Catholic Health Australia

HEALTH MATTERS

2022 NATIONAL CONFERENCE EDITION

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CONTENTS

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Acknowledgement of Country

Catholic Health Australia acknowledges and pays respect to the past, present and emerging Traditional Custodians and Elders of this nation and the continuation of cultural, spiritual and educational practices of Aboriginal and Torres Strait Islander peoples.

Catholic Health Australia is the largest non-government provider grouping of health, community and aged care services in Australia, nationally representing Catholic health care sponsors, systems, facilities and related organisations and services. 80 hospitals and more than 25,000 aged care beds are operated by different bodies of the Catholic Church within Australia. Approximately 50,000 home care and support consumers are also supported. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to all those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services.

Further detail on Catholic Health Australia can be obtained at www.cha.org.au

A MATTER OF LIFE AND DEATH

AUTHOR: Mark Green, National Director Mission Calvary

We all know death is a certainty, so planning for end-of-life care needs to become a routine part of our health planning – ideally when we are healthy.

Unfortunately, many fail to prepare for end-of-life for a variety of reasons, such as: a disregard for their mortality; misinterpretation of medical advances; the institutionalisation of dying and death; and misinformation and fears surrounding palliative and end-of-life care.[2]

To help deal with the issue Calvary Health Care and its partners, Mercy Health and Catholic Cemeteries + Crematoria, launched the I Am Living public awareness initiative in May, 2022, as part of Palliative Care Week.

I Am Living aims to help people to better consider what living the last period of life can be like in contemporary Australia. Its strategy is to further support the education of the public about the personal and highly varied complexities of the psychological, cultural, social, spiritual and medical journeys of individuals navigating their own end-of-life journey, together with the significant people in their lives.[2]

I Am Living's key message is that each and every person matters to the last moment of their life, and its call to action is prompted by the question: What are you waiting for?

The initiative encourages us to have open and honest conversations and engage in timely planning about palliative and end-of-life care, dying, death, loss and grief.

IAmLiving.org.au centres on a series of short documentaries that feature honest and authentic conversations with people living with an advanced terminal illness. They speak about the things that matter to them as they face their own mortality. Their stories show that hope-filled and positive experiences are possible, even in a hospital bed.

To see the documentaries visit iamliving.org.au/stories.

Palliative care

Those who work at the heart of palliative and end-of-life care recognise that suffering is a condition with multi-faceted, complex and notoriously difficult to identify causes, especially when approaching the end-of-life.[2]

This is because it is not only physical pain and other bodily symptoms of disease that may need addressing, but also symptoms associated with psychosocial, cultural and spiritual issues, interconnected with the natural process of confronting the reality of our own mortality.[2]

Palliative care's value is understood by many. Yet the attitudes of those who have so passionately advocated for reform have been largely ignored at the community's peril.[2]

Addressing suffering involves taking care of issues beyond physical symptoms. Palliative care uses a team approach to support patients and their caregivers.

Razak Mohammed, an I Am Living initiative contributor, observes: "They came up here this two nurses. Joff [partner] explained to them all these difficult pains he is going through and they just

took us through… this is what you do, this is what you can't do, you shouldn't have this…It was so easy. I was asking them why everyone can't speak the same language. Why is palliative care better at advising us and why can't the GP have the same knowledge? Because this is all new to us, you really do not understand what other medicines do and the ways and means that you can actually have a better life. [Palliative Care] has been wonderful."

Conversations and planning

Although significant advances in medicine have meant that, on average, people can expect to live longer and healthier lives than previous generations, this is not the case for everyone.

While some people will live for years or decades with a life-limiting illness, others may experience a sudden and unexpected death, or become unresponsive and therefore unable to make and communicate decisions for themselves.

It follows that because the moment of death cannot be predicted with any accuracy, planning for dying, death and loss has to take place, ideally, when we are still healthy.

Dr Frank Brennan AM, a palliative medicine physician of Calvary Health Care in Sydney, is part of a group supporting the development of I Am Living.

"As tempting as it might be, don't shy away from these conversations," Dr Brennan says. "Navigating these discussions is particularly crucial if you have elderly relatives, or anyone with a terminal illness."

"It is good for a person facing death in the near future to be able to express their feelings, and for them to have the opportunity to share their feelings before it is too late."[1]

"I am not afraid to talk about it, and it does not diminish me in any way," says Joff Chappel, a campaign contributor. He adds, "Razak [partner] and I went down to Michelle's [best friend] house and spent two nights there, and we just talked about it. We resolved a whole lot of stuff. I am not afraid to talk about it, and it does not diminish me in any way. I am just sick. When I am gone, there will not be a major outpouring of grief because so much of the work has been done. The planning of actually dying has been done."

What to discuss

Dr Brennan says these conversations should extend not just to the end-of-life care people would like to receive, but also their wishes documented in their will, and their final resting place.

"Whether they would like to appoint an enduring guardian or financial attorney is another important conversation to be had," he says.

"Whether the conversation occurs spontaneously, or it is scheduled ahead of time, depends on the family relationships. It can be done either way, as long as it is a conversation had face to face, sitting down quietly together."

"As you get started, you may feel like you need to leave the conversation and ensure your loved one has some normalcy for a while before continuing on," Dr Brennan says.

"It's not about pushing or insisting someone tell you things before they are ready. It is about being there for them and showing that you are willing and able to talk about difficult things and ensure that their wishes are fulfilled."

Our invitation to you

The I Am Living partners are committed to building this initiative and welcome the participation of other individuals and organisations.

Through an I Am Living partnership, individuals and organisations can contribute to end-of-life public awareness and further education, the normalisation of discussions and planning around palliative and end-of-life care, and improved palliative and end-of-life care and bereavement services. Activities may include the following:

- Contributing to the development of brief documentaries (i.e. patients, residents, clients, carers) which acknowledge the authenticity and uniqueness of people's grief, loss, death, palliative and end-of-life experience;
- Demonstrating leadership and commitment in the space through actively contributing to a wide range of I Am Living resources which address current community needs as articulated by the community;
- Engaging clinicians and general staff to encourage patients, residents, clients and the significant people in their lives to access the I Am Living resources as well as seeking and sharing feedback leading to the continuous enhancement of the I Am Living approach and resources based on real community needs; and
- Strengthening and amplifying the I Am Living message across their organisations and networks, using their own communications channels, leading to increased reach and cut-through.

There is a range of partnership opportunities available. For a confidential partnership discussion, please contact the author at Mark.Green@calvarycare.org.au or the I Am Living national manager at Campaign.Manager@iamliving.org.au.

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FIVE MINUTES WITH NEW HEALTH MINISTER MARK BUTLER.

Q. Aside from being appointed Health Minister what is your proudest achievement in your professional life to date?
My election as member for Port Adelaide (now the seat of Hindmarsh) in 2007 was just one of several career highlights. I'm proud of my time in the union movement, where I worked for some of the most disadvantaged people in the community, and my efforts to combat dementia.

Q. And a low point – where you were prompted to think about the direction your professional life was taking you? At times my professional life has taken me away from my family, a situation familiar to many MPs. While this isn't a 'low' point, I recognise I chose a career where I was often required to be physically elsewhere, while my family was in Adelaide, and I appreciate the toll this sometimes took on my family.

Regular bedtime phone calls often filled the gap, and in more recent years FaceTime has become is my 'go-to' for keeping up with the kids while I'm on the road.

Q. The health sector has faced a difficult two plus years over COVID what are your longer-term plans to ensure our health system is ready for the next major shock, whatever that may be? Our health system is clearly under pressure after a decade of a Liberal Government. We are experiencing a GP crisis, and our hospitals are under pressure.

The Albanese Government is investing close to $1 billion in primary care that will directly benefit GPs and their patients. The Government will work closely with health professionals, policy experts and state and territory governments to ensure Australians can get the care they need and keep them out of hospital.

The Albanese Government has also committed to improving pandemic preparedness and response by establishing an Australian Centre for Disease Control. The CDC will ensure ongoing pandemic preparedness and boost Australia's response capacity, strengthen prevention, improve communication, and enhance national coordination and collaboration across all levels of government. Over coming months, there will be extensive opportunities for wide consultation on the establishment of the CDC.

We are also acting to take the pressure off our hospitals, and our exhausted doctors and nurses, by creating 50 Urgent Care Clinics. These Urgent Care Clinics will treat things such as sprains and broken bones, stitches and glue for cuts, wound care, minor ear and eye problems, and minor burns, freeing up hospital resources for emergencies and acute care.

Q. Private health insurance participation continues to hover below the 50% mark and health inflation is on the rise. Do we need to review the way that we fund our private health system? A number of reviews are already underway to identify options to improve the affordability and value of private health insurance. Those reviews are scheduled to report in the coming months, and I will carefully examine the findings and recommendations.

Q. Do you have a view on where and how the $1 billion-plus of unclaimed funds that are on the private health funds' balance sheet should be directed? The premiums collected should be used by insurers to fund health care services for their members and, consistent with their public undertakings not to profit from COVID, to continue to return excess funds to their members.

I have asked my department to continue to monitor the appropriate use of these funds.

Q. What keeps you up at night? Our baby Charlie, born in early 2022. I may have bragged to colleagues what a great sleeper he was, but karma in the form of four-month sleep regression came for me!

Q. How do you relax? I wind down by spending time with my family, catching up with friends and reading.

TOWARDS NET ZERO EMISSIONS.

AUTHOR: Dr Kate Charlesworth, Climate Council

Recent events in Australia and around the world are confirming what scientists have told us for decades: human-generated carbon dioxide is destroying our planet.

This year's federal election also showed us that most Australians now understand this, and are demanding their newly chosen leaders do something about it.

The problem is that we have left it so late the planet's carbon sinks are almost full.

Sea and air temperatures are rising, weather and rain patterns are changing, arctic ice sheets are melting before our eyes, and we're in danger of hitting climate "tipping points" that will precipitate catastrophic climate breakdown.

So, the time for talk and climate inaction is over. Right now, every organisation in every section of the economy must work to decarbonise itself and, by extension, its clients.

The health sector has a particular responsibility to decarbonise.

First, we are a large polluter: globally, if the health sector were a country, it would be the fifth biggest polluter on the planet

In Australia, health sector emissions are 7% of our national CO_2 emissions.

