Taskforce releases new clinical governance framework

Palliative Care in the Catholic Sector

The future of Catholic bioethics in Australia

Q&A with Dr Peter Steer
Leading the Mater Group into a new era
Our Enduring Commitment

Our care for people who are sick, frail, aged or disabled is founded on love and respect for the inherent dignity of every human being.

In this edition of Health Matters, Catholic Health Australia shares findings of our 2019 report on Palliative Care in the Catholic Sector. As our population ages, more people than ever before will be in need of palliative care. Already, Catholic services provide 52 per cent of private inpatient palliative care beds in Australia, yet still more needs to be done to raise awareness and innovate service delivery to meet the care needs of the community.

As our Report points out, no previous work has been carried out to systematically map and categorise the wide variety of palliative care activities and programs in the Catholic sector. Accordingly, this body of work is critical to understanding the wide-ranging impact of these activities and to explore ways in which further collaboration between Catholic Health Australia members will benefit future development of palliative care in Australia.

The Report also shines a spotlight onto the enablers of care, such as partnerships, education and awareness, research, goodwill, community empowerment and volunteers. As with many areas of care service, implementing adequate and sustainable funding is also key to meeting service demand and community need.

Yet more importantly, this Report underpins that palliative care is an approach for how to live with a life-limiting illness until death, rather than being an approach for how to die. This is the commitment of the Catholic sector to end-of-life care: Our enduring commitment to end-of-life care.

On 11 February, the CHA membership came together to celebrate the launch of a suite of materials developed in response to the Voluntary Assisted Dying Act (2017) (Victoria). The event demonstrated the continued Catholic commitment to providing excellent end-of-life care and celebrated an historic collaborative effort of CHA services. The launch also marked a renewed resolve to continue our collaborative work in this area and – most importantly – in our ongoing commitments to excellence in end-of-life care for all Australians.

CHA members agreed an expectation that we would be responding consistently and collaboratively to the legislation. That expectation will continue until the legislation is enacted on 19 June 2019, and beyond. This is a moment in which we can put our best foot forward through our common commitment to our beautiful, and courageous, ethic of care for those who are nearing the end of their lives – an ethic which has been demonstrated again and again by our great systems across Australia in their exceptional care for the dying.

God Bless,
Suzanne Greenwood
## Contents

<table>
<thead>
<tr>
<th>Editor's Desk</th>
<th>/Our Enduring Commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aged Care</strong></td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>/ How well equipped is the aged care system?</td>
</tr>
<tr>
<td>06</td>
<td>/ Streamlining of Consumer Assessment for Aged Care</td>
</tr>
<tr>
<td><strong>Mission and Governance</strong></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>/ New accessible formation resources: Mission in Focus Series 2</td>
</tr>
<tr>
<td>13</td>
<td>/ Governance and Co-responsibility in the Church</td>
</tr>
<tr>
<td><strong>Health Reform</strong></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>/ To reform or not to reform – the multi-billion dollar health care question</td>
</tr>
<tr>
<td><strong>Research</strong></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>/ Aboriginal community-controlled services</td>
</tr>
<tr>
<td><strong>Cover Story</strong></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>/ Q&amp;A with Dr Peter Steer</td>
</tr>
<tr>
<td><strong>End-of-Life Care</strong></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>/ CHA launch – Our Enduring Commitment to End of Life Care</td>
</tr>
<tr>
<td>26</td>
<td>/ Taskforce releases new clinical governance framework</td>
</tr>
<tr>
<td>30</td>
<td>/ CHA End of Life Care / VAD launch Seminar highlights</td>
</tr>
<tr>
<td>32</td>
<td>/ Ethics expert advises peak Catholic health care group</td>
</tr>
<tr>
<td><strong>Ageing Well</strong></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>/ A Life-Changing Philosophy for Ageing Well</td>
</tr>
<tr>
<td><strong>Palliative Care</strong></td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>/ Palliative Care in the Catholic Sector</td>
</tr>
<tr>
<td><strong>Catholic Bioethics</strong></td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>/ The future of Catholic bioethics in Australia</td>
</tr>
<tr>
<td><strong>ELDAC</strong></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>/ Partnering to improve the care of older Australians</td>
</tr>
<tr>
<td>42</td>
<td>/ Evidence-based linkage strategies</td>
</tr>
<tr>
<td><strong>Euthanasia</strong></td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>/ The Effect of the Proposed Euthanasia Legislation</td>
</tr>
<tr>
<td><strong>Around the Network</strong></td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>/ New family support program to help people with addiction</td>
</tr>
<tr>
<td>50</td>
<td>/ Archbishop’s book ‘paves the way’ on disability</td>
</tr>
<tr>
<td>52</td>
<td>/ A four-legged friend, three days a week</td>
</tr>
<tr>
<td>54</td>
<td>/ Vinnies, St Vincent’s join fight against homelessness</td>
</tr>
<tr>
<td>55</td>
<td>/ Hunter researchers hoping for a cure</td>
</tr>
<tr>
<td>56</td>
<td>/ How do we face evil and maintain hope?</td>
</tr>
</tbody>
</table>

---

**Jesus’ death** does not take away pain, betrayal or death but it empowers us to face these things and live.

Health Matters is published quarterly by Catholic Health Australia

The views expressed in articles written by external contributors are those of the authors and do not necessarily reflect the views of CHA

---

**Editor** / Suzanne Greenwood

**Designer** / Karrissa Armstrong

**Advertising Opportunities**

email / media@cha.org.au

**National Office**

Level 2, Favier House

51 Cooyong St, Braddon, ACT, 2612

phone / 02 6203 2777

e-mail / secretariat@cha.org.au

www.cha.org.au @chaaustralia /CatholicHealthAustralia

ACN 167 751 537 / ABN 30 351 500 103 / ISSN 1443-3532

---

CATHOLIC HEALTH AUSTRALIA
How well equipped is the aged care system?

Can it meet our future needs of the Australian Community?

by Nick Mersiades / Director of Aged Care CHA

As the Baby Boomer generation ages, a significant growth in aged care services and expenditure will be required.

One of the matters witnesses appearing at the opening hearing of the Royal Commission into Aged Care Quality and Safety in February were asked to address was how well equipped the aged care system is to meet the future needs of the Australian community.

Catholic Health Australia, represented by Director of Aged Care Nick Mersiades, advised that the current system will be challenged with respect to the following inter-related matters: meeting the future need for aged care services; the sustainability of future services and the viability of providers; workforce; adoption of a reablement and wellness approach; achieving quality of life; and the availability of respite services and in-reach health services for aged care residents.

Here is part of Mr Mersiades’ Witness Statement.

UNMET NEED

Under current government policies which ration aged care services by service types, the aged care system is not meeting, and will not meet, the future demand for aged care services or consumers’ preference for service type and service provider.

The latest available government data indicates that at 30 September 2018, there were 69,086 people waiting for a home care package at their approved level, but who had not yet been offered a home care package; and 57,646 who had been offered an interim home care package while they wait for a package at their approved level.

Also, many who have a package hold a package below their assessed need.

Looking to the future, a major challenge for an aged care system highlighted by the 2017 Legislated Review of Aged Care is that there is insufficient data about the future need for aged care services or consumer preference between residential care and home-based care to provide an accurate estimate of demand, and hence future cost.
SUSTAINABILITY

Although the Legislated Review found that there was insufficient data to make accurate estimates of future demand, it concluded that, as the Baby Boomer generation ages, a significant growth in aged care services and expenditure will be required. Australia’s population aged 65-84 and 85 and over will, by 2054-55, increase by 4 million to 7 million and by 1.5 million to 2 million respectively.

Even based on the current service provision target, which will not meet demand, government spending on aged care services is estimated in the Government’s Intergenerational Report to almost double to be 1.7 per cent of GDP by 2054-55.

Government currently funds 97 per cent of the cost of home care, 90 per cent of the cost of home support and 94 per cent of care costs in residential aged care.

It is unlikely that future governments faced with an ageing population and rising community expectations about the quality of life and care for the frail aged will be able to continue to meet such a high proportion of care costs. Inevitably the focus will need to shift to increased contributions by those who can afford to pay, but this has to be in the context of greater consumer choice and control and higher quality services.

ONGOING VIABILITY OF SERVICE PROVIDERS

The availability of aged care services across Australia depends on the existence of financially viable service providers.

Residential aged care providers are currently going through a period of deteriorating financial performance since changes to the Aged Care Funding Instrument (ACFI) were progressively introduced from July 2016, and indexation was withheld for 2017-18.

StewartBrown’s survey indicates that 45 per cent of providers operated at a loss in 2017-18. This result largely reflects that the average daily ACFI for 2017-18 ($172.23) was the same in nominal terms as that for 2016-17, whereas direct care costs per bed day alone increased by 4.3 per cent.

The current financial pressures are symptomatic of revenue volatility experienced by residential aged care providers since ACFI was introduced in 2008-09, reflected in pronounced volatility in annual average funding per resident per day above indexation, which has fluctuated between 2.1 and 8.1 per cent since ACFI was introduced.

The Aged Care Financing Authority’s analysis also shows that indexation applied to care prices has been noticeably lower than growth in a range of cost price indices in the wider economy. In particular, wages as measured by WPI Health Care and Social Assistance (wages on average account for 68 per cent of total provider costs) have grown approximately twice as fast as ACFI prices since 2008-09.

Faced with indexation that does not reflect economy-wide price movements and care prices fixed by government, many providers have looked to maximising revenue through claiming under ACFI – the only avenue open to them to increase care-related income.

In the absence of a market mechanism in aged care to determine care prices which reflect, inter alia, productivity gains driven by competition in the provision of services, the current indexation formula is intended to mimic the movement of prices in a competitive service environment. Not only is it failing to do this, but its premise is increasingly misplaced as the provision of aged care services is becoming more competitive as the supply of aged care places, especially the proportion that is home care, increases.

An independent body should also be created to analyse care costs and transparently recommend prices, as happens for public hospitals.

Another negative aspect of the ACFI funding model is that it is complex to administer, requiring clinical staff who are specially trained in using the tool. Some also out-source the function to specialist organisations. Either way, it diverts resources, including clinical resources, which would be better employed providing direct care to residents.

A new funding instrument is required for personal and nursing care that is not prone to funding volatility and indexes prices more faithfully to movements in prices in other comparable sectors.

An independent body should also be created to analyse care costs and transparently recommend prices, as happens for public hospitals, and any new instrument should be administered by an independent party.
QUALITY OF LIFE

Revenue constraints under the current aged care funding system mean that providers are not as well-resourced or staffed as they could be to meet rising community expectations about quality of life outcomes for older people and for supporting meaningful lives. This includes being able to access sufficient allied health and pastoral care staff targeting wellness, social and emotional supports, social engagement and social inclusion in order to avoid loneliness, boredom, depression and anxiety.

The capacity of residential care providers to respond to community and family expectations regarding the quality of life being experienced by residents is also limited by the cap on prices (85 per cent of the single age pension) that providers can charge for everyday living services, including dining, entertainment and social inclusion activities, often in association with wellness programs, noting that that pension amounts assume self-provision.

The future aged care system will require a greater focus on reablement and wellness.

WORKFORCE

There have been some improvements to the aged care workforce over the years, as reflected in the National Institute of Labour Studies’ report The Aged Care Workforce 2016.

However, the census and survey also highlighted significant ongoing problem areas, including staff shortages across the board; attraction and retention difficulties due to aged care’s poor public reputation and its image as a low status occupation which offers poor pay and few career pathways; and concerns about the standard of certificate level qualifications and gaps in training concerning dementia care, palliative care and mental health.

The fact that only 66 per cent of residential services had more than 75 per cent of personal care assistants (PCAs) with Certificate III qualifications is a weakness in the system.

Much greater attention will be required to workforce training and development, including opportunities for continuous staff development, and to terms and conditions of employment and remuneration if the aged care sector is to be equipped to attract and retain the almost three-fold increase in the formal aged care workforce (to 980,000) that the Productivity Commission estimates will be required by 2050.

The role of government in relation to the aged care workforce in many respects is the same as for other sectors of the economy. That is, pulling its economy-wide levers to secure a strong economy and funding and regulating the higher education and vocational education and training (VET) sectors.

The significant difference that distinguishes the aged care sector from most other sectors of the economy is that the government is also the primary funder and regulator, and therefore directly and significantly influences the viability of employers.

How the government performs its funding and regulatory role therefore influences the aged care sector’s capacity to compete in the labour market, to create attractive workplaces and to foster a positive image of aged care as a career for potential employees.

Analysis undertaken as part of the report A Matter of Care shows that PCAs, on whom the residential sector depends to provide most of the direct care to residents, are under-rewarded by 15 per cent compared with comparable positions in other industries, and that there is a 10 per cent difference between nurse wages in the aged care sector and the (also largely government-funded) acute sector.

Assuming a financially viable sector, aged care providers are then, individually and collectively, responsible for determining the attractiveness of their workplaces, including terms and conditions of employment, job design, roles and pathways, and staff development opportunities.

Providers also have a vital role in engaging collectively with the higher education and VET sectors to ensure that training and education curricula are producing a workforce that meets contemporary and emerging workplace requirements, including post-entry-level courses to cater for staff development and the advance of best practice and technology.

The decision in 2018 to establish the Aged Services Industry Reference Committee and the Aged Services Advisory Committees is intended to provide the vehicle for ensuring that industry’s workforce requirements are more effectively met by the higher education and VET sectors.

Particular challenges exist for services that operate in outer regional and rural areas where there is limited opportunity for training and development of aged care workforce. There is an ongoing need for targeted measures to assist the development of the rural and remote aged care workforce, and the health workforce in general.

