The Health Advocate

ISSUE 6 • OCTOBER 2010

The official magazine of the Australian Healthcare & Hospitals Association

Your voice in public healthcare

The 2010 Chalmers Oration

Dr Tom Calma

Governance in rural health services

Graem Kelly on why it's the most important issue

Promise of the future

Shannon Nott shares the passion of rural health students

Rural and remote health

A new era for action in the bush

ALSO in this issue

- E-health update
- Primary health care
- Legal
- News

More people in health and community services choose HESTA than any other fund

Your super fund can make a lifetime of difference

- ✓ Run only to benefit members
- ✓ No commissions
- ✓ Low fees

HESTA SUPER FUND
Your Health & Community Services Industry Fund

An Industry SuperFund

hesta.com.au/super

AHHA Council and supporters

The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation, the protection of its assets and the quality of its services. The 2009-2010 Board is:
Dr David Panter (SA) National President
Dr Patrick Bolton (NSW) National Vice President
Dr Paul Scown (VIC) National Vice President
Mr Felix Pintado (VIC) National Treasurer
Dr Stephen Christley (SA) Immediate Past President

The AHHA National Council oversees our policy development program. It includes the AHHA Board above and the following members for 2009-2010:
Ms Di Aldous (QLD)
Dr Martin Dooland (SA)
Ms Jan Evans (NT)
Ms Mary Foley (NSW)
Ms Siobhan Harpur (TAS)
Mr Graem Kelly (VIC)
Mr Peter Le-Gallou (SA)
Dr Yvonne Luxford (Associate Member representative)
Dr David Mountain (WA)
Ms Shaune Noble (NSW)
Mr Patrick O'Brien (QLD)
Dr Tony O'Connell (QLD)
Mr Ross O'Donoghue (ACT)
Mr Michael Pervan (TAS)
Ms Annette Schmiede (Personal Member representative)
Mr John Smith (VIC)
Mr Mark Sullivan (VIC)
Ms Sandy Thomson (WA)
Mr Alan Wilson (NT)
Dr Owen Curteis (Asian Hospital Federation)
Professor Helen Lapsley (International Hospital Federation)

AHHA Sponsors

The AHHA is grateful to the following companies who support our work:

Primary sponsor

HESTA Super Fund

Event sponsors

DLA Phillips Fox
Tress Cox Lawyers
PricewaterhouseCoopers
Philips Healthcare

Other organisations support the AHHA with Institutional and Associate membership. You can see a list of these organisations at *www.aushealthcare.com.au/businessdirectory*. To find out about joining the AHHA and having your organisation listed contact Terrie Paul.

Prue Power Executive Director
Cydde Miller Policy and Networks Manager and Editor
Terrie Paul Business and Membership Manager
Luise Zakosteletzki Trainee Policy and Planning Manager

AHHA Office
Unit 2, 1 Napier Close
Deakin ACT 2600
Postal address
PO Box 78
Deakin West ACT 2600
T: 02 6162 0780
F: 02 6162 0779
E: admin@aushealthcare.com.au
W: *www.aushealthcare.com.au*

Editorial and general enquiries
Cydde Miller
T: 02 6162 0780
E: cmiller@aushealthcare.com.au

Membership and subscription enquiries
Terrie Paul
T: 02 6162 0780
E: tpaul@aushealthcare.com.au

Advertising enquiries
Luke Dempsey
Globe Publishing
T: 02 8218 3402
E: luke.dempsey@globepublishing.com.au

globe PUBLISHING
CUSTOM MAGAZINES

Contents

Every issue

Opinion

In depth

Briefing

President's view

DR DAVID PANTER
President of the Australian Healthcare and Hospitals Association

Welcome to our rural and remote health special issue. Rural health has never been off the agenda, but now the issues are very much front and centre with our 'new world' state of politics.

IT'S ACTUALLY VERY interesting timing that I write this after an uncertain election result: with a Government yet to be formed and the power in the lower house in the hands of three Members of Parliament who represent rural electorates and interests. When you read this, the lay of the land will most likely be clearer.

Our rural members will be in a rare state of optimism as they see the opportunities to advocate for stronger commitment from the Commonwealth Government to servicing their constituents. The public healthcare sector carries regional Australia on its shoulders, and this can often be a heavy load. But now there is a real chance for planning and resourcing that reflects the true needs of rural and remote communities.

Improving access to primary care services is one of the most important strategies to improve the health of regional communities. This includes a focus on preventive care and chronic disease management through multi-disciplinary care.

The Labor Government had gone some way to strengthening primary care services through its Super Clinics program and health reform initiatives which improve linkages between community-based health care and institutions such as hospitals and aged care facilities. It is essential that these initiatives are continued, regardless of which party forms Government.

A significant aspect to improving service delivery in the bush would be the rollout of a National Broadband Network or similar infrastructure that would not only connect communities to information and services at a broader level, but also make e-health a reality. During the election campaign we saw greater potential benefits from the Labor plan with its commitment to building the infrastructure for e-health. We remain concerned about the Coalition's intentions in both e-health and the expansion of access to the worldwide web for communities across the country.

Other health issues should also be put on the table as part of the negotiations to secure a healthier future for rural and regional Australians from this election process. These include accessible and affordable dental care, Indigenous health, mental health and the private health insurance rebate.

So in this special issue of the magazine, we hear from Gordon Gregory of the National Rural Health Alliance, Australia's key rural health body representing a range of organisations from across the country. The AHHA is a foundation member of the Alliance and is establishing a Rural and Remote Health Network through which our members can engage in policy development and general discussion about public health services in rural areas.

We also get the perspective of one of our rural members, Graem Kelly from Castlemaine Health in Victoria. Graem discusses his priority issue for rural health services – governance. Victoria has been working on local governance for many years, and Graem shares some of the insight needed with the inevitable move to boards at either regional or hospital level.

You'll also hear about the new generation of the rural health workforce from Shannon Nott who co-chairs the National Rural Health Students' Network. It will be a reminder for some of you about why you got into this career in the first place! Their enthusiasm and commitment to improve the health of rural communities is matched by their activism.

So now is not a time to be complacent or stick with the status quo. In future issues we will profile the perspectives on health of the key political players to help you gain a clearer understanding of where your industry is heading in these uncertain yet exciting times. As always, the AHHA is here to be your voice! ha

What's needed Close the

to Gap?

Summary of Dr Tom Calma's 2010 Chalmers Oration

DR TOM CALMA
National Coordinator of the Tackling Indigenous Smoking program in the Department of Health and Ageing

WE ARE VERY fortunate to have the opportunity to publish an abridged version of the 2010 Chalmers Oration delivered by Dr Tom Calma at the Flinders University School of Medicine in Adelaide. The complete speech was first published in *Rural and Remote Health*, available online at **www.rrh.org.au**.

Those of you close to the AHHA will recall that we published the 2009 Chalmers Oration delivered by Dr John Deeble. Copies of his Oration are still available – contact the AHHA at admin@aushealthcare.com.au. You can also find a summary of John's Oration in the first issue of this magazine – October 2009.

My presentation focuses on the groundbreaking role that the *Close the Gap* Campaign continues to play in making a difference to the health of Indigenous Australians, especially those who live in rural and remote areas.

I speak from the perspective of several roles. The first was my position as Aboriginal and Torres Strait Islander Social Justice Commissioner from 2004 to 2010. In that role I was convenor of the *Close the Gap* Campaign for Indigenous Health Equality (or as most of you will know it, the *Close the Gap* Campaign), which is the main topic of my Oration. The second is my role as National Coordinator for Tackling Indigenous Smoking, held since March 2010. The third is my role as National Patron of the new Poche Centres for Indigenous Health.

