and I just wondered if you wanted

23 to comment on your thinking there.

24 Particularly, Terry, you were talking about the

25 pooling arrangements for the Commonwealth, which I

26 absolutely agree is a fantastic opportunity to

27 consider. I'm aware in other countries and in other

28 States, we've been looking at social impact bonds; is

29 this another vehicle or machinery that one could think

30 about in terms of putting more sort of rigor into the

31 system?

1 MS PEAKE: A couple of comments that I would make:

2 certainly, I think there is a great prospect in

3 thinking about how outcomes are used to drive

4 everything we do, not just sort of passively reported

5 against. It is obviously really important in designing

6 any sort of outcomes-based payment models that we don't

7 create perverse incentives, whether that's perverse

8 incentives to only service people with needs that are

9 easily accommodated, or whether it's about the benefits

10 of one set of activities by one part of the system

11 really being reaped by another part of the system. It

12 is important, and I've seen lots of examples of where

13 the way an outcome payments model has been designed

14 hasn't been sufficiently well thought through and has

15 actually led to unintended consequences.

16 So, the principle I really support; the design is

17 incredibly important, and it's important that we do

18 this in an evolutionary way as we get the data systems

19 better to enable us to have better outcome measures as

20 well.

21 A separate question then is whether a social

22 investment approach is required on top of paying by

23 outcomes. I think that there's kind of mixed evidence

24 about the cost-benefit analysis, and I think it is a

25 very case-by-case scenario. Incredibly even more

26 important when you get to a social investment model

27 that you've got the measures right, that you can

28 measure effectively the change that you're trying to

29 effect.

30 I would be tempted to step it out by thinking

31 about, where are the areas of health delivery where the

1 outcomes data is most readily available, where we then

2 think through carefully what the design of the funding

3 models are to give effect to those outcomes, and think

4 through whether social investment is going to give

5 added value, or whether in practice simply having a

6 really driven outcomes approach would achieve the same

7 end.

8 MR SYMONDS: The only thing I would add, John, this is a

9 problem I think of attribution. Healthcare is not the

10 major determinant of health, and for certain

11 individuals at particular stages healthcare is critical

12 to their survival, but in general for populations

13 there's a range of factors, including their income, the

14 physical environments they're in, their access to means

15 to maintain health, et cetera, that we think are more

16 important, so attributing outcomes to individual

17 organisations, particularly healthcare organisations,

18 is difficult in that regard, but I think it's a

19 direction that we welcome, it's certainly something

20 that we and other Governments are spending a lot of

21 time thinking about.

22 From my own point of view, I think the key thing

23 is to balance incentives and I think that's the right

24 direction to go because, if there is some remuneration

25 that is tied outcomes, the same as there should be some

26 tied to quality, then it balances the other incentives

27 that are in place for providers to be efficient for

28 instance or to minimise costs, and I think we need a

29 balance of incentives for providers, not everything in

30 one basket.

31 I think, from our point of view, we're working

1 towards hospitals having at least some part of their

2 funding tied to their work to reduce admissions, rather

3 than just paying for admissions - that's a balance of

4 incentives. I think likewise for primary health

5 networks and for GPs, and the Primary Healthcare

6 Advisory Group of the Commonwealth flagged this,

7 they're headed towards a mix of incentives for GPs, not

8 just a payment of a schedule for the episode for the

9 patient that's walked through the door, but perhaps we

10 need a mix of incentives for GPs as well, and if we get

11 alignment across those platforms, then I think we're

12 moving towards outcomes for which we share

13 responsibility while looking after things that are in

14 our own patch.

15 MRS ROPER: I have a question. A lot of what we've talked

16 about this morning - they were very interesting

17 presentations - was long-term, there's a lot of reviews

18 and a lot of work to be done in integration and all

19 very important to institutionalise. But part of our

20 terms of reference is also looking at long-term

21 actions. Do you have any thoughts about where we could

22 be focusing our minds at the moment, or the local

23 community could be focusing their attention on

24 short-term actions that will help build a base as a

25 foundation towards some long-term objectives?

26 MS PEAKE: I'll start and Terry will have some other

27 observations. I think a couple that we mentioned this

28 morning are early actions that could be progressed:

29 the first, the Carepoint project, that Carepoint trial

30 really looking at integrated care in the sphere of

31 chronic disease is a really important foundation for

1 thinking about longer term approaches.

2 Similarly, the thinking about the work that the

3 PHNs are doing around web-based healthcare pathways

4 again is a really critical first step in how

5 professionals work together differently and more

6 effectively.

7 The final one for me was that example I used

8 around the community health platform and how we might

9 make more use of it to better support people who have

10 multiple needs, and to start joining up the social

11 services response and healthcare response to meet those

12 needs. It's an existing platform, it's servicing

13 clients already who often have those multiple needs,

14 it's a really good platform to start work on.

15 MR SYMONDS: I think I'd follow the same theme, Anita. My

16 observation is, the State and Commonwealth Governments,

17 they're open now to proposals to relax some of their

18 existing arrangements if it means that they will get

19 better outcomes for their investment. I think both

20 State and Commonwealth governments are open to

21 suggestions and ideas around that.

22 Every State in Australia has at least two or three

23 trials going on at the moment of integrated care

24 between primary and acute health, and each of them are

25 different, each of them represent the State

26 Government's relaxing to varying degrees on existing

27 arrangements and being prepared to invest in things to

28 see if they work; all of them rely on local players

29 coming to the table with shared agreed proposals around

30 how that might happen.

31 I've heard about discussions here around care

1 pathways, using map of medicine - a UK developed

2 tool - to come up with pathways to help us work out

3 what's the most appropriate point at which individuals

4 in the community might access the healthcare system.

5 If we can come up with proposals to share what we

6 already have on the table and move it around to ensure

7 that we get the best outcome based on evidence about

8 what we know about what people need, then I think

9 everyone's in a mood to talk.

10 I think now's a good time to think about proposals

11 for how to use the investment we've got for better

12 effect.

13 MR ROZEN: If I could change the topic a little. One of the

14 practical problems that we've heard about that people

15 face here is having to travel to Melbourne to take

16 their children to see specialists or themselves to see

17 specialists. At the same time, we've also heard about

18 the opportunities presented by telehealth in that

19 regard, the ability to reduce the inconvenience and

20 costs of travel by making greater use of technology. I

21 was wondering if that's something you're able to

22 address.

23 MR SYMONDS: So telehealth, like other developments we've

24 talked about, is at a relatively early stage in its

25 development. There is no question that telehealth

26 improves the experience for patients living in rural

27 and regional communities and avoids the inconvenience

28 of travel.

29 I think the balance that is not yet sorted

30 internationally in evidence is around safety, quality

31 and most efficient kind of model: is it more efficient

1 to do that than it is to have specialists travel or to

2 subsidise travel to large centres? Do you risk

3 disbursing the volumes that are necessary to ensure

4 that you've got quality that comes from concentrating

5 services and making sure that the people that do a

6 certain job do it in sufficient numbers, that they do

7 it really, really well - do you risk that? There's

8 some of those questions, I think, that are still being

9 sorted, but the Government, like all governments, are

10 committed to doing that and there are a number of

11 projects underway now, including in areas of

12 paediatrics, orthopaedics, et cetera, where we're

13 looking at models of doing that, and investing in

14 experiments to try and develop that evidence.

15 Again, if there are particular proposals from the

16 Valley for that kind of work, then I think the

17 Department's in a good position to discuss them.

18 PROFESSOR CATFORD: Just picking up that theme, and trying

19 to focus down on the Valley, do you think there's a

20 case for articulating a special designation for the

21 Valley?

22 In our first report we talked about the notion of

23 a health conservation zone, but leaving aside the name,

24 is there merit in thinking of the Valley as a special

25 focus for health innovation for example, where this

26 would be the place of choice to trial and investigate

27 new opportunities? Because clearly, in terms of trying

28 to bounce up, as one of our consultants recommended in

29 a previous forum, we need not just to return the Valley

30 to its former health status, but to actually advance it

31 very significantly. Therefore, is there a case to

1 actually suggest and indicate that the Valley is a

2 special focus for investment into the future?

3 MS PEAKE: I think, building on what we've both talked

4 about, I wonder whether just a slight re-framing -

5 rather than a sort of a top-down kind of anointed

6 designation, the support and encouragement to leverage

7 the local ideas and networks - and I really hand on

8 heart say that there are incredibly strong networks and

9 planning that's happening in this region making use of

10 the opportunity of these hearings that have, I agree,

11 catalysed and galvanised a lot of that collaboration

12 across the region to put forward those ideas has the

13 same practical effect of then having early action,

14 prioritised investment, exemplars and trials of new

15 ways of working, but it's really been co-produced,

16 co-created through community leadership rather than it

17 being sort of imposed on the community that, here are

18 the things that you will innovate in relation to.

19 MR SYMONDS: I'd comment that, I think there's a number of

20 reasons why I think Gippsland and the Valley has a

21 strong case for trialling new initiatives: one is to do

22 with need, and Kym's presented some of the rates of

23 chronic disease; access to services is another question

24 where I think we can do better; but social capital,

25 rates of public participation I think are promising.

26 The other thing is, the intersections between

27 providers. I think the collaboration that occurs

28 between providers is a key factor in the success of any

29 initiative that we're going to do going forward. There

30 may be more needy communities from time to time, but if

31 the relationships don't exist as a platform on which to

1 trial different initiatives, then we're asking a lot as

2 a kind of a step up; whereas, I think that platform

3 that exists here in the form of the relationships

4 between primary care and acute providers, that is a

5 very good platform in which to do something.

6 I guess my comment, and reflecting on your

7 questions about funding models and so on, I think to me

8 that's encouraging, because the national context, the

9 national reform context means, anything we trial now

10 has to be with an eye towards how this could be

11 replicated and spread for the benefit of other

12 communities, and there might be reasons to say this or

13 that community is well placed to trial something, but

14 we're in a position now where we have to develop

15 because of larger pressures around demographics, health

16 costs, et cetera. Demand for health services is a much

17 greater issue now for governments than price and cost.

18 We have to deal with those things across all

19 communities, so anything that we do in any local area

20 has to have an eye to its replicability across the

21 community.

22 MS PEAKE: I think what you're hearing from both of us is

23 that there's a natural convergence in terms of need,

24 leadership and focus, and it is the right time to

25 leverage all of that in an environment where reform

26 ideas are both being looked for and supported by all

27 levels of Government, and so, packaging up what those

28 proposals are, I would be very confident would be

29 really well received by all levels.

30 CHAIRMAN: Can I follow up that to ensure whether there's

31 any region in the last two to five years, if you like,

1 which has been particularly outstanding in overcoming

2 sibling rivalry and other problems that do apply in

3 certain areas, in just getting their act together so

4 that they really are at the forefront of pressing, the

5 State Government in particular, to be involved to lead

6 the way in some of these areas?

7 MR SYMONDS: The last part of your question is more

8 difficult for me to get a read on. If I can make a

9 couple of observations, I think Geelong is worth having

10 a look at. I think Geelong has some advantages in

11 terms of both pressing imperatives, particularly around

12 significant shocks to employment in the area, job

13 losses, but also very thick strong networks between GPs

14 and other healthcare providers, and so, I think they've

15 come up with interesting ideas and been very proactive

16 with them to the Department and the State Government.

17 That's one example that comes to mind. I can't comment

18 on how that's positioned them in terms of additional

19 Government investment, but I think it's been noted,

20 both in Victoria and nationally, how strongly that

21 group of providers has been able to say, let's think

22 about how to get shared care of patients and

23 populations across the community and put some new

24 initiatives in place. That's just one that comes to

25 mind.

26 PROFESSOR CATFORD: I wonder if we could switch tack a

27 little bit to talk about local issues. Kym, you

28 mentioned community engagement, that the Department was

29 moving on that. Maybe you could just outline what

30 actually is happening, because obviously we have been

31 very interested in that area.

1 Perhaps also as a supplementary, just comment on

2 Aboriginal health, which I think Terry also commented

3 on as well - you know, what's happening down here?

4 MS PEAKE: Sure. In terms of community engagement, again

5 there's both a Statewide approach and local activity

6 that is underway. Terry mentioned that in the last

7 month we've created a new community engagement unit in

8 his division that is absolutely intended to be a centre

9 of excellence for the sorts of techniques that you

10 adopt for different purposes and the different channels

11 that you use.

12 My substantive position in the Government is the

13 Deputy Secretary responsible for a whole range of

14 governance policy and coordination functions in The

15 Department of Premier and Cabinet, including

16 communication and sector engagement, so we're

17 partnering closely with my team back in DPC about what

18 is happening around the world, what are the different

19 techniques you use if you're talking about feedback on

20 particular services versus input to different health

21 policy questions.

22 That's at the sort of whole-of-department level.

23 More locally we're currently recruiting through the

24 regional office for a community engagement officer for

25 Morwell; they will work closely with a similar position

26 that's being created in the EPA to make sure that,

27 before, during and after any future events that we've

28 got much more expertise locally, but also obviously

29 would have an ongoing role in terms of engaging with

30 the community about what matters to them.

31 Engagement is important, that it's both ways; it's

1 not only about pushing out information, although that

2 is important, it's also about genuinely having feedback

3 back. That's probably the space on community

4 engagement.

5 The third level of this I mentioned was the new

6 regional governance arrangements. Again, I can't talk

7 too much about those, they are in front of Government

8 to be considered currently, but absolutely the

9 principle is, how do we design collaborative,

10 whole-of-region strategic planning mechanisms that

11 involve all levels of Government and community and

12 business leaders where that regional governance is not

13 the only voice that feeds back to Government but

14 actually is the vehicle through which there is deeper

15 engagement with the community. So, there will be more

16 to inform you about on the practicalities of how that

17 engagement will work and the tools that will be adopted

18 in the next couple of months.

19 In terms of Aboriginal health: certainly one of

20 the really key initiatives that was started by Gill

21 Callister in this location was a partnership network

22 arrangement where she was the champion and heavily

23 invested and involved in working with the Aboriginal

24 organisations about strategies, particularly focused on

25 children and families to improve social outcomes. That

26 work has been going on for the last five years.

27 I have just agreed that I will take over the sort

28 of championing role for that work. I think we're at a

29 point where there is really significant relationships

30 that have been built and a clear agenda. The next step

31 is to look at, how does that then translate into

1 specific projects and proposals which may include

2 looking at a cooperative arrangement which has not been

3 in this part of the region for a while. So, there's a

4 few promising - it's not health-specific, but a few

5 promising opportunities for how the Aboriginal

6 communities down here are working together and with

7 Government to achieve better outcomes for children and

8 families.

9 MR ROZEN: Thank you very much for the moment, Kym and

10 Terry, we'll be inviting you back to participate in the

11 panel discussion later on after we've had a break for

12 lunch. It is my happy responsibility now to inform

13 everyone that we're going to have a 15 minute break for

14 a cup of tea or coffee. I'm sure the catering standard

15 here is as good as it has been on previous days. I

16 make it just after 10 to 11, so perhaps if we could

17 reconvene at 10 past 11 please.

18 (Short adjournment.)

19 MR ROZEN: Welcome back, everybody. We have as our next

20 speak, Councillor Dale Harriman, who's the Mayor of the

21 Latrobe City Council, probably known to many people in

22 the room. Dale, if I could call you up to the lectern,

23 please.

24 CR HARRIMAN: Thank you. I too would like to acknowledge

25 that we're meeting on a traditional land of the

26 GunaiKurnai people and pay my respects to their past

27 and present elders and any elders who may be here from

28 other tribes.

29 Thank you for inviting me here today. It's a

30 pleasure to be involved, from our community point of

31 view, with such an important discussion; a discussion

1 that has the potential to transform our community and

2 its fundamental sense of self.

3 I'd like to firstly thank you for allowing council

4 and its officers to be involved in a range of meetings

5 and discussions. Staff have valued the opportunities

6 to meet, discuss and explore a range of health-related

7 topics with experts in their field.

8 As an organisation, we are passionate about the

9 long-term health and prosperity of our community, and

10 we implore the Inquiry to make a number of

11 recommendations which enable transformational change to

12 occur in this space.

13 We have broadly stated our overwhelming support

14 for the establishment of a health conservation area and

15 a Health Advocate, and today we will seek to provide

16 some reflection on how this may operate in the future.

17 My presentation today will consider the

18 establishment of the Health Conservation Zone, the

19 appointment of a Health Advocate, as well as council's

20 view on embedding sustainability into any approach

21 moving forward and a range of recommendations.

22 While council is a strong partner of the health

23 sector, we provide only a small reflection on these

24 matters relating to clinical care and practice,

25 believing that those more closely connected to the

26 system are best suited to identify opportunities for

27 its enhancement.

28 If we consider the establishment of a Health

29 Conservation Zone as a health response, then it's

30 council's view that the system requires the enhancement

31 across the whole of the health community.

1 However, we believe that the largest investment

2 should be made in the areas of prevention. Every

3 effort should be made to empower residents to improve

4 and enhance their own health and wellbeing to keep them

5 out of the health system for as long as possible.

6 Council's consistent position has been that any

7 structures, agencies or initiatives established to

8 support the long-term health of the Latrobe Valley

9 should be aligned to the Public Health and Wellbeing

10 Act 2008. Utilising existing legislative structures

11 leverages established Government practice, existing

12 reporting arrangements, partnerships and collaborations

13 across the sector while preventing unnecessary

14 duplication.