REABLEMENT AND WELLNESS

The future aged care system will require a greater focus on reablement and wellness. There is evidence that improving or maintaining individuals’ functional capabilities and overall wellness not only enhances quality of life, but also reduces costs for government.

There are examples where reablement and wellness programs have been applied successfully, but remain to be widely adopted. The Home Independence Program in Western Australia demonstrated that it is possible in many cases with modest interventions to reverse, slow down or prevent inability to continue to undertake the activities of daily living.
AVAILABILITY OF IN-REACH HEALTH SERVICES

An aged care home is not a stand-alone health service. Residents require and are entitled to timely access to health services, the same as anyone living in the community. The care of residents will continue to run the risk of falling short of community expectations until comprehensive and sufficient in-reach health services are developed. This includes specialist palliative care and mental health services, specialists in the management of people presenting with severe behaviour and psychological symptoms of dementia, and ready access to GPs.

RESPITE SERVICES

The increasing availability of, and consumer preference for, home-based care is already resulting in increased demand for safe and affordable respite services, and this demand is expected to increase significantly. Respite care not only gives informal carers a break, but also gives the person being cared for a chance for social engagement. The increasing prevalence of dementia will increase demand as informal carers seek to maximise the time their loved ones can remain living in familiar and non-threatening surroundings.

ELIGIBILITY AND NEEDS ASSESSMENT

Putting in place a more effective system of eligibility and needs assessment for accessing government-funded aged care services that is simple for consumers and their families to use, timely, consistent and protects government expenditure is essential.

There are currently waiting lists for assessments, evidence of a lack of consistency across assessment teams and jurisdictions, and complexity and duplication due to the lack of an integrated assessment process across all aged care types.

The full version of the Witness Statement can be accessed at www.cha.org.au
Streamlining of Consumer Assessment for Aged Care

by Shona McQueen / Senior Advisor Aged Care CHA

In the 2018-19 Budget, the Government announced that it would design and implement a new framework for streamlined consumer assessments for all aged care services, to be delivered by a new national assessment workforce from 2020.

Assessment services are currently administered separately by Aged Care Assessment Teams (ACAT) and the Regional Assessment Services (RAS).

The need for streamlining was identified in the *Legislated Review of Aged Care 2017* (Tune Review), which highlighted the duplication and inefficiency within the current assessment processes. The Tune Review also recommended that, following a review of the Aged Care Funding Instrument, the government integrate residential aged care funding assessment with the combined RAS and ACAT functions, independent of aged care providers.

The Department has released a discussion paper, *Streamlined Consumer Assessment for Aged Care*, which outlines a new assessment model.

The key elements of the Department’s proposed model are:

**ENTRY/TRIAGE**

• An assessment provider manages triage to determine the most suitable aged care assessor based on the person’s needs and the assessor’s qualifications and skills.

**ASSESSMENT**

• Assessment providers manage a workforce to undertake aged care assessment for access to all aged care services (Commonwealth Home Support Programme [CHSP] and services under the Aged Care Act).
• Changes are made to the National Screening and Assessment Form to support team-based and multidisciplinary assessment approaches.
• Support plans are standardised, enabling assessment to be undertaken and services to be recommended in consideration of the full range of aged care services and supports.

• Assessment providers are responsible for ensuring rigorous assessment is undertaken (including delegate approval for care types under the Act).

REVIEW

• Reviews of support plans are managed by the assessment provider, based on an individual’s needs and in consideration of changes in circumstances.

• Where a new assessment is required following a review, the triage process matches the person to the most suitable aged care assessor based on the person’s needs and the assessor’s qualifications and skills.

This model was informed by the following design principles:

• assessment is focused on outcomes for older people, including wellness and reablement;

• assessment to be supported by an appropriately trained workforce, undertaken face-to-face wherever possible, timely and consistent;

• assessment may apply team-based and multidisciplinary approaches as required;

• the assessment process includes efficient and effective intake and triage and referral pathways, and proportionate assessment that takes account of other service systems; and

• assessment is independent from service provision and available at no cost to consumers.

A noteworthy feature of the proposed model and the design principles is the absence of an overarching statement of the objectives, purpose and function of the proposed assessment providers in order to provide context as to how the design principles are implemented. Such a statement would outline, for example, to what extent the following elements would be the responsibility of the assessment providers:

• whether the role will go beyond determining eligibility for a Commonwealth subsidy;

• engagement with care/support planning and review;

• ensuring that a service provider implements a re-enablement approach;

• monitoring the implementation of individual support plans;

• capacity to assess/refer consumers to health services generally, not just for Commonwealth-funded aged care services.

The design principles also need to recognise consumer choice and control, and in particular the interface with a wellness and re-enablement focus to support independence and quality of life, given these are both key elements of the aged care reform agenda.

The design principles refer to a team-based and multidisciplinary approach when required. A key occasion when this approach is required is for the initial assessment process because it is crucial to helping chart an older person’s aged care journey.

Assessing for holistic need, rather than the type of care that is available or a consumer’s immediate needs, is fundamental to establishing aged care planning for the consumer.
Focusing on a full comprehensive assessment at the triage/intake point will provide downstream economies by facilitating a more effective prevention and reablement focus, including reducing duplicated assessments and review assessments further along the aged care journey by ensuring appropriate care is identified early. This approach would also provide a case history on which to base any subsequent assessments that may be required.

A holistic and comprehensive assessment at intake/ triage could also help establish consumer service preferences against assessed need and prompt and encourage consumers to seriously consider their options in older age and to plan for their future aged care needs. Including such information as part of the holistic assessment upfront provides a better understanding of future needs, options and preferences, which will contribute to better aged care planning.

It is a false economy to assume that less qualified staff can competently assess for a single time-limited CHSP service, as often a single need masks more complex care need or vice versa. For example, it could be argued that providing block-funded transport to medical services or assisting with cooking skills for a time-limited period should not require a comprehensive assessment as such, but a holistic understanding of the individual’s need and functionality is necessary to ensure appropriate care and avoidance of potential mishap.

Notwithstanding the above, expedited access to a single CHSP time-limited service, especially if it is part of a hospital discharge strategy or in case of an emergency, should be catered for in the model. As part of a time-limited service period, the involvement of a multidisciplinary team assessment would be appropriate follow-up to ensure ongoing re-enablement.

It is appropriate that MyAgedCare Contact Centre staff be limited to providing information and performing the first part of the registration and screening assessment process to establish need and eligibility for an aged care assessment. Thereafter, a qualified multidisciplinary assessment team would undertake the assessment of the older person’s function and care need.

There is also a case for reviewing, from a streamlining perspective, the current assessment requirements for home care package holders seeking to access residential respite care. There may be scope to introduce funding alignment between the level of package held and the level of subsidy provided for residential respite, thereby eliminating the need for assessments of package holders for respite care.

Given the work currently being undertaken by the University of Wollongong in trialling a streamlined funding assessment for residential care that involves minimal time from a registered nurse, there would be no need for involvement of a multidisciplinary assessment team in this aspect.

Elements of the health system, including My Health Record, Health Care Homes and GPs who access the Medicare health assessment item provide opportunities for both aged care and health systems to better integrate referrals and assessment. In the past, each has been regarded quite separately and assessments unnecessarily duplicated. Having access to such a broad range of health professionals can only enhance the skill set of the multidisciplinary team.

Consideration also needs to be given as to whether external assessors such as allied health professionals/ GPs should be funded to undertake assessment as part of the multidisciplinary team. Provision for funding external assessors would be an efficient way to engage the expertise of the wider health sector, thereby reducing waiting times and enabling the assessment to be conducted in a holistic way, ensuring a more comprehensive understanding of the client’s needs. It would also provide a mechanism to ensure a more streamlined hospital discharge assessment process.

**Having access to such a broad range of health professionals can only enhance the skill set of the multidisciplinary team.**

The primary focus for support plans and support plan reviews by assessment providers should be consumers accessing lower level care and support, rather than aged care residents and home care package holders. It is the responsibility of all home care and residential care providers to ensure annual (if not more frequent) review of care plans under the Aged Care Act. Having the assessment team prepare support plans, and to undertake support plan reviews, in these circumstances would be duplicative and unnecessary.

There is anecdotal evidence that indicates vulnerable consumers often do not engage with the current assessment system. Accordingly, an assessment framework should include linking services to support access to assessment and services by vulnerable individuals and communities.

Having an integrated assessment model that engages health and community social services will assist with early identification and better support mechanisms for vulnerable older people. There is also a case to consider that once early identification of such consumers is made, the assessment team seeks the expertise of specialist clinical and case managers to better manage such complex cases.
Consideration should also be given to an expanded role for the consumer navigation support pilot programs and for the Older Persons’ Advocacy Network. These programs could play an important support role in conjunction with the provider assessors and My Aged Care in catering for the needs of vulnerable consumers.

Given the pivotal role of assessment in the aged care system from the perspective of government, service providers and consumers, the new model should include mechanisms to monitor the performance and effectiveness of assessment providers. One option would be to implement a rolling risk-based audit program, noting that assessment providers (ACAT and RAS) are not in scope for the new Aged Care Quality and Safety Commission. Indeed, consideration should also be given to the feasibility of requiring assessment providers to be separately accredited by either the Commission or another accreditation agency.

Eligibility and care needs assessment is also one of the cornerstones of a future aged care system based on consumer choice and control. The cost of an effective assessment process should therefore be seen as an essential investment required for the sustainable provision of aged care services.

Shona McQueen is Catholic Health Australia’s Senior Advisor Aged Care

Shona was the Assistant Secretary of Home Care Reform Branch in the Ageing and Aged Care Stream

She has had over a decade of working in aged care policy at senior levels in the Department of Health and Ageing and previously the Department of Social Services

1. We value what you:

$really make

When it comes to that big question “What do you make”, most banks give you eight little boxes on a form. As a healthcare worker, how can you possibly fit everything you contribute to your community into that tiny space?

At Bank First, we believe what you really make goes way beyond a dollar figure. So while you’re investing in others, we’re here to invest in you.

Visit bankfirst.com.au and find out how we can do more for you.
New accessible formation resources: Mission in Focus Series 2

by Susan Sullivan / Director – Mission Strategy, MLP Program Director CHA

Mission in Focus Series 2 has been developed in response to further feedback from members suggesting the need for resources on new topics.

Catholic Health Australia members will be pleased to learn of the recent release of Mission in Focus Series 2 (MIF2), which is now available on the CHA website. MIF2 follows the highly successful Mission in Focus Series 1, released in 2012.

The CHA Mission in Focus series features the reflections of senior leaders, academics and other experts in Catholic health and aged care in response to key questions about Catholic mission, identity, leadership and associated ministry challenges.

The original series was conceived by the CHA Pathways Taskforce in response to member feedback suggesting the need for easily accessible resources to support their internal formation processes with boards, executive teams and other staff.

Mission in Focus Series 2 has been developed in response to further feedback from members suggesting the need for resources on new topics, as well as expansion of the content in some of the original areas of focus. The input and guidance of the CHA Mission & Identity Committee throughout the development of MIF2 has ensured the content of the new series is relevant and well targeted to existing and emerging formation needs.

MIF2 features interviews with high-profile contributors to the mission of Catholic health, aged care and community services, as well as other experts from the Catholic sector. Themes have been selected to complement and further develop MIF1 themes.

Topics in the MIF2 series include: What is God’s Mission?, The Church as a Field Hospital, What does it Mean to Work for the Catholic Church?, The Ethics Which Guide Workplace Culture, Key Principles of Catholic Social Thought, Evaluating Mission Formation, and Working Together for the Common Good. The new Mission In Focus webcasts offer new design features to enhance the viewing experience.

MIF2 follows the launch last year of a webcast series designed to help members make good use of the wide range of CHA formation publications released over the years.
These short webcasts offer practical insights from mission leaders and others about how to utilise this content in the most effective way.

There are nine of these webcasts examining: Being a Catholic Hospital, Evaluating the Impact of Formation, Formation for Mission, Language at the Heart of Mission, Mission Discernment, Recruiting Fit for Mission, Strengthening Our Catholic Mission and Identity, The Role of Mission Leaders in Catholic Health and Aged Care, and Welcome, Inclusion, Attentive Presence: Pastoral Care.

These webcasts can also be found on the CHA website under the Publications section.