A decade ago Dr Lowitja O'Donoghue delivered the Chalmers Oration. Her presentation was titled *Indigenous Health – hopes for a new century*. Since then, Indigenous health equality is firmly on the agenda through the *Close the Gap* Campaign's advocacy resulting in the appointment of a Federal Minister for Indigenous Health and the National Indigenous Health Equality Council. Thanks must go to the activities of many Aboriginal and Torres Strait Islander health activists, such as Dr O'Donoghue, who have worked unceasingly for Indigenous people for many decades.

Our efforts involve close work with government and confusion often arises because Indigenous initiatives of the Australian Government and the Council of Australian Governments (COAG) are all branded *Closing the Gap*. However, there is a fine distinction here – Close vs Closing. Although this is in part testament to the success of the Campaign, from the outset I must make a clear distinction between the programs. This is more than just a point of definition, for in that fine space of difference lies the answer to my question: 'What is needed to *Close the Gap*?'

The reasons for the *Close the Gap* Campaign

The Campaign's goal is to close the health and life expectancy gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians within a generation. This in itself is an answer to the question, because it contains the following features:

- the adoption by all Australian governments of a comprehensive national plan of action to achieve health equality by 2030 that is properly resourced and focused on a wide range of health conditions and health determinants;
- the national plan will be developed and implemented in partnership with Aboriginal and Torres Strait Islander peoples and their representatives;
- the plan will define ambitious yet realistic benchmarks and targets; and
- the plan will not only include an expansion of the role of Aboriginal Community Controlled Health Services for the delivery of primary health care to Indigenous Australians, but also increase the access of Indigenous Australians to mainstream health services.

That is what is needed to *Close the Gap*. However, to understand the rationale for the Campaign, a closer look at the gap itself is needed.

The persistent gap

'The gap' of course refers to the difference in life expectancy and health status between Indigenous and non-Indigenous Australians. The official estimation of the life expectancy gap (originally 17 years) was revised in 2009 to 11.5 years for males and 9.7

years for females. Either way, the gap is sizeable and unacceptable.

Although the gap cannot be quantified precisely, we do know that a series of smaller gaps underlie the life expectancy gap. For example, heart disease is the single biggest killer of Indigenous Australians, resulting in much unnecessary suffering. The word unnecessary is the key here, for we are all going to die some day and sickness touches us all. However our task is to eliminate as much unnecessary sickness and death as is possible, in this case among the Indigenous population.

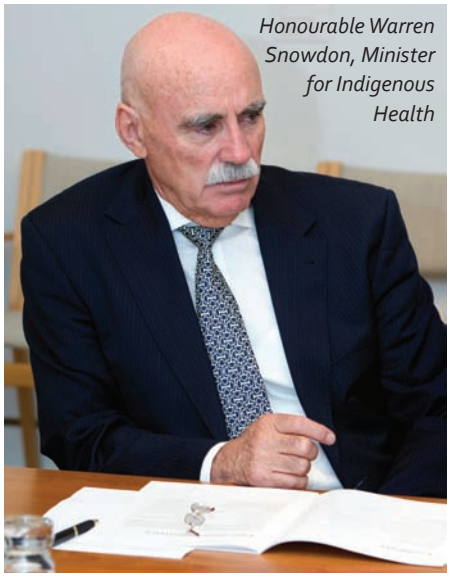
With a significant proportion of Indigenous peoples in younger age groups (the result of a recent Indigenous 'baby boom'), we have a challenge to keep up with the future demands of a burgeoning Indigenous population. It is clear that unless substantial steps are taken now, the gap could widen. There is no room for complacency. Action is required now to close the gap.

We are dying from, and being disabled by, conditions and diseases that are preventable, curable and otherwise manageable in the non-Indigenous population. The health gap is caused by a failure to act when action is needed. We die younger because we were treated differently in the past, and we are still treated differently now.

The lack of access is a big problem

Nowhere is the Indigenous lack of opportunity to be healthy seen more clearly than in access to health services.

A critical factor impacting on the use of health services is the relatively few Indigenous health professionals available to deliver



Honourable Warren Snowdon, Minister for Indigenous Health

services. As the Inala Indigenous Health Service in Queensland has demonstrated, an Indigenous face behind the desk or an Indigenous nurse can make a huge difference to our perception of the health service. Indigenous students continue to be under-represented among those completing courses in the health disciplines. While the situation is improving with initiatives such as the Poche Centre for Indigenous Health at Flinders University, action is still required to secure Indigenous peoples' full participation in the delivery of health services to their communities, and indeed to all Australians.

A lack of access to primary healthcare services is also reflected damningly in the statistics. In 2005-2006, Indigenous males and females were more than twice as likely as other males and females to have been hospitalised. Most of this difference was due to high rates of care for renal dialysis (14 times the rate of other Australians) and other potentially preventable hospitalisations (5 times the rate). In other words, poor access to primary healthcare can result in unnecessary hospitalisation.

Not only is hospitalisation a personal trauma, it also burdens the community with significant and unnecessary cost. There is, therefore, a compelling cost–benefit argument for achieving Indigenous health equality, if indeed any further argument is necessary. It is worth reflecting on the economic argument, for the whole thrust of recent reforms has been financially motivated. If people are seen earlier by doctors they can be kept out of expensive hospital beds, which are often associated with costly travel and dislocation from community and family.

A human rights-based approach – ambitious but realistic

The *Close the Gap* Campaign is based on the rights of Indigenous Australians, particularly the right to health. Indeed, the Campaign's approach is the first articulated expression of the right to health in the world. As such, it has received a significant amount of attention and approval internationally, particularly from the UN.

Under the 1966 International Covenant on Economic, Social and Cultural Rights, the primary right to health is ensured by providing opportunities to be healthy: that is, health services and a key range of goods and services that support good health (adequate food, potable water supplies, sanitation etc).

Crucially, because non-discrimination is a fundamental element of human rights law, a state is obliged to ensure or provide equal opportunities to be healthy regardless of human differences, such as race and sex. And a state that does not provide equal opportunities to be healthy is legally required to institute a response referred to as 'progressive realisation' – that is, to ensure that equality of opportunity is achieved as soon as possible. The *Close the Gap* Campaign's approach is an example of progressive realisation in action.

Self-determination, the right of Indigenous peoples, has many dimensions. However, within the broader context of the post-colonial nation state it is basically the right to self-governance. Aboriginal Community Controlled Health Services are an expression of Indigenous peoples' right to self-determination. They are pivotal in ensuring culturally appropriate health services are delivered to the communities they serve, which includes the use of traditional healing practices where appropriate. In the latter context they are also an expression of Aboriginal and Torres Strait Islander peoples'

cultural rights. The *Close the Gap* Campaign supports Aboriginal Community Controlled Health Services as the preferred services for health delivery to Indigenous Australians, while at the same time recognising that Indigenous people must also have the same opportunities to access 'mainstream' health services that exist for other Australians.

The *Close the Gap* Campaign advocates that not only social but also cultural determinants must be included in the scope of a plan for health equality. Cultural determinants can be understood as the drivers of health that are unique to Indigenous peoples in both positive terms (the positive health impacts and resilience associated with membership of strong Aboriginal and Torres Strait Islander cultures) and negative terms (the results of racism being directed at a particular group).