That's a staggering figure, when you consider recent reports put AGL's coal and gas-fired power stations – usually regarded as among our biggest environmental villains – as accounting for 8% of the nation's CO_2.

Second, moving to cut health sector carbon emissions and aiming for net-zero goes well beyond us "just doing our bit". Because the climate crisis is a health crisis.

For example, the US Centers for Disease Control recently noted:

- Extreme heat events will cause heat-related illness and death, and a rise in cardiovascular failure;
- Severe weather will lead to more injuries, deaths and mental health stress;
- Environmental degradation will lead to civil conflict and mental health impacts;
- And degraded water and air will create more disease, exacerbate common conditions such as asthma and allergies, and lead to malnutrition in less-fortunate nations.

Even if we forget CO_2's effects on our climate, acting to cut emissions will also improve our health.

For example, research led by Harvard University last year found that fossil fuel air pollution (from coal, oil and gas) was responsible for more than 8 million deaths globally – the same number as from cigarettes.

So, while we hope the rest of the world gets its act together, how do we in the Australian health sector work to net zero, and help to save the planet?

Basically, we need to address everything about how we operate and how we deliver our services.

This includes how we use and develop our energy, transport and infrastructure systems, and even how we deliver clinical care.

By one measure of Australian health care's carbon emissions, only a fifth come from buildings, electricity and gas.

The rest come from clinical care, with clinical care "carbon hotspots" including pharmaceuticals, medical devices and equipment.

It's a Herculean task, and Australia is a long way behind international leaders in the United Kingdom, Europe, some parts of the US.

But we must act, and the UK's Greener NHS may be a good starting point.

For example, the Royal Berkshire NHS Foundation Trust, through its main site, the Royal Berkshire Hospital in Reading, serves more than a million people across Berkshire and south Oxfordshire

Royal Berkshire recently posted a list of actions it has implemented based on Greener NHS.

These included:

- Appointing a board member solely responsible for the trust's net zero targets and a green plan;
- Purchasing 100% renewable energy;
- Reducing surgical use of desflurane (a common anaesthetic gas that has a huge greenhouse impact. A bottle has the same global-warming effect as burning 440kg of coal);
- Developing plans for prescribing lower carbon inhalers;
- Only buying or leasing cars with ultra-low or zero emissions, and developing a green travel plan to support active travel and transport.

Royal Berkshire also developed a minimum standard aiming for 25 per cent of its outpatient care to be delivered virtually, and increasing the ability for staff to work remotely, both resulting in direct, tangible cuts to carbon emissions.

It's also worth noting the NHS used its considerable influence to put pressure on organisations outside its direct management, forming partnerships with some of its biggest suppliers who have since pledged their support for a Green NHS.

The climate emergency provides an urgency to take steps such as these, but it is also an opportunity to build an even better health system, as sustainability is so well aligned with other objectives such as a focus on wellness and prevention, providing care closer to/in the home, innovation, and digital advances.

And of course, more broadly: a cleaner climate will have huge public health benefits: cleaner air, healthier diets, greener and cooler cities.

But whatever we do, we must do it now. As the US Special Presidential Envoy for Climate John Kerry said of climate change last year: "This is existential, and we need to behave like it."

VIRTUAL HEALTH CARE PUSHES THE BOUNDARIES.

AUTHOR: Vanessa Janissen, National Director – Strategy & Service Development Calvary

COVID has taught health systems in Australia, and around the world, the art of the possible in terms of virtual care.

Calvary has sustained the compassionate and high-quality delivery of health care for 136 years by adapting our service delivery to meet the changing needs of Australians.

In 2019 Calvary began an ambitious growth strategy to expand and enhance the way we deliver care. The strategy recognises the increasingly transformative effect digital technology is having on the healthcare industry and led to the formation of a joint venture between Calvary and Medibank.

Digitally enabled hospital care in the home

On January 25, 2021 the joint venture began delivery of the My Home Hospital program, on behalf of Wellbeing South Australia, using a centralised Virtual Care Centre (VCC) established in Calvary Adelaide Hospital.

The VCC coordinates the care for patients remotely and in-person visits from care providers. Patients receive a pack that includes a pulse oximeter, blood-pressure machine, thermometer, weight scales and an iPad, to enable interaction with the VCC to support their individualised care.

The feedback from patients is that the home setting imparts greater participation and control over their care:

> *'I had the iPad and the equipment to do the obs. My daughter helped me. The service did what they said they would and followed up with phone calls and nurse visits. What I liked most about the service was being at home in my own environment. The nurses were always on time and were very good. My daughter helped and my partner helped. I would most definitely use this service again. I would recommend this service for everyone. It was great. They should do it more often. A lot of people don't like going to hospital and would rather stay at home. That way they could save the bed for someone else with more serious injuries.'*

Patients, their carers and loved ones are supported by a specialised team devoted to assisting them, including supporting their digital literacy through the use of technology.

> *'The tech was very clever. I'm computer literate but I've been out of the industry for some time so am not fully up to date with the latest stuff. It was intriguing to be able to take my own obs. The doctors and the video calls were excellent. I had a lot of fun trying to line my foot up with the camera! I'm absolutely delighted with it and I've been telling people all about it. My cousin in Victoria was amazed. I can't speak too highly of the service.'*

From January 2021 to March 2022 My Home Hospital has provided care to more than 3493 patients. It has demonstrated high quality and safety, with a lower rate of reportable hospital-acquired complications than traditional hospital settings. And patient care experiences are very positive, with 90% reporting that the quality of their treatment was either "very good" or "good".

Introducing COVID Care at Home virtual care, in step with the broader health eco-systems

In 2021, in light of the continued challenges brought on by the pandemic, the Calvary-Medibank joint venture built on the VCC capability to establish COVID Care at Home (CCAH), a virtual hospital service for COVID-positive patients.

The first CCAH program launched in August 2021 on behalf of Western Sydney Local Health District, following a one-week co-design period.

CCAH offers a full suite of care from triage assessment through to discharge from isolation. It includes adult and paediatric patients, supporting low through to high-risk categories of disease, with a minimum of a daily phone call, and monitoring using biometric devices such as pulse oximeters and thermometers.

Care is provided by a multi-disciplinary team including non-clinical, nursing and medical staff. Importantly, the program supports links to broader social needs such as food, medications, mental health services and welfare checks.

Ability to scale up rapidly to meet consumer demand

During September to November 2021 the program needed to rapidly expand its workforce to accommodate the various outbreak waves, peaking at about 500 full-time equivalent employees contacting more than 3000 patients a day.

While health systems struggled to attract a clinical workforce, CCAH was able to readily engage staff looking to explore virtual-care employment, given the roles offered respite from front-line challenges and potential exposure of the staff and their families.

On December 20, 2021 Queensland Health contracted the joint venture following the opening of borders and a surge in infection rates higher than the Queensland public health and hospital systems could handle. A highly collaborative and rapid co-design process enabled the first patients to be admitted to the service four days later on Christmas Eve.

Introducing AI to rapidly escalate critical patients

In early January 2022 it became clear that the demand being created by Omicron would outstrip the newly created joint capacity.

Foreshadowing this crisis, the CCAH team partnered to introduce a digital assistant using bot technology. This artificial intelligence tool supported our human workforce by making initial screening calls to patients, using short "clinician defined" questions. This allowed the service to quickly identify higher risk vulnerable patients and stream them more rapidly to clinical and social support programs.

More than 65% of patients contacted completed their initial risk screen this way, with more than 90,000 adult and paediatric patients screened during the first five weeks.

Meeting the needs of rural, remote, CALD and ATSI communities

In early January 2022 the joint venture began COVID support for Western Australia.

Given WA had no prior experience with COVID it was even more important to work in collaboration with the broader system to design, educate and co-deliver a service to meet the specific needs of the jurisdiction. This included taking into consideration a model that could support the very large geography and diverse population, including rural and remote populations that did not have ready access to hospital facilities, and Aboriginal and Torres Strait Islander communities that were hesitant in accessing services.

To date the program has been referred more than 20,000 patients with a pleasing 20% being from indigenous communities. This compares favorably with 4% of the WA population identifying as ATSI.

Recently the service has begun supporting patients requiring anti-viral medications for disease-modification treatment and who do not have access to a general practitioner. Our partner GPs assess these patients and prescribe their important medications through telehealth.

> *'I would like to say thank you for your calls during my time in isolation with COVID. Being an aged person on your own can be frightening especially with COVID. But I was able to do my own check with temperature, oxygen pulse and diabetes which was very useful. Put my mind at ease, so I was able to make a good recovery. I experienced mild symptoms which was managed. I was prescribed anti-viral capsules which helped. I was supported by my local doctor, Aboriginal Health and your services. I'm very happy with receiving the daily calls to monitor my health. Thank you again.'*

COVID Care at Home, since commencing in August 2021, has now supported more than 179,000 patients in communities across NSW, Victorian, Queensland and WA in their homes, caring for them at their most vulnerable, in isolation with a disease with varying effects.

A key learning from this experience is that agile, scalable and effective virtual health care doesn't come from the traditional commissioning and procurement processes. It requires system players (public and private) to engage in co-design and co-production, to create better experiences and outcomes for patients and staff.

AUSTRALIA'S FIRST PRIVATE WOMEN'S MENTAL HEALTH SERVICE.

AUTHOR: Sharon Sherwood, Chief of Mental Health & Cabrini Outreach

SEPTEMBER 2021 MARKED THE OPENING OF AUSTRALIA'S FIRST PRIVATE MENTAL HEALTH FACILITY DEDICATED TO THE CARE AND RECOVERY OF WOMEN WITH MENTAL ILL-HEALTH.

Unlike other mental health services which are often hidden behind other buildings and secluded from other services, this facility is at the heart of the Lisa Thurin Women's Health Centre at Cabrini Elsternwick, 25 minutes from the Melbourne CBD. Cabrini Women's Mental Health service (CWMH) offers ground-breaking treatments and programs, taking a new lens on how mental healthcare should look. CWMH service looks to further Cabrini's mission to provide compassionate care for people in need, through the values of compassion, integrity, courage and respect.

Opening a new facility during the height of a global pandemic of course provided a new set of challenges never before seen by the health care sector. There was a decrease in recruitment of specifically trained mental health clinicians, including psychiatrists, mental health nurses and allied health. However, the COVID pandemic also helps people to reaffirm their values, and understand what they want out of life, resulting in more staff seeking part time work.