Both MIF series may be used in innovative ways:
• As part of a recruitment strategy for future staff – on websites, in recruitment packages;
• As stimulus for discussion during orientation and induction sessions with new staff;
• As part of a discernment process for potential board members and trustees;
• As a resource for formation at board and executive team meetings;
• As reflection material to commence a meeting;
• As general education for those wishing to understand Catholic health and aged care;

The table on page 12 offers some preliminary suggestions. We invite you to develop creative ways to incorporate the MIF2 videos into your organisation to promote mission-focused reflection and application. Please share your strategies and learnings with CHA members by sending your ideas to secretariat@cha.org.au and including “MIF2” in the subject line.
<table>
<thead>
<tr>
<th>Who</th>
<th>What</th>
<th>When</th>
<th>How</th>
</tr>
</thead>
</table>
| Potential staff | Recruitment strategy | Available on website | • Invite review potential employees to view one or more of the MIF2 videos. Build a number of questions around this into the interview.  
• Set a number of questions for pre-interview tasks based on one of the MIF2 videos and ask applicants to submit responses with the application. |
| New staff and volunteers | Orientation and induction | Reflection to begin a session | • Discuss resonance of the webcast themes with personal values;  
• Discuss how the principles explored might be evidenced in the workplace by all staff;  
• Seek examples of personal practices that can exemplify the themes in the workplace. |
| New staff and volunteers | Orientation and induction | Stimulus for group discussion | • An excerpt could be used as stimulus for reflection at commencement of an education session.  
• Discuss how the principles and values articulated relate to the education topic.  
• For example *Church as Field Hospital* suggests we be people of ‘warm hearts’ and close to people in the complexity of their experience. How do we personally live this attitude in our particular role? How might our organisation support this principle through its policies and procedures? |
| Existing staff and volunteers | Continuing formation | Reflection to begin a meeting | • Prior to the performance review meeting invite staff to view a webcast selected for relevance.  
• Compare the principles articulated with the behaviours observed. Encourage continuing awareness and commitment to the principles and behaviours. |
| Performance review | Guide to appropriate behaviours and practices | • Select a webcast for relevance to the policy.  
• What mission principles are developed in this video and what implications do they have for our proposed policy?  
• View a selected video and ask how does our present policy integrate and articulate the mission values in focus? |
| Policy development and review | Guide to vision and principles to be incorporated | • Select a webcast for relevance.  
• For example *Church as Field Hospital* suggests we be people of ‘warm hearts’ and close to people in the complexity of their experience. How do we personally live this attitude in our particular role? How might our organisation support this principle through its policies and procedures? |
| Potential board directors | Recruitment strategy | At the first approach stage | • Select a number of appropriate videos.  
• Develop a series of questions relevant to membership of an operational board.  
• Invite written responses.  
• Use the written responses as conversation starters about directors’ mission integration obligations.  
• Invite responses on mission integration with other obligations of directors. |
| New board directors | Orientation and induction | At the commencement of meetings | • Select one MIF video for starting the meeting. Invite discussion on mission themes and challenges or questions posed by the content.  
• Use selected videos to identify core values that should guide the vision and be integrated into strategic planning.  
• Invite directors to talk in pairs; one thing I am thinking about now, a question I have is or a challenge for me is... and then share with the whole board. |
| Existing board directors | Continuing formation | At the commencement of meetings | • Ask a director to reflect on one video in preparation for the meeting. Show this video to the board at the meeting. The director speaks about what questions and challenges this episode raised for her/him for 3-5 minutes. The meeting takes some time to discuss her/his reflections.  
• Ask all directors to view the same video in preparation for a meeting. Ask each to come prepared to talk about one challenge or question this video raised for her/him in the role of director for just a few minutes. Members share in pairs first and then the whole board.  
• Ask each director to view the same video in preparation for the meeting. Each reflects on the question; how do we articulate and integrate these values in the policies and work of the board and the organisation we lead? At the meeting share in pairs and then whole board. |
| Potential/New and Existing Trustees | Recruitment Orientation and Ongoing formation | Same as for Board directors | • As for board directors |
| Community engagement | Education about our sector and our mission | In response to requests | • Recommend videos to student researching Catholic health and aged care.  
• Use webcast in a lecture setting and ask students to reflect on what the video reveals about the features of Catholic health and aged care.  
• Use a video with a parish or other church group, ask how this video shaped their understanding of Catholic health and aged care ministry. In what ways could they see their organisation supporting that mission? |
| Engagement with school and university groups looking at Catholic services | As part of a promotional and engagement strategy | • Use webcast in a lecture setting and ask students to reflect on what the video reveals about the features of Catholic health and aged care.  
• Use a video with a parish or other church group, ask how this video shaped their understanding of Catholic health and aged care ministry. In what ways could they see their organisation supporting that mission? |
| Engagement with other parts of the Catholic sector e.g. parishes and community service sector | For guest lectures in medical, nursing and allied health programs. | • Use webcast in a lecture setting and ask students to reflect on what the video reveals about the features of Catholic health and aged care.  
• Use a video with a parish or other church group, ask how this video shaped their understanding of Catholic health and aged care ministry. In what ways could they see their organisation supporting that mission? |
Governance and Co-responsibility in the Church

In this brief article, I want to explore some of the evolution in governance in Catholic health and aged care services and the notion of co-responsibility. This notion has implications for who we invite onto operational boards and as trustees and also how we form them for the role of co-responsible governance in the Catholic Church.

I am assuming a two-tier governance structure: an operational board and a group of trustees. The operational board may be at the group or facility level, and relates directly to the relevant CEO and the appropriate oversight of operational matters, while respecting the limits of executive delegation exercised by the CEO. The tier above the operational board is the trustees, who normally represent the sponsoring Religious Institute (RI), diocese or other ecclesial (Church) entity, and increasingly Ministerial Public Juridic Persons.

Some of the content of this article will be elaborated on at the CHA Governance Symposium on August 26-27, 2019.

CO-RESPONSIBILITY

When Benedict XVI was Bishop of Rome, he would meet with the clergy of the Diocese and would take questions without notice. One younger priest asked how he could encourage the laity to collaborate in the work of the Church.

Benedict’s reply has something to say to those of us who work in the Church’s ministry of health and aged care. He challenged the clergy to move away from the language of “collaboration” and to replace it with “co-responsible”. He said that because the laity were baptised, they were already part of the Body of Christ, the Church, along with the clergy, and so they are “co-responsible” with the clergy for the mission of the Church. Co-responsibility was a theme Benedict first wrote about in 1961.

Those who lead Catholic health and aged care at the operational board or trustee level are co-responsible for acts of ecclesial governance. They are co-responsible for the mission and for the works established by the Church. Most of our hospitals and aged care services have been established by RIs and a smaller number by dioceses. RIs and their works are part of the institutional ecclesial mission.
The works of Catholic health and aged care are part of the healing mission of Jesus. It has always been like this, even when it was delivered and operated by members of RIs.

The initial governance of health and aged care services was directly provided by the leadership team of the RI. The leader of each RI was charged with the governance of the works of the Institute and was in most cases assisted by a team of councillors elected or chosen by members of the RI. The ministry facilities were usually managed by a member of the Institute, appointed by the Institute leader.

Some RIs had advisory boards that may include lay Catholics, but few (if any) would have had a lay board of governance. (Catholic language gets messy here, because most RIs are not clerical i.e. comprised of ordained members, but are comprised of lay women and men. So when I use ‘lay’, I am going to indicate lay people who are not members of an RI.)

During the 1980s and 1990s, many RIs began to establish boards to oversee their ministries. They began to invite lay people to participate in these boards. At first, most of the boards were advisory; only later did boards with governance authority begin to appear.

The evolution from advisory to governance represented something of an evolving understanding of the laity as collaborators versus laity as co-responsible. The mindset that guided the invitations to collaborate reflected a view that the works (mission) were intimately aligned with the identity of the RI, and so they could not be "handed over" to lay people who were not members of the Institute.

**CO-RESPONSIBILITY V COLLABORATION**

It is worth reflecting on the difference between collaboration and co-responsibility. Each marks a significant of a worldview. The Second Vatican Council (1962-65) invited the Church to adopt a novus habitus mentis (a new habit of mind). The phrase is hard to precisely translate, but it indicates not only adoption of new ideas, but a habitual lens through which to view the world and assess situations in the light of the Gospel.

The Catholic Church in the period immediately prior to Vatican II had a habitus mentis regarding the role of the laity. Laity were assigned an entirely passive role. They were the recipients of what “the Church” could provide to sustain their lives in faith. They could be invited, sometimes, to collaborate with the works of “the Church”. That collaboration was frequently limited to specific skills and gifts a lay person might have in finance or law that could be useful to the mission of “the Church”.

This is a caricature in some respects, because true lay initiatives did exist in the Church and already a deeper awareness of the Church being all of the baptised was re-emerging in the 20th century.

Collaboration assumes a certain distance between the one doing the inviting and the one invited. The invitee is considered as a helper alongside of a work that properly belongs to an RI or the clergy. Collaboration assumes that “the Church” is doing the inviting and that “the Church” is identified with the clergy and RI.

Co-responsibility calls for a novus mentis habitus. Co-responsibility indicates each has responsibility for the mission. There is no distance between the ecclesial mission and ecclesial membership. There is an equality with regards the ecclesial mission even if there must necessarily be different roles and participations in that mission because of ordination or membership of an RI. Co-responsibility does not mean all differences are dissolved.

**CO-RESPONSIBLE WITH AN RI**

There is an evolution in the manner in which lay people have been invited into the governance of the works of RIs. At operational board and trustee level, there are few members of the RI present. That few or no vowed members are at trustee level is a very significant development toward co-responsibility.

A number of RIs have established Ministerial Public Juridic Persons to govern their works and to ensure that the mission for which they were founded continues to thrive and is capable of finding new expressions consistent with the founding vision; a living heritage.

It has been a journey of trust for RIs to move from collaboration to co-responsibility. I mentioned that Benedict XVI had been writing on this since 1961, and the concept of co-responsibility is embedded in Vatican II. Yet it has taken some time for it to find expression in the life of the Church. (There is some way to go yet.)

We should not be surprised by the slow change of mind. Pope Francis, quoting Cardinal Newman, suggested that it takes about 100 years for a Council to be fully received into the life of the Church. We are only at the halfway mark of that cycle.

For RIs, we need to remember that the mission and identity of the Institute were one and the same. The question about
how lay people would be able to maintain the unique charism of each RI is a very real one.

I would suggest that the transition can be fully made from collaboration to co-responsibility when part of the new habit of mind embraces the notion that all of the works of the RI are first and foremost expressions of the one ecclesial mission.

RIs need to look through the particular heritage of a RI to the common heritage of the mission of Jesus into which all the baptised are called. This may entail some letting go of aspects of the particular heritage as a focus in order to reinvigorate mission.

ACCEPTING THE CHALLENGES OF CO-RESPONSIBILITY

Accepting the challenges of co-responsibility in governance is a task both for RIs and for the lay people who join them. The task of the trustees is not simply to shepherd the patrimony of the founding RI, but to reconnect it with the wider ecclesial mission and to ensure that those who work at operational board level and executive leadership are formed for Catholic mission.

The works of Catholic health and aged care are part of the healing mission of Jesus. It has always been like this, even when it was delivered and operated by members of RIs.

A future challenge is the formation of lay people invited into governance of Catholic ministries. In this, too, a novus habitus mentis is required. RIs may need to explore new ways of sustaining the Catholic mission and identity of the works they commenced and forming the next generation of leaders for that task. Some of these questions I will take up in another article.

---

First Australian Catholic Health Care Conference 1978. What would this picture look like today?

It is worth reflecting on the difference between collaboration and co-responsibility. Each marks a signification of a worldview.
While all these policy objectives are laudable and welcomed, there is presently a lack of clarity about how this Commission would actually succeed.
To reform or not to reform – the multi-billion dollar health care question

by Annette Panzera / Director of Health Policy CHA

One of the Opposition’s major policy pledges in the area of health reform is to establish an Independent Health Commission. Labor argues that with commissioners appointed for five-year terms, this would break the short-term political cycle inhibiting long-term reform, as well as an ability to work more closely with other bodies indirectly related to health service delivery including social services and education.

The Shadow Health Minister also stated in her recent National Press Club lunch that this body would be able to tackle the barriers to health reform created by jurisdictional boundaries. 1

While all these policy objectives are laudable and welcomed, there is presently a lack of clarity about how this Commission would actually succeed where current health reform bodies don’t. As an example, the Commonwealth Department of Health already has a distinct division dealing with long-term health reform.

To this end, this article looks back at some of the numerous health system policy reviews 2 conducted over the last few years to assess enablers and barriers to reform and what such a Commission may need to look like in order to succeed.

The Productivity Commission (PC) has in recent times released several reports that focus on improving the productivity of our health system (in part or wholly). In 2017, *Shifting the Dial* recommended agile funding arrangements at the regional level and more funding to improve population health initiatives. It recommended patient-centred care and the elimination of low-value health interventions. The timeframe for implementing these interventions was estimated to be five years; as of early 2019, there is little evidence that this advice has been acted upon.

...the PC noted high-quality data was central to improving the effectiveness of human services across the board.

In their report into human services, also published in 2017, the PC focused on delivering improvements through more competition and informed user choice for recipients of human services, including social housing, public hospitals, palliative care and remote Indigenous communities.

The recommendations included developing better standards of quality and accessibility, giving more support to enable informed user choice, stronger consumer safeguards and a framework of continuous improvement. In order to do this, however, the PC noted high-quality data was central to improving the effectiveness of human services across the board.

In 2015, a report was released by the PC entitled *Efficiency in health*. It was a comprehensive report that focused on opportunities to improve the health system without changing existing institutional and funding structures – while acknowledging that larger-scale reforms would potentially achieve better efficiency.

Some of the major recommendations included the promotion of clinically and cost-effective medicine by redesigning how we do health technology assessment. This identified a need to eliminate duplication, fragmentation and increase transparency. The PC also suggested improving health system regulations, including amending the scope for health professionals, removing pharmacy ownership restrictions and eliminating delays in the Pharmaceutical Benefit Scheme (PBS) price disclosure processes, and identifying ways to apply larger statutory price reductions to PBS. Finally, and again the word transparency here is key, it advocated the enhancement of information available to consumers by publishing performance indicators of individual health care facilities and clinicians.

The Commonwealth Department of Health has released many reports over the years focusing on more specific health areas where they are primarily responsible for policy reform. The most recent, which began in 2015 and is still under way, is the Medicare Benefits Schedule (MBS) Review. The aim of this work has been to deliver affordable and universal access to best-practice health services while ensuring the sustainability of the MBS. The review also tries to contemporise the MBS to allow for the huge advances in medical science that have occurred over the life of the MBS. While it is too early to evaluate the outcomes of this review, the recommendations have been few and slow to implement at this stage.

The Department also undertook a number of consultations into private health insurance (PHI) in 2015-2016 aimed at enhancing the value of PHI to consumers and finding ways to improve the financial sustainability of the sector. The outcomes of these consultations included better transparency of information for consumers, decreasing PHI product complexity and reducing exclusionary products that provide no value. They also examined government incentives for increasing the uptake of PHI. To date, these reforms have been partially implemented. A notable absence has been addressing the growth of exclusionary PHI products.