15 It is important to note that the Act currently

16 requires the council to develop an MPHWP, examine data

17 about health status and health detriments, identify

18 goals and strategies based on available evidence,

19 provide for the involvement of people in the local

20 community and specify how council will work in

21 partnership with agencies undertaking public health

22 initiatives.

23 Council meets these requirements through the

24 provision of appropriate resources and staffing.

25 However, the scale and impacts sought to be achieved

26 through a structure such as a health conservation zone

27 is well beyond the financial capacity of council,

28 particularly with so many current constrained rates

29 environments.

30 In an innovative approach, council is

31 demonstrating the ability of the public health and

1 wellbeing lens, currently utilising the Municipal

2 Public Health and Wellbeing Plan, to guide its most

3 recent emergency recovery activities.

4 In partnership with the Community Recovery

5 Committee, council is facilitating the development of a

6 mine fire community resilience plan for the community

7 at Morwell South and as an addendum to the Municipal

8 Public Health and Wellbeing Plan at appendix A.

9 This strategy will require the same level of

10 accountability and public transparency as is provided

11 to the Municipal Public Health and Wellbeing Plan. The

12 structure further provides a framework within which the

13 community can be focused on enhancing their health and

14 wellbeing outcomes as opposed to focusing on the trauma

15 of the event.

16 The data of the trial has been completed in the

17 community of Morwell South, or the Rose Garden

18 community as they now refer to themselves as. Through

19 a community development strength-based approach, the

20 council has supported the neighbourhood to build their

21 own localised health and wellbeing plan owned, created

22 and now being delivered by the neighbourhood.

23 Likewise, it may be possible to shape the

24 establishment of the Health Conservation Zone and a

25 Health Advocate within the current frameworks of the

26 Public Health and Wellbeing Act 2008. The Act

27 currently makes provision for the establishment of

28 consultative councils. We believe that this may be the

29 appropriate access for the creation of a Health

30 Conservation Zone.

31 Utilising an existing structure further has the

1 benefit of timeliness in that, as the existing

2 provisions, it can be enabled by the Minister

3 immediately. Such a model would utilise existing

4 structures and settings while maintaining public

5 accountability, transparency, as well as a lens to

6 support confluence within the existing health system.

7 Council recommends that the Health Conservation

8 Zone should be established for a period of at least

9 10 years to coincide with the work being undertaken

10 through the Monash Health study. The Health

11 Conservation Zone should provide an annual report to

12 the community; use a strengths-based approach; focus on

13 the social determinants of health; ensure that the work

14 of the Health Conservation Zone is placed through the

15 lens of an asset-based approach; facilitate the

16 establishment of neighbourhood health and wellbeing

17 plans following on from the work already commenced by

18 council.

19 To ensure that the Inquiry's recommendations are

20 able to make a meaningful difference, adequate funding

21 will need to be provided to facilitate opportunities

22 for innovation, transformation and dynamic co-creation.

23 During the Inquiry hearings, the forums, and

24 indeed the Inquiry's report, there's been considerable

25 discussion around the conditions of our community.

26 Part of this has been an examination of the Latrobe

27 community in a range of health statistics, most of

28 which painted a fairly bleak picture about the

29 continued health and wellbeing of our community.

30 However, if we look to our community through the

31 lens of a strengths-based approach, there are many

1 things we can remain proud of. In my mind, the most

2 critical of these is local community leadership.

3 Local leadership during the mine fire, after the

4 mine fire and in more recent weeks and months has been

5 one of the greatest strengths of this community, which

6 is remarkable if we consider the range of challenges

7 that our community has faced: bushfires, flood,

8 structural adjustments to its economic base, pockets of

9 chronic disadvantage, long-term industrial exposure to

10 asbestos, just to name a few. In spite of all this,

11 ours is a community that, even in the most difficult

12 and challenging of times, will nurture leaders, leaders

13 who will speak to the community, connect with the

14 community and give tireless service in support of the

15 community.

16 Local leadership continues to be our strength and

17 council's position is that any structure of methodology

18 moving forward should seek to harness and utilise this

19 strength.

20 We would like to acknowledge with gratitude and

21 thanks three key local groups who have played an

22 important role in the local leadership space: the

23 Community Recovery Committee has, for over the last

24 12 months, worked with council, the State and the

25 community to develop and implement a recovery

26 methodology which seeks to empower community to build

27 stronger resilience, social cohesion and wellbeing.

28 The Morwell Neighbourhood House: during and after

29 the event the Morwell Neighbourhood House has provided

30 a vital information conduit to the community,

31 establishing itself as a trusted source of information.

1 Voices of the Valley have emerged through

2 adversary to become a strong voice of the community,

3 challenging the status quo, holding others to account

4 and seeking to draw attention to uncomfortable issues.

5 A Health Advocate will need to ensure that the

6 community, in speaking to Government, does not replace

7 the voice of the community. A Health Advocate will

8 need to have a strong and positive working relationship

9 with the health and Allied Health sector, council and

10 the State and Federal Government.

11 The role of the advocate may be difficult for one

12 individual to fill, therefore again we look to the

13 Public Health and Wellbeing Act for guidance. Within

14 the provisions of the consultative council it states

15 that the Minister may appoint a number of members

16 specified by order.

17 Of the members appointed by order under

18 subsection (3), one must be appointed as Chairperson,

19 one may be appointed as the deputy chairperson, with

20 the majority being appointed with special knowledge in

21 the relevant matters. This structure allows specialist

22 skills and knowledge and can be shared amongst the

23 members.

24 Council sees the key specialist skills requirement

25 being, knowledge and experience in empowering

26 communities in health prevention, community development

27 and clinical health. Our position is that these three

28 advocates are possibly one Chief and two deputies. The

29 Office of the Health Advocate will require a team of

30 skilled professionals to support the advocates, much

31 like the highly skilled team supporting the Inquiry.

1 The Office of the Health Advocate will require

2 appropriate funding to empower a community-centred

3 methodology, which is perhaps bolder and more

4 experimental in its approach to health prevention and

5 health services.

6 The Office of the Health Advocate must - and I

7 emphasise, "must" - be located in the Latrobe Valley;

8 more specifically, it must be located in Latrobe City.

9 The work of the Office of the Health Advocate must

10 leverage, complement and enhance work already being

11 undertaken; have experience in deploying a

12 community-led strengths-based approach which is deeply

13 grounded in engagement and community capacity building.

14 There must be a resolute belief in the wisdom of

15 the community to empower the community and to create

16 solutions to community issues. A strengths-based

17 community approach will be critical to creating

18 momentum, sustainability and growing community

19 resilience. The Health Advocate must recognise that

20 the real leaders and creators of any sustainable

21 solution will be the community itself.

22 Healthy Together Latrobe has a unique partnership

23 between Latrobe City Council and the Latrobe Community

24 Health Service. This approach occurred in the health

25 prevention space through a settings approach. As with

26 any unfunded programs, there is a risk this work will

27 be forgotten in the rush to embrace the new health

28 prevention paradigm. We would simple request that we

29 not lose the good work already undertaken but use it as

30 a platform for what's next.

31 Council's mine fire recovery work is a trial of

1 neighbourhood settings and we believe this has worked

2 well in connecting with the community. The investment

3 through Healthy Together Latrobe is a demonstration of

4 possibility, that agencies are able to work

5 productively in creativity in partnership to improve

6 the health and wellbeing of our community.

7 Finally, having read, listened and participated in

8 a range of forums on health and wellbeing in our

9 community, council respectfully presents to the Inquiry

10 a range of replications for consideration.

11 In the short term it is difficult to disassociate

12 the health challenges of our community from its broader

13 social, empowerment and economic challenges.

14 Indeed, the social determinants of the health

15 requirements are a significantly broader consideration

16 than just the health system or the health prevention

17 system.

18 The recommendation: the Community Engagement

19 Communication Panel recommended that the State lead the

20 development of a bipartisan, economic development and

21 transformation plan for the Latrobe Valley, and that

22 this plan involve significant community engagement,

23 consultation and investment. Council supports this

24 recommendation with a request that the work commence in

25 2016.

26 The Health Conservation Zone must be holistic in

27 its consideration of the Latrobe Valley community. A

28 purely clinical health system response will not fix the

29 underlying determinants of ill-health.

30 Council's view is that a community which is

31 healthy, connected and engaged, is more inclined to

1 take action to ensure its own health and wellbeing

2 outcomes and will be sustainable beyond any initial

3 investment.

4 The recommendation: a neighbourhood setting

5 approach to community health and wellbeing such as that

6 currently being undertaken by Latrobe City Council be

7 immediately funded to continue to work with the

8 community to identify opportunities to enhance health

9 and wellbeing. It should be noted that council's work

10 in this space will conclude in December 2015.

11 A Health Conservation Zone provides an opportunity

12 to deploy a range of initiatives and trials to a

13 community in desperate need of intervention. While

14 such a recommendation may be challenging for the State

15 to consider from a funding perspective, there are many

16 pioneering community-led engagement approaches which

17 could be trialled in the Latrobe Valley and then

18 replicated more broadly across Victoria.

19 The recommendation: that the Latrobe Valley be

20 established as an innovative health preventative hub of

21 excellence and share its learnings with other

22 communities. The establishment of a Health

23 Conservation Zone and Office of the Health Advocate,

24 and engage with the community to co-create the

25 objectives, functions and public reporting requirements

26 of the Health Conservation Zone and the essential

27 characteristics of the Health Advocates.

28 Expand the terms of the Hazelwood Mine Fire health

29 study to include persons who worked in Morwell but

30 reside outside of Morwell. This is an area of major

31 concern to the community, and I know it's not in my

1 notes but I want to reiterate this.

2 We have a large number of people that worked

3 within Morwell and worked within Latrobe City that

4 reside outside of Morwell or reside outside of Latrobe

5 City. They were in that mine fire doing their eight,

6 10, 12 hour days and bearing the brunt of it. We know

7 the residents took 24 hours a day, but those working

8 there took their eight to 12 hours a day as well and it

9 had a huge impact on them as well, and we think they

10 need to be undertaken into the health study as well.

11 Recommendation: particular focus and commitment be

12 given to screening and managing health within

13 vulnerable communities through engagement with the

14 community to create and craft a unique screening and

15 engagement response that is both safe and in place.

16 The Health Advocates immediately investigate the

17 issue of roof cavity cleaning and make recommendations

18 to the State.

19 Immediately consider the role of the Health

20 Advocates within the State emergency arrangements,

21 including liaison with the State and community

22 communication and engagement principles as well as the

23 Municipal Emergency Response Plan.

24 At the moment, if there is another fire, if there

25 is another issue relating to the health of the Latrobe

26 City community, the Health Advocate cannot get involved

27 until after that emergency. We need the Health

28 Advocate to be involved as soon as the emergency

29 starts, to be part of the State emergency arrangements,

30 so that, when it happens we have somebody who's

31 advocating for the community, in the interests of the

1 community, there on the ground speaking for the

2 community. We don't need, as has happened in the past,

3 bureaucrats coming from Melbourne telling our community

4 what they need to do. Our community knows, our

5 community understands, and having an advocate that is

6 locally based, that is aware of the issues in this

7 region, will be able to step in and will be able to

8 provide a trusted local voice.

9 Recommendation: adequate funding be allocated to

10 implement the Morwell urban design revitalisation plan

11 currently in development as a response to the mine fire

12 to enhance the liveability and economic resilience of

13 the Morwell community.

14 Recommendation: that the Health Conservation Zone

15 have a strong focus on prevention, recognising that the

16 focus must be on keeping the community healthy as

17 opposed to focusing on treating them once they become

18 ill.

19 Recommendation: that the state regulators commit

20 to undertake a process with Health Advocates to create

21 within the community a vision for the remediated

22 Hazelwood Mine.

23 Recommendation: that the state use all available

24 mechanisms to ensure that there is not a repeat of the

25 Hazelwood Mine Fire and that the risk of such an event

26 is eliminated for the community.

27 Recommendation: that the State utilise its

28 considerable employment capacity to grow jobs in the

29 Valley through regionalisation of Melbourne-based

30 agencies. It is recommended that at a minimum the

31 Department of Energy and Earth Resources and the

1 Environmental Protection Authority be relocated to the

2 Latrobe Valley.

3 Recommendation: investigations be given to

4 enhancing the customer experience within the health

5 system with a particular focus given to client

6 centricity, connectedness of service and the

7 establishment of a client concierge which supports

8 those experiencing ill-health to make decisions,

9 appointments, connections and arrangements during a

10 time of impaired or compromised capacity.

11 In closing, I'd like again to thank the Inquiry

12 for the commitment to the community of the Latrobe

13 Valley. Your collective investigation, consideration

14 and commitment to a wide number of issues pertinent to

15 the long-term health and wellbeing of this community

16 has been remarkable.

17 Our thanks to you and your staff for your

18 generosity with your time and expertise. We wish you

19 well in your deliberations and we look forward with

20 a degree of excited anticipation to your final report.

21 Thank you very much.

22 MR ROZEN: Dale, I might just ask if you could stay. Thank

23 you very much for that very focused and practical

24 presentation. We have a short amount of time now in

25 which questions could be asked of you, if that's all

26 right.

27 CR HARRIMAN: That's fine with me.

28 MR ROZEN: They won't be too challenging, I hope. The first

29 thing I'll ask, if I can kick it off, one of the themes

30 that has come through some of the consultations by the

31 Board has been general support for the idea of an

1 Office of the Health Advocate, general support for the

2 idea of designation as a health conservation or

3 improvement zone, or whatever title one gives it. But

4 a concern that, in an already complicated health

5 system, one wants to avoid adding another layer of

6 bureaucracy. I just wonder if that's something you

7 could make some observations about.

8 CR HARRIMAN: What we're looking at is, we have some highly

9 qualified professionals already here, we have some

10 organisations already set up to work in that area.

11 It's not a matter of setting up a new organisation to

12 run it. Use the organisations that are already there;

13 just fund them to do it.

14 We've got Latrobe Regional Hospital, we've got

15 Latrobe Community Health, just to name two, that can do

16 the work, that have the expertise, that have the

17 people, that understand the local community and have

18 people, more importantly, that understand the local

19 community. They need funding to be able to do that,

20 and that's where we'd be looking at, to those

21 organisations, and I won't talk to all of them because

22 they are here to talk for themselves, but we would see

23 organisations such as those that already exist being

24 the bodies that are used to provide the people to

25 provide the Health Conservation Zone and the Advocates.

26 They're already doing most of the work already, they're

27 just underfunded. Fund them properly, let them do the

28 whole work.

29 So rather than setting up a new level of

30 bureaucracy, rather than setting up a new level that

31 the community's got to fight through, these are groups

1 that are already in contact with the community and

2 already working with the community.

3 MR ROZEN: The second question that I had concerned the

4 long-term health study, which is an issue that's come

5 up for the Board, and particularly the scope of the

6 health study and the focus in it on residents of

7 Morwell rather than, as you explained, people who came

8 into Morwell to work during the mine fire.

9 My question is this: you paused in your

10 presentation to talk to us about that. Is that

11 something that's been raised with council?

12 CR HARRIMAN: It is, it is a comment that continually comes

13 up and it is something that is of major concern to the

14 whole community. There's a lot of people that worked

15 through the mine fire, in the Morwell area, in the

16 Morwell South area; there's a lot of people outside the

17 city that came to within the city and we need to look

18 at those people as well, because their health has been

19 affected majorly by the mine fire.

20 A prime example is, we had a lot of CFA volunteers

21 came in, were doing a lot of 12, 14 hour shifts; they

22 don't live in Morwell but they're in the mine fire

23 fighting the fire and they're not included in the

24 health study.

25 We had a lot of staff in Latrobe Valley, our

26 office is in Morwell South, that came into every day

27 doing 10, 12 hour shifts that were in amongst the mine

28 fire smoke that lived outside the Valley.

29 We have a lot of business owners and a lot of

30 people that come and work within Morwell in offices, in

31 retail outlets, that work in Morwell that do 8-10 hour

1 days that aren't covered by the health study. So we

2 think it's vitally important, not just for the people

3 that had to put up with it 24 hours a day, but those

4 that got high level exposure to it as well.

5 PROFESSOR CATFORD: May I thank you very much, you've made

6 some very compelling recommendations; I counted 15, I

7 don't know if my arithmetic is correct.

8 CR HARRIMAN: I only had 20 minutes to speak, sorry.

9 PROFESSOR CATFORD: I suppose my overarching question is

10 about the council's commitment to advance any of those

11 recommends. Perhaps you might couple that with your

12 intended response to continuation of Healthy Together

13 Victoria.

14 We've heard a lot of very good complimentary

15 comments about the work the council's been doing

16 through Healthy Together Victoria, but clearly there's

17 some concerns about the continuity with that. So,

18 would you like to make a comment about your commitment

19 to investment in some of those measures?

20 CR HARRIMAN: Certainly, with Health Together Latrobe

21 council is currently funding it with Latrobe Community

22 Health Services. Government funding has dried up,

23 we're continuing on with it. We believe funding will

24 run out in December from the State Government, which

25 will make it very hard for us to continue with it.

26 Unfortunately, as a council we're constrained now with

27 rate capping, which makes it very difficult to run a

28 lot of these programs.