Despite these challenges, we have been able to create something special. Mental health professionals are disillusioned with the current

mental health service system. They come to us looking to create change, to provide clients with the high-quality care and respect that they deserve. We hope to attract this demographic of staff to help rebuild the fragile mental health system.

The historic building offers a homely 30-bed inpatient unit, inviting clients to feel safe and welcome when starting their journey towards recovery and wellness. It is staffed by a multidisciplinary team which includes women specialist psychiatrists, mental health nurses, mental health allied health, support staff and volunteers. Following a stay at our inpatient facility, clients are supported to engage in our eight week day program, helping them to develop and refine skills for living well in the community. Our short stay bundle of care is one of a kind in Australian private healthcare and teaches women skills to manage their symptoms so that they can live a meaningful and fulfilling life.

We work under the principle that women experiencing acute phases of mental illness have an effective response to treatment, higher quality outcomes and better overall wellbeing when they receive treatment in a women's-only facility, with treatments and programs that are individualised to the needs of women and the characteristics of the illness that is specific to women. The following principles underpin everything we do:

Client-centred care is an approach in which clients are viewed as whole persons; it is not merely about delivering services where the client is found, as happens in most mental health services today. Client-centred care involves advocacy, empowerment, and respect for the client's autonomy, voice, self-determination, and participation in decision-making.

Recovery-focussed means different things to different people and is personally defined by the woman. This involves an integrated approach addressing a range of factors that affect wellbeing, such as housing, education, employment, family and social relationships. It encourages self-determination and self-management of mental health and wellbeing and works with principles of change. A holistic approach means to provide the support that looks at the whole person, not just their mental health needs. A woman is more than just her mental ill health. The programs and treatments offered to consider the woman's physical, emotional, social, cultural and spiritual well-being are reflected in the programs offered.

Trauma-informed care understands and responds to the impact of trauma and creates opportunities for survivors to rebuild a sense of control and empowerment. Many people who have mental ill health have also experienced some sort of trauma in their lives. Trauma informed clinicians work with hope, optimism and unconditional positive regard, to create safe, respectful and trusting relationships, while also embracing the power of choice and collaboration.

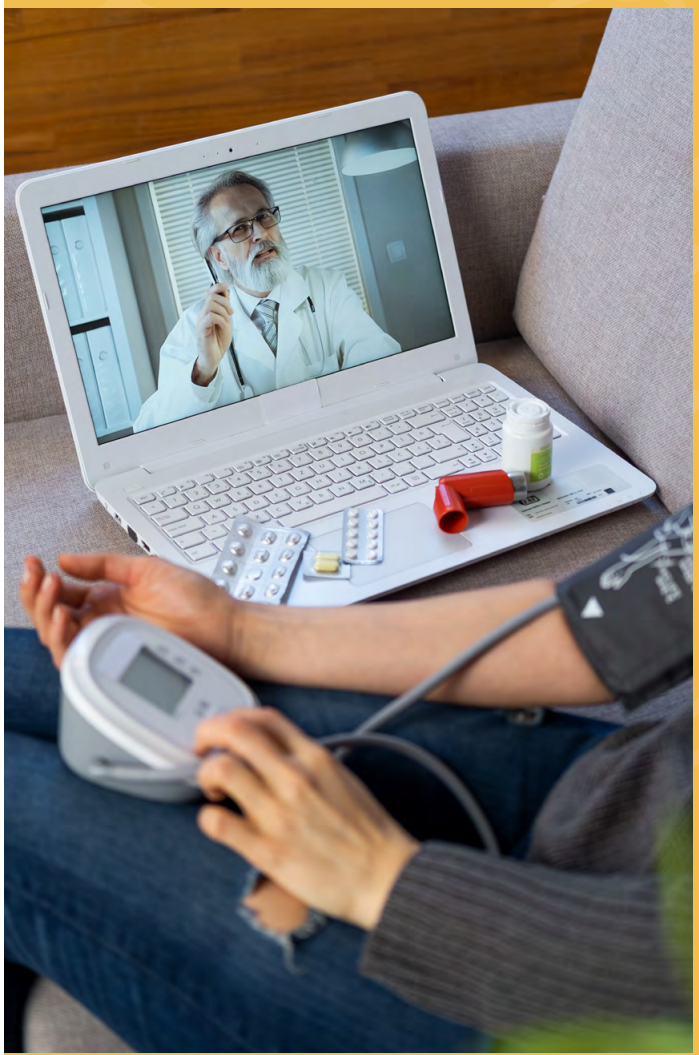
Through our women's mental health service, Cabrini is working to revolutionise mental health. By highlighting the disparity in specialised services, we work not only to better every patient's health but to change their life by the time they are ready to walk out of our doors. We take a contemporary approach with the integration of traditional values that will transform the local community and hopefully inspire a shift in healthcare worldwide. Cabrini was not the first organisation to understand the complexity of women's mental health, but we are proudly the first to target our care and make a difference.

ADAPTING TO FUTURE TRENDS IN HEALTHCARE.

AUTHOR: Alex Lynch, Health Policy Manager - Catholic Health Australia

The COVID pandemic has seen the acceleration of relatively new trends in health care, some of which will have a disruptive impact on how patients expect to have their health needs met.

Increasingly patients have and will seek access to information about quality, service availability and price in a manner that is more transparent and accessible than has previously been typical for the health sector. We've listed a few of the trends health care providers will need to contend with in the coming years in order to meet the needs of their patients.



Telehealth

Telehealth is not new. Forms of digital access to health services have existed for decades. However, services were expanded dramatically throughout the COVID pandemic out of necessity – it was often not safe to receive healthcare in person that might risk transmission of the virus. The Commonwealth Government greatly expanded access to Medicare-supported GP, specialist, nursing and allied-health services via telehealth soon after lockdowns were implemented across Australia. Recognising the ongoing expectation from Australians that Telehealth services would be offered, both the Commonwealth and state governments as well as private providers are expanding the range and type of Telehealth services available on a permanent basis.

Virtual care

COVID saw existing health services ranging from tertiary hospitals to small clinics stand up 'virtual hospitals' – entire service units dedicated to treating patients remotely. Both public and private providers are using virtual hospitals to manage COVID patients at home, in many instances providing 24/7 access to a health team. However, the option is in no way limited to patients with infectious diseases, with increasing access for palliative care patients, oncology patients, and routine GP appointments. Internationally, entire hospitals are being set up purely to provide virtual care as part of a broader care network.

Wearables (and swallowables!!!)

Health service providers have begun using patient-owned devices to help monitor health. This ranges from heart rate sensors on smart watches to diet tracking in apps and even swallowable capsules to monitor and diagnose issues with gut health. Patients are increasingly able to monitor elements of their own health with widely available technology, and are looking for their health service providers to incorporate this information into their care. While apps to track diet, periods and alcohol consumption are not new, their incorporation into routine care is increasing. They are also beginning to play a role in how health is funded, with insurers in Australia and internationally showing a willingness to offer incentives to patients who can prove they are leading a healthy lifestyle.

Primary care and prevention

It has long been understood that effective preventative health, with a focus on primary care delivery, is preferable to a higher volume and severity of acute episodes requiring expensive hospital treatment, generally with worse health outcomes. While governments recognise this reality, it is often poorly reflected in the design of health systems, which focus on acute treatment.

This shows in the structure of the private health sector, which to a large extent limits private providers ability to engage in preventative health, particularly primary care (privately-owned GP clinics being the main exception). Both insurers and large health service providers are increasingly focused on how to improve the overall health of their patients and limit their acute admissions – to the benefit of both the patients' health and budgets. However, this is challenging in a system that was not set up to prioritise funding for preventative health care and is leading to more persistent calls for reform.

Price and quality transparency

Quality measures are increasingly baked into funding arrangements for both public and private hospitals. Working together, the Australian Commission on Safety and Quality in Health Care and the Independent Hospital Pricing Authority are implementing a suite of incentives for improved quality in health service delivery.

Examples include funding implications for hospital acquired complications and avoidable readmissions. Similar programs will be featured in contractual arrangements between private health funders and providers at higher rates in coming years.

There are also calls for improved transparency in pricing structures offered by insurers, hospitals and doctors. The Commonwealth Government recently launched a (voluntary, for now) price transparency website for specialists to show their prices for a given procedure or service. It is not difficult to imagine a 'Yelp! for doctors/hospitals' emerging in the near future – it may become broadly accepted that patients can rate their experiences. This in turn leads to...

PROMs and PREMs

Patient-reported outcomes and experience measures are finding a place in measuring the quality of health service delivery, for both improvement and funding purposes. PROMs and PREMs can include measures like self-assessed short and long term clinical outcomes – a patient's perception of their own health, as well as how they felt their health service provider treated them and what their experience was like. It is important that patient experiences are a focus for health service delivery, though using these experiences as a performance metric will present a challenge for health services going forward.

THE MISSION OF CATHOLIC HEALTH: 2022 AND BEYOND.

AUTHOR: Brigid Meney, Director of Strategy & Mission - Catholic Health Australia

Faith based health providers play a significant role around the world, and the Catholic health, aged care, and social services footprint in Australia speaks to the importance of our sector.

But as the world, the church and indeed health care changes, it is worth examining what makes up our Catholic Identity, why it is relevant, and the commendable works being undertaken by providers that contributes to our Catholic identity daily.

Much has changed since the five Sisters of Charity endured months at sea to travel to Australia and founded St Vincents Hospital in 1857. Or since Venerable Mary Potter responded to Cardinal Moran's request for help and sent half a dozen Little Company of Mary Sisters to Australia, who began caring for the frail within a day of arriving. Or since the Sisters of St John of God followed their calling from Ireland, all the way to the Goldfields of WA to tend to the poor in 1896.

Certainly, there is a more comprehensive interest by governments in the health and wellbeing of populations since those early days of Catholic health, with universal health care and public funding available. Governance changes have also led to an increased role of the laity in Catholic health, as committed individuals have increasingly stepped into the sizeable shoes of the religious orders who pioneered Catholic health across the country. And although bold, it may be that the public perception of the Catholic identity or Christianity generally even, is somewhat less revered than it was in the mid nineteenth century.

When considered in this context, the nature of Catholic identity can bring about a range of responses. Some view it as the adherence to certain theological practices or the prohibition of certain practices, or the presence of religious symbolism within our facilities. These are certainly elements of Catholic identity.