Another policy reform area the Commonwealth has concentrated on is delivering better outcomes for people with chronic and complex conditions. The Primary Health Care Advisory Group was designed to consider options that shift from the current fragmented and siloed system of primary care to a more integrated system. One of the main outcomes of this review was the establishment of health care homes that support flexible team-based care for those living with multiple chronic conditions.

Other areas where improvement could be achieved were cited as focusing on regional planning, a restructured payment system and maximising the effectiveness of PHI investment in the management of chronic conditions. Finally (again!) the review stated that better datasets were needed to measure and support continuous quality improvement in the primary health care system. All these reforms, as of early 2019, are either ongoing or not yet implemented.

Mental health also came under the spotlight in 2014 when the Mental Health Commission released *Contributing lives, thriving communities*. This very comprehensive report focused on a person-centred approach, a population-based system architecture and a shift in funding to “upstream” to support prevention and early intervention. It set out clear roles and accountabilities for government, asked for national targets and local organisation performance measures, recommended shifting funding priorities from hospitals to community and primary health and a host of other policy measures.

While there is no official evaluation on how successful this report has been in improving outcomes for those living with mental health conditions, it is notable that at the end of 2018, the Health Minister announced that the Productivity Commission would now be reviewing the social and economic benefits of improving mental health.

It has also been estimated that 32 statutory reviews of the mental health sector have been undertaken in Australia since 2006.
The reviews listed above represent only a small sample of the health policy reform advice given to government through various external and internal bodies over the last five years. However, key themes still emerge: Better information for consumers to help navigate the complexities of the health care system; Better data to be able to measure performance and evaluate over time; Numerous recommendations to unify the system from the current fragmented and siloed model to one that provides seamless care across jurisdictional and professional boundaries.

Similarly, when identifying the challenges that our health system faces moving forward, the reviews are in almost universal agreement. Ageing demographics, an increasing burden of chronic disease and new technologies will increase demand and expenditure on health care. Health expenditure is rising at a greater pace than GDP, with that expenditure increasingly financed from non-government sources, including individuals, through out-of-pocket costs. Out-of-pocket expense prevents many Australians from accessing timely health care and contributes to the relatively high rate of preventable hospitalisations.

Workforce shortages and geographical maldistribution of health professionals are other barriers that contribute to inequities in health outcomes and access to services. While some improvements have been achieved by training doctors in rural settings and encouraging them to settle, we still have over-supply in metropolitan areas.

Other workforce shortages are exacerbated as Australia has been relatively slow to adopt changed scope of practice and/or new roles, which has resulted in under-utilisation of skills.

Probably one of the biggest challenge that an independent commission would face is in addressing the inefficiencies generated by the blame game and shifting costs between levels of government. This can be overcome if the commission has a permanent national structure that is jointly owned by national, state and territory governments and is responsible for policy advice to governments.

It could also benefit from a “Reserve Bank” style of guidance and oversight. Expert appointments including both public and private sector representatives to the Commission should also be independently made.

Creating such a body would take political courage, but a truly independent body would be capable of implementing health reform decisions in a timely manner that put improving the health outcomes of the Australian people first. As responsible stewards of precious health care dollars, all levels of government would have to agree that is moving forward their mandate.

The value to a strengths-based approach to research in
Aboriginal community-controlled services

by Stephanie Panchision / Senior Health Policy Advisor CHA

Health experts and policy-makers strive for an evidence-based approach to drive clinical practice and improve health outcomes. Evidence-based practice involves the integration of the most advanced research with clinical expertise and patient values. Research provides the knowledge and evidence base to shape how the health system can best deliver services and improve population health, particularly in closing the gaps between Indigenous and non-Indigenous health outcomes.

Closing the Gap is a government initiative to reduce higher rates of disadvantage among Indigenous populations, including the disparity in health outcomes that encompasses a lower life expectancy, higher infant mortality and greater burden of disease.

Research is an important component in developing a knowledge base to combat these health disparities and promote positive outcomes for Aboriginal and Torres Strait Islander people. However, research has not always benefitted Indigenous communities, and complex ethical concerns have been raised in how research is conducted and applied in the Indigenous context.

It is currently recognised that research with Aboriginal and Torres Strait Islander people must be driven by Aboriginal and Torres Strait Islander people and communities. This includes a nationally recognised set of guidelines that outlines the six core values for conducting ethical research: spirit and integrity, cultural continuity, equity, reciprocity, respect and responsibility (National Health and Medical Research Council, 2018).

Apunipima Cape York Health Council is Queensland’s largest Aboriginal Community Controlled Health Organisation, delivering health care services to 11 Cape York communities through a family-centred model of comprehensive primary health care.
Apunipima identified an urgent need for Aboriginal and Torres Strait Islander-led local research in the Cape York communities that experience some of the greatest rates of disadvantage in the country. All research proposals are currently reviewed by the Apunipima Research Governance Committee to ensure that projects adhere to their values.

Research must be conducted within culturally intelligible and acceptable frames of reference; it must not disrupt or upset the community; it must reflect the interests and needs of the community; and must be identified using a respectful and culturally appropriate consultation process. The research coordinator role is designed to support this committee, build on current research activities and build the capacity of Apunipima's workforce to engage in research.

In 2018, Apunipima, Catholic Health Australia and Cabrini came together as part of their strategic partnership to collaborate on the funding for a research coordinator role for Apunipima Cape York Health Council. All participating partners recognise the valuable role research has for developing an evidence base that can be used to improve health outcomes for Aboriginal and Torres Strait Islanders and that health organisations serve as agents for advancing the translation of research into practice.

CHA and Cabrini provided $40,000 each in seed funding to assist Apunipima to fund the role for one year to strengthen research governance and oversight by developing a sustainable funding arrangement for an ongoing research coordinator function within the organisation.

Professor Yvonne Cadet-James was recruited to lead the research coordinator role for her depth of experience in health and academia, particularly around her leadership in education and expertise in social and emotional well-being and community-based models of care. Her roles on academic and NHMRC boards have given her a voice in guiding research in an Aboriginal and Torres Strait Islander context and strengthening the capacity of Apunipima researchers while identifying priorities for the communities.

Since commencing her role, Professor Cadet-James has initiated a range of activities, including conducting a scoping study of the ongoing research projects, developing a research strategy, leading workshops with staff to build the organisations research capacity and assisting with grant applications and research publications.

She has been successful in engaging with early-career researchers and strengthening the organisational research culture to drive an Aboriginal and Torres Strait Islander perspective in forums and committees that are responsible for influencing policy and practice.

Professor Cadet-James has also identified and reiterated some of the challenges to coordinating research activities for Aboriginal community-controlled organisations. As not-for-profit health groups, resource allocation is generally reserved for the delivery of services that does not include funding for research – a crucial activity that is necessary to target the needs and address priorities of the communities.

Many health agencies lack the infrastructure and resources to coordinate the work needed to earn and deliver large competitive grants. Large rural and remote geographic regions, limited on-site resources for researchers and uncertain funding responsibilities create limitations in an organisation’s ability to coordinate research.

"Yvonne has changed the direction of evidence-based child and maternal health," says Jo Neville, program advisor maternal and child health strategy at Apunipima.

"We are reframing all of our research and programs to be strengths-based for Aboriginal and Torres Strait Islander communities by having a research lens across all planning, implementation and evaluation stages of program design."

Embedding research into community-controlled health services will drive programs and services in a way that promotes research that is community-driven and translated into improved health and wellbeing outcomes for the people they serve. Having a dedicated research coordinator role is giving Apunipima the capacity to form the partnerships needed to explore novel approaches to health care and prevention where there is not always an established evidence base.

As a truly responsive Aboriginal-controlled health service, Apunipima is building the evidence through action-based research in genuine partnership with communities in Cape York.

As part of joint strategic partnership, CHA and its members are continuing to work with Apunipima to facilitate research support and develop research capacity within the organisation built on the premise of empowerment to support training, organisational practices, mentorship, skills exchange and locally-led research for the growth of locally-run health services.

Reference: National Health and Medical Research Council (NHMRC). (2018). Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: Guidelines for researchers and stakeholders. NHMRC: Canberra.
Using his global experience, coupled with his solid early career development at the Mater in Brisbane, Dr Steer was chosen to lead the group at a time of great challenge in health care worldwide.

Dr Steer commenced his medical career at Mater South Brisbane in 1982 after graduating from The University of Queensland. He worked at Mater’s Adult and Children’s Hospitals until 1987, then after several years in New Zealand and Canada with further training in neonatology, he returned to Mater Mothers’ and Children’s Hospitals in 1991 and continued there until 2001.

“My professional life began at Mater and it’s really great to be able to return at this stage in my career,” Dr Steer said.

“From the day I started working as a young doctor at Mater, I have never forgotten the genuine compassion and dedication of my colleagues who embodied the values established by the Sisters of Mercy.”
– Dr Peter Steer

The Mater Group recently announced the appointment of Dr Peter Steer as its new chief executive officer, seeing him come full circle in his health care career.

Using his global experience, coupled with his solid early career development at the Mater in Brisbane, Dr Steer was chosen to lead the group at a time of great challenge in health care worldwide.

Dr Steer commenced his medical career at Mater South Brisbane in 1982 after graduating from The University of Queensland. He worked at Mater’s Adult and Children’s Hospitals until 1987, then after several years in New Zealand and Canada with further training in neonatology, he returned to Mater Mothers’ and Children’s Hospitals in 1991 and continued there until 2001.

“My professional life began at Mater and it’s really great to be able to return at this stage in my career,” Dr Steer said.

“From the day I started working as a young doctor at Mater, I have never forgotten the genuine compassion and dedication of my colleagues who embodied the values established by the Sisters of Mercy.

“Our legacy is still very much alive today; and it’s an honour to be leading Mater Group as we carry those values forward to promote a healthy community.”

Dr Steer took time out from his busy schedule to reflect on his recent move back home to Brisbane and the opportunities and challenges facing the Mater Group and health care around the world.
Q: **Hm**: What attracted you to return to the Mater?

A: **PS**: After an exceptionally rewarding four years overseas, it was an opportunity to return “home” to Brisbane and home to Mater. I previously worked at Mater on two separate occasions in different roles for more than 17 years. I am grateful to the Mater for the extraordinary training opportunities it provided me early in my working life. Mater has a respected and deserved reputation in the Brisbane and Queensland community for more than 112 years. It is a privilege to return to be part of the Mater future.

Q: **Hm**: What insights do you have from working in Canada, New Zealand and the UK about the future of health care?

A: **PS**: The experience of working in different countries has emphasised the common challenges facing all first world countries, including the changing and ageing demographic; the increase in chronic disease; and technological advances in care. There remain profound challenges in all communities to timely access and adequate funding. There are shared future opportunities as a consequence of advances in genomics, regenerative medicine, big data and artificial intelligence. Future generations will see even more significant and rapid changes.

It has been invaluable to see, across different geographic settings, the commitment to community and to service and within academic centres a relentless drive to innovation and excellence. This is also relevant to the Mater future and Catholic health across Australia.

Q: **Hm**: What are your thoughts on the role of faith-based health care delivery?

A: **PS**: Faith-based health care organisations have a remarkable opportunity to impact the sector. Our Catholic health care organisations are built on a solid foundation – a rich tradition of service to meet emerging need and of courage to change and innovate.

Our sector is driven by value, not by profit, and works to serve, independent of politics or profit. We can provide alternate models of care and a distinct voice to positively influence policy across the public and private sectors.

Q: **Hm**: What do you see as emerging challenges?

A: **PS**: The emerging challenges are to meet the ever-increasing needs of an ageing population. As already mentioned, there is the ever-increasing burden of chronic disease, the urgent need to invest further in mental health, particularly children and youth, and work in partnership and strive to close the gap in health and social outcomes within the Aboriginal and Torres Strait Islander population.

Q: **Hm**: Do you see any particular challenges or opportunities around the introduction of electronic health platforms and the digital age?

A: **PS**: The Electronic Health Record (EHR) is just one element of the requirement to deliver a digital platform and an essential building block for precision and personalised medicine.

The challenges around an EHR and digital platforms are myriad – the cost; the difficulty and fraught delivery and rollout so often experienced; the frequently noted inefficiencies in institutions as they launch their EHRs; and finally the risks around personal information management and privacy.

Despite the risks, there are enormous opportunities for the community in the pooling and learning from “big data” and this learning provides the promise of a transformative change in care.

Q: **Hm**: Do you see any short-term or long-term goals as CEO?

A: **PS**: My clinical background as a neonatologist as well as my time in various clinical and academic leadership roles has allowed me to see complex challenges in the health sector from different perspectives.

It has provided me with an understanding of disease and its impact and consequences in the context of family and the broader community. Our organisations like the Mater must continue to be innovative and courageous. We must strive for excellence and commit to working in partnership, not just to care for those requiring acute or indeed ongoing clinical care, but to contribute to the health and wellbeing of the community.

My long-term goal is to see the Mater as an indispensable and respected contributor to the health and wellbeing of the community we serve.

In the short term, we build on the great work and stewardship of those who have come before, to shape our offering to our funders and stakeholders and to be relevant and valuable – an effective and efficient partner.

Q: **Hm**: How have you felt walking the corridors of the hospital where your career began?

A: **PS**: It has been wonderful walking down memory lane! It has brought back so many memories of times past, but most importantly, fond and grateful memories of many extraordinary teachers and colleagues, whose role-modelling and wisdom has been invaluable over the years.

The staff have been incredibly warm and generous. It feels like I was meant to come back. I’m just sad the welcome morning teas are over.
On February 11, the Catholic Health Australia membership came together to mark the launch of the suite of materials developed in response to the Voluntary Assisted Dying Act (2017).