29 As a council, we voted in support, and written

30 letters to the Ministers and to the State Government,

31 extolling them, begging them to keep funding Healthy

1 Together Latrobe. It is vital to this community.

2 There's so many health issues that we have in the

3 community that were just exacerbated by the mine fire,

4 and they continue to be issues that we're continuing to

5 face.

6 We'll continue to lobby the State Government on

7 that. I was in Melbourne, so was the CEO, last week

8 and part of those discussions were with that particular

9 issue.

10 With the recommendations, as a bare minimum, as a

11 bare minimum, the State Government needs to fund a

12 Health Conservation Zone and we need to be an exemplar

13 program for the rest of the State, and we also need the

14 Health Advocates as a bare minimum. To do less, in my

15 opinion, would mean that the State is abrogating its

16 responsibility to the community of Victoria.

17 We as a community have put up with decades of

18 neglect, from both sides of politics; we've put up with

19 mines surrounding our community; we've put up with the

20 health issues of those mines for decades. We

21 understand that they're vital to the rest of Victoria,

22 because we'd have no manufacturing base in Victoria

23 without them; Victoria wouldn't have had the cheap

24 electrical supply it's had since 1949; it wouldn't have

25 had the ability to build into the community it's got

26 now. All we're saying is; we've worn a lot of that.

27 We've now gone through a major, major health issue

28 because of it; it's time that the State Government

29 turned around and funded something back into this

30 community.

31 The mine fire put the community on its knees.

1 Health wise, there's so many people that have developed

2 asthma since the mine fire, didn't have it beforehand,

3 have developed it since. There's a heap of people that

4 can't live in their homes at the moment that we know

5 have moved out because of the mine fire, there's a heap

6 of people whose health has deteriorated. The least the

7 State Government can do is to turn around and help

8 those people. The least it can do for our kids coming

9 through is to make sure that we're getting preventative

10 health measures put in place so that they don't have to

11 put up with what our parents and the generations before

12 had to put up with.

13 So, yes, we will continue to fight for it every

14 day; every day we're in contact with Ministers and

15 State Government demanding that they do something for

16 this community. I think every group within Latrobe

17 City is doing the same. It's just, we're well aware of

18 it; we know the Government's well aware of it and we're

19 going to make sure they never forget it.

20 MR ROZEN: Thank you, Dale.

21 CR HARRIMAN: Sorry, I got a little bit off track there,

22 John, I do apologise.

23 MR ROZEN: This time we will let you leave the stage, but

24 only temporarily, because you'll be back after lunch.

25 Thank you very much for your presentation.

26 Our next speaker is no stranger to the Inquiry,

27 she's been present at a number of the previous

28 seminars, it's Kellie O'Callaghan, who's the chair of

29 the Board of the Latrobe Regional Hospital. Welcome,

30 Kellie.

31 CR O'CALLAGHAN: Thank you so much for that warm welcome.

1 Thank you, Mr Mayor, you've saved me some talking

2 points.

3 I apologise in advance in relation to the

4 presentation, because as we've had our conversations

5 this morning I've gone through and done a bit of a

6 slash and burn, so you don't have to sit through the

7 same information twice.

8 Also, I guess as much as possible I want to be

9 able to take your questions so that it's relevant to

10 what you would like to know and to give it some

11 context. We'll see how we go in relation to the

12 presentation and we'll try and keep up as we go

13 through, then I will definitely jump off presentation

14 and keep talking as we go.

15 I also would like to acknowledge that we are

16 meeting here today on the traditional land of the

17 Bratwoloong people of the GunaiKurnai clan, and I pay

18 my respect to their elders past and any of those

19 present.

20 I would also like to acknowledge the Inquiry Board

21 and thank you for taking a genuine interest in our

22 community and for facilitating a range of conversations

23 that I strongly believe will result in longer term

24 benefit for our community and for our people.

25 I would like to thank those members of our

26 community and our partner agencies who have, through

27 their discussions and interactions since the mine fire,

28 informed my understanding and have patiently allowed me

29 to question and explore in more detail their

30 perspectives.

31 Whilst I speak to you today in my role as the

1 Board chair of Latrobe Regional Hospital, it would be

2 impossible for me to separate my broader role within

3 this vibrant and diverse community.

4 I was born and raised in Morwell and I hold a

5 range of other roles within the local area. I was one

6 of those kids that was brought up in a family who knew

7 nothing but coal industry. My dad worked at the SEC,

8 all of my uncles worked at the SEC, and we haven't

9 known any different. This is our community, this is an

10 industry that we have accepted, grown up alongside and

11 had a significant role in.

12 I think it's important that I highlight the

13 importance of the history in this community and the

14 understanding of belonging in place and how this

15 relates to health services.

16 The concept of the former Central Gippsland

17 Hospital in Traralgon was conceived as a Rotary Club

18 meeting in 1940. Historically hospital services in

19 Yallourn and Moe were also community-driven and funded.

20 This community has a strong and proud history of being

21 directly engaged in the development and ongoing support

22 for health services and I can assure you that that

23 continues to this day.

24 Community partnership takes many forms at LRH and

25 we have a dedicated team of volunteers who are invested

26 in the positive outcomes of their community.

27 We are also generously supported by individuals,

28 service clubs, businesses and larger corporations

29 through our fundraising programs. Our Community

30 Advisory Committee drive our initiatives to engage

31 consumers within our service.

1 For more than 10 years LRH and many other health

2 services, as Terry spoke of earlier - have embraced the

3 philosophy of doing with us, not for us. This is not a

4 new concept but one that is entrenched in many of our

5 organisations. With us, not about us; with us, not for

6 us.

7 We are the regional referral hospital and demand

8 for our services continues to grow. We continue to

9 strive to provide services that meet not only the needs

10 of our local community, but also those members of the

11 broader Gippsland area who require our services.

12 As our CEO Peter Craighead highlighted during

13 previous health forum sessions, compared to Bendigo,

14 Ballarat and Geelong, we are at a disadvantage. We are

15 so far behind in regard to infrastructure investment

16 that we are and will continue to play catch up.

17 We provide both inpatient and community-based

18 mental health services and we continue to see

19 increasing demand for services. That demand does not

20 only relate to adults living with mental wellbeing

21 challenges, but we are also seeing many children and

22 young people in our community mental health facilities.

23 I will present to you some of that data on the next

24 slide, and these are referrals received each month to

25 our small but dedicated team.

26 The data is overwhelming, but it can in no way

27 give you an understanding of the individual stories and

28 experiences of the children, young adults and families

29 who live with mental health challenges within our

30 community.

31 We are the largest employer in the Valley and, as

1 such, we are working in partnership with our partner

2 agencies to improve the health of our staff.

3 We continue to experience increasing demand for

4 chronic disease programs and, with this increased

5 demand, we are experiencing waiting lists for services.

6 The wait list for pulmonary and pain clinics are the

7 longest, and you could anticipate a wait of

8 approximately three months.

9 We are also seeing significant demand for our

10 chronic disease management program, HARP, with a

11 27 per cent increase in 2014 and a projected rise of

12 14 per cent in 2015. We need to look at managing

13 demand for our secondary and tertiary implications of

14 chronic disease.

15 With those things in mind, what is the way

16 forward? I've taken the opportunity to attend the

17 community consultations and each of the health forums

18 sitting days being held to date. I have listened to

19 the information shared, discussed it in detail with my

20 colleagues and community members, and we are to provide

21 a response in regard to governance, sustainability and

22 leadership.

23 We require a shared vision for health and

24 wellbeing in Latrobe. We need a champion for change;

25 someone to focus the community on our agreed vision for

26 health and wellbeing; to support and encourage

27 innovation, to engage community in conversation,

28 projects, ideas and thinking that will inform service

29 delivery in Latrobe and drive the further enhancement

30 and development of natural patient pathways in health.

31 We need to have an advocate who can work alongside

1 our community and service agencies, and then engage

2 with Government and corporate stakeholders about local

3 opportunities.

4 We shouldn't just be focused on responses to

5 health issues. We will build a more resilient

6 community that is more able to actively engage in their

7 own health and wellbeing with the support and

8 encouragement they need at all levels of our community.

9 Our funding models currently see us segregated by

10 silos; not as inclusive as we could be or should be.

11 We can't do it effectively with the current

12 organisational structure and there needs to be an

13 advocate or a similar role in place.

14 We need to work together. What we do needs to be

15 a reflection of our community's expectation.

16 The Health Advocate: our champion for change, the

17 individual who would drive the innovation, breaking

18 down the barriers and building up the relationships.

19 The Health Advocate needs to be underpinned by a strong

20 values base, with a focus on leadership, accountability

21 and the capacity to report back to community,

22 integration and collaboration across a broad range of

23 stakeholders, and flexibility with the capacity to

24 change and adapt approaches to ensure responsiveness.

25 The behaviours demonstrated by the advocate and

26 their supporting board, council or officers, need to

27 include respect for others, their experiences and

28 perspectives; the desire to work as one in approaches

29 to overcoming challenges relating to health and

30 wellbeing; the focus on working with and in community;

31 a willingness to listen and communicate effectively, no

1 matter how challenging the conversation. But also have

2 the important focus on acknowledging those good things

3 that are happening within our community and focus on

4 new and emerging opportunities.

5 It is also important, as the Mayor has previously

6 highlighted, that the advocate has a closely and

7 clearly defined role in relation to emergency response.

8 We need to be clear on how the role operates in

9 parallel with Emergency Management Victoria.

10 The Board, or the council, as many of our previous

11 speakers have alluded to, there is a very clear role

12 highlighted in many of the discussions that have taken

13 place at the health forums for a board or a council to

14 support the work of the advocate.

15 But there is also an important requirement for an

16 office of the advocate - and I know the Mayor has

17 spoken to this as well. It will be established to

18 underpin the work and the functions of the role.

19 Trusted local representatives, communities and

20 organisations all working together to underpin the work

21 of the advocate: they will provide the governance

22 oversight, including strategy, compliance and risk

23 assessment. As we've heard this morning, the Act

24 clearly provides for the creation of councils.

25 The advocate needs to be a trusted and tested

26 community leader; they also need to be prepared to work

27 alongside the community to identify other trusted

28 leaders and foster their development and roles to

29 enhance a shared health and wellbeing message.

30 We also need community champions identified and

31 supported to work within their own trusted networks to

1 further facilitate and engage a community-based and

2 driven program that enhances sustainable health and

3 wellbeing pathways and support.

4 Grassroots champions within communities: the

5 unlikely leaders who will support and become the

6 champions for their own community's change.

7 The Health Conservation Zone: by placing an

8 immediate focus on decision-making, resourcing and

9 planning that focuses on the health and wellbeing of

10 our local community; developing models and practices

11 that are reflective of community expectation, working

12 alongside community organisations and service agencies

13 to identify current gaps, barriers and inhibitors to

14 good outcomes for individuals and groups; and then

15 implement pathways, processes and models in partnership

16 with all stakeholders to ensure a strengthening of

17 outcome for a local community.

18 There's been lot of discussion around the health

19 forums around the name, labelling or impact of

20 identifying the municipality of a Health Conservation

21 Zone. Our priority needs to be for access and support

22 for the Valley. We need to ensure that whatever we do

23 does no harm but enhances the opportunities for our

24 local community.

25 There are also other ways we can strengthen the

26 representative role of our community. We also need to

27 focus on the importance of local representation on our

28 own boards. It sends a very strong message to the

29 local community about the services within their own

30 communities that they're not able to run if board

31 appointments made at Regional Health Services are not

1 local community members.

2 I do not believe that there is a lack of skill,

3 experience or willingness by members of our local

4 community to run their own Regional Health Service.

5 In response to whether the Health Conservation

6 Zone will in some way cause a detriment, and whether or

7 not we should just embed this practice within our

8 current bureaucracy and service provision network;

9 doing more of the same isn't going to work. We're

10 nearly two years down the track, at the rate we're

11 going, if we don't make a change, there will be no

12 change for this community.

13 I wanted to reflect on some of the work of Evelyne

14 de Leeuw and Don Campbell - for those who have been in

15 attendance at the previous sessions you'll be well

16 aware of the conversations they've had with us.

17 They've spoken at length about everything being health;

18 about communities with chronic bad health and about

19 providing the conditions for healthy communities, for

20 communities to thrive, for a healthy economy and

21 examples that we can learn from.

22 Evelyne spoke at length around Corio and Norlane

23 and communities taking health and wellbeing into their

24 own hands. When it comes to a question of cost - the

25 question was asked at one of the sessions "can we

26 afford it?" We can't afford not to.

27 If we don't make the changes now, not only will

28 the health comes deteriorate further, but the cost of

29 providing healthcare to a population and the increasing

30 incidents of chronic and acute presentation will be a

31 burden that we will not be able to carry.

1 Don Campbell spoke at length around the Atlanta

2 Regional Collaborative Health Improvement Model - I

3 tell you, I feel like I've been studying for VCE exams

4 since the close of the last session. I have done my

5 homework, not pretending to be at all academic because

6 I'm not, I'm community focused. But I have gone and

7 had some conversations, people like Wendy, and I know

8 John and I have had some conversations throughout the

9 sessions around the model.

10 I agree that the Atlanta Regional Collaborative

11 Model for Health is one that is strong and is solid.

12 The playbook that's available on the website gives some

13 very clear examples of what we could implement within

14 our own community; it's easy to understand and there's

15 some real quick wins in that model.

16 The Stanford Model For Social Innovation, the

17 collective impact approach and the five conditions of a

18 common agenda, shared measurements, mutually

19 reinforcing activities, continuous communication and

20 the backbone organisations creating and managing

21 collective impact could easily be implemented within

22 our community with the commitment of organisations.

23 Working alongside community to assist them to

24 overcome challenges and barriers to participate in

25 their own healthcare should be our focus. We can

26 actively encourage awareness and engagement for the

27 broadest range of activities, supports and networks

28 that will sustain and underpin an improved health

29 outcome for our community.

30 We can create pathways to advantage by promoting

31 healthy behaviour and preventing risky behaviours

1 through care coordination approaches, comprehensive

2 care, patient-centered practice, coordinated care,

3 accessible services, quality and safety, and we still

4 have a lot of work to do on integrated information

5 system and the formation of evidence-based strategies.

6 So, what might the specifics look like? Health

7 Conservation Zone: we can look at creating bulk billing

8 initiatives within our community. We can remove

9 financial barriers to care.

10 Our system at the moment is not set up to take

11 into account multiple presentations and multiple

12 conditions. We need to build a focus on

13 person-centered care. We need to treat the whole

14 patient and make their journey seamless.

15 Chronic disease patients tend to be more

16 responsible for their own care and conditions - how can

17 we support them to do that better?

18 It's important for us to train more Allied Health

19 professionals and create these education opportunities

20 within our own community. We need to build our own

21 local workforce. Amanda Cameron spoke at length about

22 those opportunities when she presented.

23 We need to keep local. We need to grow, train and

24 work in the Valley. Sustainability is something about

25 us doing our own work, and working with us and not for

26 us is so paramount.

27 The commitment of LRH as a Regional Hospital, in

28 that very true sense of a regional provider, needs to

29 include appropriate infrastructure. LRH needs to be

30 brought up to the level of Bendigo, Ballarat and

31 Geelong, and there is an importance for the Latrobe

1 Valley community and Gippsland more broadly to have the

2 equity of access to services that exist in other

3 regions.

4 This includes access to those services - and I

5 know Wendy's spoken at length about access to

6 specialist services, but also those issues of transport

7 and other incidental support.

8 The broader availability of Gippsland Medical

9 Students Program we've heard about in one of the other

10 sessions, where they're mentoring high school students

11 and creating pathways to education.

12 What use is it to treat people with presenting

13 health problems if we're going to return them to

14 circumstances that made them unwell to start with?

15 Proportional universalism - I hadn't heard of that

16 before. But the interesting concept of the same for

17 all but more for those who need it most. It's a way of

18 thinking about how we work with our communities to

19 ensure a focus on, those who need it, get it.

20 We can look at the Stamford model, we can look at

21 the Dutch nursing model, we can look at concierge

22 models - there are any number of opportunities

23 available to us to learn and we can implement those

24 learnings.

25 We can attach funding to a patient. Treat locally

26 wherever possible. If the money is in the system, and

27 that is a capacity of a local service provider to

28 provide that service, you should not have to go to

29 Melbourne for that treatment.

30 Evidence informed strategies together with

31 innovation and community generated and owned

1 opportunities must be paramount. We've heard of many

2 examples over the period of the Health Improvement

3 Forum discussions about children being engaged in

4 communities - doing our blood pressure checks; it's

5 stuck in everyone's mind, it's simple. A lot of this

6 stuff is simple concepts and just applying them.

7 John spoke of health screenings and the

8 opportunity for health screening days hosted by service

9 providers. They're quick wins, they're things we can

10 do, we just need those resourcing and partnership

11 opportunities to work together.

12 We heard of positive media messaging, sharing the

13 community narrative. Our media outlets and community

14 engagement professionals within all of our agencies

15 that spoke at the forum said they're prepared to do it

16 and they're doing it now. They started on Twitter that

17 afternoon. They will do the work and we need to

18 support them in taking that initiative.