However, one enduring fact remains in our Catholic identity despite the changes, that bears the same relevance today as it did to the sisters who ventured so far from home 150 years ago. The belief of God's love for every person and the healing ministry of Jesus. It was this mission that inspired the Sisters of Mercy to go directly to the source of a fatal influenza outbreak in Melbourne, and found a hospital in 1920. And it is this mission even today that inspires so many Catholic health providers to look for the gaps, and service those in need even throughout our own recent pandemic.

Because even with Australia's universal healthcare system, we know there are still significant gaps that Catholic health providers identify and work to rectify daily.

During the Covid pandemic St John of God Accord has worked tirelessly to protect and service the needs of a vulnerable population of those with lifelong disabilities, at significant risk from the virus. St Vincent's Hospital Melbourne established the first mass vaccination hub at the Royal Exhibition Centre, which eased some of the serious accessibility issues individuals were facing in protecting themselves during the pandemic.

Calvary has recently launched their "I am Living" campaign, which promotes open, honest conversations on the meaning of life, particularly from the perspective of those with a terminal illness. Mercy Health continues to provide the only breastmilk bank in Victoria, providing hundreds of vulnerable babies annually with safe, screened, and pasteurised nourishment.

Catholic Health Australia is routinely inspired by the work of our members and the Catholic health workforce, who live out this healing mission, with their sights set on caring for all with a focus on the vulnerable. This work drives our own social justice advocacy, focused this year on mental health reform, incarceration health and social services, and the culturally and linguistically diverse communities. It has inspired us to review our own commitment to sustainability and commence the development of a Reconciliation Action Plan.

Despite advancements and progress, there will always be more we can do. We need to always be looking for the gaps; who is missing out on God's healing and how can we help. This will ensure the legacy and relevance of Catholic health ministries into the future.

HEALTH'S VISION FOR COMPASSIONATE CARE MUST CONTINUE.

AUTHOR: Caitlin O'Dea, Health Policy Director - Catholic Health Australia

Over an extraordinarily difficult past few years we have seen firsthand the health sector pulling together and delivering exceptional care under the most trying conditions.

The private health system should be extremely proud of our collaborative approach and the hard work that helped Australia navigate a path out of Covid-induced lockdowns and largely back to pre-pandemic life.

It has not all been sunshine and rainbows. Elective surgery being turned on and off like a tap, two plus years of compounding healthcare worker burnout, health inflation in the double digits and cascading supply chain disruptions have exacerbated pressures on the private health sector.

On top of this, there are issues with private health insurance coverage, uptake and spiralling premium costs as younger people increasingly opt-out.

This is an opportune time for the Catholic not-for-profit sector to shine.

Catholic hospitals have been operating in Australia for more than 165 years. A lot has happened in that time, and Catholic hospitals have continued to advocate for the disadvantaged and marginalised, often in the face of structural oppression and against the wishes of powerful people and institutions.

Catholic hospitals' history is one of young women combining nursing with social transformation. They articulated a vision of care for the marginalised and vulnerable, and lived their values by establishing some of the most enduring healthcare entities in the country, and indeed the world.

We must re-embrace that vision and strive for better. Our private healthcare system needs reform. Not tinkering around the edges, but significant structural reform.

For too long private health insurance reform has been mistaken for private health system reform.

The private health system is an interdependent triangle with healthcare professionals, hospitals, and private health insurers at each apex. True reform must embrace each of these.

Macro and micro reform is needed and we are in a strong position to contribute to both policy discussion and action.

There is no doubt private health insurance regulation has not kept pace with the care patients expect in the 21st Century.

Health insurance that does not universally fund substitutional care in the home is illogical. Out-of-hospital care is the way of the future. Patients want it, hospitals and clinicians can support it, and care can be delivered more efficiently, yet the funding is not there.

Virtual care is growing overseas but regulation and funding in Australia has not kept pace. Pockets of excellence pop up here as hospitals stick their necks out and do the heavy lifting, but this is no way to deliver widespread reform. To truly move the dial these innovations must be enabled and encouraged at a higher level.

We need to ask the bigger questions too: What do we want the private health system to look and feel like in five, 10 and 20 years?

Do we envisage a dual system where the purpose of private health care is to complement the public system, or one in which it is a substitute? Has the silo of primary care been bought into the fold, and can we deliver preventative care in a holistic way to give people support before they deteriorate to the point of being patients? What are the design features of that system in our minds' eye, and what regulations and incentive structures do we need to get there?

There is lots to do. There is also no one better placed than us to be a trusted partner, leading the way.

Catholic not-for-profit hospitals can articulate an authentic vision for compassionate, best-practice care. We can celebrate delivering a spectrum of care to the the community. We offer healthcare workers a career in purpose-led organisations that advocate for equity of access and outcomes. We offer cradle-to-grave care to patients and life-long employment with purpose.

There are absolutely headwinds on the horizon. In fact they are here.

But our hospitals have delivered pioneering care through wars, pandemics, social unrest and everything in between. We have earned our seat at the table and are ready, able and eager to work with all stakeholders to build the private health system of the future.

FROM TEA CART TO SECTOR SAVIOUR.

Anika Wells experienced aged care's humanity and compassion while working in the sector as a student. Now, as its new Federal Minister, she is determined to change it for the better. She speaks to Health Matters about the challenges ahead.

Q. In your inaugural speech you made much of being a millennial, but you clearly have an affinity for older Australians. Where does that come from? Older Australians have done so much for our country. Generations like mine haven't had to deal with global conflict and incurable childhood diseases, intense food shortages and other hardships. I'm grateful to previous generations for building this great nation for us to enjoy.

In terms of my passion for fixing the aged-care system, we're only doing what everyone wants for themselves and their families – restoring security, dignity, quality and humanity.

Q. Do we have a problem with ageing in Australia? Are we in awe of youth to the detriment of the elderly? I'd have to disagree with you here. In my experience as the member for Lilley, where I have seven RSL sub-branches, my experience is that Australians venerate older people. That's never more evident than days, such as on ANZAC Day, where we've had growing turnouts at services.

Q. As a child, what did you want to do when you grew up? In Year 12, I wanted to either go into politics or psychology because both are about helping people. Meanwhile, in my high school yearbook I was voted most likely to be first female Prime Minister. Obviously Julia Gillard beat me to it but, as it happened, I got to work with Julia briefly, we got to know each other and she ended up launching my first campaign.

Q. Tell us more about your experience working in aged care? I worked in aged care while I was studying Arts Law at university and I got to experience the humanity and compassion of aged care when it's done well.

I worked in the kitchen and did the tea cart for morning and afternoon tea, going in and out of all the rooms. You get to know everyone's order but you also get to know who has visitors every day and who doesn't get any – that's really stark when you're the person doing the afternoon tea run.

There were some really lovely people in the dementia ward. And I remember a lady called Peg, she had lived in the home for around 10 years. She was one of those real stayers, a bit of a busybody. She used to wheel herself around the centre and come see us in the kitchen and chat to us through the window.

But mostly I remember the workers, these lovely ladies who were mums and worked so hard, earning so little money, and all they did all day was care and demonstrate compassion. That left a lasting impact on me.

Q. You are no longer on the aged care 'shop floor', but from where you stand what has changed since then, for better or worse? I'm excited about seeing fresh ideas in the sector – we can be more ambitious today, I think. There are providers doing really innovative things in aged care now. For example, the Prime Minister and I visited a new facility, under construction in Brisbane, that will be co-located with a kindy.

What's worse today? COVID has really pushed everyone to breaking point. We know people are leaving, some are working double shifts, and we know centre directors are back out on the floor because they can't get staff, and that has an impact on the residents. We know it makes such a difference when people can see their family and friends, and lockdowns make that really hard on everybody.

Q. What did your parents do, and how did that influence you? Mum worked in aged care for 15 years, she was an administrator onboarding people, so she worked with the families. Dad was an accountant at the airport.

It was great to work with my mum, not many people get to do that. They always needed people in the kitchen at the aged care home she worked in, so I signed up. It was a great job for a uni student.

Q. How did you end up in the law doing workers compensation claims? What was the toughest thing (intellectually or emotionally) you had to deal with? I did a gap year in France and that year there were teacher strikes every week. This made me aware of progressive political issues. All these teachers were striking during the week, but coming back and volunteering so the Year 12s wouldn't suffer and would be ready for their Baccalaureate exams

I was always doing debating and stuff at high school, but that experience in France was really formative; watching politics in action and how the teachers made sacrifices for their students.

I studied Arts Law because I felt it gave me maximum options and then I went to work as a lawyer at Australia's leading social justice firm. This gave me the opportunity to try employment law, class action law, personal injuries, superannuation law and more.

The toughest but more interesting work to me was representing people who had been injured at work through no fault of their own, knowing it was going to change the entire course of their lives. If there is negligence you have to sue your own employer and people find that very difficult. The cases take a long time, and you see people's lives get harder and harder across the 12, 24 or 36 months it takes to go to court.

As their lawyer, you're often the hope, the one that's going to fix it for them. It can be a lot of personal responsibility – but that's the same as being a member of parliament.

Q. How did you end up in politics, if it wasn't part of your grand plan from the start?

In 2016, a series of events happened that changed my life. Twenty weeks into my pregnancy with my first child, Celeste, I was diagnosed with an aggressive chronic disease. Because I was pregnant, there wasn't much they could do for me. I got sicker and sicker and was in and out of hospital.

Celeste was born three weeks early and underweight and I had this lightning-bolt moment while lying in hospital, my new baby daughter in one arm, an IV in the other, finally getting the treatment I needed. The TV was on and women in America were marching to protest the new President elect, Donald Trump. I watched the women saying how shocked they were, how they had assumed Hilary Clinton, the Democrats and decency would prevail.

In my hospital bed in Brisbane, I felt like one of those women. Like them, I had assumed that the arc of the moral universe would continue to bend towards justice. I realised I had taken it for granted that things would get better. I resolved then not to take that arc for granted anymore.

So, after discussions with my family and after learning that Wayne Swan would soon retire from politics, I decided I would run for Parliament. I sought Wayne's support to succeed him in Lilley, he mentored me, and I won.