In welcoming delegates, CHA chair Paul Robertson said: “One of the great things we’ve seen is the spirit of cooperation and collaboration which indeed has been evident through the whole of the taskforce work.”

Keynote speaker Carol Taylor said based on the US experience, too often there is only two positions explained to the public.

“So, if you’re diagnosed with a serious illness, you’re either told you’re going to die horribly or we should have some form of legally assisted dying in some legalised fashion available to folks and what doesn’t get attention is the middle option, which is excellent palliative care,” Dr Taylor said.

“And coming right out of our enduring ethic of care, as we continue Jesus’ healing ministry that (palliative care) should be where we excel, but in the current context of society it’s going to be really challenging to make that a competitive and real vision. And it means that every day, frontline caregivers have to be giving that message that we care and that we have the competence and means and motivation to be who you need us to be.”

Dr Taylor said once assisted suicide or “aid in dying” becomes an option, frontline caregivers are going to have huge challenges and many of them believe that that’s the right thing to do.

“So the challenge that we have in Catholic health care is to prepare them to be true to how they understand their duties as health care professionals and to what’s required in the context of a health care professional-patient relationship, as well as be true to our Catholic mission and ministry. I think it’s going to be a huge challenge moving forward,” she explained.

“I think Australia is in a marvellous position to learn from the mistakes we’ve made, the successes we’ve had, in places that have been faced and confronted with this a bit earlier. I love the current emphasis here on trying to find compassionate competent creative solutions and you’ve got a lot to work with.”

Catholic Health Australia CEO Suzanne Greenwood said CHA has had a very important role bringing members together and providing opportunity for dialogue and discussion to discern the very difficult issue of voluntary assisted dying.

“It’s important that we have that opportunity as a sector to come together because it is not something that’s going to only impact one or two members. It’s going to impact everybody and it’s certainly an issue that is going to impact the whole community,” she said.
“And so it is not for us to be separate from that community. We really are services that are about people and caring for people. We need to understand what our position is and we need to support the staff in that position.”

Mrs Greenwood said Australian Catholic health and aged care services are receiving strong support from colleagues in Canada and the United States, where many of the impending challenges are already being faced.

“I had the privilege in May last year of also going to Canada and speaking at their conference and it gave me a great opportunity to speak to a lot of representatives from the systems to find out what their response has been to the legislation coming into Canada,” she said.

“I think they really focused our attention on two things which really resonated with me. One was how critical it is to support our staff, to keep staff informed and to make sure that there’s some really clear and open channels for them to communicate with us at an organisational level and also how they communicate with the people that we care for.

“We need to understand what our position is and we need to support the staff in that position.”

– Suzanne Greenwood

“The other is maintaining really open channels of communication with the greater Church. That’s why it is just terrific that we’ve had such great collaboration across all of the Australian systems.”

More coverage on pages 26-33.

CATHOLIC HEALTH AUSTRALIA

is this for you?

If you are in a senior leadership or executive position within your organisation, this course is for you.

how should i apply?

Express your interest to your Group Director of Mission.

what is the commitment?

There are nine (2-day) sessions over 18 months. MLP Cohort 3 commences 25-26 July 2019.

cha.org.au/mlp

“This program fulfils the dream I, and many others, have had for decades.”

– Fr Gerald Arbuckle
Christian anthropologist and author

As Fr Gerry Arbuckle says, the MLP is the fulfilment of a dream for mission integration formation for leaders in Catholic ministries.

Participants report significant changes to their leadership approach in Catholic health and aged care services and notice the impact that their learning from MLP is having on their organisations.

If you require further information about MLP please contact Susan Sullivan, Director Mission Strategy susans@cha.org.au, or Dr Anthony Gooley, Manager Mission Services anthonyg@cha.org.au
Taskforce releases new clinical governance framework

A special Catholic Health Australia taskforce has just released a Clinical Governance Framework in response to voluntary assisted dying (VAD) legislation in Victoria.

Dr Dan Fleming, chair of the VAD Response Taskforce, said that the Clinical Governance Framework is the outcome of intense and careful work undertaken collaboratively between Catholic health and aged care services in Victoria.

“Our services have a beautiful ethic and framework for end-of-life care, which we have proudly offered to all who we serve for nearly 200 years,” Dr Fleming said.

“The legislation of VAD doesn’t change this; we’ll continue to offer excellent end-of-life care, and we’ll continue to work hard to get better at it. The challenge our Taskforce has been grappling with is how to continue with this commitment in a context wherein physician-assisted suicide, something which doesn’t align with our ethic, is now a legal possibility under the VAD Act.

“This has involved a lot of deep reflection and analysis, which has been led by experts in end-of-life care, clinical governance, ethics and law. An especially important aspect of the work has been the development of a Clinical Governance Framework, informed by the expertise of frontline staff and experts in clinical governance, which will prepare our services to respond to issues relating to VAD in a way that reflects our ethic of care.”

More than eight months in the making, the VAD Response Taskforce document offers a series of recommendations for CHA members to adapt within the context of their own governance frameworks.

“Our services have a beautiful ethic and framework for end-of-life care, which we have proudly offered to all who we serve for nearly 200 years.”

– Dr Dan Fleming
Harvey Lee, the group manager medical administration of St Vincent’s Health Australia and a member of the Taskforce’s clinical governance group, said the VAD legislation raised a multitude of complex issues for clinicians, both related to their practice but also their personal beliefs.

“When VAD is in place, it’s going to take time to navigate these issues while continuing to provide the best end-of-life care. The critical thing here is to continue providing the best support we can,” Dr Lee said.

“We have some of the best clinicians in the country; they don't need instructions on how to provide excellent end-of-life care. What they will need is clarity around the organisational position on some of the complex issues related to VAD, along with a framework of relationships and the tools to empower them to make the necessary decisions.

“This is the basis of the framework. It is simply a structured system to clarify for our clinicians the purpose, tasks and responsibilities related to the legislation and, more importantly, where to go to ask for help and support.”

Dr Lee said Catholic health agencies work in a variety of different environments and would be implementing the framework in different ways.

“For the framework to work, it must work for the services that implement it. This is why it’s important that the rationale behind the framework is well understood. Addressing the underlying rationale is far more important than doing it exactly the same way at every single agency or facility,” he said.

“For instance, aged care facilities will need to address a different population to that of an acute tertiary hospital. In large hospitals, we will be able to find palliative care specialists who are world leaders in this field. It would then be appropriate that complex issues are addressed by these specialists – and the framework will empower them to work with patients to reach a good outcome.”

Dr Lee said that in aged care facilities, the same issues can be addressed, but instead of a specialty referral, it will be important to work closely with GPs, who often have long-term relationships with their patients.

“This will allow us to address the same relevant issues but using different pathways,” he explained.

“It’s absolutely crucial that clinicians are involved and engaged with this issue, and any respectful and robust discussion is welcome. The tiered system itself has not been controversial during the consultation process and our stakeholders agree that regardless of personal positions on this issue, it is important to have clarity on support and escalation, and this is something the framework provides.

“It’s important to understand that the document is aimed at supporting clinicians to do what they excel at: accompanying our patients on their journey and providing the very best care. While we specify the roles of each member involved in responding to the legislation, the document is designed to empower and support clinicians to make decisions based on their judgement; it’s not a bureaucratic process for reporting purposes.”

Dr Lee said the eight months of work that led to the Clinical Governance Framework involved representatives from a range of fields within Catholic health and aged care services, including doctors, nurses, health managers, ethicists, mission leaders, legal advisors and communication specialists.

“The framework aims to synthesise this expertise, and while it’s a straightforward document, it’s an expression of effort by all the working parties involved,” he said.

“Importantly, the underlying preparation and insights were based on the input of clinical staff who answered surveys and participated in dialogues within individual organisations. A proposed framework was then developed and distributed to allow clinical input prior to being finalised by the Catholic Health Australia Taskforce.

“Some members of the Taskforce were also involved in visiting peer health organisations in Canada for face-to-face discussions with clinicians about their experiences with that country’s VAD legislation and the insights they’d gained.”

Dr Lee said the framework would provide some confidence for Catholic health care professionals in the way they deal with difficult conversations around VAD.

“One of the benefits of the framework is that it allows for each organisation to deliver structured training and support to those people who may need assistance. This will have a direct impact on the confidence and outcomes for those engaging in these conversations,” he said.

“I just want to emphasise that the issue here is not the legislation. It is about how we can provide an environment that offers the best care for patients in our facilities, supported by a solid governance framework.”
Alison White, director of hospice and palliative care services at St John of God Murdoch Community Hospice, said the framework would provide Catholic facilities with a comprehensive structure to support caregivers at all levels, both clinical and non-clinical, with an approach to address questions around VAD.

“We recognise that we need to provide excellent end-of-life care for all patients within our facilities and community organisations within the Catholic framework in which we work,” she said.

“As such, it is crucial that we provide all of our staff with the appropriate education and skills to discuss these matters with patients, families and carers and to recognise when referral to colleagues with expertise is required.”

Associate Professor Natasha Michael, director of palliative medicine at Cabrini Health, said: “In Catholic health, we’ve had a long tradition of palliative and hospice care where we’ve really cared for the people who are sickest in our society and people who have probably needed the most experience in expert care.

“This legislation poses us with many challenges but I also think many opportunities for our standard and our ethic of care to shine through. And also to keep to our principles of accompaniment and non-abandonment,” Dr Michael said.

“Regardless of what our beliefs or our shared tradition might be, we make a commitment to those who need our care that we will continue to be there with them, we’ll continue to be present with them and we’ll continue to support them through to the end of their lives.”

Eastern Palliative Care Association chief executive officer Jeanette Moody said: “I think the framework will be very good for organisations that have a range of programs and staff. For my organisation, the tiers will be compacted due to the nature of our work.”
“A proposed framework was then developed and distributed to allow clinical input prior to being finalised by the Catholic Health Australia Taskforce.”

– Dr Harvey Lee
Thank you to all who participated in the Melbourne conference in February, particularly those Taskforce members who contributed to the development of the new CHA VAD framework.
“One of the great things we’ve seen is the spirit of cooperation and collaboration which indeed has been evident through the whole of the taskforce work.”
– Paul Robertson

Suzanne Greenwood
Catholic Health Australia
CEO

Caroline James
St John of God Health Care

Dr Bernadette Tobin
Plunkett Centre for Ethics
An international ethics expert has told a peak group of Catholic health care professionals to use the introduction of Victoria’s voluntary assisted dying legislation to vigorously promote their enduring ethic of care.

Providing some context for why Catholic health care professionals cannot regard assisted suicide as a medical service, American ethics expert Dr Carol Taylor has warned the Melbourne gathering, led by Catholic Health Australia, about the emergence of incrementalism and an easing of restrictions once the legislation is introduced.

“In Victoria, it’s (the legislation) very restrictive, as it was in other countries when it started for only people with life-limiting, six-month terminal conditions and then being later available to those with psychological symptoms and from people who had capacity (to make their own end-of-life choices) to others, like infants and small children,” Dr Taylor said.

“We must be wary of that type of incrementalism – it is a challenge for all of us.”

The meeting of the CHA VAD Taskforce, which included Calvary, Villa Maria Catholic Homes, St John of God Health Care, Cabrini, Catholic Healthcare, St Vincent’s Health Australia and Mercy Health, was held in February as a result of the Voluntary Assisted Dying Act 2017, set to roll out in Victoria later this year.

Dr Taylor said the legislation and Catholic health care’s framework was the first time these organisations had worked together to build on the Church’s centuries-old practice of providing multidisciplinary support to people in their final months of life.

“The taskforce’s work is amazing and they’ve learned from the US experience and the Canadian experience and from the European. The preparation that they are doing at the top administration level and frontline caregivers is phenomenal,” she said.

Dr Taylor praised the collaborative approach being made by Catholic health care services from all states as they worked to respond to issues arising from the introduction of the legislation.

“It’s not a simple solution and we are calling on their collective wisdom. We are not going to have a perfect solution we need to bring your concerns forward and talk about it,” she said.

“We talk about the sacredness of all life. In someone with advanced dementia or motor neurone disease, we see the broken body of Christ; we continue to see the broken body of Christ in the suffering today.”

– Dr Carol Taylor
Dr Taylor said the US experience, and particularly the very useful statistics gathered from Oregon, the first state to introduce VAD legislation, clearly showed that those choosing the voluntary end-of-life option were predominantly white, well-educated and wealthy.

She said the results from VAD death statistics were strikingly familiar: "This is a group of people who want to remain in control of what happens to them. It’s a group of people who have lived their entire life that way and who say: ‘Why should I not control the time and manner of dying?’"

Dr Taylor said the statistics also revealed that more males than females chose to end their life in this way.

“We’ve had some interesting literature this past year in the US where they are all reporting on a ‘loneliness epidemic’ and this notion of a 25 per cent increase in suicide deaths in the US since 1999, across most ethnic age groups.

“I am convinced that our nation’s suicide crisis is, in part, a crisis of meaninglessness. Greater detachment and a weaker sense of belonging are increasing the risk of existential despair. One of the things that assisted suicide proponents say is that we won’t have any violent deaths,” she said.

The rise in secularism and atheism or “no religion” is causing people today to become separated from their traditional sources of meaning – whether through a lack of extended family ties and/or religious beliefs.

“Western society continues to secularise in breadth and intensity. This will continue to negatively impact care of the poor and vulnerable. In this context, we offer a clear and compelling witness to the fullness of life to which our faith calls us,” Dr Taylor said.

“When my life gets hard, we do not have anything to reach into. Absolutely, that is the challenge for Catholic health care: How can we create a credible alternative decision?