19 Our focus needs to be on healthy behaviours, our

20 smoking and tobacco interventions, diet, nutrition,

21 exercise, physical activity, alcohol, drug,

22 preventative care for physical and mental health

23 problems. We need to create pathways to advantage for

24 children in relation to family environment,

25 communities, early education and maternal and child

26 health; for our older learners through pathways to

27 achievement, mentored learning and employment

28 transition, and for all through employment and

29 Government supported economic development, as the Mayor

30 has spoken about earlier.

31 We are a very strong community. We have strong

1 community leaders, and they want to be part of

2 returning this community and our people to a strong

3 position of health and wellbeing. Thank you all very

4 much for your time and I'm happy to take your

5 questions.

6 MR ROZEN: Thank you, Kellie. Perhaps, if I could kick it

7 off and ask you a question that relates specifically to

8 your role with the hospital.

9 We had a session about recruitment and retention

10 of the medical workforce and the particular challenges

11 that that presents in the Valley, and I notice you

12 mentioned earlier you were talking about Allied Health,

13 and that was one area that was identified. Perhaps if

14 you could expand on that and what the particular

15 difficulties are and what you think needs to be done to

16 address those particular problems.

17 CR O'CALLAGHAN: I think one of the opportunities for

18 conversation that we had in the previous session, I

19 know Amanda spoke to it at great length and I don't

20 pretend to be an expert on this at all, but with some

21 of the changes that have come about in terms of

22 educational opportunities and the changes in relation

23 to Monash University and Fed Uni, there hasn't

24 necessarily been a re-population of training in

25 formalised education for Allied Health professionals at

26 a local level, and any opportunity where that could be

27 provided will then create pathways for our own local

28 students, not only to learn more about the job

29 opportunities that might be available for them, but to

30 stay within community, continue their education and

31 then work in amongst - and not only our acute

1 facilities, but at our primary health networks and with

2 Ben at LCHS and all these other places. There's lots

3 of job opportunities out there for our Allied Health

4 professionals.

5 But in a lot of ways we are having to go out and

6 find them outside of community, and that's never going

7 to be bringing strength to our own capacity to meet our

8 own community's needs. Part of it's education based

9 and creating pathways. The employment opportunities, I

10 think given what we're presented with, are going to be

11 there.

12 PROFESSOR CATFORD: Kellie, can I thank you very much for

13 attending, I think, virtually all of the forums over

14 the previous four days and for such an excellent

15 summary of the outcomes, we've obviously got a record

16 of all that so it will be very useful to us.

17 You've spoken very passionately, as has the Mayor,

18 about the role of the Health Advocate. Do you have a

19 view of how this actually works in practice, in terms

20 of the advocate being sufficiently independent not to

21 be captured by agencies but, I mean, how are they

22 employed, whether they work, how is this office

23 created?

24 CR O'CALLAGHAN: If I had to visualise it, I think it's a

25 stand-alone office in downtown Morwell, it's got its

26 own staff, it's got its own shop front, it's a walk-up

27 facility, it's where community can go in and get

28 information, support and advice on referral. It's a

29 bit of a brains trust for the community to access

30 information and create a bit of a pathway to get in

31 touch with other things that you need.

1 In terms of working alongside the partner

2 agencies, and I think it is that, it's not about

3 another level above, it's about working alongside the

4 other community agencies and service providers. One of

5 the most important things coming out of the discussions

6 we had, and the roundtable was referred to, and a

7 number of attendees today were part of the roundtables

8 for the service providers: all of the organisations in

9 attendance agreed that this was an opportunity for them

10 to further expand what they're able to do. One of the

11 great difficulties you have as a service provider is,

12 you're effectively delivering on either a statement of

13 priorities or contracted service, you're lobbying for

14 infrastructure and new opportunities and service

15 delivery. To have someone to bring all of that

16 together and to help work through the priorities, to

17 talk about what the priorities are for all of those

18 service providers, and then work alongside the

19 community is really important.

20 For me, I think it connects everything up. It's

21 all of those gaps that we've never been able to bridge

22 as independent service providers, and it creates an

23 opportunity there. I think the strength in it is that

24 the agencies want it, they support it and they can see

25 the benefit in it.

26 The independents: it's going to be a strength of

27 personality thing, you can't have an advocate there

28 that's going to be easily rolled or leant on to too

29 heavily. You need someone who's got the strength of

30 character to be able to stand there on their own

31 merits, put a good argument and, above all else,

1 represent the view of the community, irrespective of

2 lobbying that may come from service delivery agencies

3 or bureaucracy.

4 MR ROZEN: Thank you, Kellie, we'll excuse you temporarily,

5 if we may, and invite you back to join the panel

6 discussion after lunch.

7 Our next speaker is John Guy. John is the chair

8 of the Board of the Latrobe Community Health Service

9 and John's also been present at previous sessions that

10 we've run. Welcome, John.

11 MR GUY: Thank you, and thank you for the opportunity. I'm

12 not going to talk specifically about the Latrobe

13 Community Health Service, but rather talk about my

14 experience with "health".

15 I've been involved with various aspects of health

16 for the past 45 years. My involvement commenced with

17 work in the safety programs with the former State

18 Electricity Commission of Victoria, continued with an

19 appointment as manager, occupational health and safety

20 with the State Electricity Commission, and perhaps ends

21 with my position as chair of the Latrobe Community

22 Health Service Board.

23 No one can deny that the event of 9 February 2014

24 was unprecedented and severely impacted on the health

25 of a section of our Latrobe Valley and Morwell

26 community, and those who worked in Morwell during those

27 45 days.

28 I might also state that I've been a member of the

29 recover committee since its inception and I represent

30 the Latrobe Community Health Service on the Hazelwood

31 Mine Fire health study.

1 On the question of the ongoing long-term effect of

2 this event on the population of Latrobe City, I think

3 that's best left to the Hazelwood Mine Fire health

4 study.

5 Another fact that cannot be denied is that the

6 health of the Latrobe City community was well below

7 Australian standards before the fire occurred, and this

8 situation has existed for many years.

9 As the saying goes, there is nothing new under the

10 sun. In 1991 I was involved with others in this

11 community in the planning and implementation of the

12 Latrobe Valley Better Health Program funded by the

13 Victorian Health Promotion Foundation.

14 At that time, there was a concern that coal dust

15 was having a detrimental effect on the population of

16 the Latrobe Valley and it was the cause of a higher

17 than average incidence of deaths.

18 The release of the Latrobe Valley Health Study

19 in August 1990, led by Dr Jonathan Streeton,

20 highlighted community concerns about the health of our

21 residents.

22 An analysis of the death rates between 1969 and

23 1983 revealed higher death rates than the rest of

24 Victoria for in doctrine (sic), nutritional disease and

25 from accidents. Dr Streeton identified contributing

26 factors as alcohol, nutrition, smoking and lack of

27 exercise.

28 On 31 August 1990, in the Medical Observer, an

29 article appeared, "Latrobe Valley Tries Healthy

30 Experiment. Victoria's Latrobe Valley could be the

31 site for one of Australia's biggest experiments in

1 preventative health following the release of a study

2 which found lifestyle was the main cause of high death

3 rate in the area. Alcohol, motor accidents, poor

4 nutrition were major contributors to the higher than

5 average death rates for Latrobe Valley.

6 "The study found that air pollution from the coal

7 mines and power stations which dot the valley about

8 70 kilometres east of Melbourne was not the cause of

9 the high death rates. Health and Local Government

10 authorities in the region are preparing to embark on a

11 major preventative health campaign targeting the

12 primarily blue collar industrial workers who make up a

13 large proportion of the Valley's population." It goes

14 on to talk about the project.

15 The Latrobe Valley Better Health Project involved

16 participants from community health, Local Government,

17 hospital, unions, employees, health organisations, the

18 Aboriginal community and migrants. Two project

19 officers were employed to raise awareness in the

20 Latrobe Valley community.

21 The project involved a number of projects: a food

22 service improvement program, food as a fundraiser, a

23 point of sale program, growing your own vegetables,

24 breastfeeding, workplace health promotion, injury

25 surveillance system, youth and alcohol safety house,

26 reducing back injuries and reducing sporting injuries.

27 All projects had listed goals, activities, settings,

28 participants, research systems and evaluations.

29 In relation to the injury surveillance system, The

30 Express of 10 July 1992 carried a headline, "Better

31 Health Project Labelled One Of The World's Best. A

1 Swedish health expert has labelled the Latrobe Valley

2 Better Health Project as one of the best in the world.

3 The director of the Stockholm County Council Health

4 Promotion Program, and an internationally recognised

5 leader in the field of injury prevention, was in

6 Morwell on Wednesday at the invitation of the Latrobe

7 Valley Better Health Program, VicRoads and the Monash

8 Health Accident Prevention Centre.

9 "The Stockholm Health Promotion Program has

10 operated successfully since 1983, improving community

11 awareness of accident prevention." It goes on to talk

12 about the success of the program in the Latrobe Valley.

13 Over the years we've seen a pattern of the

14 introduction of health programs funded by Government,

15 and then, for various reasons, including change of

16 governments, the recent phenomena of one term

17 governments and other additions, these programs have

18 been abandoned.

19 The latest victim of change in Government funding

20 policy is the Healthy Together Latrobe project which

21 commenced in July 2014 and was jointly managed by

22 Latrobe City and the Latrobe Community Health Service.

23 The program was funded by Federal and State Governments

24 and recently abandoned by the Federal Government, with

25 the State Government indicating it will not fund the

26 program into the future.

27 Turning to the information gathered from the

28 consultations on health at Morwell, Moe and Traralgon,

29 I find it difficult to draw conclusions from numerous

30 dot points based on opinions which would require

31 further investigation as to their veracity. In some of

1 the responses to question 2, with regard to health

2 services in the Latrobe Valley, it appears to

3 contradict the responses to question (1), what are the

4 health challenges in the Latrobe Valley? So, there's a

5 lot of work, I think, that needs to go into analysing

6 some of those responses.

7 There is no doubt that, as mentioned in this

8 feedback, there is a problem in the Latrobe Valley with

9 long-term unemployment and the consequences that this

10 has had on the health of this population.

11 The Latrobe Valley Health Conservation Zone: I

12 agree with the concept of a Health Conservation Zone

13 but disagree with the name. I've attended two sessions

14 where this concept has been discussed and I'm a little

15 frustrated about the fact that the project is not

16 progressing, or not progressing as fast as I would like

17 it to progress.

18 I also agree with some of the comments made by

19 people who attended the community consultation, in

20 that, a Health Improvement Zone would have some

21 positives in that it would be based in the Latrobe

22 community, be resourced and focused on services; it

23 would have common priorities and have people working

24 together. It's important to bring together with a

25 united focus for a long-term measurement improvement.

26 The Latrobe communities need to be seen as a whole, not

27 individually.

28 It would be a good platform to have a

29 conversation, and something that was ongoing

30 particularly around the schools.

31 The mine fire has resulted in an upsurge of

1 pressure to close the Hazelwood Power Station which, if

2 not managed correctly, will add to the already serious

3 unemployment situation that will lead to further health

4 problems in this community.

5 While the future changes to the power industry are

6 certain, it requires an orderly and considered

7 transition that ensures that the Latrobe Valley can

8 bring in new industry, together with job replacement

9 and re-skilling in order to address the socio-economic

10 status of this community.

11 What is needed is a program that is focused on

12 Latrobe City population funded on an ongoing basis,

13 managed by local people and directed at measuring the

14 improvement in the health of our citizens over a five

15 to 10 year program.

16 The program should focus on lifestyle issues as

17 evidenced by the 1990 findings of the Latrobe Valley

18 Better Health Study, lifestyles affecting the

19 population of the Latrobe Valley residents as, in my

20 opinion and evidenced by recent articles in the press,

21 these factors are still very much evident in our

22 community and indeed across Victoria and the nation.

23 In the short-to-medium term the State Government

24 should agree to the ongoing funding of Healthy Latrobe

25 project and do further research to test the validity of

26 the determinants of ill-health in the Latrobe Valley

27 population.

28 We should use the definition of

29 Professors Campbell and Clarke, that health is a state

30 of complete physical and mental well-being, not merely

31 the absence of disease and health, and that the

1 environment are interrelated.

2 I believe we should take a lesson from the Latrobe

3 Valley Better Health Program and form a local

4 Management Committee to manage the Healthy Together

5 Latrobe program. This group should be made of

6 community representatives from council, community

7 health, unions, industry and the migrant community.

8 Again, as Campbell and Clarke state, placing the

9 consumer's perspective relentlessly at the centre of

10 the process of health improvement will be critical to

11 success. In the long-term the proposed Health

12 Improvement Zone should assume responsibility for the

13 ongoing programs designed to improve and sustain the

14 health of the La Trobe Valley residents. Thank you.

15 MR ROZEN: Thank you very much, John, for that historically

16 informed presentation, I think very valuable for the

17 Board to, as you say, recognise that there's nothing

18 new under the sun and things have been tried before and

19 we can obviously learn from that.

20 A question I have for you concerns the Health

21 Advocate, which I don't think was something you

22 mentioned in your presentation but certainly featured

23 in a lot of our fora and the consultations we've had.

24 Do you have a view on whether or not that would be

25 a valuable addition to the landscape?

26 MR GUY: I think it would be, and I think, as outlined by

27 Kellie, it needs to be an independent position, placed

28 in its own office in the Latrobe Valley where people

29 have access to it from the street.

30 MR ROZEN: Thank you. Members of the Board.

31 PROFESSOR CATFORD: John, thank you very much, and also for

1 attending some of the other forums.

2 I wondered if you just might talk a little bit

3 about the interface with the primary health network and

4 the community health service, and how do you see that

5 working in practice?

6 MR GUY: Probably, that's a difficult question, because I

7 think there's always been problems between the various

8 health functions. As somebody said, I think earlier,

9 we tend to operate in silos. I have, in my role, tried

10 to advocate connections between the Latrobe Community

11 Health Service and the hospital. I think there should

12 be a closer liaison there and closer communication to

13 make the transition of people who are in that primary

14 health area to the acute area a lot more seamless.

15 Likewise, when they come out of the acute area, that

16 they're looked after into the ongoing treatment in the

17 primary healthcare sector. I don't know whether that

18 answers your question.

19 PROFESSOR CATFORD: Just take it another way: what do you

20 feel about the future of primary care partnerships,

21 particularly in the Latrobe Valley and Gippsland?

22 MR GUY: They've certainly operated in the past and had

23 limited success. I suppose what I'm promoting is that

24 people from the community come together and form a

25 partnership, probably with the Health Improvement

26 Advocate, to look after the health of the Latrobe

27 Valley people, rather than have bureaucratic

28 organisations do that function.

29 MR ROZEN: Thank you, John. We might temporarily excuse

30 you, if we may, and we'll invite you back to join our

31 panel discussion.

1 Our last individual speaker today before we have a

2 break for lunch is Nola Maxfield. Nola is the chair of

3 the Board of the Gippsland Primary Health Network.

4 Thank you, Nola.

5 DR MAXFIELD: Thank you. Before I start, I'd like to

6 acknowledge the traditional owners of the land, the

7 GunaiKurnai people, and acknowledge their elders past

8 and any who may be present.

9 Thank you to the panel for inviting me to speak,

10 and you will be pleased to know that there's actually

11 some synergy between what's already been said this

12 morning and what we would suggest we will be doing and

13 the panel can also look at for the short, medium and

14 longer term in this field.

15 Can I start by just talking about Gippsland

16 Primary Health Network. There are some people here who

17 have been intricately involved, and I acknowledge my

18 fellow board members and CEO. There are others to whom

19 we are a relatively new organisation. We only started

20 on 1 July. We are funded primarily by the Federal

21 Government and we are there to be a primary healthcare

22 organisation with a focus on supporting primary care,

23 so general practice, Allied Health. We're there to do

24 health planning, health system integration and

25 commissioning of services in line with national and

26 local priorities.

27 We haven't come absolutely out of nowhere. There

28 were the Medicare Locals prior to this, and in

29 Gippsland we were fortunate that our boundaries

30 remained the same and we have the same board who is

31 ongoing. There's been some staff changes, but we've

1 been able to build on what was already there but to be

2 able to put a new focus into the organisation and what

3 we're planning to do.

4 Our objectives are to increase the efficiency and

5 effectiveness of medical services for patients, and in

6 particular those at risk of poor health outcomes, and

7 to improve the coordination of care so that patients

8 are going to get the right care in the right place at

9 the right time.

10 Our mission previously was to work for a

11 measurably healthier Gippsland, and we're going to

12 continue to do that. As I'll mention later, we will

13 use data to be able to try and measure that and then to

14 utilise that data to improve healthcare for people.

15 Our mission aligns very well with what's trying to be

16 achieved for improving the health outcomes of the

17 people in the Latrobe Valley.

18 The mine fire, as has already been mentioned, did

19 demonstrate a need for more cohesion among health

20 service and community support providers with regard to

21 both a coordinated response and support to the

22 community. It's been very encouraging to hear the

23 incredible passion and willingness expressed by the

24 community and the service providers to learn from the

25 events and to improve the capacity to, not only respond

26 to the situation, but also to address the underpinning

27 health and economic disadvantage of the people of

28 Morwell, the Valley and of greater Gippsland.

29 There's many social determinants of health that

30 have already been mentioned that have contributed to

31 the poor health of the Valley. Unfortunately, coming

1 from a lower socio-economic status, those people tend

2 to make more of the unfortunate lifestyle choices - the

3 rates, as already have been mentioned, of smoking and

4 obesity are much higher. There's lower education and

5 employment opportunities and then, added to that, we've

6 got the risk of the environmental exposure to burning

7 of coal and the long-term exposure of asbestos for the

8 people of the Latrobe Valley who are now exhibiting

9 symptoms of that.