Generation of the *Close the Gap* Campaign

The foundation of the *Close the Gap* Campaign is a collective of peak Indigenous and mainstream health bodies, health professional bodies, NGOs and other institutions. The Campaign is led by a Steering Committee that operates by consensus, taking direction from an Indigenous Leadership Group. The first meeting of the Campaign Steering Committee was held after the 2005 Social Justice Report was tabled in the Australian Parliament in March 2006. In April 2007, the Campaign was launched by its patrons, Olympians Catherine Freeman and Ian Thorpe.

There is no funding from government – the membership donates funds for operational costs, and the Australian Human Rights Commission hosts the secretariat. Significant funding support from Oxfam Australia enabled the Campaign to be established as well as the rapid advancement of its objectives.

In addition to the official partners, over 140,000 Australians have pledged support for the Campaign. This wide community support is evidenced by the 570 community events that marked national *Close the Gap* Day on 25 March 2010.

In August 2007, the Federal Opposition under the leadership of Kevin Rudd signalled its support for the *Close the Gap* approach in its Indigenous affairs election platform. As a result, 'Closing the Gap' entered the policy lexicon. Following the election of the Rudd Labor Government, many aspects of the *Close the Gap* Campaign became official government policy. Since then, Australian governments through a number of COAG commitments have adopted elements of the *Close the Gap* approach. In December 2007, COAG adopted a target to 'achieve Aboriginal and Torres Strait Islander life expectancy equality within a generation' – our first great success.

Since the National Indigenous Health Equality Summit held in March 2008, *Close the Gap* branded programs from Australian governments have reached funding of approximately $5 billion, of which $1.6 billion is specifically targeted to closing the gap in life expectancy within a generation, the biggest single injection of funding into Indigenous health in history.

Campaign achievements

The *Close the Gap* Campaign Steering Committee has been actively involved in the majority of reform processes undertaken since the Summit. I am involved with the National Partnership Agreement on closing the gap in Indigenous health outcomes, through overseeing a$100 million-plus program aimed at drastically reducing the rates of smoking in the Indigenous population.

With the support of Indigenous Health Minister Warren Snowdon, the *Close the Gap* Steering Committee convened the *Close the Gap, Making it Happen* workshop in June 2010 to focus on the development and implementation of a plan for Aboriginal and Torres Strait Islander health equality within a generation. The meeting was significant in foreshadowing a national plan for Indigenous health equality.

In terms of a partnership for health equality, the creation of the National Congress of Australia's First Peoples' in April 2010 heralds a new dawn for Indigenous affairs in Australia. The model for the Congress was developed by an Indigenous steering committee under my leadership after extensive community consultations. In this and other developments the Australian Government has taken significant steps forward in working with us and giving us a voice on the policies and laws that affect us, including those relating to health planning. However, we are still waiting for the development of a formal partnership.

The role of philanthropy in Indigenous health involves a second type of partnership and is vital because it can significantly accelerate essential developments, particularly those where government support is too restrictive to enable innovative initiatives. An example of such a partnership is the Poche Centre for Indigenous Health, set up with the assistance of a $10 million grant from Greg and Kay Poche to Flinders University to recruit and train Indigenous health professionals and undertake targeted research.

Where to from here?

While the *Close the Gap* Campaign continues to work behind the scenes with government, it is also willing to criticise when necessary, as it did this year in its *Shadow Report to the Prime Minister's Annual Report to Parliament on efforts to Close the Gap*, repeating the call for inclusive planning processes and a partnership approach to Indigenous health initiatives.

The answer to the question 'what is needed to *Close the Gap*?' is and can only be a human rights based approach to Indigenous health. Such an approach includes a bold and ambitious plan and partnership between Indigenous Australians and their representative Australian governments.

For Indigenous peoples, the health gap is not experienced as a table of statistics but as suffering and pain for those with poorer health, and grief and trauma for those who care for them – their families and communities. In this way, the damage from health inequality is not just inflicted on individuals.

The drive for Indigenous health equality is a matter of great personal concern to Indigenous Australians. It is about our happiness as individuals and families; it is about our children, our parents and our grandparents, our communities, our languages and our cultures.

Conclusion

While I have no doubt that things are improving, we are still a nation that has not yet faced up to its past and in need of reconciliation. There is work to be done! This involves a national effort to reconcile us, to bring us together in expectation of what it is to live in this great nation – health, happiness, respect and esteem from and for each other and the government we create together.

Only by acknowledging the past can we move forward together to a future in which black and white Australians truly do stand together as brothers and sisters, enjoying an equally high standard of physical and mental health.

For more information:
closethegap.com.au
lowitja.org.au
sydney.edu.au/medicine/poche

Safety is Peace of Mind

Safety Infusion Therapy

Safety Injection

Safety Blood Collection

Sharps Disposal

BD

Helping all people live healthy lives

Healthcare Safety Solutions

The statistics are staggering. Every year, thousands of healthcare employees in Australia suffer the trauma of needlestick or sharps-related injuries at work.[1] It can happen in an instant. Even the smallest skin puncture can expose the employee to more than 30 potentially life-threatening bloodborne pathogens.[2] And yet, the majority of these injuries can be prevented by implementing safety-engineered medical devices combined with education and training.[3-5]

For nearly two decades, BD has led the global effort to protect healthcare employees from the significant risk of occupational exposure to bloodborne pathogens. The passion that BD associates have for improving safety in the healthcare workplace is seen through innovations in technology, product development, manufacturing and education, as well as collaborations with organisations that share our purpose for *helping all people live healthy lives.*

[1] Murphy C. Improved surveillance and mandated use of sharps with engineered sharp injury protections: a national call to action. *Healthcare Infection 2008;* 13:33-37.

[2] Tarantola A, Abiteboul D, Rachline A. Infection risks following accidental exposure to blood or body fluids in health care workers: A review of pathogens transmitted in published cases. *Am J Infect Control, 2006;* 34:367-75.

[3] Sohn S, Eagan J, Depkowitz K *et al.* Effect of Implementing Safety Engineered Devices on Percutaneous Injury Epidemiology. *Infect Control Hosp Epidemiol 2004;* 25:536-542.

[4] Lamontagne, F, Abiteboul D, Lolom I *et al.* Role of Safety-Engineered Devices in Preventing Needlestick Injuries in 32 French Hospitals. *Infect Control Hosp Epidemiol 2007;* 28:18-23.

[5] Jagger, J. Caring for Healthcare Workers: A Global Perspective. *Infect Control Hosp Epidemiol 2007;* 28:1-4.

BD Medical
Becton Dickinson Pty Ltd,
4 Research Park Drive,
Macquarie University
Research Park, North Ryde,
NSW, 2113.
Toll free telephone:
1800 656 100.
www.bd.com/anz

In the news

Have your say...
We'd like to hear your opinion on these or any other healthcare issues. Write to us at **admin@aushealthcare.com.au** or **PO Box 78, Deakin West, ACT, 2600**

Are more hospital beds the answer?

THIS APPEARS TO be a trick question and it is – with hospital usage and access block, no single answer will give us the solution we need.

And of course, change for hospitals will not occur without serious investment in other parts of the system and not without clinical service redesign in hospitals, according to new research reported in the August issue of *Australian Health Review*, the AHHA's elite peer-reviewed journal.

Associate Professor Ian Scott, Director of Internal Medicine and Clinical Epidemiology at the Princess Alexandra Hospital in Brisbane, has a worrying vision of the future if we continue to focus on increasing beds without changing demand and models of care. He says that "increasing demand on public hospital beds has led to what many see as a hospital bed crisis requiring substantial increases in bed numbers. However, by 2050, if current bed use trends persist and as the numbers of frail older patients rise exponentially, a 62% increase in hospital beds will be required to meet expected demand, at a cost almost equal to the entire current Australian healthcare budget."