“We are fighting strong cultural currents, the focus on autonomy, messaging promoted by compassionate choices. It will be increasingly necessary for us to be able to articulate the Catholic teaching and vision on end-of-life care in a compelling and clear way and that’s part of the goal of this project.

“We talk about the sacredness of all life. In someone with advanced dementia or motor neurone disease, we see the broken body of Christ; we continue to see the broken body of Christ in the suffering today.

“In the Catholic Church we have this enduring ethic of care that every day, on so many fronts, helps people to die comfortably and with dignity. We are not going to abandon you, we are going to accompany you, we are going to support family caregivers.

“When people make a request [for assisted suicide], we want to turn that around to ask them: What are your fears? What are your concerns? And how can we help you? And that’s the challenge for us as Catholic health care professionals today.

“We need to look with respect and compassion on the suffering and that goes a long way to meeting the concern of the aged and dying: I don’t want to be a burden on anyone and I don’t want to lose my dignity.

“Pope Francis provides a powerful witness. He is non-judgmental and acutely aware of people’s experience. We do not need to agree (with those choosing assisted suicide), but acknowledge their experience and the difficulties they face and not judging but saying, ‘We do think there is another way to proceed and here it is.’"
A Life-Changing Philosophy for Ageing Well

Marcus Riley, an international positive ageing advocate and CEO of a Catholic Health Australia member service, has published a book to shine a light on successful ageing.

Mr Riley’s career in the field of ageing spans over two decades, providing leadership and influence on local, national and global levels. He was recognised in 2018 with the Global Ageing Influencer award by Ageing Asia.

He regularly addresses the issue at the United Nations, is director and past chairman of the Global Ageing Network and member of the governing committee of the Global Alliance for the Rights of Older Persons.

Mr Riley is currently CEO of BallyCara, which is owned and operated by the Queensland Hibernian Friendly Society and provides accommodation, health and care services for older people as well as a range of support and advisory functions to service-based industries.

He has previously held key roles within Leading Age Services Australia, Aged and Community Services Australia and Retirement Villages Australia.

Mr Riley said the idea for his first book, Booming: A life-changing philosophy for ageing well, was generated four years prior to publishing, with the actual writing and researching taking two years.

It was released late last year.

Through Booming and his life work, Riley has sought to foster the opportunity for people to pursue their potential, irrespective of social or health circumstances, and to age successfully.

“The intended chapter format and flow of the book was to enable people to refer to different sections and access particular content that may be pertinent to them at a given time,” Mr Riley explained.

“Successful ageing is self-defined and therefore attainable for all.

“Through my work locally and internationally, I am acutely aware of the global megatrend that is ageing and the wonderful opportunity and responsibility this creates. I am also very aware of the negativity that underpins society’s view about getting older”.

Mr Riley said he had a great relationship with his grandparents and he began working in the field of ageing from age 17.

“I have again been fortunate over the past two decades to learn from inspiring people and observe why some people age very successfully and perhaps why some others do not,” he explained.

In Booming, Mr Riley has aimed to “Inform and hopefully inspire people, individually, to make the choice to pursue the opportunity to boom and age successfully and as a society for us to embrace ageing more positively”.

“The book is intended to be for everyone. Certainly people aged 50 plus and people with older family members would have a sharper interest; however, people of all ages have provided positive feedback about Booming.”

“Irrespective of our health or social circumstances, we have potential to be realised and by embracing positivity, planning to retain control over one’s life and understanding the need for purpose, we can all boom!”

– Marcus Riley
Mr Riley believes for too long there has been a lack of taking a complete view of ageing.

“We often hear about particular segments related to ageing, e.g. financial planning, care options, housing, end of life, but usually in isolation,” he said.

Mr Riley hopes Booming will “help individuals understand there is a choice for all of us, that we can either accept that old age means to fade away, deteriorate and wither on the vine – like society often tells us – or we can seize the opportunity to revel in our later years with joy, passion and wisdom”.

“Irrespective of our health or social circumstances, we have potential to be realised and by embracing positivity, planning to retain control over one’s life and understanding the need for purpose, we can all boom!”

“I gratefully acknowledge the many older people who I have been privileged to know and the fun, wisdom and inspiration they have provided, as well as my colleagues at BallyCara and all that they teach me and others from around the world whom I’ve worked with and shared a vision for more positive ageing across the globe.”

Marcus Riley’s top tips for ageing well:

1. Know there is a choice to make:
   Most of us are going to live a long life and the choice is ours whether we thrive in later life or wither away on the vine. Irrespective of our social or health circumstances we all have the opportunity to pursue successful ageing.

2. Identify your passions: Reflect on what is important to you and identify your particular passions and then prioritise regular time for them. Your passions may include your family, your roles at work or in the community, your favourite pastimes or hobbies, sporting or cultural pursuits. Engagement with our passions helps fuel our positivity, increases self-esteem and importantly fosters our social connections.

3. Future thinking: Spend 30 minutes today thinking about your FUTURE, identifying an experience or adventure you would like to have and start making a plan to make it happen. Immediately this begins to give us a sense of purpose, excitement and more of a future-oriented mindset. A common failing of our ageing is ceasing to contemplate our future, which is something we should do no matter what age we may be.

4. Always open to opportunities: Maintain an attitude of saying “yes” to new opportunities. Whether it’s a social invitation, the chance to learn something new or participate in an activity or event, have a consistent approach of being open to such opportunities. Such an attitude supports our emotional wellbeing and the health of our brain plus has the potential to help build new social connections.

Booming: A life-changing philosophy for ageing well, published by Ventura Press, is available through online retailers.
Palliative care reduces hospital-associated costs and the number of aggressive interventions. It enables people to die in a setting of their preference, which for most people is at home.

The way people die is an important part of life. Issues surrounding the end of life are becoming increasingly pressing as more Australians will need end-of-life services than ever before. In fact, the Australian Bureau of Statistics estimates that the number of deaths will double by 2061 in Australia, due to an increasing burden of disease and an ageing population.

Partly in response to this, states and territories around Australia are exploring the introduction of voluntary assisted dying. There are alternatives, such as palliative care, which aim to relieve the physical, spiritual and psychological problems associated with end of life.

Palliative care reduces hospital-associated costs and the number of aggressive interventions. It enables people to die in a setting of their preference, which for most people is at home.

Catholic Health Australia recently released a report titled Palliative Care in the Catholic Sector, which describes the vast network of CHA member palliative care services throughout Australia and the innovations they bring to the sector.

Palliative care in Australia is ranked second in the world, with only the UK outperforming Australia, yet just half of the people who would benefit from palliative care actually access it. Referrals to palliative care are absent or late, and only 14 per cent of people die at home, even though studies suggest between 50-70 per cent want to.

There are many opportunities, often missed, to improve access and quality of palliative care in Australia. Funding and resources were identified by CHA member staff in the report as the largest barrier to achieving access to quality palliative care. Fragmentation of service, workforce shortages and palliative care awareness both within the health care workforce and in the public arena are also barriers to achieving improvements.
CHA and its members are a significant provider of palliative care in Australia. Thirteen per cent of all palliative care-related hospitalisation occurs in a CHA member hospital and CHA members provide more than 53 per cent of palliative care in the private sector, including 52 per cent of all private palliative care beds available in Australia.

CHA and its members also deliver in the community and aged care sector, which are areas where people still struggle to access services. For example, even though 90 per cent of aged care residents will die within two-and-a-half years of entering an aged care facility, only 2 per cent have a funding needs assessment — the Aged Care Funding Instrument (ACFI) — that indicates the need for palliative care.

CHA members have adopted a number of innovative strategies in order to improve access for those who typically receive poorer outcomes. Catholic Homes in Western Australia has invested in an Australian-first, purpose-built hospice facility within a residential aged care facility, which acts as a step-up facility for those in the aged care home, but also an important step-down facility for those leaving hospital.

Calvary Clare Holland House is also working towards improving palliative care outcomes for aged care residents through nurse-led needs assessments in an outreach model into aged care facilities. Both initiatives have the added value of improving palliative care awareness among the aged care facility staff, which will ultimately improve palliative care needs identification and referral.

Other areas of growth within the CHA membership are both the private and public community-based services. CHA members at Mater Brisbane, Cabrini and Calvary North Adelaide Mary Potter Hospice are among the first providers to be able to offer palliative care in a community setting that is funded by private health insurance.

In both public and private services, where members have been enabled to provide a continuum of service from tertiary inpatient services to community-based palliative care, integration of service is greatly enhanced.

The drive for CHA members to undertake palliative care research, education both within the health care sector and in the general public and to form vast networks of palliative care organisations and partnerships is deeply rooted in Catholic ethos and organisational mission.

As a result, many aspects of palliative care service provision are funded at a cost to the organisation or by donations. With appropriate funding and resourcing and by sharing learnings within the Catholic sector through the formation of a National Catholic Palliative Care Alliance, CHA members have the potential to achieve more.

There are many opportunities, often missed, to improve access and quality of palliative care in Australia.
In an initial burst of energy in the 1980s, every mainland capital city in Australia established its own Catholic bioethics centre to service the needs of a health and aged care sector that was just beginning to transition to lay leadership.

The aim of these centres was to provide sound ethics advice to health and aged care providers, as well as a degree of comfort to local Churches that these important ministries would continue to observe Catholic ethical principles.

As the centres shifted shape over the years, it became obvious that there was no Plan B for bioethics: No long-term strategy for the identification or training of future bioethicists, no significant career paths and no secure funding.

Over time, some centres closed, while others merged into acute health care systems, leaving the rest to ponder a potentially bleak future.

Two years ago, the bioethics and moral theology communities in Australia began a series of consultations to address future needs.

Led by Professor Gabrielle McMullen, a small representative group surveyed stakeholders, arriving at conclusions and identifying challenges eerily similar to a study conducted by the Catholic Health Association in the United States.¹

Where will future bioethicists come from? How will they be trained? What career paths can be created? How will it all be funded?

Aware that the Catholic community in Australia is large and diverse in many respects, the working group developed three recommendations aimed at balancing the need for a concerted nationwide effort with full respect for differences between local Churches.

Recommendation 1 establishes a national coordinating body intended to keep some momentum behind what is likely to be a long and complex process across the country. The first meeting of this National Ethics Advisory Group took place in Sydney in March.

Recommendation 2 engages an existing body of senior health and aged care leaders, the CHA CEO Forum, in two tasks: defining the scope of future need in their own ministries and engaging with Australia’s two Catholic universities to deliver graduate formation suitable to meet those needs.

Recommendation 3 calls for cross-sector conversations in each ecclesiastical province (mainland capital city) to develop models of ethics delivery suitable to the needs of each province.

The future of bioethics in Australia does not rest with local dioceses alone, as underpinned the original 1980s model.

Nor can it rest simply with the Catholic universities, whose structure and purpose do not naturally align with the needs of the acute health and aged care providers.

The future of bioethics in this country lies in a series of as-yet undefined collaborative, cooperative models each grown organically to suit the needs of a local environment, both actively engaging and creatively serving our many excellent Catholic ministries.

Watch this space.
Partnering to improve the care of older Australians

“...reported at the end of the project that staff felt much more confident in having conversations about advance care planning and end-of-life care...”
– Maddy Cosgrove

Creating linkages between palliative care, aged care and primary care providers and networks can improve the care clients receive at the end of life and can benefit aged care service providers by enhancing staff skills and confidence in providing palliative care and advance care planning.
Linkages are a significant part of the End of Life Directions for Aged Care (ELDAC) Project, a $15 million palliative care and advance care planning project funded by the Commonwealth Department of Health to improve the care of older Australians.

Catholic Health Australia is a member of the ELDAC consortium. The ELDAC linkages program supports aged care providers to implement evidence-based strategies that have been developed through a systematic literature review conducted at the Queensland University of Technology. Participants also work with one of ELDAC’s facilitators, who are trained to support implementation within services.

Strategies to enhance linkages between palliative care, aged care and primary care providers and networks include:

• multidisciplinary teams;
• written and verbal communication pathways;
• formalised agreement plans;
• designated linkage worker;
• role clarification;
• knowledge exchange and upskilling; and
• continuous improvement.

Sites that have been supported to use the seven linkage strategies have showcased positive outcomes. For example, mecwacare and Cabrini Health developed specialised training for their staff and improved confidence in palliative care and advance care planning through their use of the linkage strategies.

Despite being geographically close to one another, the residential aged care service and specialist palliative care service had no prior relationship and were not sharing resources or expertise in the care of their clients.

“...”

Both organisations also made a commitment to provide education and training for staff and undertook training for 250 staff in providing better care for residents, a process that has been described as invaluable.

“It was also reported at the end of the project that staff felt much more confident in having conversations about advance care planning and end-of-life care, and that staff confidence was important in enabling those conversations to occur.”

Additional specialist palliative care, aged care and primary care providers across Australia are being sought to create linkages for the improvement of end-of-life care for older Australians.

All aged care services or sites (residential or community) that enrol and participate in the ELDAC linkages program will be eligible to receive a grant of up to $20,000 to support site engagement in ELDAC activities.

For more information about the grants and participating in the linkages project, please email eldacteam1@qut.edu.au and a facilitator will contact you.