10 So Gippsland Primary Health Network has both a

11 mandate and an opportunity to contribute to a

12 collaborative governance system and leadership that's

13 going to create a sustainable response and support to

14 grow the health of the Valley community.

15 Chronic disease management: unfortunately, all

16 health indicators are more pronounced in the Valley,

17 reflecting the lower health status and greater

18 disadvantage. Chronic disease management is becoming

19 more complex. So, general practice, Allied Health, are

20 seeing people with larger numbers of comorbidities -

21 they've got more chronic health problems and the impact

22 of lifestyle choices and also of ageing.

23 We need to see better coordination and integration

24 of the care and increased access to secondary and

25 specialist care.

26 In primary care, we need to have the nurse

27 educators who are embedded within primary care; the

28 care coordinators, the Allied Health and shared care

29 approaches with specialists. We need to build

30 community health literacy to increase the timeliness of

31 service access and integration, to maintain people in

1 the community and support their journey of care, and

2 we've already heard about that from other people.

3 We also need to develop secondary specialist

4 clinics as a shared care model across primary and

5 hospital care sites, to increase access for the

6 community and to help reduce unnecessary hospital

7 attendances. I think it is vital that the primary and

8 the secondary systems are working together to develop

9 those.

10 Health workforce development, we've already heard

11 about. We know that between the hospital and the

12 community and primary care providers health is going to

13 be the largest employer in the Valley, and yet, it

14 still seems inadequate to meet the health needs of the

15 community.

16 As has already been said, we need to attract and

17 retain health workforce to the area, and that's vital,

18 and we need to replenish the ageing workforce as well.

19 We need to develop health workforce capacity to

20 share the workload and encourage generalists and

21 proceduralists to expand the specialisation that's

22 available, shared care, advanced practice and skilled

23 substitution. We need to make sure that we have people

24 here who can work across a variety of fields and not

25 just very narrow specialities.

26 We also need to attract investment to build an

27 infrastructure for health and also for the economy.

28 Care pathways have been mentioned, and this is a

29 constant message about improving evidence-based care

30 and increasing both provider and community knowledge

31 about service options. We need a model of community

1 care where GPs and specialists together adopt and

2 promote care pathways.

3 Care pathways I'm still explaining to GPs, so

4 apologies if you don't actually know what we're talking

5 about here, but it's a model which is developed for

6 specific diseases. You sit down, the GPs and the

7 specialists together, and work out what needs to be

8 done. There are a couple of generic models out there,

9 so there's a basis, but the important thing is about,

10 if a specialist is receiving a referral from a GP, what

11 information needs to go with the patient, what do they

12 need to know, rather than have the person turn up and

13 then they're sent off because they haven't got the

14 right test, they haven't got the x-ray with them. Then

15 the GP also needs to know what's required back to them

16 in order to be able to continue to care for that person

17 in the community.

18 Part of the value of that is also sitting down

19 those groups together and having the discussion, about

20 what does it mean for that place. So it would be for

21 the Latrobe Valley, how does that work there, and then

22 that is available as a web-based system for the health

23 providers to use. That work will need to be informed

24 by clinical councils and community groups.

25 E-health connectivity, care coordination - we've

26 heard about that as well. We need timely access to

27 information and it needs to be sensible information, it

28 needs to be legible if it's handwritten. People in the

29 community need to be able to know about waiting times

30 and options for treatment.

31 In Gippsland, we have S2/SE referrals, which

1 enables encrypted communication between GPs, community

2 health, hospitals, councils, and that should allow for

3 good feedback and it needs to be a system that actually

4 is easily able to be used or else it doesn't get used.

5 Any developments in E-health will pave the way for

6 increased electronic literacy for providers. For

7 example, there's telehealth as has already been

8 mentioned. I know that I find it valuable, because I'm

9 a GP and working in general practice, that if the

10 telehealth consultation is occurring in my clinic, and

11 I have the patient beside me, and we have the

12 specialist who we can see on the screen there, that

13 both of us are getting the same information at the same

14 time, and I'm able to, actually later on, decode some

15 of that information from the specialist with the

16 patient as well. But I know what to watch out for,

17 what the specialist wants me to be looking for, if

18 there's any problems to send back, at the same time as

19 the patient is finding this information out.

20 This is particularly helpful in the Latrobe

21 Valley, but also in more remote communities, but it

22 should not be seen as a substitute for providing health

23 services on the ground, it should be in addition and

24 supporting those health services.

25 The My Health Record is the latest iteration of

26 the Commonwealth Government's personal controlled

27 electronic health record, and the Commonwealth

28 Government is currently debating how that will roll out

29 and there may well be some trials on people having to

30 opt out of that system, rather than everyone having to

31 opt in. If we have more people utilising that, if

1 there's more information populating those records, then

2 it will be useful and people will want to use it.

3 Again, the State is also looking at more

4 systematic approaches to E-referral and investment in a

5 Statewide approach for consistency and access across

6 primary care and hospital settings, and the Valley is

7 well placed to embrace these more durable systems.

8 Collaborative population health planning is

9 another thing that the primary health network is

10 working on. We will need to know the community health

11 needs and identify the people at risk at an early

12 stage, and that's then the starting point for health

13 improvements.

14 As we've heard, both Local Government and primary

15 health networks have a mandate for population health

16 planning and we need to make sure that they align.

17 We need to work together to plan the approach,

18 particularly including hospitals, community health, the

19 primary care partnerships, the Department of Health and

20 Human Services, our regional office. These will

21 improve access to diverse sources of information, and

22 in particular we'll look at bringing general practice

23 information into that as well to aid our understanding

24 and interpretation of the social and health challenges

25 and to develop a shared action plan that addresses the

26 needs and appropriately leverages the respected

27 organisational mandates and resources.

28 So we do need data, data and more data. We need

29 to develop a data warehouse that enables interpretation

30 of the information, and that's whether it's clinical,

31 social, environmental. We need to look at cross-data

1 analysis or even linked data that helps to understand

2 the journey of the consumers and the carers, and then

3 to be able to identify the gaps and where the care

4 coordination is needed.

5 There's a lot of data held in general practice and

6 that can be extracted by the Gippsland Primary Health

7 Network to report back to the GPs so that they can

8 identify and target population health issues in their

9 local community. If they see a value in that data

10 being able to be interpreted back to them, then we're

11 going to get even more involvement of them in the data

12 collection.

13 We've got Statewide health data, episodic hospital

14 data, but often what it's missing is the reasons and to

15 be able to predict when people are going to actually

16 start to become frequent attenders in Emergency

17 Departments or into hospitals.

18 The GP data is actually more granular and can tell

19 a longitudinal health story, and so, we think that the

20 GP data, when we can utilise some systems that are out

21 there and hopefully more that will be developed, can

22 fill some of the information gaps and be of use to

23 planning secondary and tertiary specialist services.

24 It can also help to determine social and lifestyle

25 drivers that can cause health disadvantage and

26 inequities.

27 So, about addressing gaps and building capacity

28 and service availability: lack of service access has

29 been frequently mentioned during the mine fire forums.

30 The primary health network has a mandate for

31 commissioning services to address service gaps, to

1 build organisational capacity to meet community needs

2 and to encourage employment investment.

3 We're not competitive with other service

4 providers. We have inherited very few action direct

5 service provision and we are in line with Commonwealth

6 Government expectation, moving out of those fields

7 completely.

8 We don't want to be competitive with the other

9 service providers; we want to work with them to procure

10 and tender services from existing providers and as well

11 as attracting new business investment to the area.

12 We not only tender for service delivery, but we

13 prioritise models that embed care coordination.

14 Essentially, we purchase health outcomes and

15 integration of care.

16 We want to create and participate in

17 community-based collective impacts, so we want to

18 restore and grow health that will take more than

19 individual service development; it will take a

20 co-ordinated and long-term investment in health

21 outcomes by all parts of the health, social and

22 economic systems, which is what we've heard about

23 today.

24 We have a focused commitment by a network of

25 health and community leaders to assist in building

26 community trust and sustainable health and wellbeing

27 solutions, and we need to leverage our respective

28 skills and expertise to build that capacity and to

29 augment the finite resources.

30 We need shared measurement and tracking outcomes

31 for accountability to help to attract economic and

1 social investment.

2 Health advocacy needs both leadership and

3 intuition and effective social entrepreneurs, effective

4 start up engineers and community engagement

5 individuals. But sustainability comes from building

6 community ownership and trust and an enduring

7 institution of shared commitment.

8 So, what is the best way forward to improve the

9 health of the community? From our perspective,

10 short-term, 6-12 months, creation of a collaborative

11 network of community and health leaders to drive

12 commitment to action and collective impact for

13 population health improvement.

14 To develop the role of a Health Advocate and

15 entrepreneurial, individual or a group, who will be

16 engaged with or have a mandate for developing a

17 sustainable institution.

18 To help employers focus on the health and

19 wellbeing of employees who in turn become informal

20 local community advocates.

21 Gippsland primary network will embed clinical

22 councils and community advisory councils. The

23 Commonwealth Government require us to set up clinical

24 councils, and in Gippsland, recognising that there are

25 a number of subregions - we will have three. Each of

26 those will cover two Local Government areas and for

27 here it will be Latrobe City and Baw Baw. Those

28 clinical councils are required to be GP led and we have

29 in place GP chairs for each of those councils and we

30 are about, in the next short week or two, to ask for

31 expressions of interest for other clinicians to be

1 involved in each of those, so that will shortly be

2 available to people of this area.

3 We're also required to have a community advisory

4 council and we are keen not to duplicate. There are

5 already a lot of advisory councils across the

6 community, and in particular also in the Latrobe

7 Valley, the Latrobe Regional Health and other

8 organisations. We're investigating how we can utilise

9 all those community advisory groups that are out there

10 and look at, do we target for particular issues

11 particular groups. We're keen not to just set up

12 something that is very small and duplicates what's

13 going on.

14 The care pathway system that I've mentioned will

15 be developed to guide evidence-based practice and

16 provide a one-stop-shop for access to clinical and

17 referral information. Data warehouse capacity will be

18 developed to enable GP and other data sources to be

19 used for collaborative health planning amongst agencies

20 and to inform system procurement.

21 Looking at the medium term, one to two years, the

22 primary health network commissioning of increased

23 access to services with coordinated and integrated

24 models of care will develop.

25 There should be investment in primary, secondary

26 and tertiary services to augment chronic disease

27 management and access to specialists and Allied Health

28 support.

29 We need to advance E-health and workforce support

30 through clinical placements, and we need to develop

31 commitment to measurably improved health outcomes

1 through shared data and feedback accountability to the

2 community.

3 For the longer term, three to five years, we

4 acknowledge that continuous reform causes change

5 fatigue and a bit of political distrust amongst health

6 providers in the community, but we do need coordinated

7 and long-term investment in health outcomes for all

8 parts of the health, social and economic systems

9 essential in building trust and community resilience.

10 To conclude, Gippsland Primary Health Network is

11 committed to working collaboratively to achieve all of

12 these objectives. Thank you.

13 MR ROZEN: Thank you very much, Nola, for that presentation.

14 As I think has been remarked in a number of the forums,

15 the recent introduction of the PHN is timely in many

16 ways; it sort of dovetails quite nicely with the work

17 of this Inquiry.

18 One of the issues that have been discussed and

19 that I'd just like you to comment on is, the PHN is

20 unique in the organisations we've heard from today

21 because it plays that coordinating rather than service

22 provision role, and so, it raises the question of how,

23 if there was to be some designation of the Latrobe

24 Valley as a health conservation or improvement zone and

25 a Health Advocate introduced, which is certainly

26 something that people seem to be supporting, how would

27 those concepts work alongside the PHN in your view? Is

28 there scope for collaboration between them?

29 DR MAXFIELD: I think there's definitely scope for

30 collaboration, and our role would be to assist in

31 coordinating their work and linking them to the

1 providers who are already out there. So, general

2 practice/Allied Health. The person who's out there is

3 going to need to know what's available and they may

4 also be able to help guide system redevelopment or even

5 service redevelopment; it's not just the public system,

6 but also, the private providers out there who need to

7 also be aware of what's needed and how they can change

8 what they do in order to better serve the community.

9 MR ROZEN: Thank you. John.

10 PROFESSOR CATFORD: Nola, thank you very much. You're

11 really quite a different organisation compared to the

12 others because you're a creature of the Australian

13 Department of Health and Ageing and the others are

14 essentially creatures of the Victorian Government and

15 Parliament, and so the interface is really important.

16 To what extent will we be able to determine your

17 own future, do you think? Will you have sufficient

18 autonomy and flexibility to join what could be a very

19 exciting development down here?

20 DR MAXFIELD: I think that, certainly from talking to

21 Minister Ley recently, if we can actually show that

22 we've used our data, that we've done our population

23 health planning, and that certain services are needed,

24 and we can be the Commissioners of those services to

25 improve the health of the community, then they're

26 prepared to look at that.

27 Now, everybody's constrained by money, but we're

28 there to present what the needs are, and it may be that

29 we're actually not just going to the Federal Government

30 for money, but we're also saying to the other

31 providers - so the state of the private providers,

1 look, this is what we need and this is how we can do it

2 and everybody needs to put in. I'm not sure if that

3 answers your question, but if we can see what the need

4 is, then I think we have opportunity.

5 PROFESSOR CATFORD: Certainly, some of the earlier

6 presentations looked towards potentially some new

7 funded models, or pooling funds and so on, and if the

8 State were joined with the Commonwealth on this, that

9 could be very exciting. Would your PHN be happy, do

10 you think, to participate in those?

11 DR MAXFIELD: We'd certainly be happy to look at it.

12 Certainly the Federal Government is looking at other

13 models of service, and I think that's already been

14 alluded to. How do you pay for things differently

15 rather than just rewarding people for doing - in

16 consultation, as the Medicare system currently does,

17 how can we change that.

18 I think that part of our role will be to take our

19 private providers along for the discussion on that.

20 It's certainly asking them to do things differently,

21 but I think we've certainly got a core group out there

22 who, provided that they were engaged in the discussion

23 in the right way, would be amenable to looking at other

24 ways of achieving better health outcomes.

25 PROFESSOR CATFORD: So, innovation is very much part of the

26 work you want to do?

27 DR MAXFIELD: Certainly for us, and I think Gippsland

28 actually has a bit of a reputation for being prepared

29 to embrace those things.

30 PROFESSOR CATFORD: The Latrobe Valley is just one part of

31 your total patch. Could this cause tensions or

1 difficulties if there's a lot happening here and

2 perhaps less in other parts of your area?

3 DR MAXFIELD: We've always had to manage that since we've

4 become Gippsland, because it's always felt that, if

5 you're in the Latrobe Valley and if you stood on your

6 chair and you looked east, well maybe you could get to

7 Sale or Bairnsdale but you couldn't see further than

8 that, and you couldn't really see over the Strzelecki,

9 so we've always had to be mindful that there's other

10 parts of Gippsland that need to be considered, and

11 again, I think we need to make sure that we consider

12 all of our parts, but there's obviously a particular

13 focus happening in this way in the Latrobe Valley,

14 we'll look at what needs to be done in the other parts

15 of our community.

16 PROFESSOR CATFORD: Just a final question. You presumably

17 have core funding from the department?

18 DR MAXFIELD: Yes.

19 PROFESSOR CATFORD: Do you have provision to bid for

20 innovation funds in the way that we're sort of hearing

21 in Victoria may well be occurring?

22 DR MAXFIELD: There may well be some coming up in the future

23 from the Commonwealth Government.

24 PROFESSOR CATFORD: Thank you very much.

25 MR ROZEN: Can I just ask you about one expression you used,

26 which we've heard mention on previous occasions, that's

27 "social entrepreneur". I just want to get some

28 understanding of what you mean by that term and how it

29 might relate to the work of the Inquiry.

30 DR MAXFIELD: I think it's about people who actually do have

31 a vision about things being able to be done differently

1 and looking at the point of view of having communities

2 and what are the needs of the community, and how can we

3 develop systems within the community to improve. I'm

4 not sure if that - but, yeah.

5 MR ROZEN: That's very helpful, thank you. Any other

6 questions? No.

7 Thank you very much, Nola, for your time and we'll

8 excuse you for the moment and ask you to join us in our

9 panel discussion at 1.30.

10 Thanks, once again, to all the speakers that we've

11 heard from this morning, it's been very valuable for

12 the Board to hear the views of such a group of

13 community leaders in the health area.

14 We'll now break for lunch till 1.30 and then we

15 will reconvene for a one hour panel discussion. Thank

16 you.

17 LUNCHEON ADJOURNMENT

18 MR ROZEN: Thanks very much everyone and, as you can all

19 see, the six panelists who presented this morning have

20 been kind enough to come together as a group for what

21 we anticipate will be up to an hour now where they're

22 available - some are looking a bit concerned at the

23 thought of that - an hour where they're available.

24 It's a format that we have used, as I know some of you

25 will be aware from previous forums.