Q. What is the best thing about being in Parliament, and the worst? You will never have a job as dynamic, important and with the ability to create change on a daily basis as being an MP. Whether it's someone who walks into your electorate office who needs you to make a call to the NDIS about their case, or whether it's being the Aged Care Minister and getting to determine the future of one of the most important sectors in the country.

The worst part, of course, is the time away from your family and the toll your absence places on your urban village. We are so reliant on our family and friends, and I am extremely grateful to them.

Q. The workforce issue is key to the future but, realistically, how quickly can it be fixed? Addressing workforce shortages is an absolute top priority of mine, and the ministers I work alongside in this space – Workplace Relations Minister Tony Burke, Immigration Minister Andrew Giles, and my Cabinet Minister, Mark Butler.

We are working together to make sure that we can do everything possible to address this workforce shortage as soon as possible. It's a complex problem that needs a considered solution.

We know that there are so many people who have been part of the care and support sector in Australia who have left because remuneration and conditions are not good enough. And we want to lift wages so that those people want to come back to the sector.

We are making our submission to the Fair Work Commission Aged Care Work Value case by August 8 and expect a decision over summer. We will be guided by the Commission for implementation timeframes.

Q. You have until May 2025 to fix aged care. What would success look like for you then?

This is not a one-term project, it's a generational commitment. It's taken decades to put us into the situation we are in; it's going to take years to build a better future in aged care.

There's hope for people because there's innovation in the sector, and I want to do everything I can to drive more of that.

I also feel a great sense of hope because never before in the history of federation has there been such a groundswell of commitment – fiscally and practically – to reform one sector.

What does success look like? It's an aged-care system Australia can be proud of, and that we can have confidence in for our loved ones, and ourselves.

COVID DOESN'T DISCRIMINATE, BUT ITS SOCIAL AND ECONOMIC IMPACTS DO.

AUTHOR: Tom Barnes, Senior Research Fellow, Institute for Humanities and Social Sciences, Australian Catholic University

Many of us *felt* that the social and economic impacts of the COVID pandemic were unequal and were worse for the poorest or most disadvantaged people in our community. But was there evidence to support these suspicions?

As an economic sociologist at Australian Catholic University, I was commissioned by Catholic Health Australia to find the hard evidence that might support the experience of Australia's most marginalised.

This culminated in *Unlucky in a Lucky Country: How COVID has exposed social inequity,* a research report that provides a comprehensive account of the pandemic's social and economic effects in Australia's largest cities.

Combining insights from health and social service experts with analysis of data collected during the depths of the pandemic from 2020 until 2022, it demonstrates that the material impacts of the pandemic and extended lockdowns in Melbourne and Sydney were highly unequal in terms of household and workplace outcomes.

That is, that the poorest and most marginalised people in Australia's two biggest cities were disproportionately affected by COVID.

The report analyses the unequal distribution of coronavirus case numbers and vaccination rates by locality, as well as the unequal impacts of public health orders and lockdown restrictions.

The pandemic was highly unequal, not just in health terms, but also in terms of social class and ethnicity.

Key findings include:

- Local government areas (LGAs) with the highest proportions of workers in blue-collar occupations and the highest proportions of residents from culturally and linguistically diverse (CALD) backgrounds had the highest case numbers.
- Every 1 per cent increase in blue-collar workers per LGA led to a 0.55 per cent increase in COVID cases. In Sydney, based on the average LGA population, this meant that every percentage increase in blue-collar workers led to 848 additional cases. In Melbourne, every percentage increase in blue-collar workers led to 895 additional cases.
- Every 1 per cent increase in CALD residents per LGA led to a 0.39 per cent increase in COVID cases. In Sydney, this meant that every percentage increase in CALD residents led to 609 additional cases on average; in Melbourne, that figure was 642 cases.

These findings show that coronavirus case numbers were heavily concentrated in some of the most disadvantaged places in Sydney and Melbourne.

In Sydney, blue-collar workers are concentrated overwhelmingly in its western suburbs. Nearly 20 per cent of cases during the "Delta Wave" in the second half of 2021 occurred in the Canterbury-Bankstown LGA in the city's southwest; there was also a high proportion of cases in the Western Sydney LGAs of Cumberland (15 per cent), Blacktown (12 per cent) and Liverpool (10 per cent).

In Melbourne, 19 per cent of cases over the same period occurred in Hume LGA in the city's northern suburbs, as well as high case numbers in other outer-suburban LGAs such as Whittlesea (9 per cent) and Wyndham (8 per cent).

The report's findings also reflect the greater risk and exposure to COVID by many essential workers, including those in blue-collar occupations such tradespeople, machine operators, drivers

and manual labourers, but also many workers in essential industries such as early childhood education and care, aged care and home care.

In contrast, workers in many office-based white-collar occupations or professions were relatively better positioned to work from home during lockdowns.

An unequal vaccination rollout

LGAs with the highest case numbers tended to have the slowest rates of vaccination until late in 2021, well after the worst impacts of the Delta variant had set in.

In Sydney, the fastest vaccination rates tended to concentrate in wealthier LGAs along the city's north shore or in its eastern suburbs. Although vaccination rates eventually caught up across the west, the spatial inequality of the vaccination rollout should be a source of great concern to policymakers.

Melbourne's Hume, the LGA with the highest case numbers locally, had the third lowest full-vaccination rate in the city by late October. Whittlesea, with the second-highest case numbers, had the fourth lowest full-vaccination rate.

Despite falling unemployment figures, the lockdowns in Sydney and Melbourne in late 2021 resulted in sharp declines in total employment, labour-force size and labour-force participation. These were on a similar scale to the "COVID Recession" in 2020.

They were also worse in LGAs with high numbers of blue-collar workers and CALD residents. The size of the labour force in southwest Sydney, where the impacts of the pandemic and lockdowns were greatest, declined by a remarkable 14 per cent in August 2021 alone.

Making matters worse, emergency fiscal measures that saved jobs and prevented wider-scale destitution in 2020, such as JobKeeper and the Coronavirus Supplement, were not repeated during the Delta Wave, and policy responses were much less comprehensive. COVID Disaster Payments, for example, were not directed towards saving business or jobs, or towards most existing welfare recipients, including many poor or vulnerable individuals and households.

In Sydney, the inadequacy of this safety-net was coupled with a distinctively LGA-oriented, often punitive approach to public-health orders. This meant applying lockdown restrictions more stringently in 12 "LGAs of concern".

The report suggests that this spatially unequal approach magnified the social and economic impacts of the crisis in already disadvantaged areas.

The report also shows that economic impacts were worse for women, who experienced a larger fall in jobs and labour force participation. For example, the female labour force in Sydney shrank by 9.2 per cent during the Delta Wave – higher than the 8.3 per cent overall decline.

Women were concentrated in the sectors with the highest job losses such as retail trade, which declined by 15 per cent in Sydney during the Delta Wave, or hospitality and arts and recreation, which declined by 36 per cent each.

Women also shouldered the burden of additional care and household work under stay-at-home orders, including care for dependent children forced to home-school. The mental health impacts of these additional burdens on women have been significant.

The report discusses the impacts on those with a disability, and Aboriginal and Torres Islander people, who were already at an economic disadvantage and who saw their chances of securing jobs further depleted by the pandemic.

These vulnerable groups were meant to be prioritised during the first phase of Australia's vaccine rollout from February to April 2021, but problems in obtaining access and basic resources quickly became clear.

The findings and recommendations in this report are a valuable resource to help policymakers, experts and the public understand ongoing socio-economic impacts, particularly as it concerns the poor and disadvantaged, as Australia transitions into a "post-pandemic" world.

My hope is that the research will help those in leadership understand the likely consequences of policy measures in the event of future pandemics and public health emergencies.

The full report is available at www.cha.org.au

LIFE FOR OUR STAFF UNDER COVID.

As a large, Catholic provider of health care services in three states in Australia, St John of God Health Care has managed the complexity of the COVID pandemic with a continuous focus on providing safe, high quality care to our communities.

We established a COVID taskforce to ensure we could quickly and appropriately respond to the fast-changing and varied COVID guidelines and requirements of each jurisdiction we operate in; New South Wales, Victoria and Western Australia.

Our taskforce and leaders provided expertise and guidance to all of our services, including acute hospitals, many with emergency departments and maternity wards, mental health and rehabilitation hospitals, home nursing services, disability services and community-based programs.

Throughout this time, as always, our priority continued to be the safety of our patients, clients, their families, and our caregivers.

We are proud to share just some of the stories and reflections of our caregivers, working on the frontline and behind the scenes, to respond to this pandemic.

Lucille Ridley, Group Infection Prevention and Control Coordinator, St John of God Health Care

"I took on the role of Group Coordinator of Infection Prevention and Control in a part-time capacity in late November 2019, with a plan for a six-month secondment. By the end of January I was full-time and part of our coronavirus taskforce.

"When I think back to those days, there was constant change and trying to balance COVID requirements across three States was very challenging. I felt an enormous sense of responsibility, with the safety of our patients and caregivers the utmost priority.

"I remember a particular day when I received a parcel in the mail, which was a thank you from a St John of God Accord client for the work we did, and I cried. Right there and then, I realised how much this virus affected everyone else too and how valuable our work was."

Dr Georgina Hayden, Director of Emergency, St John of God Geelong Hospital, Victoria

"The challenge at the start was that we didn't know much about the virus, how it was going to present, or who it would present in and we were rapidly learning treatment options.

"Clinically, we were doing things like making a COVID area, designating cubicles for suspected patients and addressing evolving requirements in terms of personal protective equipment (PPE).

"We were counting boxes of gowns and working out how much hand sanitiser we would need. As part of our huddle we were giving stock updates making sure we would have enough gowns over the weekend shifts. Things I had never had to directly address in such a way before.

"Our caregivers were incredibly anxious, particularly in the early days, but credit to our executive and stores, their messaging was very consistent – we have enough equipment, we just have to ask."

Carol Ashcroft, Pastoral Practitioner, St John of God Berwick Hospital, Victoria

"At 1pm on Tuesday, July 29 2021, I received a call saying that 30 aged care residents were in transit to Berwick, a COVID-positive unit was being established, and a pastoral practitioner was needed. I reported for work two hours later.

"All families of our aged care residents were contacted within 24 hours of transfer, and then at least twice weekly, which proved a colossal task.

"Empathy, patience and understanding were required, as was a quick adaptation to provide care via the telephone and Zoom. I also made sure essential items - such as glasses, hearing aids and clothing – were available as many residents were transferred only with the clothing they were wearing at the time."