The study found that hospitals could be made more efficient by adopting a number of strategies, including:

- outsourcing public hospital clinical services to the private sector;
- undertaking whole-of-hospital reform of care processes and patient flow that address both access and exit block;
- separating acute from elective beds and services, increasing rates of day-only or short stay admissions; and
- curtailing ineffective or marginally effective clinical interventions.

In the non-hospital sector, potentially the biggest gains in reducing hospital demand will come from improved access to residential care, rehabilitation services, and domiciliary support as patients awaiting such services currently account for 70% of acute hospital bed-days. More widespread use of acute care and advance care planning within residential care facilities and population-based chronic disease management programs can also assist.

Overall, the study concludes that, in reducing hospital bed demand, clinical process redesign within hospitals and capacity enhancement of non-hospital care services and chronic disease management (CDM) programs are effective strategies that should be considered before investing heavily in creating additional hospital beds devoid of any critical reappraisal of current models of care.

Professor Scott says we must be cautious when asking for more resources in one area without seriously resourcing other services and planning these all as an integrated system. He says that "there are no magic bullets for increasing hospital capacity or decreasing hospital demand. Health service managers must assess potential strategies on the basis of evidence and not prematurely adopt strategies promoted by enthusiasts that lack proof of concept, adequate pilot evaluations, and evidence of cost-effectiveness."

"We need a public debate about the role of hospitals within the healthcare system and how we can manage future population healthcare needs in a sustainable way. In the meantime, all hospitals must consider implementing reforms with potential to improve their productivity and reduce access block for those who really need acute hospital care," he concludes.

Citation: Australian Health Review, 2010, 34, 317–324

*To obtain a copy of this article, visit the AHHA website (**aushealthcare.com.au**) or subscribe to the Australian Health Review via **aushealthreview.com.au**.*

AHHA joins other peak bodies to push for dental

AS REGULAR READERS will be aware, the AHHA has long been advocating for action on oral healthcare in the context of national health system reforms.

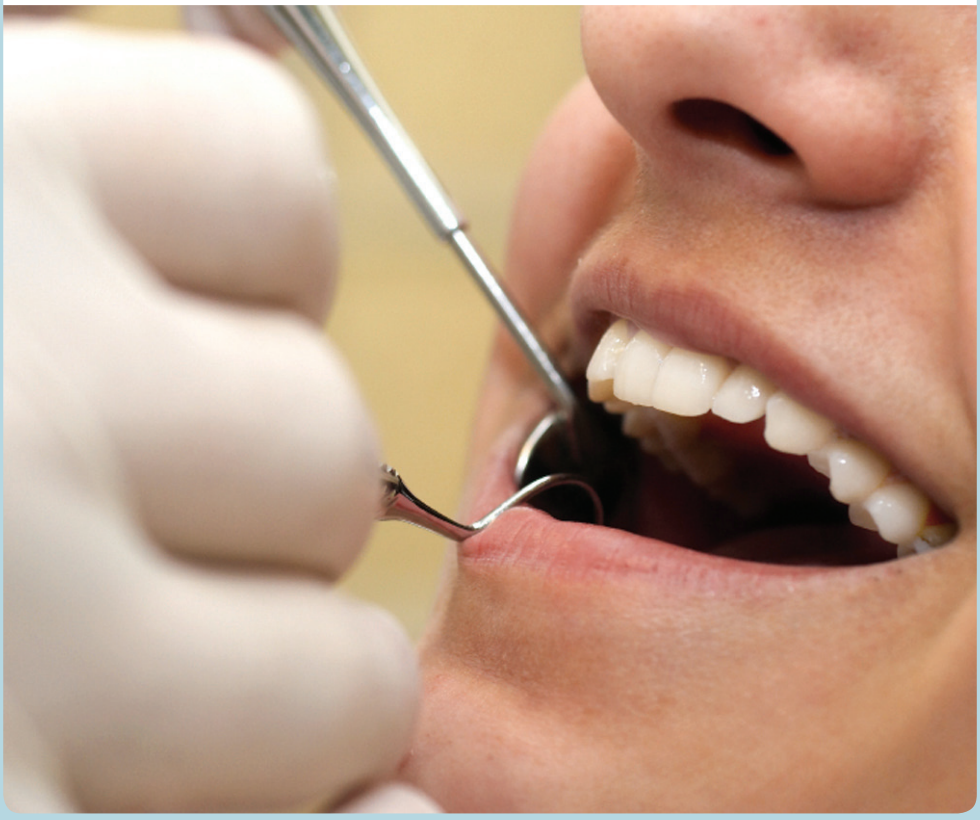
As a minimum we want to see more funds flowing to state and territory public dental services with a longer term commitment to systematic funding of basic preventive and restorative treatments as part of primary health care.

You will also be aware that there are a number of organisations that have an interest in seeing better oral healthcare, particularly for those who struggle to afford and access private dentists.

To this end, the AHHA joined with a number of other peak bodies to form the National Oral Health Alliance. The Alliance includes the Australian Council of Social Services, Australian Dental and Oral Health Therapists' Association, Australian Dental Association, Australian Health Care Reform Alliance, Australian Nursing Federation, Australian Research Centre for Population Oral Health, Brotherhood of St Laurence, Dental Hygienists' Association of Australia, Health Issues Centre, National Rural Health Alliance and the Public Health Association of Australia.

If this group could not bring about commitment to improved oral health, then it's a fair sign that neither of the major parties understands the gravity or the urgency of the problem. Their inaction will resign those languishing on public dental waiting lists to continuing months and years of pain.

We encourage you to visit the website at **oralhealth.asn.au** or contact the AHHA on 02 6162 0780 to find out how the campaign for better oral health services is going.



Election note

WHEN YOU READ this the result of the election will be known, but policy details are sure to be still a work in progress. The elected Government, regardless of its pedigree, is likely to be implementing policies in some of these areas. However we encourage you to think about whether progress has been made on the key issues rather than just some preliminary implementation of 'small biccies' election promises.

Without doubt there will be some degree of system reform, particularly for how hospitals are organised and run, though this may not include changing models of care (see our article on the previous page on whether more hospital beds are the solution). Reform of primary and community health must also be at the top of the reform agenda for the Government.

The AHHA remains concerned that evolution of the acute, primary/community and aged care sectors continues to be insufficiently coordinated. We have been saying this for a long time, and we would encourage you to go back to our 2008 policy on Service Integration to see some of the recommendations and decide for yourself which of those are being acted on by the Government.

To help you assess the main points, visit the AHHA website to download our 2010 Election Statement and revisit our policy position on Service Integration (**aushealthcare.com.au**).

Is effective governance an issue for rural and remote health services?

GRAEM KELLY
Chief Executive Officer
of Castlemaine Health

More than **anywhere else**, says Graem Kelly

HEALTH CARE SERVICES in rural and regional areas are under tremendous pressure with issues such as recruitment and retention of staff, funding, infrastructure and, not least, having their voices heard. The system is in crisis and requires effective and responsible governance to assist it through the current planned health reforms.

Health services are at the centre of rural communities

Rural and remote health services are an integral part of the overall health system and have a fundamental synergy with other services like education, local government and police in building the capacity of local communities to survive. Contextually, successive governments over the years have treated health as a silo of funding with internal service working relationships in need of making change under the banner of economic rationalism. The undermining of community capacity and the lack of community consultation has left the entire breadth of the health system in need of reform. We must learn from this and ensure the planned reforms do not allow the same errors to occur again. We must take into account how, in rural and regional Australia, the local health service fits into the fabric of its local community.