26 We're going to do it slightly differently today

27 and that is that, in addition to questions the Board

28 may have and questions that I may have of you, we

29 thought, given that this is a culmination of a five day

30 process and we've had a number of members of the local

31 community who have come along to some or all of those

1 five days, that we thought we would give members of the

2 community an opportunity to ask you questions now.

3 I should say, to preface a couple of remarks about

4 that, firstly if anyone does have a question to ask of

5 anyone on the panel, we would ask that they wait until

6 the microphone comes around to them so that they can be

7 recorded for the transcript, and also, that they

8 identify themselves by name, and if they're here

9 representing an organisation, that they identify the

10 organisation.

11 The second thing I would say is that, I'm sure

12 people in the audience would understand that some

13 members of the panel, and I'm thinking particularly of

14 people who work for the Department of Health and Human

15 Services, may be somewhat restricted in what they can

16 say, particularly about questions of likely future

17 Government policy, and so we just ask that people

18 respect that. I'm sure that it won't be that they're

19 avoiding answering questions, but rather, that it goes

20 with the territory that they occupy that they may not

21 be able to be as fulsome in their answers as they

22 otherwise would want to be.

23 So, rather than me starting the questioning,

24 perhaps if could invite people, perhaps by raising

25 their hand, if they have a question for anyone on the

26 panel, and we'll take it from there.

27 CR HARRIMAN: No questions, thanks for that. Thanks.

28 MR ROZEN: Come on Dale, you'll be used to being asked

29 questions in a community forum, I'm sure.

30 We've got one here. I'd just ask you to identify

31 yourself for the transcript.

1 MR ARKINSTALL: John Arkinstall, I'm a member of the Voices

2 of the Valley. I'd like to ask the panel what they saw

3 as the role of the Health Advocate or the community

4 more generally in concierging to assist people to make

5 use of services more effectively.

6 MR ROZEN: Kellie looks like she wants to go first.

7 CR O'CALLAGHAN: Thanks for the question, John. I think one

8 of the potential opportunities for a health concierge

9 model, particularly for those members of our community

10 living with chronic illness, is we can break down some

11 of the barriers of access, and also, just break down

12 some of that level of disadvantage that we know exists

13 in terms of getting access to services, but also

14 connecting up all of those incidental and Allied Health

15 related opportunities for care that could exist within

16 the community, but it's also the other social supports

17 and networking opportunities.

18 I think what we do know, for people living with a

19 chronic condition, that any opportunity to form a

20 relationship with a trusted individual who can help you

21 guide your way through care is going to add some

22 advantage.

23 I know I had a conversation with some clinicians

24 at the VHA conference last week, and we were comparing

25 the differences between models of care for different

26 types of illnesses, and the example I gave in my

27 instance was having lived with a chronic condition for

28 14 years, the complexity of having to work through that

29 pathway as opposed to having a recent breast cancer

30 diagnosis, where you effectively get on the train and

31 it just follows through. So there's a natural pathway:

1 I didn't have to think about my treatment for breast

2 cancer, yet I still have to on a daily basis think

3 about my treatment for my chronic condition. The

4 reality; the chronic condition is actually probably

5 more potentially threatening than the breast cancer

6 diagnosis, so it actually doesn't fit in terms of

7 access.

8 I think that concierge style of approach, no

9 matter whether that looks at individual support or a

10 community nursing model like the Dutch model, would

11 actually provide some advantage to community.

12 DR MAXFIELD: There may also be some advantage in looking at

13 things in a different way and, if the Commonwealth

14 Government is prepared to look at different ways to

15 funding chronic disease management in general practice,

16 part of what that will fund would be a nurse or

17 somebody within the practice who would actually be

18 facilitating people's journey through management of

19 their conditions.

20 MR ROZEN: Thank you. I don't know if anyone else wants to

21 add anything there. Looks like, no. Do we have any

22 other questions from the audience? No, looks like back

23 to me. Anita?

24 MRS ROPER: If there are no questions, sorry, Dale, but this

25 is directed to you. It was a question I wanted to ask

26 earlier, and then Kellie referred to it in her

27 presentation as well.

28 More clarification: when we were talking about the

29 Health Advocate, you talked about, as it currently

30 stands and implies in the future, that the Health

31 Advocate could not get involved in any emergency

1 situation until the end. So, what are the barriers?

2 CR HARRIMAN: Just under current legislation, the current

3 legislation states who can be involved in an emergency

4 situation. So, it would need to be put in that the

5 Health Advocate becomes part of that Emergency

6 Management process.

7 We have an Emergency Management Plan for the

8 region and there's a State Emergency Management

9 Protocol, about who can be involved, when they become

10 involved and what obligations they have or what

11 responsibilities they have, and a Health Advocate's not

12 in there from the start, and I think we need to look at

13 that; that when we have an emergency situation,

14 particularly like the mine fire, that there is a Health

15 Advocate and a health person in there from a local

16 point of view, not coming from Spring Street, but a

17 local person that knows the region and can advocate on

18 behalf of the locals so we don't end up with the

19 situation we had with the mine fire last year.

20 MR ROZEN: I was wondering if we could return to the three

21 themes that we are focusing on today, and just to

22 remind everyone the three themes are governance,

23 leadership and sustainability.

24 I thought what I'd like to do is open it up to the

25 panel, and this may stimulate some questions from the

26 audience as well, to consider each of those issues, and

27 I want to ask some fairly broad open-ended questions

28 rather than trying to focus in on specific areas of the

29 presentations because I think we've already done that.

30 In relation to governance, I want to open up to

31 the panel to ask the broad question about what can be

1 done, either by existing institutions or by way of

2 recommendations by the Inquiry, what can be done to

3 improve governance in relation to health in the Latrobe

4 Valley?

5 MS PEAKE: I'm happy to start. I think when we talk about

6 governance, we're talking about three things: we're

7 firstly talking about, how do we bring people together

8 to plan and how do we make sure that, in planning,

9 there is better access to data so that we're really

10 focusing our plans from a population perspective, what

11 are the issues that are most relevant to this

12 community. I think a lot of what we've heard today is

13 the opportunities that exist, in large part with what

14 might be the future directions of the PHNs, but also

15 through the goodwill of the leaders from the different

16 parts of the health service to really combine their

17 data to understand health issues for this region.

18 So, bringing that together into a health plan

19 which really focuses on the priorities and the measures

20 of success, I think, is incredibly important, and that

21 enables you to have an evidence based approach, but

22 drawn from the community and connected to the

23 community.

24 The second element of governance is then how

25 services work together to provide more integrated care.

26 That is really about the operating model for how

27 services function. I think we've heard a lot today and

28 over the last five days about the ways in which funding

29 models and organisational models either help or impede

30 different ways of working together, and so, I think

31 there's some really fruitful discussions to be had

1 about what pooled funding models might look like, what

2 outcomes based fundings might look like, how we can

3 have some local flexibility to really not have the

4 stop-start programs we've seen in the past, but instead

5 have sustainable leveraging of existing resources on

6 evidence-informed approaches to delivering better care.

7 Then the third level of governance recognises the

8 discussion we've had over the morning that health is

9 not just about health services. Better health, better

10 wellbeing is about a whole-of-community approach to how

11 communities work, about how people get access to

12 opportunity.

13 I think the discussion we had earlier about how

14 regional strategic planning can be informed by public

15 health policy and practice is the third opportunity for

16 strengthening governance in the region. What comes out

17 of the review that's happening at the moment of

18 regional governance structures is one opportunity, but

19 it's also about how local leaders in the private

20 sector, the community sector and Government, keep

21 working together to be thinking about healthy

22 workplaces, to be thinking about, with local council,

23 how town planning is occurring, how land use planning

24 is occurring, how our schools are promoting healthy

25 behaviours and pathways for kids, and how our various

26 services are really creating those opportunities for

27 community participation and community inclusion.

28 I think in each of those domains of how health

29 services plan, how we organise ourselves to deliver

30 more patient-centered, joined-up integrated services,

31 informed by the sort of technology which helps with

1 care pathways, and then thirdly how we think as a

2 community as a whole about building a stronger

3 community and opportunities for participation, all

4 comes back at the end of the day to good use of data

5 and strong community leadership, good ways of engaging

6 the community so the community has a voice and good use

7 of evidence for where we put our effort.

8 MR ROZEN: Thank you, Kym. Can I invite anyone else to add

9 to those observations.

10 DR MAXFIELD: The primary health network's been mentioned,

11 and I think this is what makes it so exciting to me to

12 be involved in the Gippsland Primary Health Network at

13 this stage, is that we've got the opportunity to use

14 data and to be able to get more data than we've had

15 before. And we also have a structure that's going to

16 be in place shortly with our clinical councils for

17 people to be able to look at that data and then to use

18 all our networks and our relationships with the public

19 and the private providers to then utilise that for the

20 good of the community.

21 MR GUY: A lot of people talk about, for the good of the

22 community. I think where we fall down is our process

23 of connecting with the community to find out what they

24 want. So we really need to concentrate on that area, I

25 think, about how we can interact with all sections of

26 the community and find out what the needs of the

27 community are.

28 MR ROZEN: Just picking up on that, is that something that a

29 Health Advocate might be able to assist with, do you

30 think?

31 MR GUY: I think it could play a major part in that process,

1 yes, and particularly as Kellie mentioned before, if it

2 was set up with a shop front in a town somewhere, where

3 people have easy access.

4 Because a lot of people, with formal communication

5 set-ups won't attend those, but if it was somewhere

6 where they could walk in off the street, maybe that

7 could make it more accessible.

8 MR ROZEN: Are there existing barriers, do you think, to

9 understanding community wishes and wants?

10 MR GUY: I believe there are, yes.

11 MR ROZEN: What are they?

12 MR GUY: I think probably education is one of them. We've

13 talked about the socio-economic situation that exists

14 in the Valley, and that's a factor. People being

15 perhaps a little bit put off by formal structures.

16 There's probably a multitude. I think there's a lot of

17 comment in some of the sessions that have been held,

18 with some input from people about some of those

19 obstructions too.

20 MR ROZEN: Yes, I think so.

21 CR O'CALLAGHAN: I think one of the interesting points, and

22 John's highlighted some barriers there, but there's

23 also an opportunity for us as providers in setting up a

24 governance structure to ensure that it is a transparent

25 process and that there's an availability for community

26 to learn about those structures of governance that

27 exist and learn about the setting of strategies and

28 learn about how compliance and risk and all of those

29 resource allocation issues, how they actually operate.

30 I think we often talk a lot in governance about

31 the rules of governance and we forget who our

1 stakeholder is. So, in terms of setting up a

2 governance structure in this particular scenario, our

3 primary stakeholder is the community. If we think of

4 them as the company we're operating for, then we need

5 to get their best outcome, then we would apply our

6 strategy and our compliance structure and our risk

7 framework to meet their need. But if we're not talking

8 to them about how that works and what that means, then

9 why we're operating in that way, we're immediately

10 going to have a disenfranchised community anyway.

11 Part of it is about breaking down some fairly

12 complex concepts into a level of understanding from

13 community, and then also mirroring back and making sure

14 that it's understood, not just assuming that when we're

15 talking about governance everyone knows what we're

16 talking about.

17 I think we are all within organisations where it

18 works very well, but we need to be a bit better at

19 explaining that and ensuring that we're creating

20 opportunities for our community to ask questions so

21 that the governance process is operating in their best

22 interest.

23 MR ROZEN: Just reflecting, as you were saying that, on some

24 of what we've heard in some of the other sessions, one

25 of the things that comes back to me in relation to

26 community engagement is that one size doesn't

27 necessarily fit all. And we talk about community, but

28 the community is actually quite diverse - we've got an

29 indigenous community, we've got a non-English speaking

30 background community. These must be things that

31 council faces on a day-to-day basis, Dale; are there

1 lessons from that experience?

2 CR HARRIMAN: I think part of what we do is go out and

3 engage with a variety of the community, and I think

4 part of good governance is that it's not just the same

5 group that you go to every time; it has to be a broad

6 spectrum. We have one of the largest populations of

7 indigenous culture in Latrobe City. We have, I think,

8 55 per cent of our population has a parent, either one

9 or both parents born overseas, so we have a huge

10 multi-cultural population.

11 Part of what we do as a council, and I think a lot

12 of groups in the area, when they go out and engaging,

13 it's engaging on six or seven or eight different fronts

14 with people so that you're getting a wide range.

15 You're getting your multi-cultural groups, but you're

16 also getting your different sporting groups, you're

17 getting your disabled, you're getting your carers,

18 you're getting the broad spectrum.

19 Part of what has been done at a couple of

20 councils, I know the City of Yarra has done it, is

21 actually put out an application for the community to be

22 involved in a community input session. They got 200

23 applications, short-listed it down to 60, by having

24 who's in our community, age group, nationality and got

25 the whole spectrum covered, and I think that's part of

26 what we probably need to do. That's something new

27 that's been done; they've only done it this year, but

28 it's worked exceptionally well in them getting feedback

29 from their community, so that you're not getting the

30 same voices, you're getting different voices and you're

31 getting the whole community involved in it.

1 MR ROZEN: Terry, I wonder if I could bring you in here if I

2 could because, when you presented earlier to us, I

3 think it was either you or Kym told us, there was a new

4 community engagement section within the area that

5 you're responsible for. Perhaps if you could tell us a

6 little about that please and how that's intended to

7 work.

8 MR SYMONDS: I guess there's probably three things I'd

9 mention. I might say as an overarching comment that,

10 although it's a branch within the Department, I don't

11 think it's only focused on how the Department directly

12 engages with communities. I think one of the questions

13 for the Department is, when is it appropriate and

14 useful for the Department to engage directly with

15 communities, and when is it our job to support other

16 organisations who are in communities and on the

17 frontline to engage better with their communities and

18 give them tools and resources to do that, and that's an

19 interesting question.

20 For example, how do we understand the views and

21 the needs of populations? One is by directly engaging

22 with them in their local community, but there are other

23 sources of intelligence about this; they occasionally

24 fill out surveys, they occasionally provide information

25 to others. The ABS regularly surveys people about

26 barriers to healthcare, about their views on access to

27 healthcare, about priorities and so on. We get that

28 information. How well do we share it with local

29 organisations? We survey populations ourselves. How

30 much do we break that into local cohorts and share it

31 with organisations at a local level so they can see the

1 intelligence that we've got?

2 We now have for the first time access, not only to

3 the hospital statistics that were talked about before,

4 but access to MBS data from the Commonwealth is being

5 shared, which is a really welcome contribution I might

6 add from the Commonwealth. So, have we started to

7 analyse that and break that down into bundles of

8 information that we can share in the way that Kym

9 talked about and give resources to other organisations,

10 so I just make that comment at the beginning.

11 I suppose there's three issues: one is about the

12 Department's relationship with other organisations, so

13 sector engagement, how well are we talking to other

14 service providers, making sure we know the issues

15 they're seeing on the frontline; the kind of issues

16 reported today from these organisations or others, how

17 well we are building that into our own policy.

18 The other is a direct engagement with

19 communities - I've said that's not only our focus, but

20 occasionally that is important. When do we engage the

21 communities about priorities for Government, what's

22 their view on what our policies should be? What's

23 their view on priorities for State Government?

24 The third is clients and patients. I think it's

25 important that we also run processes to make sure that

26 we're directly engaging with the clients and users of

27 services that we fund.

28 For example, we fund a survey of patients that

29 leave hospital, it's done on a Statewide base, I know

30 that service providers do that for themselves, but we

31 also do it Statewide and we get some benefits from

1 doing that on a large scale across the State and then

2 report those results back. That tells us, for

3 instance, about whether people leaving hospital feel

4 they've got adequate support from the community to help

5 manage their care at home. Do they feel their GP was

6 adequately engaged by the hospital? We can now see

7 that information at a local level, and we report it

8 back publicly as well as to local organisations.

9 I suppose I'm giving you a feel for some of the

10 work that our branch is going to do. There's one

11 another, I might add, which is the use of new

12 technologies. We have a significant investment in

13 digital technology in the Department - it's

14 traditionally thought of as the good looking websites

15 department, but I think we have to think about the fact

16 that the internet and accessing the web is only one

17 means for transmitting information - let's think about

18 technology as a way to actually get advice and feedback

19 from communities. You know, young people don't mostly

20 sit on a PC and use the internet and browse public

21 websites, they're going to use their phone, and so,

22 what can we put on their phones that means they can

23 give us feedback about things? Is it possibly to poll

24 users of services?

25 I don't expect lots of service providers to be

26 able to do that within their own scarce resources,

27 that's something that we can do at a Statewide level

28 and put those tools back in the hands of other

29 organisations. So that's some of our early thinking.

30 MR ROZEN: Kym, I wonder if I can bring you in here. In

31 relation to the new position for which recruitment is,

1 I think, presently ongoing, the role, is it a

2 Morwell-specific role?

3 MS PEAKE: It is.

4 MR ROZEN: How is that expected to work?

5 MS PEAKE: It's absolutely a Morwell-specific position that

6 is intended to be really from community, within

7 community, deeply engaged, particularly around any

8 emergency events, but there as a resource ongoingly to

9 be working with agencies but also working with the EPA,

10 to be tapped into what are the concerns, the questions

11 from members of the community which can then be fed

12 back in - very much the role that I know many people

13 today here have played, but in an ongoing supported

14 way.