Linda Allen, CEO, St John of God Langmore Centre, Victoria

"In a two-week period, about 50 caregivers worked tirelessly to re-open St John of God Langmore Centre (which had been decommissioned in 2018) to provide compassionate care for aged care residents who were awaiting the green light to return home after recovering from COVID.

"To have commissioned this hospital in record breaking time is testament to the caregivers of St John of God Health Care, with contributions and support from all over the country, including many caregivers from regional Victoria who were prepared to leave their families to support us."

Lisa Evans, CEO, St John of God Accord (disability services), Victoria

"In August 2020, our worst fears were realised when the virus entered our service and impacted eight clients and eight caregivers in our accommodation group homes.

"The day of the outbreak we experienced significant challenges to find caregivers to staff the affected accommodation group home and having to relinquish care of our clients was ever-looming until a manager stepped in, rolled up her sleeves, donned PPE and worked in this impacted house for the remainder of that outbreak.

"On reflection, it's been our clients and their families we support who are really my true heroes in all of this. Their resilience and ability to forever seek joy in a day, well it's incredibly inspirational in my book."

Ashly Grabski, Nurse Unit Manager, St John of God Mt Lawley Hospital, Western Australia

"In March 2020, when COVID had first reached Australia and little was known about the virus and vaccines were a long way off, I received a text message from a colleague which simply said: I have been tested and am COVID-positive.

"Within an hour, all close contacts were notified and isolated, the ward locked down, patients and families informed, and strict infection control measures implemented.

"In total, seventeen caregivers, including myself and our two doctors, were in home quarantine. Infection control directions were so well executed that not one other positive case emerged from this exposure."

WHAT NOW FOR AGED CARE?

AUTHOR: By Jason Kara, Director Aged Care - Catholic Health Australia

In a series of general audiences on the elderly held by Pope Francis throughout this year, the Pontiff has urged "The whole of society must hasten to take care of its elderly – they are its treasure! – who are increasingly numerous and often also the most abandoned".

Here in Australia, the ongoing COVID pandemic has cast a particularly harsh light on the need to heed this call and improve the treatment many of our older Australians receive in their residential homes as soon as possible.

So, it was incredibly encouraging that the first piece of legislation passed by the incoming Albanese government and new Aged Care Minister Anika Wells was to enact reforms from the Aged Care Royal Commission. The final report of the Commission was handed down 18 months ago with the 2021-22 Morrison Government Federal Budget delivering over $19 billion over four years to fund improvements yet some of the actual reforms were delayed in the previous Parliament.

While Australia's continued response to the Royal Commission involves much needed and substantial reform, there remains considerable uncertainty about the sustainability of the system that will deliver it.

Future Financial Sustainability

The Royal Commission recommendations themselves will add significantly to the cost of subsidised aged care services and to structural costs for the Commonwealth Budget, especially the cost of future aged care services. This was already set to increase substantially with increasing demand for aged care services as Australia's 'baby boomer' population ages.

By 2060-61, 1.9 million Australians are projected to be 85 and older (5% of the population -more than double the 2% in 2019-20), with the bulk of the increase occurring during the 2030s.

The Royal Commission effectively recommended that a levy on personal income tax should be used to fund a future rights-based aged care system, though the two Commissioners had their own take on what form a levy should take. The Commissioners also recommended the removal of all consumer contributions towards care.

The former Government did not accept either of these recommendations and there is no indication that the new Government has immediate ambitions in this area. Instead, it has left current consumer contributions and the potentially politically problematic area of means testing arrangements untouched.

Catholic Health Australia is growing increasingly concerned about the question of who will pay and how will this be managed sustainably over the longer term?

Workforce sustainability

Workforce reform in aged care revolves around more staff and better skilled and remunerated staff, which come together as one of the essential pre-conditions for the delivery of high-quality aged care services.

We are now seeing the implementation of the Royal Commission's recommendation to increase residential direct care staff by making minimum staffing levels mandatory from 1 October 2023 with at least 200 minutes per resident per day for the average resident, rising to 215 minutes from 1 October 2024. The Albanese Government has also introduced legislation for each aged care facility to have a registered nurse on site 24 hours a day.

The last Morrison Government Budget included measures to improve the supply of better-trained aged care workers but the investment to support these fell some way short of expectations. Training will need to be a joint focus of Minister Wells and the Minister for Skills and Training, Brendan O'Connor, if we are to see a sustainable supply of trained staff.

Minister Wells has made two immediate positive moves on workforce, the most important being a submission to the Fair Work Commission supporting a pay increase to the sector that will be fully funded by Government. The Fair Work Commission will have hearings in September and hopefully reach a determination in a timely manner. Minister Wells has also sought to lower immigration barriers for skilled workforce migration.

HOW CATHOLICS AND THE WIDER WORLD VIEW THE WORK OUR AGENCIES DO.

AUTHOR: Brigid Meney, Director of Strategy & Mission - Catholic Health Australia

The narrative that has developed around the Catholic Church in recent years has tended to centre on its failings rather than its successes.

Critics have often used the problems that have beset the Church to question whether its social contract with Australian society should exist at all.

As Catholics we recognise that there is still some work to do for the Church to better spread the message of Christ but that should not overshadow the work that is done every day, particularly by its ministries. So, it is encouraging to report that research commissioned recently by Catholic Health Australia confirms that the Australian community not only acknowledges the work of Catholic ministries but values it too.

The research sought to find out what people thought of the Catholic ministries – in this case hospitals, aged care facilities, social welfare organisations, schools and universities - how effective we are at servicing the needs of people, and how we can enhance our reputation. The results provide us with some intelligence on how we can counter that narrative.

Catholic ministries have played an important role in communities for decades and, in some instances, for more than a century, educating children, tending to the sick, looking after the elderly and helping those in need.

It should not come as a surprise that they are valued given the footprint of the Catholic sector, something that is all too often overlooked by politicians and commentators.

Overwhelmingly the people we surveyed believed our ministries are a force for good in Australia. That sentiment rose among Catholics, where at least 7 out of 10 people had a positive view of Catholic run schools, universities, charities and hospitals.

Almost 6 out of 10 people agreed that Catholic health and social organisations - the collective term used to describe our ministries - try to make Australia a better place. Again, that positive outlook was higher among Catholics. This is encouraging news because it demonstrates that people believe the Church positive contributes to the community.

However, almost two-fifths of people don't see their own values reflected in the ministries – even while thinking they otherwise do a good job. This is stronger among non-Catholics, of whom 46% don't agree that ministries reflect their values. The timeless truths of the Church however cannot necessarily adjust to the sentiments of of a generation. How Catholic ministries continue to be in the world, but not of the world, will often be a matter to be wrangled with when living out our mission.

Those identified as Coalition supporters tended to view the Catholic ministries more favourably than those who leaned progressive. This political divide is interesting given the largely radical mission of these ministries, rooted in Catholic Social Teaching of preferential options for the poor, solidarity and human dignity. Indeed it was St Vincent's Hospital led by the Sisters of Charity, who in 1984, opened the first HIV/AIDS ward in the country, during a time of fear, uncertainty, and stigma. These notions would ordinarily appeal to a progressive voter, and yet an unsophisticated view of the ministries work and mission, seems to drive opposition. Ultimately however, our ministries should not be viewed through the prism of right and left but instead through the search for what is true, good, and right.

Our health, aged care and social services are agnostic in who we treat, as has always been the case. In many instances, Catholic ministries were providing essential care and education to those who needed it long before public sector stepped in. Yet all too often the accusation is that the Church and its ministries are privileged, irrelevant or unvalued. Work remains to be done in how we continue to provide prominence to our faith through ministries, but the research suggests that such criticisms remain anecdotal at best, unfounded at worst.

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UNITING CARE QLD JOINS THE CATHOLIC HEALTH FOLD.

On June 22 Catholic Health Australia (CHA) members took an historic step and voted to change the organisation's constitution to allow a non-Catholic hospital group, UnitingCare Queensland, to join.

Members voted to change the rules to widen the criteria to enable other Christian not-for-profit health or aged care providers to join CHA.

UnitingCare officially joins our other hospital groups, St John of God Health Care, St Vincent's Health Australia, Cabrini Health, Calvary Health, Mercy Health, Canossa and St Vincent's. It currently operates The Wesley and St Andrew's War Memorial Hospitals in Brisbane, St Stephen's Hospital in Hervey Bay and Buderim Private Hospital on the Sunshine Coast.

It is the first time in CHA's history that non-Catholic health or aged care providers have joined our organization and it is expected that over time others will follow UnitingCare's lead.

UnitingCare has been operating hospitals in Queensland since the 1940s and operates a number of other services.

The benefits of Christian providers of health or aged care joining forces to articulate their common purpose – that of fulfilling Christ's ministry of healing – are obvious and persuasive.

Bringing together Christian providers of varying denominations to enable them to articulate their common purpose and policy concerns to government and the world at large has ecumenical value.

It will also strengthen the voice of Christian providers in the public arena, advocating for better health outcomes for those in the community who rely on the not-for-profit sector.

UnitingCare at a glance

- **4,384** employees
- **1,075** beds
- **132,381** admissions
- **342,639** bed days per year
- **38,992** emergency presentations
- **1,609** births
- **1,266** robotically-assisted operations
- **14,505** rehabilitation admissions
- **3,841** mental health admissions

CHA CEO Pat Garcia welcomed UnitingCare into the fold as CHA's 40th member.

"This is a historic moment for Catholic Health Australia and for our ministry and I am grateful to our members and to our church leaders for embracing this wonderful ecumenical opportunity," Mr Garcia said.

"We're delighted to represent Uniting Care Queensland's four hospitals. We all need to focus on the fundamental challenges impacting our shared ministry and present a united front on the reforms we need to better help those who need our care.

"Workforce supply challenges, the ongoing pandemic, health and construction inflation and ongoing prostheses reform impact on all of our mission. Together, we can bring about much needed change.

"I know all of us at CHA are proud to represent a quality values-based provider like Uniting Care Queensland."

UnitingCare's Group Executive Hospitals Michael Krieg said he was pleased to join CHA and participate with other like-minded providers to consolidate the voices of Christian health providers.