The difficulty for the Boards and decision-makers in rural and remote

health services is that, while they have direct organisational responsibilities they are required, at the same time, to understand the flow-on impact their decisions will have on the capacity of the community and/or region. Often the hospital/health service is one of the biggest local employers, if not the biggest. In this environment good governance is critical to the sustainability of rural and remote communities and critical to the success of the current health reform agenda.

Change for everyone is afoot – and it's risky

While the health system presently has mixed roles and delegations for health service Boards and management teams across jurisdictions, it is expected as a result of the implementation of a health reform agenda that greater conformity and clarity in roles for health Boards across the nation will occur. This may be notional because the fine detail is at this time focussed on the roles of the intended Boards rather than governance more generally.

Because of this, it invites questions from all quarters about how these Boards will operate. Noises are being made about the need for greater clinical input. Good governance by its nature seeks recommendations from stakeholders before setting organisational strategy. The Board is charged with the responsibility of ensuring the best interests of the organisation are met. They are now also accountable to the local community in ways not seen across the country for a long time, and in some places ever before.

The danger is that when you put personal interests into the workings of a Board you will create potential for conflicts of interests and questionability of the Board's integrity.

The same can be suggested to occur if, in the process of appointing Boards, governments do not maturely allow for the right mix of skilled persons to be selected. The integrity of governance has to be guaranteed as it is a basic tenet of these reforms and there is no room for arbitrary political appointments undermining the Board selection process.

What are the precedents and principles of good governance?

In reviewing the workings of effective governance there are learnings to be taken from the failures arising in corporate Australia (for example, One Tel and HIH). If governments understand hospital bodies to be corporate bodies with corporate responsibilities, then they will ensure only the best practices of governance are introduced into the health system.

In the public sector governance is suggested to be "... the set of responsibilities and practices, policies and procedures, exercised by an agency's executive, to provide strategic direction, ensure objectives are achieved, manage risks and use resources responsibly and with accountability" (Australian Pubilc Service Commission, 2007).

Public agency Boards would still be expected to conform to the public service governance framework (Australian Public Servcie Commission, 2005) and meet the following principles of:

- Accountability;
- Transparency/Openness;
- Integrity;
- Stewardship;
- Efficiency; and
- Leadership.

These are not inconsistent with but rather complementary to the Corporate Governance Principles and recommendations developed by the Australian Stock Exchange Corporate Governance Council (2007) in which are to:

1. Lay solid foundations for management oversight;
2. Structure the Board to add value;
3. Promote ethical and responsible decision-making;
4. Safe-guard integrity in financial reporting;
5. Make timely and balanced disclosure (on all material matters concerning the company);
6. Respect the rights of shareholders (in health's case the government and health service consumers);
7. Recognise and manage risk; and
8. Renumerate fairly and responsibly.

None of these principles are inconsistent with current expectations, especially when we have cases such as Dr Jayant Patel in the media and the constant barrage of political verbiage looking to make health services accountable.

Rigour and skills

Historically Boards have been at risk from Board members' poor skills, lack of understanding of the Board's duties and responsibilities of its members, lack of training and support and even a risk of too much influence being exerted by political factors which can arise from local, state and federal intervention.

Whether a health service is a multi-million dollar business or a just a basic rural service, governance does require extreme rigour. The difference in the rural setting is that attracting the calibre and breadth of skills needed to build an effective Board can be difficult.

We all have to move into the contemporary reality that Boards perform essential functions of setting strategic direction, making resources available for the success of their strategic plan, monitoring performance, ensuring organisational compliance, setting the organisation's risk appetite and putting in place a framework of risk management. Not least they are accountable to the communities they service and the governments that fund them.

It is not an easy role to be on the Board of any public service, as in reality there are tensions between meeting the needs of the consumers of these services and governments who pay for the service. Government, as a result of its need for accountability, does set out expectations which, with the agency caught in between, may not align with consumer expectations.

Regional communities can't afford failure

The health care system is in a higher state of flux than usual. It is critical that the intended reforms be built on the strong foundations of effective governance undertaken by suitably skilled directors.

Success will come as result of good governance and so will effective resource management, but our society and particularly rural and remote Australia can ill afford for this to fail. Health must be accountable and lean as we all expect public funds to be appropriately and responsibly allocated.

Health service Boards face many challenges but must not become blinkered to the broader social context in which health care is enmeshed in community life.

References

Australian Pubilc Service Commission (2007). Building Better Governance. Canberra: Commonwealth of Australia.

Australian Public Servcie Commission (2005). Foundations of Governance in the Australian Public Service. Canberra: Commonwealth of Australia.

Australian Stock Exchange Corporate Governance Council (2007). Corporate Governance Principles and Recommendations. ASX.

A doctor in every town

DR PATRICK BOLTON
Vice President of the Australian Healthcare & Hospitals Association

Patrick Bolton suggests a way to improve health outcomes for **people in the bush**

WHEN I WAS single, I enjoyed jumping in the car and driving over the mountains into rural Australia for the weekend with a mate. We'd aim to go where we hadn't been before, stay off the main roads in pubs in small country towns where the tariff was often ten bucks a night.

One of the things I observed on these trips was that pubs were the basic utility in a town. A collection of houses became a town when it had a pub. If it was a bit bigger it would have a general store, which doubled as a post office. It generally required two or three pubs before a town was big enough to get a GP and hospital.

Another thing I noticed – at least in those places which were close enough to get to on a weekend of moderately hard driving – was that the distance between towns tended to be around what I guessed to be one day on horseback, or two on foot.

For the first fifty to one hundred years of white settlement many country people lived at least two hours from town and the doctor.

Agriculture has become increasingly centralised and dependent on the economies of scale. Towns don't need to be as close together as they once were. A journey which used to take a day or two can now be travelled by car in less than an hour, but the expectation remains that there will be a doctor in every rural town.

People make choices about where they live based on their perception of the amenity that those places offer them. The tranquillity of the bush is incompatible with some of the services available in the city.

Early stenting for acute myocardial ischaemia needs a high volume of demand, for reasons of both cost and quality. It cannot be delivered in rural areas under current service models. This is a clear example of where the choice to live in a rural setting means reduced access to health services, but the same argument applies to some extent even to primary care services.

Healthcare funding follows the provider not the consumer. This is most evident in Medicare funding for GP services where rural areas attract less funding because they have fewer GPs. However, the same principle applies to hospital based services – if a doctor won't work in a town then there is no need to fund him or her! A partial response to this might be to weight funding in proportion to demand, rather than supply. In this way the standard fee for general practice in Sydney's eastern suburbs, where there is more than one GP per 500 people, would be subsidised by the government at a quarter of the rate that it is in Broken Hill, where there is around one GP per 2,000 people.