15 The key to its success is going to be that it's

16 someone who is trusted and who is very open and

17 listening, and that there is follow up. I think,

18 really to John's point, one of the critical things in

19 how you have an authentic approach to engagement with

20 the community is that it's not simply going out and

21 surveying and talking to people and then there's no

22 follow-up. We also, through this position, are looking

23 to have really good processes where it's not always

24 going to be possible to do everything everyone would

25 like us to do, but being able to explain what is

26 possible, what's being done and what's the process

27 going forward.

28 MR ROZEN: If I could raise the question of sustainability

29 because, if there's one theme that has come through a

30 lot of the work that the Inquiry has done in the

31 previous four days of Health Improvement seminars, it's

1 the frustration people feel with this stop-start aspect

2 of Government programs. We heard quite a bit about

3 Healthy Together, and that's an example that's been

4 used on a number of occasions.

5 How can that be overcome, I suppose, is the

6 question? In particular, I'd ask the panel to reflect

7 on the role that the community itself can play in

8 trying to mitigate against that occurring in the future

9 with any new initiatives that are put in place.

10 CR HARRIMAN: I'll start, if you like.

11 MR ROZEN: Thanks, Dale.

12 CR HARRIMAN: That's all right. I think John mentioned a

13 similar program started in 1990, and there was one in

14 1983, I believe, before that. I think from my point of

15 view, the outcomes could have been achieved if the

16 money put into re-running the program in 1983 had have

17 been put into actually funding the necessary outcomes

18 and recommendations, I'd be about 5 kilos later,

19 looking more like John, fit and healthy, and I think a

20 lot of the community would be a lot better off. I

21 think part of it has to come down to, if we can get

22 that enhancement region, or a health enhancement region

23 organised, then we can see the benefits because the

24 Government would have to make a long-term commitment.

25 I think we really need to force the Government into

26 picking an area, and I think this is a great area to do

27 it, and making a long-term commitment to the health and

28 wellbeing of those residents, and having a bipartisan

29 approach where what works in this region is then rolled

30 out to the rest of Victoria.

31 I think that's important, I think there has to be

1 a commitment to funding it through one particular

2 region and seeing what works and it has to be

3 bipartisan. It's great to have all these programs

4 coming out every five or six years, keeps a lot of

5 people employed, but leaves a lot of people unhealthy.

6 We had 500 people come in with Healthy Together,

7 went through the Jamie Oliver school, did the cooking,

8 had a huge impact on the schools. I know a lot of the

9 schools are involved with the kitchen garden and

10 they're producing salads, and kids normally that don't

11 see vegetables are actually eating fruit and

12 vegetables, which is great, it's a great outcome. But

13 that's while they're in primary school. Once they hit

14 secondary school, 2-3 years in the message is lost if

15 there's no constant reinforcement, and I think that's

16 where we need to have that bipartisan approach and a

17 commitment that we're not going to fund a program for

18 four years or the term of this Government; it needs to

19 be, we will fund it, but then there is going to be

20 money set aside for any recommendations that come out

21 of it, particularly in regard to health.

22 MR ROZEN: Thank you, Dale.

23 MR GUY: I agree with that, I think it's got to be a

24 whole-of-Government approach, it's got to be probably a

25 five year plan which gives time to set the process up

26 and go through to an evaluation stage so that you can

27 see the benefit of the program. Otherwise, we're not

28 going to get anywhere.

29 MR ROZEN: Kellie.

30 CR O'CALLAGHAN: I think, having the ongoing Government

31 commitment is the first step. I think the other thing

1 you need is for everyone to agree what the principles

2 of the measures of success for the programs will be so

3 that there is that quite clear and measurable indicator

4 of whether or not something is working.

5 I think we see a lot of seed funding, we see a lot

6 of initial program commencements, but then when it

7 comes to the actual, did it work, how do we measure it,

8 we don't necessarily agree the principles for success

9 up front. I think, if we do that, it's easier to

10 defend - so I put the political hat on, sorry about

11 that, Mr Mayor.

12 CR HARRIMAN: That's all right, go for it.

13 CR O'CALLAGHAN: Easier to defend something from the

14 political perspective if you know you've got the

15 measures to back it up.

16 The other thing is, if we have flexible and

17 responsive program models, you allow the programs to

18 adapt and you allow a service provider to be more

19 flexible in their approach, be more responsive. So, if

20 there's a deficit that starts to show in the program,

21 they can pick up the slack and be more attentive to the

22 need of the community and, therefore, get greater

23 engagement.

24 So, sometimes we give these program models out as,

25 it's like this and you've got to deliver it this way

26 and you can't step outside the bounds. So, if you give

27 a much more flexible and responsive framework setting

28 you're likely to get a few more measures of success.

29 So put in formal evaluation models, but I think

30 the other thing, we've been talking about it a lot over

31 each of the five days, is having community ownership of

1 the programs. Because, once you give something to a

2 community that's working and you try and take it away -

3 you know, good luck with that. So, there's some work

4 there that can be done on ensuring that in the first

5 instance the programs that we get are appropriate and

6 relevant, that they're measurable and we're evaluating

7 them in an effective way, and then they're defensible

8 because the community owns them and wants them and sees

9 the inherent value in them.

10 I think some of that sustainability model is

11 around ensuring that it's appropriate in the first

12 instance, and then has a level of solid service

13 delivery ownership and community attachment as well.

14 MR ROZEN: Thank you. Nola, I wonder if I can just bring

15 you in on this question, because I recall from your

16 presentation earlier you talked about measurable

17 improvement in health as being one of the key

18 components of the PHN. I just wondered, what does that

19 mean in practice? How is it envisaged that you'll

20 measure improvements in health?

21 DR MAXFIELD: It was also the vision for our Medicare Local,

22 and I don't think we actually came to grips with how we

23 were going to measure that. I think that now we're

24 actually going to be able to get a bit more data and be

25 able to work out - start to look at some dashboard

26 reporting and look at what are the important areas, and

27 then to be able to monitor that over time. We're going

28 to have to be informed by our clinical councils and our

29 community reference groups as to what are the important

30 issues for those communities to start with.

31 We will also be judged by the Government and they

1 will also use some of their data, so things like

2 immunisation rates, chronic disease management,

3 screening of various things, whether it be perhaps new

4 breast screening, bowel cancer screening, so we are

5 going to be held to account by them in providing some

6 of the data and we'll use that as a starting point.

7 MR ROZEN: Thank you. Kym.

8 MS PEAKE: I was just going to add, slightly cheekily, that

9 I think we're really talking about prevention and

10 primary prevention initiatives and how do we sustain

11 those when we ask the question about sustainability.

12 It's interesting, when we think about road safety,

13 the role that the research partners have played in

14 really, not only evaluating what's been done, but

15 giving good advice to both the transport authorities

16 and the justice authorities about where to put the next

17 lot of effort in campaigns.

18 I think one of the really valuable contributions

19 that VicHealth makes, and I think they do make this

20 really well and we've got to keep leveraging that, is

21 to play that role in giving advice about, what are the

22 health promotion and prevention activities that have

23 the most affect and how, both at a local level and at a

24 Statewide level, do we take account of that in where

25 we're putting our next lot of effort. That was one

26 point I just wanted to make about sustainability, that

27 the link with research and evaluation is, I agree with

28 Kellie, is critically important.

29 The second point I guess I just wanted to make is

30 that, in our approaches we also want to leave a little

31 bit of room for experimentation as well and we want to

1 make sure that it's okay to try things and they don't

2 work, and that they do stop, and that we're adaptable

3 in that way.

4 I think we just want to be careful that, in

5 promoting sustainability and adaptability, that we

6 don't cool the ability to experiment, innovate, and

7 actually put our hands up and say, actually that didn't

8 work, we're going to try something else.

9 MR ROZEN: Any questions from any of the board members -

10 John.

11 PROFESSOR CATFORD: I wondered if I could continue the theme

12 of resourcing, and clearly, some of the local agencies

13 are very clear that they need some additional help from

14 Government to advance their cause.

15 But, of course, there are a range of resources

16 available. We've heard I suppose predominantly looking

17 at Victorian Government resources, but there's

18 obviously Federal Government resources, and potentially

19 the PHN can tap into that.

20 But there are also resources coming from outside

21 Government, and I was wondering if the panel might just

22 comment on this: whether large employers or businesses

23 might be a source of resourcing, or indeed

24 philanthropy. There are examples in other parts of

25 Australia where philanthropy has also played a really

26 good role at levering further investments from

27 Government.

28 So, I really wanted to address the question of

29 resourcing, and also just of course make the point that

30 we are already spending significant resources already

31 in the Valley; to what extent can we lever or use our

1 resources that we have got at the moment more

2 effectively?

3 Can we think in innovative ways about finding new

4 resources, but could we also use our existing resources

5 more effectively? I wonder if you could help ask the

6 panel that question.

7 MR ROZEN: Sure. You don't need me to repeat it, I'm sure.

8 Kellie.

9 CR O'CALLAGHAN: Happy to jump in. I think, what we don't

10 acknowledge sometimes is that the corporate entities

11 within our community are willing to be engaged and be

12 involved.

13 MR GUY: And are engaged.

14 CR O'CALLAGHAN: Absolutely. I think a lot of the time we

15 don't necessarily make it easy for them to do that. We

16 can get very focused on our core business arrangements

17 and delivering on our departmental obligations and

18 contracts, and don't think about innovative approaches

19 to engaging organisations and entities.

20 I know I've had lots of conversations - and often

21 it's come about since the mine fire - around the old

22 days of the SEC where if you wanted something done at a

23 primary school, you'd ring up and the works guys would

24 come out and they'd build a new library at a primary

25 school or they'd paint something for you, or if a

26 community agency wanted something, you'd engage with

27 the corporate who would come out and offer some kind of

28 in-kind support.

29 The other thing that I think's happening a little

30 bit, and it certainly has happened since the mine fire

31 itself, is that, for some of that Industry Group

1 they're almost a bit bashful about getting out on the

2 front foot and then offering up some of those

3 opportunities in case they are in some way criticised

4 for coming into that arena for the wrong reasons.

5 I think there's a time and a place for us to sort

6 of open that discussion again around what that can look

7 like. The other thing is, it doesn't need to be big

8 cheques. I think we always had this idea that

9 someone's got to write a cheque and buy something or

10 give something.

11 There's quite a lot of value in having corporates

12 engaged in assisting organisations, whether it be with

13 skills resourcing or in-kind contributions or other

14 levels of value-added within organisations. So I think

15 we can probably be a bit more creative about how we do

16 that and formalise some of those opportunities.

17 Look, it's another thing that the Health Advocate

18 can do, partner up and actually help organisations

19 match up and share skills and share resources, so that

20 they're not having to spend money on things that can be

21 provided by a corporate who's happy to support them, so

22 I think the opportunity's there.

23 The other thing is, philanthropic organisations

24 have a very strong history within the Valley. I know

25 my initial experience was through Good Beginnings, when

26 it lost its Federal funding, I was a coordinator there

27 for a while and it was the SIBEK(?) Trust that stepped

28 in and funded it for two years after seeing an article

29 in the paper, and Roger Eden stepped into that space

30 and said, "You know what, I'll pay for it; it's an

31 important program". So philanthropy is well entrenched

1 in a lot of the organisations that we work within and

2 there are good, solid relationships.

3 But one of the difficulties is for smaller

4 community-based organisations and health services to

5 know how to gather that money, to know how to get out

6 there for themselves and attract those sorts of

7 partnerships. I think there's almost an introduction

8 relationship building connecting up space, where if we

9 had this central point where all that information came

10 into, you could start to share it out across the

11 network a little more equitably, and having said that,

12 obviously across the paddock, we don't have too much

13 trouble getting people engaged, because it's a

14 hospital, and people say, "Great, I'll give the money

15 to the hospital".

16 But it might be more appropriate that they are

17 providing money to a program that John's doing at LCHS.

18 You know, who's not to say that we shouldn't be sitting

19 down and working out how we best use our community

20 resources through corporates and philanthropy. So, I

21 think we've got to start having those conversations and

22 planning more effectively as a community.

23 MR GUY: I think a lot of that sponsorship has occurred over

24 a number of years; we just haven't thought about

25 applying that to health. It doesn't matter where you

26 go in the Latrobe Valley, you will see, if you go to a

27 concert, you will see sponsorship from a power company.

28 The hospital ball that's coming up, sponsored by a

29 whole lot of organisations in the town. We just

30 haven't thought of that angle of asking for sponsorship

31 for health programs.

1 MR SYMONDS: If I can just comment, I think there are some

2 communities and health services that have done very

3 well with that, and I think one of the things we should

4 do is make sure we spread good practice around that

5 kind of stuff.

6 I think support for philanthropics is also

7 something which the engagement branch of the Department

8 is looking to do. They've pointed out that in the past

9 State governments have done a bit more to marshal some

10 of that support and brief philanthropics, make sure

11 there's good connections between the donors and the

12 other organisations, that's something we can do a bit

13 more of at Statewide level without getting under the

14 feet of local organisations.

15 In terms of leveraging existing funding and John's

16 questioning about that, I completely agree, I think

17 there's a significant amount of money invested by State

18 Government in acute health services for instance, and

19 our funding model has strong positive incentives for

20 that money to be spent efficiently, but it's kind of

21 agnostic about whether that money is spent well to

22 avoid people having to come to hospital.

23 In fact, if hospitals spend that money

24 efficiently, they get to keep the difference between

25 what it costs for them and what an efficient price

26 might be. But, if they don't spend that money on

27 admitting patients, we take it back, and so, you could

28 argue that it acts as a kind of perverse incentive to a

29 certain degree.

30 One of the things for us to think about in terms

31 of leveraging existing investment, and this gets back

1 to a governance investment, is how to make sure that

2 acute health services share accountability for

3 prevention of avoidable admissions and chronic disease

4 driving admissions and, if we do that and tie that to

5 funding, then the funding we've got is working harder

6 for overall health, not just for activity, and it's

7 balancing that investment being for what gets done,

8 which is what it does now, versus what is needed, and I

9 think the investment has to work a little harder for

10 what is needed, not just what gets done. I think

11 that's a change to make in funding models I think.

12 MR ROZEN: Sorry, Kym, just before you start, I'm just

13 reminded of something you said earlier, Terry, about

14 the difference between outcomes and outputs and I

15 wondered what you meant, but I think I've just learnt,

16 have I? Is that what you're - - -

17 MR SYMONDS: That's exactly what I meant.

18 MR ROZEN: So an outcome would be better health, and output

19 would be treating people.

20 MR SYMONDS: We fund Latrobe Regional Hospital something

21 approaching $200 million a year for hospital services.

22 That's a not insignificant investment by the State

23 Government in the health of the Latrobe Valley. But

24 that money is tied to outputs, like treating an

25 orthopaedic patient and them leaving hospital. Now,

26 there's plenty of orthopaedic surgery needed in the

27 Valley, I have no problem with that at all, but I

28 think, in line with earlier comments, we should also be

29 giving Latrobe Regional Hospital and the community some

30 flexibility, to say that, on balance, if that funding

31 could also meet other needs and be deployed or pooled

1 with other things to achieve better outcomes, providing

2 we agree on how that's measured and understood, perhaps

3 that's a model we should be thinking about, and that's

4 exactly what we are starting to toy with, and I think,

5 if that fits in line with the Inquiry, then it has

6 relevance.

7 MR ROZEN: Sorry, Kym, I think you were about to say

8 something?

9 MS PEAKE: I was just going to make a small point that

10 there's also the broader determinants of health where

11 all employers and a whole range of other actors within

12 the community play such an important role - whether

13 we're talking about sporting clubs and how they

14 maximise participation or we're talking about attitudes

15 to women and violence and how employers model

16 expectations and support, people who might be finding

17 themselves having the experience of exposure to family

18 violence. So, if we actually gathered up all of the

19 indirect ways through some quite deliberate activity,

20 that a whole lot of different institutions and places

21 in communities could contribute to reducing the burden

22 of disease and promoting healthier communities, we can

23 also have conversations within communities that not

24 only are about providing sponsorship, but making a

25 contribution in a different kind of way.

26 MR ROZEN: I'll just check if there are any other questions

27 that the Board has of the panel.

28 PROFESSOR CATFORD: Could I ask now about community

29 engagement and this whole question about co-design or

30 co-ownership and really partnering with communities.

31 I think all of you have commented on that in some

1 way but, I mean, do you think there's an opportunity in

2 the Valley to actually do something which is quite

3 remarkable in terms of linking with organisations - we

4 have Voices of the Valley here with us today, and there

5 are other organisations. Could you do something that

6 sets you apart in terms of a new way of governing and

7 leading?

8 CR HARRIMAN: I'll jump in on that one. I believe we

9 already are. I believe the basis for it is already

10 there, the community groups are there, the community

11 input is there, the willingness is there, it just needs

12 to be harnessed. I think that's where, from this

13 panel, that might be the harnessing, that the people

14 are there - as you've seen, the people are there,

15 they're willing, they want to be involved, and I think

16 it's just a matter of harnessing that. I think it can

17 be something that can be modelled and rolled out across

18 the rest of Australia.