"This union enables UnitingCare to take advantage of CHA's growing influential advocacy in health and provides our communities with greater certainty about the services they have come to expect from UnitingCare," he said.

Q&A WITH FR JOE PARKINSON.

Health Matters spoke with last year's recipient of the Sister Maria Cunningham Award, Father Joe Parkinson about what his career.

You celebrated 40 years as a priest in 2021. What drove your Catholic faith and encouraged you to enter the priesthood?

I come from a large Catholic family and attended Mass every Sunday at our local parish. I was educated by the Sisters of Mercy in primary school, and the Servite Fathers through secondary school in the early 1970s. There was a lot of excitement about Catholic faith in those days, filled with new possibilities and emerging new ministries, and that was all very encouraging for me. But the trigger point for me was when at the age of 16 I accepted a challenge to read the whole New Testament, end to end. That totally changed my perception of faith: it went from being a 'family' commitment to church, to being a personal commitment to the Jesus I met in the Gospels. And that has remained my primary commitment all these years.

As you reflect back on forty years, what have been some of the contributions that you are most proud of, as a priest, and academic, and a Catholic?

I believe that the greatest privilege I have been given is the opportunity to live among the people of God in various parishes, including one as parish priest. But there have been some other interesting twists and turns along the way: one day in 1986 Archbishop William Foley asked me out of the blue to take on studies in moral theology in Rome, with the Redemptorists, while living at the Irish College – such a gift! Then my six years in youth ministry, also a total surprise. And the last twenty years at what is now called Bioethics Perth (previously the L J Goody Bioethics Centre) where I have been engrossed in many facets of public as well as private health care. Certainly one the greatest gifts has been to have served these past 13 years as a Trustee of St John of God Health Care, where I am constantly in awe of the commitment and professionalism of so many people, both in St John of God and in every other Catholic health, aged care and disability service.

How have you maintained your commitment to Church ministries with such longevity, what inspired your ongoing work?

Without doubt I have been blessed by others far more than I have blessed them! The Prayer of St Francis of Assisi says 'it is in giving that we receive' and that is never more true than in my life as a priest: every parishioner, ever young person, or doctor or patient, every Trustee or Board member has taught me how to be a better person and a better priest, and for that I am eternally grateful. Like many Catholics I have to say that at times my faith in the Church has been sorely tested, as I'm sure we all understand, but as I look back across the sweep of my whole life I can easily identify the abiding presence of God in Jesus, accompanying and guiding me, as well as lifting me up whenever I fall.

You are the recipient of the Maria Cuningham Lifetime Achievement award, however you're still currently such an active and significant contributor to the church ministries. What are you most looking forward to into the future in relation to your work and mission?

Receiving this award was a complete shock to my system. That my peers had the generosity to choose me as the 2021 recipient took some time to process, because priests aren't often singled out for such honours. And the idea of a 'lifetime achievement' had me worried, because it makes it sound as though I am approaching the end of my life! But I can give you my two top priorities for the next few years: one is to complete some writing projects that will take a while (including helping to revise the Code of Ethical Standards) and to launch an online site to promote the study of moral theology. I hope this will include my own written and video contributions as well as those of as many others as I can convince. The other priority is to take some down time!

How can we encourage more Catholics to become bioethicists and lead the Church into the future?

Bioethics is becoming a nebulous term, I'm afraid. Where many in the first generation of Australian bioethicists – people like Norm Ford, Bill Daniel, Walter Black and the inimitable Cormac Nagle – were clergy with some general theological training, today a bioethicist is more often trained in philosophy: not a bad thing in itself, but a theological ethics is characteristic of the Catholic way. My postgraduate training was in moral theology, of which bioethics is a subdiscipline. My personal preference for the future is that we have many more women and men trained professionally and to the highest standards in the Catholic moral traditions. To misquote Ronald Reagan, if we forget our traditions – even those that may have had their day – we will soon forget who we are. I would have found it virtually impossible to do Catholic bioethics at all if I had not been given a solid background in moral theology more widely.

The McMullan Review identified several blockages in the pipeline of future bioethicists: lack of candidates, lack of career path, lack of resourcing, and lack of training opportunities within Australia. I think some creative thinking by our health ministries can address the first three, and some committed partnerships with both of our Catholic universities can address the fourth.

From your perspective, as a priest and bioethicist, what are the gravest challenges facing the Church and its ministries in today's society?

You can probably adduce from my previous responses that I believe we will find our gravest future challenges within the Catholic community itself, and not outside it. The current Plenary Council is predicated on the need for us all, including Church leaders, to listen actively to the People of God and to the movements of the Holy Spirit within us, and we have to be prepared to cooperate with one another to meet the challenges that lie ahead. Pope Francis has manoeuvred us to a point where we have a choice: we can go back what we knew, to old certainties that have contributed greatly to the current parlous state of Christian faith, or we can go forward to an unknown future, holding unforeseeable challenges and opportunities for the Church. Which way will we choose?

Above and beyond particular ethical issues, I think one of the greatest challenges for the Church and its ministries in Australia today is identification and formation of the next generation of canonical stewards and directors of our many health care, aged care, disability care and social service ministries. I look forward to the day we have linked our educations systems and universities into the great quest to ensure our Church can continue the healing ministry of Jesus in all of these ways.

END-OF-LIFE PROJECT BUILDS AGED-CARE PALLIATIVE CARE CAPACITY.

Australia's growing ageing population is placing a huge stain on the nation's aged-care and palliative-care systems.

In the next 25 years the number of Australians aged 65 and over will more than double, reaching at least 7.4 million people by 2024.

And during that time there will be a concurrent rise in the number of us who die each year, many after needing aged and palliative care.

The End of Life Directions for Aged Care (ELDAC), a project funded by the Federal Government's Department of Health, aims to improve the aged-care workforce's capacity to provide quality palliative and advance-care planning.

ELDAC is run by a consortium of universities, and national aged, palliative and primary-care bodies, including: Queensland University of Technology; Flinders University of South Australia; the University of Technology Sydney; Palliative Care Australia; Aged & Community Care Providers Association; Australian Healthcare and Hospitals Association; and Catholic Health Australia.

ELDAC's resources and activities span five areas integral to the provision of quality palliative care across the aged-care sector, and support its goal to improve end-of-life care for older Australians,

They include:

1. **Information and advisory services:** ELDAC's website (www.eldac.com.au) hosts a range of resources for the aged-care workforce, general practitioners and other primary-care providers.

   These include five evidence-based tool kits developed to support workers in specific aged-care settings (residential aged care, home care, and primary care), and in specialist areas including end-of-life law and creating linkage partnerships with other services.

2. **Technology and innovation:** A series of technology-based activities are being co-designed, developed, and embedded into aged care.

They include: a dashboard application embedded into several national residential aged-care sites' IT systems, to help managers and staff track residents' and clients' palliative care and advance-care planning needs; an online self-care resource for aged-care staff and organisations, to identify and address self-care needs; and an app for home-care staff to help them identify end-of-life care, and respond according to evidence-based practice.

3. **Workforce capability:** Learning pathways are being developed to guide aged-care providers and health-care disciplines to relevant learning resources. Links are also being included in the PACE app to include existing educational activities; and education and training activities will be designed to address identified gaps.
4. **Service development:** ELDAC is working to improve quality-of-care, prevent unnecessary hospital admissions, and shorten hospital stays by improving linkages between aged and palliative-care services.

   A team of linkage facilitators will work with aged, palliative and primary-care local partnerships and primary health networks to implement a range of evidence-based, sustainable linkage strategies, and to implement the ELDAC resources into their services.
5. **System capability:** ELDAC contributes to system capabilities by conducting evidence reviews and engaging with national, state, and other jurisdictional groups to build awareness of its work.

   A national campaign has been launched to acknowledge aged care's role in care at the end of life, and to improve death literacy and awareness of aged care workers.

Mercy Health is a member of Catholic Health Australia and is participating in the ELDAC Linkages Program with the aim of developing a standardised approach to palliative care across its 30 aged care homes in Victoria, Queensland, NSW and Western Australia.

"Residents are coming into aged care older and often sicker and frailer than ever, and many of them are palliative from the time they come into the facility," Mercy's dedicated Palliative Care Clinical Nurse Consultant Fran Gore (pictured) says.

"So we want to ensure we're providing the best-quality palliative care for them and their families."

Fran says four Mercy residential aged care sites are participating in the Linkages Program and, through its audit function, have identified different areas of learning for each site to focus on.

"I would absolutely recommend working with ELDAC," Fran says. "I've only ever had strong support from our senior leadership and executive team due to their commitment to palliative care, and I'm already identifying areas through the Linkages Program that I'd like to share with our other aged-care sites that aren't participating in the program.

While Mercy is still in the early phase of the ELDAC Linkages Program, the work it has completed mapping service sites – including local ambulance and specialist palliative care services – has supported it to set up referral processes in advance.

Mercy Health Home Care Clinical Lead Joanne Morabito says the ELDAC facilitators are also now working with the North West, Geelong and Cairns home-care sites.

"The goal of these sites is to educate staff in advance care planning and early recognition of palliative signs in clients as, by supporting our staff to have a better understanding of the palliative approach, our aim is to provide our clients with holistic care from initial assessment."

Fran says she is now working on getting the message out to all of her sites that "when you're looking for palliative care information, you don't need to reinvent the wheel".

"Go to the ELDAC website, go to the clinical care section of the toolkits for tips on providing clinical care to your residents, and you can feel confident in your practice knowing that the information you find is supported by evidence as well," she says.

INTERVIEW WITH NEW BISHOPS CONFERENCE PRESIDENT.

Archbishop Timothy Costelloe SDB has officially taken over the presidency of the Australian Catholic Bishops Conference. Health Matters spoke to him about his role, his faith and the importance of Catholic ministries.

What drove your Catholic faith and encouraged you to enter the priesthood?

I grew up in what I would call, in the best sense of the word, an ordinary Catholic family in Melbourne. My parents made great sacrifices to ensure my brother and I were able to go to Catholic schools, primary and secondary, and as a family we were very faithful to Sunday Mass. Being Catholic was just a normal part of my life.

I was greatly influenced by the priests in the parish in which I grew up and, as young people often do, I thought to myself, "I would like to be like him (them) when I grow up." This was reinforced by the Salesians as I came to know them as a student at Salesian College in Chadstone.