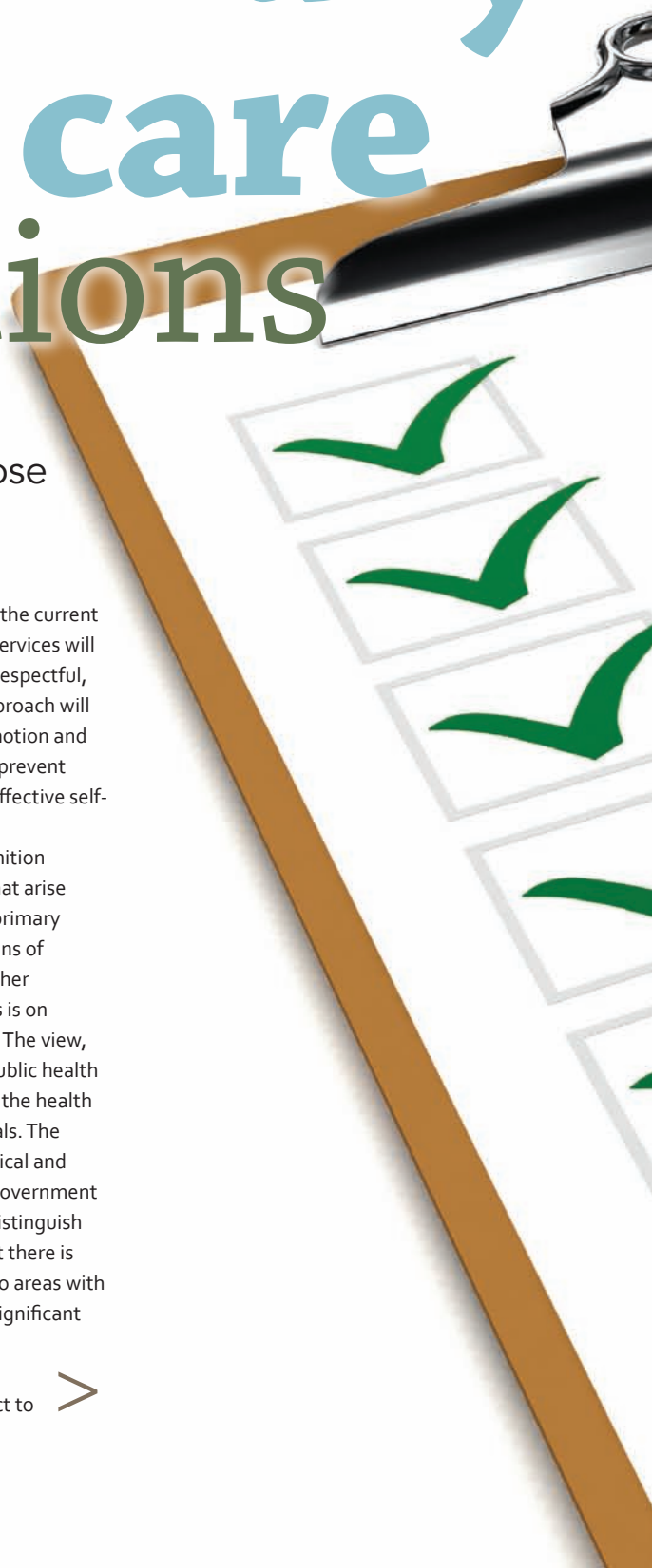
The weighting could be further adjusted for mortality and morbidity, which are higher in the bush.

Healthcare resourcing can't be always be equitable because of the economies of scale required to support some specialist services, but funding should be equitable. Equity of inputs is not the same as equity of outputs, but it is a start, and it is easier to measure.

People living in rural Australia should have the same access to public healthcare dollars as their urban counterparts. Having said this, it needs to be recognised that some rural health services are relics of a bygone era. Supporting them can be inefficient and this leads to inequity because those health dollars might be better used elsewhere.

> People living in rural Australia should have the same access to public healthcare dollars as their urban counterparts

Tensions in local primary health care organisations



Balancing the **needs of individuals** with those of populations

INCREASING LIFE EXPECTANCY and improvements in health outcomes over the last century are largely attributable to clean water, sanitation, injury prevention, reduction in smoking and better nutrition. Despite this, the focus of decision makers is overwhelmingly about improving the way the medical and, to a lesser extent, allied health professions and systems deal with the health of individuals.

The focus on the establishment of the Medicare Locals under a Labor Government as alternative primary health care organisations (PHCOs) to the Divisions of General Practice raises the question about what real change will take place. Perhaps we should start by asking what we mean by primary health care.

Primary health that includes preventive health

The Primary Health Policy of the Public Health Association of Australia (PHAA) suggests that an effective primary health service will include a multi-disciplinary range of services and programs that are well beyond the current emphasis on the role of GPs. Such services will be accessible, equitable, culturally respectful, safe, effective and efficient. The approach will include prevention and health promotion and should empower the population to prevent risky behaviours and enable more effective self-management of chronic conditions.

A broad primary health care definition effectively identifies the tensions that arise from differing perspectives. When primary health care is viewed through the lens of general practitioners, nurses and other allied health professionals the focus is on improving the health of individuals. The view, however, from the perspective of public health professionals focuses on improving the health of populations rather than individuals. The decisions in this area are often political and taken at the local, state or federal government level. Although it is convenient to distinguish between the two, it is apparent that there is substantial overlap between the two areas with many professionals playing a very significant role in both.

When examining the health of individuals, for example with respect to >

MICHAEL MOORE
Chief Executive Officer
of the Public Health
Association of Australia

chronic disease care, there is a need for a range of health care professionals who are well resourced to provide ongoing care so that appropriate self-management occurs by people living with chronic disease. However, a focus on improving the health of populations requires an understanding of the social, cultural, political, legislative/regulatory, economic determinants and the physical context as well as the characteristics of particular populations.

Leadership lacking

There is a crying need for leadership to muster the population's ability to participate in key elements of improving health and well being. This is the sort of leadership that requires paying attention to such elements as increased health literacy, the role of gender, age, health promotion, injury and disease prevention, nutrition, mental health, environmental health, oral health, social determinants, political processes and preventative care for the community as a whole.

As part of the health reforms and debate throughout the election campaign there has been precious little effort to identify and resolve the distinctions between these two elements of individual and population that are both fundamentally important to maintaining and improving health. The politics of health expenditure over the last couple of decades has been overwhelmingly on hospitals, emergency departments and elective surgery waiting lists that provide the fodder for the media and opposition parties in the political arena.

The next level of focus has been on what GPs and other health professionals can achieve within the remit of the Medicare Locals. The emphasis has been in areas such as better treatment, coordination, delegation, education and management of resources. It is good that the growing role that nurses, pharmacists and other allied health professionals can play is also being appropriately recognised.

How does government deal with preventive health?

Through all these considerations, however, there has been precious little focus on public health issues. The Government did appoint the Preventative Health Taskforce to wrestle with the most effective ways to handle tobacco, alcohol and obesity. They also gained agreement from the Council of Australian Governments (COAG) to establish the Australian National Preventive Health Agency and have provided funding for the organisation. Unfortunately, this key element of reform, with its prime focus on tobacco and obesity at this stage, is languishing in the Senate.

The Preventative Health Taskforce set specific goals and targets with rational time frames to achieve *Australia: The Healthiest Country* by 2020. The Government tabled its response on 11 May 2010 called *Taking Preventative Action*. The Government's response starts with a quote from the Minister, the Hon Nicola Roxon: "The saying is true – prevention is better than cure. But for all the strengths of our health system Australia has historically not invested enough effort and funding in preventing chronic and life-threatening diseases". Although the Taskforce's remit and recommendations were limited to tobacco, alcohol and obesity the Minister's introduction with regard to social marketing campaigns touched on other issues.

It seemed that prevention and public health would finally get the guernsey that it deserves. However, the priority argument seems to have hamstrung the sort of action that is urgently needed. It is action not just on tobacco, alcohol and obesity but on a range of other public health measures.

There are still remote communities within Australia that do not have appropriate environmental health and in some cases even lack appropriate clean water and sanitation over a century and a half after John Snow identified their importance.