19 I work with a local charity that are working with

20 carers that are doing a similar thing - it's the carers

21 at a ground level enhancement, and I think that's what

22 we need here. It has to be, not a top -down, but it

23 has to be the community driving this, it has to be the

24 community from the ground up building the system. I

25 think we've got the people who are willing to do it,

26 we've got the people with the qualifications to do it,

27 we've got the people with the drive to do it long-term

28 and I think that's important. It's not going to be

29 something that the community is going to run out of

30 puff within six months; I think we've proven that we've

31 got people that are willing to stay the long-term, so

1 I believe it's something that just has to be harnessed.

2 CR O'CALLAGHAN: I think community engagement really is just

3 about facilitating an understanding, and I think we

4 over-complicate it. We like to over-egg it because it

5 makes us feel important.

6 There's nothing that I do in my job that someone

7 else couldn't do. There's no process within an

8 organisation that someone couldn't understand if given

9 the respect and the time and the consideration and the

10 genuine goodwill to share that understanding.

11 I think that's where we're at; it's about

12 acknowledging that there are differences in the way

13 that we see things, that there are learnings that can

14 be had and, if we just accept that facilitating that

15 process of sharing information and being transparent,

16 and agreeing to disagree. Like, Wendy will tell you,

17 we don't always necessarily agree about everything, but

18 we can have a robust conversation about those things

19 which we may not share an agreed position on and get to

20 a point where we can move forward with some

21 understandings.

22 I think that's probably what we're doing, and also

23 looking at how do we help community to actively

24 participate in their own engagement, not just telling

25 them that they need to participate in community

26 engagement, but helping them to do it themselves and in

27 bringing those ideas to the table.

28 Some of the frustrations that I know Wendy and

29 Marianne and John will probably tell you about is, in

30 the initial stages trying to be heard, trying to get

31 credibility, trying to have some champions for either

1 their message or understanding what it is that they're

2 trying to question.

3 Some of those conversations were quite accidental;

4 we ended up sitting at tables in other forums and

5 learning from each other that way. I think we just

6 need to formalise some of that, so we force ourselves

7 into conversations that may be uncomfortable, that we

8 don't want to have. It doesn't need to be easy, it

9 doesn't need to be comfortable, but if we can't even

10 get to the point of having conversations and working

11 out what we are trying to achieve - I think part of it

12 is handing over to the community that engagement. What

13 would you want it to look like? How would you do this?

14 We can't always assume it's the providers or

15 administrators or counsellors or whatever we are at the

16 time, that we know better, and we've got to stop

17 telling communities what we're going to do for them and

18 let them tell us how they would like to be engaged with

19 and facilitate that understanding.

20 MR ROZEN: What I'd like to do now is bring this session to

21 a conclusion in this way - we've done this with each of

22 the previous panel sessions that we've had - sorry, is

23 there a question on my left?

24 MS ROBINSON: I did have a question.

25 MR ROZEN: Sorry, there's a microphone coming your way.

26 Would you please identify yourself for the transcript?

27 MS ROBINSON: Marianne Robinson, I'm a member of Voices of

28 Valley. In some respects this is a follow-up to what

29 Kellie has just said, but it's something I've been

30 thinking about all the way through the presentations,

31 about leadership and governance.

1 The question is to all members of the panel, what

2 would need to happen to make it possible that we can

3 make decisions about resources and programs at a local

4 level? Various people have spoken about what a Health

5 Advocate could do, and you're expecting a super human

6 person perhaps, but also, what we've learnt over the

7 last year, 18 months is, quite often get a response

8 when we suggest something, "We don't need to do that,

9 somebody else is doing it. We don't need to suggest

10 this line of operation, somebody else has already got

11 that under control." That is, I think, one of the

12 significant barriers to greater community

13 participation, and it's a barrier in two ways: one is a

14 perception that it's not the community's job, it's the

15 agency, the Government, whatever it might be - that's

16 the perception from the community side.

17 There's also the acceptance, which I think we've

18 heard quite a lot - that whatever we want to do is

19 subject to what the Federal Government decides, what

20 the State Government decides; we have to get permission

21 to do what we need to do.

22 So, what sorts of things do you think need to

23 happen, need to change for us to be able to do what we

24 want to do?

25 MR ROZEN: It's a big question. Dale.

26 CR HARRIMAN: I'll jump in on part of it, I don't think I

27 can answer all of it, Marianne, but I'll get part of

28 it.

29 I think part of what needs to happen is that we

30 need a change of view from State, Federal and even

31 Local Government. We've always gone top-down, and

1 we've just seen that works in some instances, but

2 there's cases where it doesn't work. I think part of

3 what we need to do is start looking at building those

4 community-up sounding boards. We need to have that

5 community-up input. As Kellie said before, rather than

6 telling the community how we're going to do something,

7 asking the community, how do you want it done, and

8 having those community groups in place, similar to what

9 the City of Yarra have done, they've done it with

10 planning, they're now rolling it out across a whole

11 range of issues, asking the community, how do you want

12 it done, what do you see as the future, how do you want

13 us to go about it, and having that input from the

14 community, from a range across the community, and it

15 just gives you that better understanding of what's

16 actually needed; because, if the Government imposes

17 something that the community doesn't want, we've seen

18 it before, it fails and it falls over in a very short

19 time; the Government will drive it for six months, fund

20 it for 12; 13 months in it no longer exists or no

21 longer relevant.

22 MR GUY: An interesting question. It's interesting when you

23 talk about community, isn't it, because a lot of the

24 things I do, I'm doing as part of the community; or all

25 the things Kellie does is for the community, the same

26 as Dale. What we've got to do is, I think, think about

27 how we can bring other people into that, and a lot of

28 people don't want to get involved in committees, they

29 don't want to take on jobs.

30 If you advertise, and some of the organisations

31 I'm in, if we advertise we're having an annual meeting,

1 people won't come because they know there's a danger

2 they're going to get tapped on the shoulder to take on

3 a position. If you advertise it just as a meeting

4 where you're going to discuss something, people will

5 come along.

6 So, I really don't know what the answer is, but

7 somehow or other we've got to try and involve a lot

8 more people in the discussion.

9 MR ROZEN: Kellie?

10 CR O'CALLAGHAN: I'm happy to jump in. I think we start at,

11 yes, and we work out the how. I think we immediately

12 take a defensive position of not enough and

13 insufficient resourcing and it's all too hard. I think

14 the other thing; we take it personally, and I know,

15 gee, I've done it on more than one occasion; you

16 immediately take the question or the suggestion as an

17 attack on the basis of what you're doing now as being

18 inadequate, so therefore you jump to the no.

19 I think if we start at the yes, but I don't know

20 how, and then have that conversation and work out the

21 how from that, we're probably going to be communicating

22 a little bit more effectively. So, I think rather than

23 discouraging people from bringing ideas to the table,

24 start at yes, acknowledge I'm hearing you; all right,

25 now how are we going to do this, because I'm not really

26 clear of how we're going to make that happen.

27 The other thing I think we need to do is

28 understand we're just the custodians of the health

29 services we're operating, and we need to be respectful

30 of that. We are here effectively for a very short

31 period of time and we'll make certain changes and we'll

1 instigate certain systems and practices, but we are

2 only the custodians of the system, and these systems

3 will have had history before us and will continue far

4 beyond us. And, if we keep operating on the basis that

5 it's just ours and it's all closed and we say no to

6 anybody making changes to it, then it will never

7 evolve. So we need to be considering that as well.

8 I think one of the most important things that

9 we've experienced, particularly within this local

10 community, is that acknowledgment is key, but action is

11 essential. We need to be listening to our community,

12 acknowledging that we're listening to what it is that

13 they are concerned about and fearful of, but we also

14 need to be instigating some action so that they can see

15 that they've been heard and there's been an outcome

16 from it. I think, yes, start with a yes, and then work

17 out the how from there.

18 MR ROZEN: Thank you. Wendy.

19 MS FARMER: Two questions - Wendy Farmer from Voices of the

20 Valley. The first one's to Kym. Kym, you said there's

21 a recruiting position at the moment for a community

22 engagement for Morwell. Can that be broadened to be

23 for Latrobe Valley?

24 One of the things - and I know you can't answer me

25 on this one straight away because you have other people

26 to go to - one of the things that we saw right through

27 all the forums that we've had is, by dividing the

28 Latrobe Valley into separate areas, you know, Moe,

29 Morwell, Traralgon and surrounding areas, we have a

30 real divide. I believe, and I'm pretty sure Dale and

31 Kellie being on council also believe, that we need to

1 start working to build Latrobe Valley together, each

2 town, each little area supporting each other, so we

3 really need to start looking at these agencies that

4 come into Latrobe Valley on how they can build this

5 area as Latrobe Valley rather than as four or five

6 different separate areas.

7 MS PEAKE: Thank you. So look, I'm really, really happy to

8 take the feedback and go back and talk to the team

9 about what's possible.

10 MS FARMER: The other question/statement that I probably

11 have is, we just touched on funding, and we know that

12 the coal companies pay a lot of Crown royalties. None

13 of that money actually comes back to Latrobe Valley.

14 You know, is there a way of saying, okay, you've been

15 working in our backyards for the last 90 years, that

16 it's time that some of that Crown money be handed back

17 to the Latrobe Valley to improve Latrobe Valley?

18 That's all.

19 CR HARRIMAN: I'm probably the one that's going to handle

20 the coal royalties, quite happily, quite happily. This

21 council actually wrote a letter to the State

22 Government, there was a notice of motion put forward at

23 a council meeting calling on the State Government to

24 pay part of the royalties it receives from the three

25 mines to the council or into a fund for development of

26 Latrobe City, within Latrobe City.

27 To paraphrase the response, "It's ours, go away"

28 was the response from the State Government. It is

29 State Government money that they put into general

30 revenue and it won't be coming back here.

31 As a council, we fully believe that our residents

1 have put up with the mines being here for the

2 betterment of the whole of Victoria, and that part of

3 that should come back - we know it happens in other

4 states. We know in WA in particular that part of those

5 royalties are dedicated to the communities that that

6 money comes from, and we believe, whatever Government's

7 in play, that that needs to be what's done here; that

8 part of those royalties is put back in - doesn't have

9 to come to council, I'm quite happy if it doesn't come

10 to council, if there's an independent body that's set

11 up that says for the development of Latrobe City,

12 Latrobe Valley, this is what we're going to do -

13 whether it be better roads, whether it be bridges,

14 whether it be pools, whether it be sporting facilities,

15 whether it be paying businesses to come down and set up

16 here so we can transition, happy for it to be spent by

17 an independent body, this council has gone out and

18 chased it, the State Government has said no, that

19 doesn't mean we've given up.

20 MR ROZEN: Thanks, Dale. What we've done with previous

21 panels is asked a final question to see if each member

22 of the panel had one message, if you are able to give

23 one message to the Board, and specifically focusing on

24 today's topics of governance, leadership and

25 sustainability. So, if you could leave the Board with

26 one message about those topics and about improving

27 health in the Latrobe Valley, now's your chance. I'm

28 happy to start anywhere.

29 CR HARRIMAN: I'll jump in first, always happy to ask for

30 money. With sustainability, we have the systems

31 basically ready to go here already, we have the people

1 ready to go, we've run a number of programs in the

2 past - make them sustainable. Don't give us something

3 for two years, don't give us something for three years;

4 look at what we're already doing, look at what's making

5 a difference already, and make sure that we've got it

6 for 10, 15 years. We're doing a health study for

7 10 years; anything that we do needs to be modelled on

8 that 10 year guideline, because we need to see at the

9 end of 10 years how it's gone, if it's made a

10 difference or not. So, with sustainability, 10 years

11 is our guideline if we can ask for it.

12 MR ROZEN: Thank you, Dale. Terry?

13 MR SYMONDS: I suppose, picking up on some of the themes

14 around sustainability that's come up in this session,

15 one thing to leave the Board with I suppose from my

16 point of view would be to focus on the infrastructure

17 of the system. There is a significant investment

18 already at play, there are bodies and structures and

19 relationships already in place. How could the

20 accountability and the performance measurement and the

21 governance around those structures serve the interests

22 and meet the needs that the Board's identified?

23 I think it's easy to identify, in every situation,

24 not just here, it's easy to identify new things we can

25 do and new investments, I think those are always at

26 risk by their nature. Whereas, I think if we can get

27 at modifying the DNA of what's already at play in

28 primary care, acute health, the governance of those

29 arrangements, it's already here, then I think we're

30 talking immediately about something that by its nature

31 is more sustainable. That is an historic opportunity

1 that I think is in front of us because of the timing of

2 the board's Inquiry. There is a constellation coming

3 together around the way in which primary and acute care

4 providers work together for population health, and

5 there is a convergence of interest across Government,

6 through things like family violence, in the way that

7 health and social care come together; I think that's an

8 opportunity that I think I'd be very interested to see

9 how the Board considers that as you form your own

10 recommendations.

11 MR ROZEN: Thanks, Terry. Kellie, one last thought to leave

12 the Board with?

13 CR O'CALLAGHAN: I think we just need to trust that this

14 community has its own inherent strengths and that we

15 should build upon those as much as possible.

16 I understand that we want to be to build a future

17 for our children and that, as leaders within the

18 community, we are genuinely interested in ensuring the

19 sustainable health outcomes for our own community and,

20 given the appropriate support and commitment, we can do

21 that.

22 MR GUY: As I said earlier, I think we should push ahead

23 with the Health Advocate role. There certainly are a

24 number of organisations that are working in the health

25 area, they tend to work in silos, so we need to pool

26 some of that together, I think the Health Advocate can

27 do that. We need to look at ways of empowering the

28 community at all levels to be involved in that.

29 MR ROZEN: Thank you. Nola?

30 DR MAXFIELD: I think the primary health network is here and

31 raring to go and to take on some challenges, and I

1 think we'd welcome being asked to bring our various

2 providers together and the community, with some

3 funding, to look at different ways of doing things.

4 MR ROZEN: Thank you. Last, I hope not least.

5 MS PEAKE: I would really welcome and encourage an

6 engagement with the Family Violence Royal Commission.

7 I think that they will be making recommendations at a

8 pretty similar time about how - very similar

9 conversations about different funding models and

10 governance models and operating models to integrate

11 social care, so looking at how their work interfaces

12 with the very same things in health. So that, picking

13 up on Terry's point, there is an opportunity for the

14 Latrobe Valley to be building on all the leadership

15 resources that are very clearly on display,

16 demonstrating new ways of working, getting new

17 investment to have those new ways of working as trials

18 for the rest of the State, and in fact the rest of the

19 country. I think there's such an exceptional

20 opportunity and there is a strong both need and case,

21 because of the leadership capability here, to be

22 positioned in that way.

23 MR ROZEN: On that very positive and inspiring note, it just

24 remains for me to sincerely thank each member of our

25 panel. We're very grateful for the time that you've

26 all made available today, and I think the Board has

27 benefitted greatly from hearing your views about the

28 various topics that we've discussed, so thank you very

29 much.

30 PROFESSOR CATFORD: It's up to me, I think, to close the

31 afternoon.

1 We heard a little bit about some of the history

2 here in the Valley, and I think perhaps when the next

3 history book of health in the Valley is written there

4 will be the time before this meeting and the time after

5 this meeting.

6 Because, for our part, we think it's been quite a

7 remarkable roundtable and, if you just reflect that we

8 have the leaders of the principal health agencies

9 coming together and discussing, giving up your very

10 precious time to come together to discuss the future of

11 health in the Valley, and you have been amazingly

12 generous not only in your time but your ideas and your

13 thoughts and your energy. I think you've been

14 extremely open and constructive, you've presented a

15 willingness to work together co-operatively between

16 agencies and partner with the community, and for that

17 reason I think it has been really quite a remarkable

18 roundtable, so thank you all very much indeed on behalf

19 of the board.

20 I'd also like to pay our thanks and respect to all

21 the other members of previous forums, and there have

22 been 12 before you, that have also given very

23 generously of their time and they have also presented a

24 wide array of suggestions and ideas.

25 I think what you've embodied today we saw

26 previously at the other forums about spirit of

27 cooperation and thinking very positively and

28 constructively as you move forward.

29 As Anita mentioned, our time as an Inquiry is

30 really very limited and it will be up to those of you

31 and your organisations to move forward, but I think we

1 have a lot of confidence that that will occur.

2 So, thank you very much indeed. I'm reminded to

3 say that transcripts of today's discussions will be

4 available on our website overnight and, if people would

5 like to send a further submission, this is your very

6 last chance of saying anything further to the Inquiry,

7 those submissions need to be in by this Thursday,

8 22 October and thereafter hold your peace, certainly in

9 terms of the work of the Inquiry.

10 We will be putting our heads to the grindstone,

11 which is no mean feat, because there's been such a rich

12 array of ideas and suggestions. Anyway, our intent is

13 to bring together a report that respects the various

14 contributions that have been made and comes forward

15 with recommendations that will help the Government and

16 you, the agencies and the community, take forward a

17 brighter future for the Latrobe Valley.

18 So again, on behalf of the Board, thank you all

19 very much for coming, and for all the various people

20 who have been supporting us, members of the community,

21 support teams from the various agencies, our own

22 Inquiry team led by Genelle Ryan, who's just standing

23 at the back door behind me, it's been a fantastic

24 effort and not without a considerable amount of

25 organisation and skill.

26 I'd particularly like to thank our audio-visual

27 assistant, John, our media communications support

28 person, Spencer Mitten, and particularly the health

29 lead, Monica Kelly, who's done so much to put all these

30 forums together.

31 So, I wish you a very good day and we look forward

1 to seeing you in another capacity on another occasion.

2 Thank you very much.

3 FORUM CONCLUDED

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31