Catholic Health Australia's mission is centred on bringing Christ's healing ministry to people, with a focus the most vulnerable in our society. How has your formation through the Salesians informed your mission as an Archbishop, particularly as the first member of a religious order to take on this position?

The founder of the Salesians, Saint John Bosco, once said to his Salesians that it was not enough to love the young, for they have to know that you love them. I have always understood this to mean that our love has to be real, active, concrete and "down-to-earth".

This doesn't just apply to young people. It applies to everyone, and therefore to all those who undertake any ministry in the name of the Church. We are called to express our love in concrete ways, adapted to the particular person or people we are seeking to serve.

Theoretical formulas don't always work; it is only through personal relationships that we can share Christ's love in a way that touches people's live, and hearts. After all, this is the way Jesus operated. He met each person in the concrete reality of their situation and, through establishing relationships based on respect, he was able to help them move forward.

This is the approach I try to follow, though sadly not always as fully as I would like.

From your perspective, what are the gravest challenges facing the Church and its ministries in today's society?

There are so many that I hardly know where to start, but perhaps my response to the previous question provides the basis of an answer.

One word I would use is "fidelity". In a culture which in many respects seems to be detaching itself from its Christian foundations, it is not easy for us as Catholics to keep alive a sense of who we are and just what God is asking of us at this time (the early decades of the third millennium) and in this place (Australia). This is, of course, the key question being addressed by the Plenary Council.

In this regard the Second Vatican Council spoke of the need to discern, which is to recognise and evaluate, the signs of the times in the light of the Gospel. But for this to happen we must be sure that we, God's faithful people, are deeply steeped in the Gospel, so familiar with Jesus, if I can put it this way, that we have an instinctive understanding of the "mind and heart" of Jesus and therefore know how to respond to the very complex situations we face.

In this regard I think we all have a long way to go. And this is why, I suspect, the theme of "adult faith formation" has emerged so clearly as a central issue for the Plenary Council to consider.

The Church no longer holds the same position of influence it once held in our society. There are many reasons for this, but chief among them is the dreadful failures of Church institutions and individuals in relation to the sexual abuse of the young.

We must continue to respond with compassion and generosity to those who have been so badly hurt, we must be brave enough and humble enough to learn the hard lessons from our failures, and we must continue to explore every avenue to ensure that no-one is ever damaged again in this way in any of our communities.

And here, again, it is a question of fidelity, for surely no one could dispute that the widespread abuse of the young in Catholic institutions represents a dreadful failure in fidelity to what the Lord requires of us.

This question of fidelity, in all aspects of the Church's life, will require from all of us in the Church a challenging and confronting "examination of conscience". And this is as essential for our Catholic healing ministries as for any other dimension of the Church's life.

Both Pope Benedict and Pope Francis have alerted us to the danger of our Catholic ministries becoming NGOs rather than communities of discipleship. Here, too, we must remember that it is his Way that we follow, his Truth that we proclaim and his Life that animates us.

Catholic Health Australia and its members have been working to cater to the needs of Australians during an immensely difficult period due to the Covid pandemic. What does the Australian Church and its ministries need to address together as we combat the impacts of the pandemic?

As I reflect on the experience of the COVID pandemic, one thing which stands out very strongly for me is the value of the Church's tradition concerning the "common good".

We live at a time in history, at least in many societies, where the rights and desires of the individual are often exalted at the expense of our responsibility to care for others in our society. In the Christian "worldview" we are called to "break our bodies and spill our blood" in memory of Jesus for the sake of others.

Catholic Health Australia, at least as I have experienced it "on the ground" in the Archdiocese of Perth (and I am sure this is the case in other places through the country), has been outstanding in responding with courage, flexibility and compassion to this challenge. This is equally true of Catholic education, of Catholic social services, and indeed of local Catholic parishes and other communities.

And I must say that this is not unique to Catholics or to Catholic institutions. In many respects the pandemic has brought out the best in so many Australians of all religions and none.

At the same time, it has been distressing to see how some people have put their own concerns above the need to take the necessary steps to protect others from a very dangerous disease. For me this underlines the importance of the fundamental principles upon which our faith rests: they are not dry philosophical or theological formulations; they are life-giving guides to practical action.

Pope Saint Paul VI once said that if people listen to teachers, it is because those teachers are first witnesses. It is not enough for the Church to proclaim in words, written or spoken, the fundamental truths about humanity to the wider world; the Church must, above all, proclaim these truths by the way we act, and by the coherence between what we say and what we do.

As President of the Plenary Council, you have overseen some significant conversations with Catholics nationally. What messages are emerging for ministries like Catholic Health through this process?

One of the key discernment themes, or questions, which emerged through the discernment process of the Plenary Council was this: What does it mean to be a Christ-centred Church which is humble, healing and merciful? This is a rich theme and one which will need ongoing prayerful reflection which hopefully leads to action.

In relation to being a Christ-centred, healing Church, I would say that this has special resonance for our Catholic health and aged-care ministries. I would think it fair to say that for Catholics, for people of other faiths and for people of no faith, there is a high expectation that the quality of care and personal engagement they encounter in any of our institutions is irreproachable in both aspects.

We might sometimes feel burdened by these high expectations, but in a very real sense they are a compliment to us, and a recognition that we are grounded in something special. Often people cannot easily verbalise what that "something special" is, but they certainly know when it is missing.

I would suggest that the "something special" is what I might call "the Catholic thing" or the Catholic worldview.

It is much more than, for example, the particular medical procedures we will not perform in our hospitals, or the particular stance we take in relation to voluntary assisted dying in our facilities, thought it certainly includes all that.

It is that vision of life which recognises that God exists and is the foundation of all life, that God has made himself known in and through Jesus, and that the presence and work of Jesus continues in the Church through the power of the Holy Spirit.

One of the great challenges for Catholic health care (and for other Catholic ministries) is to recognise this reality, embrace it willingly, and live it faithfully. It is the solid foundation upon which our ministries rest. If the foundation is undermined, the whole building may eventually become unstable.

Each Catholic institution is being called to discern, within its own particular circumstances and according to its own particular ministry, how it can best ensure the solidity of its foundations, so that, in the case of our healing ministries, we really are a "sacramentalising" of the presence of Jesus as the great healer.

Just like you, care and compassion are in our DNA.

In 1972, 48 educators came together with a shared belief in community, and formed a bank based on supporting others. Our first loan was not to a business or investor, but to a single mother who needed a bond to rent a home for herself and her two kids.

From those humble beginnings to today, we remain committed to supporting those who support our community.

At Bank First, we know that by empowering you, we're empowering our community.

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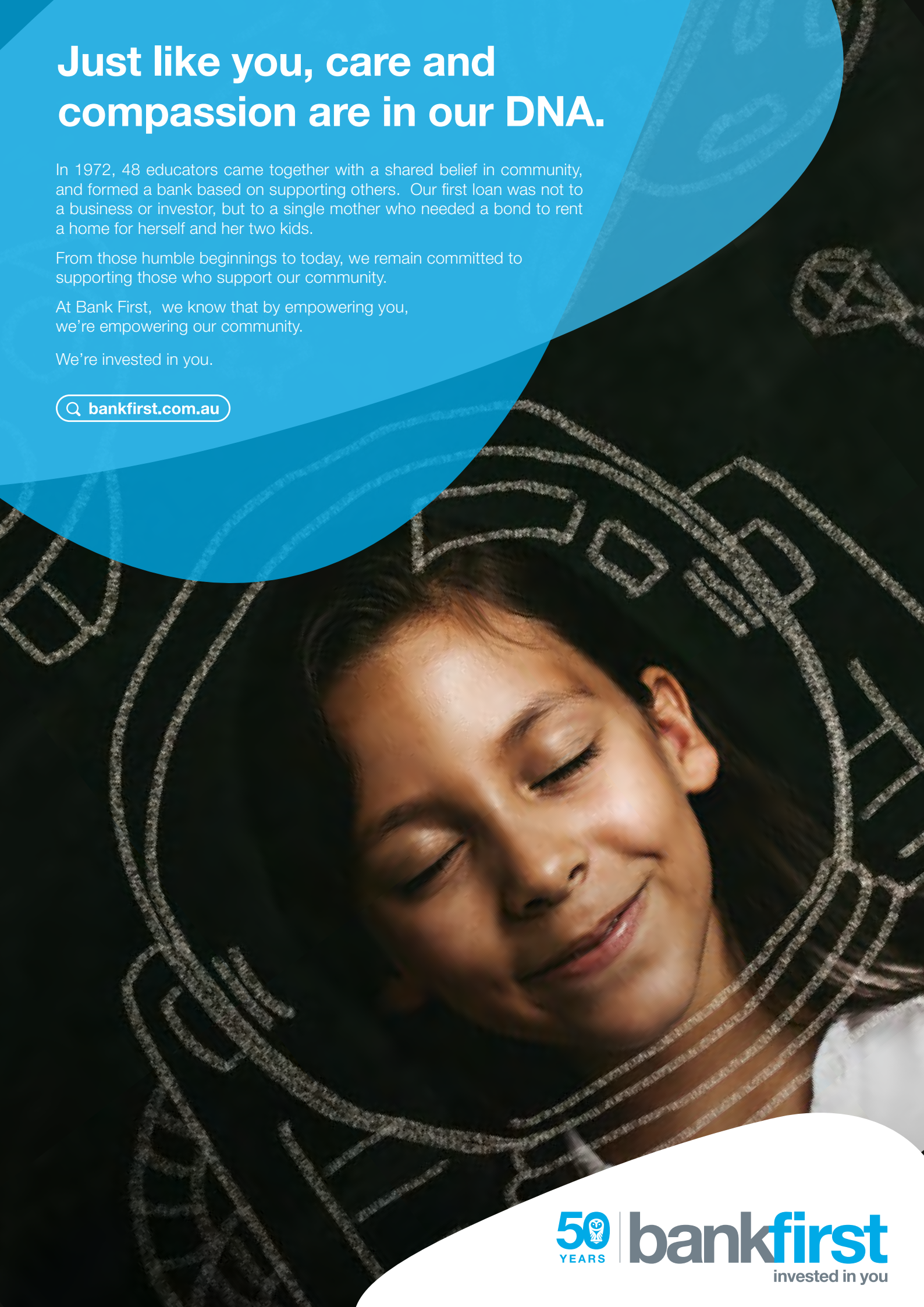

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