Taking action

Prevention also includes focussing on healthy rather than unhealthy behaviours, disease prevention and the myriad of challenges in the area of environmental health. Although the government has rightly prioritised on the areas that are responsible for the greatest burden of disease, taking the next steps means tackling the social determinants of health, identifying evidence that points to policy failures and successes and having the courage to implement solutions.

The sort of courage that is important in preventive health policy is demonstrated by the early action the Labor Government took to increase taxation on tobacco and its commitment to plain packaging. The government always understood that large international tobacco companies would not want Australia to be the first cab off the rank in international terms and the industry duly funded a campaign purportedly to be conducted through small retailers in a desperate attempt to wind back the clock.

Some action has been started in the prevention area. However, the question still remains about how these issues might be addressed in terms of the new primary health care organisations. There seems to be an assumption that these PHCOs will be able to manage them. When questions are put regarding the areas of prevention and population health to government and bureaucracy, the answer invariably falls in to the region of "it will be the next cab off the rank" and "government will focus on it after the second phase of the reforms take place – the PHCOs".

The reality is that the focus of reforms from all sides of politics has been on phase one – hospitals. Political reality has required enormous expenditure so that everyone in the community can have reduced waiting times for elective surgery and so that governments at all levels are not embarrassed by media shots of ambulances ramping outside emergency departments.

There is an important role for a Preventive Health Agency to run Australia-wide marketing campaigns. However, its action with the appropriate funding should rapidly move beyond tobacco and obesity to alcohol and then to other areas of population health.

The Hong Kong approach to public health

Governance – getting the balance right

Will the structure of the PHCOs mean a genuine engagement with the population health issues or will the growing demands of those already with chronic conditions dominate the thinking and the funding? It is difficult, although not impossible, to see how the transition from Divisions of General Practice to Medicare Locals will be able to resolve this tension. The most critical issue will be the governance structure. It is important that GPs and allied health providers are involved in the governing boards. There is also a need for legal, financial, administrative and other professional representation.

Most importantly, the governance structures should embed appropriate understanding of the social determinants of health and their impact within the local environment. According to the Australian Institute of Health and Welfare, governments around Australia average about 2% of health spending on prevention. The PHAA believes that doubling this spending to around 4% will be just a first step in adequately addressing the need.

A stronger, more integrated primary health care system seems to be the catch-cry of many of those who are committed to reform. The two priorities of this integration seem to be within the PHCOs themselves and in the relationship with hospitals. Of course these are important – but there is more! If genuine integration is to occur across the spectrum of health, the challenge for those who are involved in primary health reform and who believe that primary health care should include a focus on populations as well as on individuals will be to ensure the preventative role in Medicare Locals, or their equivalents, will not be lost in funding, in key performance indicators or in evaluation.

There is a window of opportunity in the development of PHCOs. Our communities cannot afford to miss the opportunity to have these organisations working towards all individuals having access to the best possible integrated care from the primary level through to the tertiary teaching hospital. Even more importantly, individuals should have the support and social structures in place to provide them with every incentive to engage in healthy behaviours and to remain healthy throughout their lives.

ALICIA COOK
Project Manager
of Clinical Systems,
ACT Health

The human factor

Alicia Cook considers the real **value of IT**

THE EVER-INCREASING demand for health care means that Australia needs a sustainable, more lithe health system to evolve from the one we have at the moment.

No doubt you are quite familiar with the rhetoric on this subject: a key principle supporting sustainability is to introduce new ways of working that will increase the efficiency and effectiveness of health care delivery.

This should, in turn, help alleviate some of the pressure on resources. Information technology (IT) systems are seen as being an appropriate solution to help drive those improvements, as well as delivering gains in quality and safety of health services.

Introducing IT systems into health care is nothing new. For many years now, systems have been rolled out in hospitals with the intention of creating better quality and more efficient health services.

Yet there are plenty of examples in the literature of IT systems failing to live up to expectations, or worse still, creating more problems than they solve.

Unquestionably, technology has a massive role to play in health. And yet IT systems in isolation are not the silver bullet that will deliver those efficiency gains or the quality improvements for which we are striving. A recent letter to Health Affairs sums it up perfectly.

"Any software that mediates social collaboration and alters long-standing work flows is socio-technical in nature and will never be understood by looking only at the technical aspects," the letter said.[1]

What this means is that while IT might be seen as a solution to many of the issues facing the hospital and healthcare sector, it is not enough to simply wheel in the IT gurus and leave them to get on with the job.

Simply because thehealth sector is such a knowledge-intensive industry, this does not mean that the experience of other sectors, such as finance, can be replicated here.

Applying a 'one size fits all' approach to an IT solution in health is akin to eating a vindaloo curry, drinking a few glasses of red, and then crossing your fingers as you flop into bed in hope that heartburn will not strike as you sleep tonight.

Our health system is a complex canvas of social, cultural and political structures. If IT systems don't make a genuine effort to fit within those structures, they are almost certainly going to struggle to achieve their intended purpose - and may in fact create what is delicately referred to as "unintended consequences".

If we are serious about creating efficiencies and improving quality, we should be focussing on delivering new technologies and ways of working that support and leverage the health workforce.

The systems we introduce must make their jobs easier, not harder. They must be intuitive, not irritating. They must deliver better quality health outcomes, not worse. They must be embraced by the workforce, not avoided, or worked around.

> The systems we introduce must make their jobs easier, not harder. They must be intuitive, not irritating.

To achieve this, we need to look to what other successful health IT implementations have done well and make certain we do not replicate their mistakes.

This means putting a bit of elbow grease into engaging across a hospital, thereby truly understanding where the system is supposed to fit in, making sure that clinical workflows are maintained or streamlined, and going back, time and time again, to consult with the users to make sure the system interface is easy to use.

This kind of approach – the one that considers the human factors, the people at the centre of the IT system – is exactly what is consistently reported in the literature as being an attribute of a successful health IT system. And when we have IT working with clinicians, we can start to reap the benefits! ha

1. Schuette, R. Wade. The social side of adopting technology. Health Affairs. 2010;29:6

UNIQUE™ Care

Manufacturer of quality care products

Designed and engineered from the highest quality components, incorporating the latest safety features and state of the art technologies.

SafeCare floor beds have a minimum height of only 50 mm and will stow away in seconds with the optional space-saving folding mechanism.

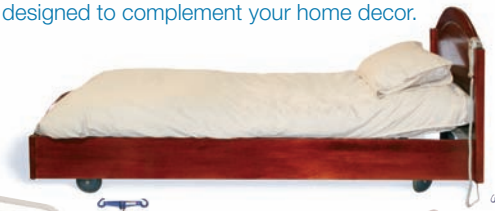
Our Bariatric beds are available in a range of sizes and options.

Evo bed mover suitable for use with our range SafeCare Floor beds and Standard beds.

Standard High-Low bed with optional wood grain Bed heads.

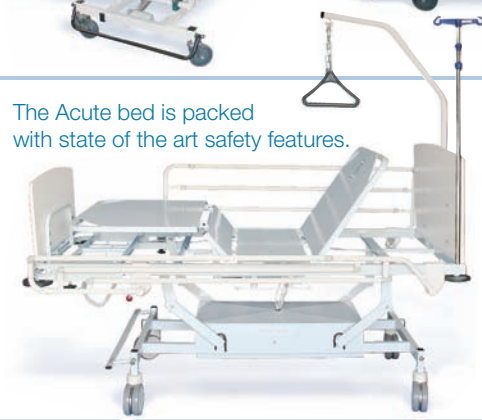
Pressure Sensitive Mattresses (PSM). 2 Layer high density foam construction and waterproof, breathable & flame retardant cover.