Find out more about the ELDAC project at www.eldac.com.au
## Evidence-based linkage strategies

*Used within the ELDAC project*

<table>
<thead>
<tr>
<th>Linkage Strategy</th>
<th>Description</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| **Multidisciplinary Teams**             | Input into clinical care is provided through regular scheduled communication between team members from a range of disciplines and services delivering palliative care and aged care | • Improved symptom control  
• Increased number of scheduled multidisciplinary interactions  
• Improved communication between providers  
• Sharing of information  
• Increased number of shared care plans  
• Increased confidence in partner organisations and their staff |
| **Written and Verbal Communication Pathways** | Shared and standardised documentation and communication processes support care delivery, and may include usage of common language, standardised referral forms, agreed assessment tools, and Advance Care Plans. | • Improved continuity of care  
• Increased possibility of meeting patient choices  
• Established contact with local services  
• Increased meetings arranged to create and maintain linkages  
• Developed shared documentation  
• Increased use of shared care plans  
• Increased continuity of care  
• Increased case conferencing and communication about care  
• Increased use of technologies (i.e. telehealth and ehealth records)  
• Provided consumer information  
• Improved understanding by consumers |
| **Formalised Agreements and Plans**      | Formalising linkages through written agreements and governance arrangements can ensure discussion of and commitment to resource allocation, mutual responsibilities, agreed outcomes, and communication processes. | • Evidence of formal linkage partnerships established, including formal agreements (e.g. MOUs) and shared service plans  
• Adequate allocation of resources to sustain linkage activity plan  
• Evaluation service data to provide information for continuous improvement |
| **Designated Linkage Worker**            | Appointment of a key worker whose responsibility it is to act as a care and linkage coordinator across settings is seen to improve access to services, improve cooperation between services, improve continuity of care and promote shared understanding of the Linkage worker role. | • Improved communication across settings  
• Shared understanding of the linkage worker role  
• Increased confidence among linkage partners  
• Improved continuity of care |
| **Role Clarification**                   | Clarity of roles and responsibilities for each practitioner involved in the linkage partnership leads to improved continuity of care particularly when transitioning between settings of care. | • Improved understanding of roles and responsibilities of each partner service provider  
• Improved communication about care  
• Improved continuity of care |
| **Knowledge Exchange and Upskilling**    | Shared learning opportunities, both formal and informal, increase knowledge and develop capabilities in providing palliative care for older Australians. | • Improved knowledge, skills and confidence of service providers in providing palliative care to older Australians |
| **Continuous Improvement**               | Processes for continual review of linkage strategies and their outcomes enable identification of their effectiveness and efficiency. | • Evidence of strategy embedded into organisational quality processes (e.g. PCOC)  
• Minimum data requirements collected and reported |
In the Summer 2018 issue of *Health Matters*, an article by Professor Keith McNaught and Dr Geoffrey Shaw, "Understanding the Patient’s Experience", was inadvertently published without correct attributions and footnoting.

Professor McNaught is the Regional Director Mission Integration Western Australia, at St John of God Health Care, and Adjunct Professor at the Institute of Ethics in Society, University of Notre Dame Australia, Sydney. Dr Shaw is a Consultant Researcher and retired University of Notre Dame Australia academic. The full article was first published in *The Australasian Catholic Record*.

The Effect of the Proposed Euthanasia Legislation

On Two of Australia’s Most Vulnerable Groups

by Darryl Mackie

This article is an abridged version of a presentation given at the 2018 Ethics Colloquium on Vulnerability and Health Care. It first appeared in Health Care Ethics USA.

INTRODUCTION

Like most Western countries in the world, Australia is also facing challenges around the question of the right to die through euthanasia. Euthanasia calls us to reflect on the meaning of life and care for the sickest and most vulnerable within our society. It further challenges us to see how society will protect them.

For our predominately still Christian country, when reflecting upon the meaning of life, we are reminded in Scripture, “I came that they may have life, and have it abundantly.” (John 10:10b) What is life? What is death? What is its meaning and value? What environment allows for full human flourishing in the context of family and community?

DEVELOPMENT OF THE “EUTHANASIA MENTALITY”

A number of influences have developed and nurtured what I would call a “Euthanasia mentality” - a societal change of view on killing someone that runs parallel to a wider acceptance of suicide. These include:

Lack of Palliative Care: Palliative care focuses on improving the quality of life and alleviating pain for those who are dying. Good palliative care is holistic care of the psychological, social, spiritual and physical needs of the individual and their family, which should mean that euthanasia is unnecessary.

Due to the size of the country and limited resources, palliative care in Australia lags most other countries. Access to good palliative care services remains largely dependent on patient location and socioeconomic status. Many rural areas rely on general practitioners and community nurses for care, where a large proportion are not appropriately trained in the provision of palliative care. Some services have been described as being akin to those in the 1960s.

Human Autonomy/Subjectivism: John Keown defines autonomy as the capacity to be valued in so far as its exercise makes for the wellbeing and flourishing of the human beings who possess it. Australians pride themselves in their autonomy in life and in their health care decisions. It is common to hear the statement that “no one has the right to tell me what I should do with my life or my body and it’s my right to die with dignity.”

A recent Australian Human Rights Commission report on euthanasia states that society’s “obligation to protect life must be balanced against the right to personal autonomy which is contained within the right to privacy... and any refusal to allow passive euthanasia or assisted suicide despite the express wishes of the patient therefore represent interferences with the right to privacy.”
The Power of Language: In a postmodern world, language is often reality. Use of such words as poison, suicide and homicide carry enormous emotional and social stigma. Support seems to vary for euthanasia on what language is used, and has consequentially driven a move to the more politically correct term voluntary assisted dying. In the United States, the former Hemlock Society is now known as Compassion and Choices.

Support seems to vary for euthanasia on what language is used, and has consequentially driven a move to the more politically correct term voluntary assisted dying.

Trust in Health Services and Physicians: Trust is a powerful healing tool when you are sick. To ask medical teams to go against their role as healers would undermine trust within the community. As the Australian Medical Association (AMA) in its submission to the inquiry on euthanasia stated: “This conflicted with the basic ethical principles of medical practice...such a [changing of the] law would undermine the healing reputation of the medical profession and trust in them not to hurt or damage their patients, as espoused by the ancient Hippocratic Oath.”

The AMA recommendation is for increased funding for palliative care, as this would reduce the perceived demand for assisted suicide and euthanasia. Some doctors see euthanasia as a great temptation to a cash-strapped health department.

Malthusian Theory: This theory outlines that if the natural tendency was for populations to grow without end, food supply would run out against the limit of finite land. Recent government policy in Australia has alluded to this principle with thoughts that large arrivals of refugees by boat escaping war-torn areas of Syria and Afghanistan would mean less food supplies for the Australian population. This principle is also reflected in the recent movie Downsizing by Paramount Pictures.

Pope Francis’ ongoing conversations allude to neo-Malthusianism, which he sees as a selfish and irresponsible response of the world’s rich toward their poor brothers and sisters. In Pope Francis’ view, population-control programs are nothing more than an attempt to eliminate poverty by eliminating people.

Church Is Losing Moral Authority: The Australian Census of 2016 saw a significant decline from formal religious traditions with a third of the population claiming to be either spiritual or having no religion (a rise of 8 per cent). Catholics are still at 22 percent of the population. Between 2013 and 2017, a Royal Commission was held in Australia into Institutional Sexual Abuse. The results of this Royal Commission damaged the credibility of the Catholic Church by suggesting as many as 7 per cent of priests or religious leaders either committed some form of abuse, covered it up or failed to protect children in years past. The Church’s credibility and the effectiveness of its arguments are so poor that in the same-sex marriage debate, it no longer had a voice.

AUSTRALIAN ABORIGINALS
For over 60,000 years, Australia has been occupied by what is regarded as the oldest living people and culture in the world. They are a very spiritual people believing in the Dreaming, which created all things around us, and because of these beliefs, Aboriginals have a special spiritual connection to land, community and time – connection of land (often referred to as country) where it feeds, nourishes, provides and is the life-giving spirit; connection to a community where you can’t speak about the well-being of individuals without their connection to the community and to the land; and finally, the connection to time, for Aboriginal people time is all one: past, present and future.

On arrival in 1788, the British classified Australia as a new colony, assuming ownership of what was considered uninhabited by a recognisable people with any recognisable structure or laws (Terra Nullus).

This event was to change Aboriginal history forever. It created intergenerational trauma, mistrust and the death of many. Intergenerational trauma and mistrust is a result of the colonisation that saw disease and policies of “kill the savages” reducing the population. The first half of the 20th century involved the forcible removal of children into government and church missions for the perceived sake and benefit of assimilation. This is known to us as the Stolen Generation. For many years, we only saw Aboriginal people with colonial eyes.

Change was happening in the 1960s, when Aboriginal people were first acknowledged as persons and given the right to vote. In 1992, the term Terra Nullus was abolished with the much-celebrated Mabo Case. In 2008, the Australian Parliament offered a National Apology to those of the Stolen Generation. This has led to a 10-year program entitled Closing the Gap, which seeks to improve the life expectancy (which is 17 years below that of the non-Indigenous population), education and employment outcomes for Aboriginal People.
In the most recent census, 600,000 people were identified as Aboriginal or Torres Strait Islander, or 3 per cent of the population. This figure is highly inaccurate given that identifying as Aboriginal carries a certain stigma and discrimination and identifying is often seen as a barrier to proper services and care.

EUTHANASIA AND ITS EFFECT ON ABORIGINAL PEOPLE

Aboriginal Australians suffer from complex and higher rates of disease than the general population including cancer, diabetes and cardiovascular disease. These are often left undiagnosed because of the intergenerational trauma and mistrust of hospitals, as they are perceived as places of death. It’s the place where you say goodbye to your loved ones.

If euthanasia legislation is approved, this would again create further mistrust among Aboriginal peoples, as highlighted in the findings of the introduction of legislation in the Northern Territory in the 1990s. During the period of the legislation, there was a major decrease in seeking medical advice and a significant increase in sexual diseases (some causing sterilisation) because of the mistrust that a needle could end a life. The following comments were made in testimony to the Senate Legal and Constitutional Committee in 1996.

• “We are all really frightened... They reckon the government is going to round up all the real sick people and those with V.D. and things like that and finish them off. That’s not the Aboriginal way. People are frightened to go to hospital now.”
• “It was not ‘the Aboriginal way’ or that it was contrary to Aboriginal Law.”
• “We strongly believe that natural death is the best way. Even if the person is suffering and is in pain, the person knows and the family knows that the person will finish soon. The brothers and cousins they have the final conversation with the person who is dying and all other family members sit around the person in a big circle.”
• “Our spirit goes away when we die naturally but it won’t if we get the needle.”
• “Because of our strong preservation of life, to kill someone is an evil act and therefore that evil must be destroyed.”

Any legalisation on euthanasia would require a large amount of resources to bring attitudinal change. This would need to be achieved by educating Aboriginal people, in order to alleviate mistrust in doctors. This money would have been better spent on preventing diseases in this vulnerable population.
AUSTRALIA’S ELDERLY

Australians are living much longer lives, with 3.7 million Australians (or 15 per cent of the population) over 65 years of age. With this growth has come a higher proportion of elder abuse. It is expected to become more common as there is a wealth divide between generations.

The World Health Organisation defines elder abuse as “a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person”. Elder abuse can be physical, psychological or emotional, sexual or financial. Recent reports released from an elder abuse hotline saw 2,130 calls received in 2016-17, with the most common form being psychological and financial abuse. The financial abuse was mainly incurred by other family members to what is known as inheritance abuse.

EUTHANASIA AND ITS EFFECT ON AUSTRALIA’S ELDERLY

With elder abuse on the rise, as well as the growing costs of health care for the ageing, euthanasia could become a great temptation. As Sydney surgeon Robert Claxton writes, “Medically assisted suicide would be a great temptation to a cash-strapped health department and an irresistible temptation to those seeking to inherit money from relatives.”

Current proposals have safeguards in place, but what happens when the slippery slope occurs and laws become more relaxed?

What about cases like that of the scientist David Goodall, who at 104 was in reasonably good health, declared that he had just had enough? What happens to those who are old or live with disabilities, or even just perceive themselves as a burden on their families? Religion used to carry the respect for life in society but will law and medicine carry this forward?

AUSTRALIAN RESPONSES

The Catholic Church in Australia is the largest health care provider outside of the government with more than 70 hospitals (21 public and 54 private) and more than 550 residential and aged care facilities.

Catholic Health Australia, which represents these facilities, has responded by declaring that euthanasia will not take place in Catholic hospitals. In its submissions to government, CHA wrote that its members are committed to providing the best possible compassionate care and that governments should divert funding into palliative care programs where we can compassionately protect and dignify a patient’s life rather than hasten their death.

There may be some uncertainty on the future impact on our Catholic public hospitals by taking this stand if we are to continue to receive government funding.

Secondly, there are emerging discussions on changing the education of health care providers. Part of this change is to provide training for all interns in palliative care departments, prior to the practice of their immersion in emergency departments. This move would have doctors well trained in understanding palliative care to help cover the shortfall in regional areas. With greater education in palliative care for all relevant health professionals, and palliative care training modules in universities, a far better treatment in palliative care is highly likely.

Finally, we can learn from Indigenous wisdom. Aboriginal people have taught us about connection with land, community and time. Aboriginal people speak of the need of human memory and the spirits of the great, great, great grandfather in order to look forward to the great, great, great grandchild through imagination when we are making important collective decisions.

For Aboriginal and Torres Strait Islander people, health is a holistic notion; it is considering not just the wellbeing of individuals, but also that of communities, time and country. The question must always be asked, how do we want our future grandchildren to die?

CONCLUSION

Catholic health care in Australia, like most countries, has a long history of caring for the poor and vulnerable. As the Australian Parliament continues to debate current euthanasia legislation, Catholic health care will continue to advocate for the vulnerable, especially its First People and the elderly.

In a growing secular world, we are challenged by Jesus’ words of fullness of life and the parable of the Good Samaritan.

That is the mission entrusted to us, to continue to be that voice for the voiceless. To lose compassion is to lose what it means to be human. When St Paul wrote to the people of Rome that the life and death of each of us has its influence on others (Romans 14:7-12), he recognised the most fundamental fact: We are relational beings and, for us Australians, our Aboriginal people show us this truth. We have much to learn from our Aboriginal people and those in end-of-life care, for they teach us how to care, they teach us how to let go and they teach us how to live and how to die.
The program, at St John of God Burwood Hospital in Sydney, invites family and carers of patients with alcohol and drug addiction to meet with their clinician to better understand the nature of addiction and how they can support their loved one.

St John of God Burwood Hospital counsellor and psychotherapist Andrew Howie said the program was designed to give patients another layer of support when they returned home from hospital after completing the drug, alcohol and addictive behaviours program.

“This gives us the opportunity to provide a patient’s family with an assessment of where their loved one is at on the recovery journey and, particularly, the challenges ahead and what their ongoing recovery might look like,” he said.

“It is also an opportunity for families to have their specific questions answered and find out about resources available as they accompany their loved one in recovery and minimise their risk of relapse.”

The program, which is one of the few of its kind to be offered at a private mental health facility, was introduced in late 2018 in order to provide another layer of support for people returning home from hospital, which can be a trigger for substance abuse.

“We have long recognised the need to include families and carers of patients into their recovery process and, as such, general information evenings are held for families and carers where they received general information about the nature of addiction and have their questions answered,” St John of God Burwood Hospital CEO Colman O’Driscoll said.

“The feedback we have received from these additional individual sessions has been overwhelmingly positive. This program brings families into the mental health recovery process and reduces their feelings of exclusion or misunderstanding.

“Patients and their families have been grateful to come together in a mediated environment in order to prepare the patient for discharge back into their families and their ongoing engagement with recovery.”

The hospital’s director of allied health, clinical psychologist Jae Lee, said family members and carers were often the first to identify problem alcohol and other drug use and addiction issues.

**New family support program to help people with addiction**

A leading Catholic mental health hospital has introduced a new family support program to help people with addiction manage their condition.

The program, at St John of God Burwood Hospital in Sydney, invites family and carers of patients with alcohol and drug addiction to meet with their clinician to better understand the nature of addiction and how they can support their loved one.

St John of God Burwood Hospital counsellor and psychotherapist Andrew Howie said the program was designed to give patients another layer of support when they returned home from hospital after completing the drug, alcohol and addictive behaviours program.

“This gives us the opportunity to provide a patient’s family with an assessment of where their loved one is at on the recovery journey and, particularly, the challenges ahead and what their ongoing recovery might look like,” he said.

“It is also an opportunity for families to have their specific questions answered and find out about resources available as they accompany their loved one in recovery and minimise their risk of relapse.”

The program, which is one of the few of its kind to be offered at a private mental health facility, was introduced in late 2018 in order to provide another layer of support for people returning home from hospital, which can be a trigger for substance abuse.

“We have long recognised the need to include families and carers of patients into their recovery process and, as such, general information evenings are held for families and carers where they received general information about the nature of addiction and have their questions answered,” St John of God Burwood Hospital CEO Colman O’Driscoll said.

“The feedback we have received from these additional individual sessions has been overwhelmingly positive. This program brings families into the mental health recovery process and reduces their feelings of exclusion or misunderstanding.

“Patients and their families have been grateful to come together in a mediated environment in order to prepare the patient for discharge back into their families and their ongoing engagement with recovery.”

The hospital’s director of allied health, clinical psychologist Jae Lee, said family members and carers were often the first to identify problem alcohol and other drug use and addiction issues.
“They can provide insight and perspective into the impact of the problem alcohol and drug use or behavioural addiction on the individual, family and community that the individual may not have considered or have been unaware,” she said.

“Therefore, it is really important to engage carers throughout the assessment, care-planning and discharge process. Family and carer involvement facilitates ensuring safety and welfare of any children in the home, as well as improving overall family relationships.

“While our sessions are primarily aimed at enhancing treatment outcomes for the individual undergoing treatment, we also assist the family members and carers to look after their own welfare.

“Caring can come at a great cost and, without support, can become unsustainable. We want to assist our clients to preserve these key relationships as good support is an important factor in treatment outcome.”

– Jae Lee
Archbishop’s book ‘paves the way’ on disability

Australian Catholic University recently hosted the Victorian launch of Melbourne Archbishop Peter A. Comensoli’s new book, *In God’s Image: Recognizing the Profoundly Impaired as Persons*.

The book, which began as Archbishop Comensoli’s doctoral thesis at the University of Edinburgh, has been developed and refined into its current form.

ACU vice-chancellor and president Professor Greg Craven said Archbishop Comensoli made a robust argument in the book for the personhood of every human being, arguing that it is all too easy to overlook and marginalise those who don’t fit into our category of “able-bodied” or “able-minded”.

“In *God’s Image* has received many generous endorsements from scholars, who have praised its contribution to contemporary Catholic theological discourse on the nature, dignity and destiny of the human being,” Professor Craven said.

“The book demonstrates we have a responsibility to live alongside those with cognitive impairments as friends, in a community, and to be open to learning from them how it is we can be more perfectly human.

“The book will pave the way forward for Christian theologians working on the topic of disability and impairment.”

Medi Ann Volpe, a lecturer in theology and ethics in the Department of Theology and Religion at Durham University, describes Archbishop Comensoli as “turning the usual question about being in the image of God on its head”.

She writes: “Drawing on St. Thomas Aquinas, he argues that the profoundly cognitively impaired are in the image of God by nature. There is thus no need to prove that they bear the image of God.

“It is we, the ‘rationally capacious’, who have the capacity to mar the image of God by conscious opposition to God’s grace. Comensoli’s book is a must-read for anyone interested in theology and intellectual disability.”

Late last year, ACU also hosted the New South Wales launch of the book at its North Sydney campus.
A four-legged friend, three days a week

Several days a week, the residents of Catholic Healthcare’s St Francis Aged Care are joined by an extra member of staff. But you won’t find this employee on the payroll.

Lotte, a nine-month-old chocolate labradoodle, has been visiting St Francis in the NSW town of Orange every Tuesday, Thursday and Friday since she was a puppy. On these days, with the home’s pastoral care worker in attendance, Lotte does much of her good work as a trainee therapy dog.

“When Lotte arrived, there was a lot of bonding to do. Lotte needed to get used to the home – the smells, the sights, the people – and the people needed to get used to her,” says Sharon Hesse, residential manager at St Francis.

Therapy dogs like Lotte are an increasingly common sight in many homes, where they provide affection, comfort and love to the residents, while helping to improve socialisation, emotional wellbeing and more. Therapy pets are also known to have other positive impacts for aged care residents such as reducing stress, increased enthusiasm in everyday life and decreased symptoms of depression.

Lotte often serves as an icebreaker as she wanders the hallways of the home under supervision. As employees move from room to room or navigate the home, residents who might not usually stop and talk or engage socially are encouraged to give Lotte a pat or a scratch.

Through this simple interaction, pastoral care workers can strike up a conversation and connect with residents who may usually be isolated or uncommunicative.

“We have a relatively young resident, Suzie, who suffers from advanced dementia. Lotte will climb up on her walker whilst Suzie wheels her around the unit. Suzie has a big smile on her face whenever this happens,” adds Ms Hesse.

Lotte isn’t a certified therapy dog yet. Once she is 12 months, a local accredited trainer in Orange will take her for training, supervision and assessment. When she passes her tests, Lotte will become a registered therapy dog and be allowed to walk the home without supervision.

In the meantime, Lotte continues to make a big difference in the lives of both staff and residents.

“St Francis now has an animal reflection area in the gardens with some furniture for employees and residents to use. The pastoral care co-ordinator has started running prayer groups in this new space and Lotte joins them,” Ms Hesse said.

“Lotte’s presence is great for the residents. Both residents and Lotte have developed a deep connection with each other. She is like family to many of them.”
Catholic Health Australia members Vinnies NSW and St Vincent’s Health Australia have joined a collaborative group in New South Wales as part of a global initiative to end street sleeping.

In February, NSW Premier Gladys Berejiklian announced the joint commitment between the Institute of Global Homelessness, the City of Sydney, the NSW Government and the sector’s leading NGOs to a collaboration and targets to end street sleeping.

The parties to the collaboration aim to:

- Reduce rough sleeping in the City of Sydney by 25 per cent by 2020;
- Reduce rough sleeping in the City of Sydney and NSW by 50 per cent by 2025;
- Work toward zero rough sleeping in the City of Sydney and NSW.

In her announcement, Ms Berejiklian said: "We cannot be complacent and by signing this agreement we are pushing ourselves to do even more.

"We have set this target to halve street homelessness across the entire state by 2025."

The City of Sydney has signed a memorandum of understanding to work with the state Government and the Institute of Global Homelessness to pursue the targets, providing $100,000 in seed funding to St Vincent de Paul Society NSW to set up the institute’s headquarters in Sydney.

Sydney Lord Mayor Clover Moore said: "While homelessness is a state Government responsibility, the City has been working to help people sleeping rough in the city for over 30 years. In our experience, the single most significant driver of homelessness in our city is the lack of social and affordable housing.

"Less than 1 per cent of houses and apartments built in Sydney in the past eight years are affordable. Without urgent action to provide housing in the inner city, the efforts of this initiative will simply not work."

Vinnies NSW CEO Jack de Groot signs on as a key partner to fight homelessness in Sydney and across New South Wales.
Hunter researchers hoping for a cure

The Hope4Cure Foundation and Calvary Mater Newcastle public hospital have joined forces to support women and their families experiencing ovarian and gynaecological cancer in the Hunter region.

Hope4Cure was established after founder Sarah Frith's cousin, Trish, died from ovarian cancer in 2015 after a late diagnosis. The foundation's purpose is to support locals fighting gynaecological cancers by raising funds for research and clinical trials, as well as raising awareness to assist with early diagnosis.

Following a $40,000 donation from Hope4Cure Foundation, Calvary Mater Newcastle launched a special grant to help bolster research in ovarian and gynaecological cancer.

Dr Jennette Sakoff, Calvary Mater Newcastle’s chief hospital scientist medical oncology, and her collaborator Professor Janice Aldrich-Wright from Western Sydney University are the recipients of the inaugural Hope4Cure grant fund. The funds will go towards a project to pursue the development of new platinum-based molecules for the treatment of ovarian cancer.

"Platinum-based compounds have been used for the treatment of cancer since the 1960s. These agents kill cancer cells by binding to DNA," Dr Sakoff explained.

"However, they do have side effects such as kidney and nerve toxicity, and cancers do become resistant to their use over time. To overcome these problems, we need to discover agents that function differently and which only target the cancer cells and not healthy cells."

The researchers have discovered a unique class of platinum-based compounds that are different to the standard platinum-based, intravenous chemotherapy treatments.

"These compounds are very selective at targeting ovarian cancer cells. Indeed, they are 1,000 times more potent at killing ovarian cancer cells grown in the laboratory compared with non-cancer cells and cells derived from other tumour types," Dr Sakoff said.

"The funds will be used to understand why this occurs and how we can exploit this for the development of better treatments for ovarian cancer."

Ms Frith said Hope4Cure Foundation is “so pleased” to be able to support local research to combat ovarian and gynaecological cancer.

“We are fortunate to have the unwavering support of the local community, who have supported our fundraisers,” she said.

Ovarian cancer has the lowest survival rate of any women’s cancer. Each day in Australia, four women are diagnosed with the disease and three will die.

“We need to discover agents that function differently and which only target the cancer cells and not healthy cells.”

– Dr Jennette Sakoff
The spiritual challenge for us now is not to deny the evil but to face it and still maintain our joy and involvement.
How do we face evil and maintain hope?

by Fr Noel Connolly / Priest of the Missionary Society of St Columban

The recent conviction of Cardinal Pell has troubled many of us. As a Church founded to care, love and support the “little ones” and the vulnerable, we feel for the survivors and their families whose pain we are coming to appreciate. We also feel for all those who care for the Church and are saddened, confused and lost, with an increasingly crushed hope in the Church. The spiritual challenge for us now is not to deny the evil but to face it and still maintain our joy and involvement. We are forced back on our faith and the hope we find in Jesus’ life, passion and death.

Jesus was conscious of the power of evil and open to the suffering of the people he met. He did not retreat into a private spiritual world where he could be intimate with God but closed to the suffering that faced him daily. On the other hand, he was also known as someone full of life and hope.

Jesus came to live, not to die, and he came that we might have life and have it to the full (Jn 10, 10). From the beginning of his ministry, he was conscious of two things: the power of Satan and the fact that something radically new and wholesome was happening, “The Kingdom of God is at hand” (Mk. 1, 15). His whole life was a struggle against anything that would stifle life – especially for the marginalised, whom he loved.

Jesus did not choose to die. He was killed because of a life of generous, courageous and uncompromising love. He chose to defeat the powers of darkness not by force but by suffering evil, and not allowing it to define or determine him. Like Isaiah’s Suffering Servant, he did not fight back. He did not “put out the flickering flame or crush the bent reed”. He continued to love.

Jesus’ resurrection is not primarily about life after death, but about life before death. It was a vindication of his way of living and loving. It does not take away pain, betrayal or death but it empowers us to face these things and live. It enables us to both confront the evil of child abuse and at the same time discern our way to the future.

Our experience of sin and shame may be a better launching pad for renewal as it reveals our need for God and others. It gives us a special openness to God’s love without which we cannot face evil and at the same time love generously.
26–27 AUGUST 2019

2019 GOVERNANCE SYMPOSIUM

Novotel Manly Pacific

Supporting fidelity to mission and Catholic identity

Catholic Health Australia hosts its biannual conference for those entrusted with Governance of Church Ministries.

For further information contact Deborah Reynolds – deborahr@cha.org.au

www.cha.org.au