The HomeCare bed has all of the features of the Standard High-Low bed enclosed in a solid timber frame and designed to complement your home decor.



The Ward bed is designed with ease of use and reliability in mind.

The Acute bed is packed with state of the art safety features.



The full Trendelenburg tilt functions is smooth and seamless.

TGA Approved & Manufactured to AS/NZS 3200.2.38:1997 and AS/NZS 3200.2.38.2007

AUSTRALIAN MADE AND OWNED

Australian made toughness and reliability

Proud Gold Associate Member of Australian Private Hospitals Association

Support those who support you

CorporateSupporter

Proudly a member of Aged & Community Care Victoria

Also proud supporters of ACAA WA

Unique Steel Design Pty. Ltd., 9-11 Point Henry Road, Moolap, Vic 3221.

(03) 5248 8369 | www.uniquecare.com.au

Developing a passion for rural health

The next generation of health professionals reminds us **how to care**

FOR YEARS THERE have been arguments about the state of rural and remote health and how we can address the issue of access and equity. Today we have a new generation of vibrant, energetic and optimistic students who are striving for change in this arena. These students are part of the National Rural Health Students' Network (NRHSN).

The NRHSN is Australia's only multi-disciplinary student organisation and comprises more than 9,500 students from medical, nursing and allied health backgrounds. The students are members of one of 29 NRHSN rural health clubs which are spread across every state and territory. Not all members are rural students – in fact the majority come from metropolitan backgrounds. Their mission is to improve the health workforce and health outcomes for rural and remote Australia. The NRHSN as of late has been steamrolling ahead in terms of its activities, membership and, of course, its advocacy.

The NRHSN was established in Kalgoorlie in Western Australia in 1996, following the National Rural Medical Undergraduate Conference, with the aim of encouraging students with a passion for rural health to truly make a difference. The Network began with a commitment to making a change at a grassroots level, with university health students participating in rural school visits to educate students about healthy living as well as providing them with inspiration to continue on to tertiary studies, in particular rural health. Today this grassroots commitment continues, only on a much larger scale with well over 100 rural high schools visited each year.

In addition to the school program, the NRHSN is committed to Closing the Gap in Indigenous health outcomes and conducts education programs for Indigenous children at Indigenous festivals throughout the country. The NRHSN has partnered with Wakakirri, Vibe Alive and Deadly Days Indigenous festivals to deliver programs on healthy eating, diabetes and general wellness. NRHSN students represent the Network at these festivals by coordinating workshops that teach children about health and ways in which they can get into further studies when they finish school.

While these local initiatives continue as the Network's core priorities, each of the 29 rural health clubs deliver adjunct rural health education to their members at a local level. Activities include academic speaker nights with topics ranging from Indigenous health forums to health workforce advocacy which inspire students to head to the bush.

The rural health clubs also provide their membership with practical skills which can equip them for later careers in rural practice. HOPE4HEALTH, our club based at Griffith University in Queensland, runs annual trips to Cherbourg where they provide dental care to the local community. Not only does this give their students invaluable experience in their future profession but more

National Rural Health Students' Network members are ready to jump at the challenges ahead

SHANNON NOTT
Co-Chair of the National Rural Health Students' Network

A visit to a rural school

importantly, it provides much needed care in an otherwise poorly serviced area of Australia.

The clubs are at the core of what the NRHSN stands for. Many have established regional events across the country that are designed to promote rural practice among NRHSN members and involve local communities from rural and remote regions.

One example is the Western Australian Children's Festival run by the WAALHIIBE and SPINRPHEX rural health clubs. This festival started in 1991 with the ideal of bringing both Indigenous and non-Indigenous people together through uniting children in harmony, giving the town a reason to celebrate, and for participants to think about rural pathways into undertaking health degrees. This event continues to this day and is governed by these same ideals.

Campfire is a regional based event run by AURHA, FURHS and ROUSTAH rural health clubs and is run in a conference-like format to inspire future health professionals to head to the bush when they graduate. Delegates gain practical skills such as suturing and learn from some of South Australia's most renowned health professionals.

Another regional event which has grown over the past four years is the Rural Appreciation Weekend, more affectionately dubbed RAW. RAW is organised and hosted by RAHMS, the rural health club at the University of NSW, and is held on a sheep, cattle and cropping property near Dunedoo in central west NSW. It promotes a rural lifestyle to students through integration with the community, various workshops and guest speakers, and has expanded to include local high school students to give them an understanding of the issues facing their own communities and ways in which they too can make a difference in their home towns.

In addition to the local and regional events, there are a couple of critical national events organised by the NRHSN. The inaugural National Rural Leadership Development Seminar was held this year in conjunction with the Australian Medical Students' Association.

More than 100 of Australia's brightest leaders from all rural health clubs and medical societies were selected to gain vital skills in leadership that will not only aid them as professionals but as hopefully future champions of rural health. This event saw speakers from a variety of backgrounds inspire, teach and share a little of themselves with all delegates.

Then there is NURHC – the National University Rural Health Conference. This year it was held in Alice Springs in July and gave over 350 NRHNS members a chance to get together to learn, share and network with other delegates, speakers and stakeholders. The conference is the best known of all the NRHSN's endeavours and attracts some of Australia's most exceptional leaders in the fields of rural and remote health and Indigenous health. This year's theme was Central to Health, highlighting that rural and remote communities are at the core of everything we do as a Network and all of our programs, and our advocacy, is directed toward one common purpose – to improve the health workforce and health outcomes for rural and remote Australians. The NRHSN is currently compiling recommendations from the conference.

The National Rural Health Students' Network prides itself on being a conduit for its membership to discuss health reform in rural and remote communities. The Network also prides itself on promoting a multidisciplinary approach to improving inequalities in rural health. Most importantly though, the NRHSN prides itself on being active at the grassroots level to nurture the next generation of Australia's rural and remote health workforce.

For more information about the NRHSN please visit the website at www.nrhsn.org.au. The website includes information about the Network's position on issues pertinent to rural and remote health as well as further information about all of its activities. ha

Shannon Nott (left) with the minister, Warren Snowdon and AURHA co-president Jasmine Banner

Do you produce a magazine for your customers, members or staff?

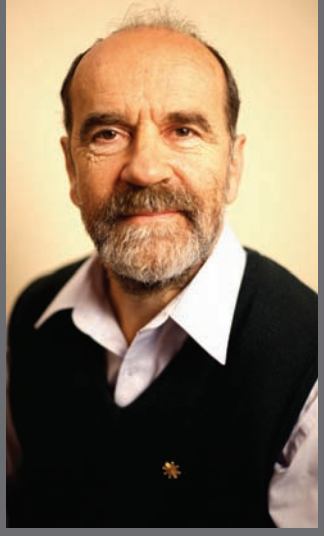
If the answer is yes, then maybe you should talk to our experts. We have a proven track record of reducing magazine costs and increasing readership for a wide variety of clients across Australia.

globe PUBLISHING

CUSTOM MAGAZINES

www.globepublishing.com.au

Call David Kettle:
02 8218 3401
Or Email:
david.kettle@globepublishing.com.au



GORDON GREGORY
Executive Director of the National Rural Health Alliance

Sustaining good health in the bush

What road will the Commonwealth take?

IN THE LAST issue you would have read a piece from me on what exactly primary health care is and means for Australians. This month I return to the core work of the National Rural Health Alliance (NRHA).

In the recent election campaign, the NRHA found itself again championing broad policies to underpin the sustainability and vitality of communities in rural and remote areas.

'Rural health' is more than just health

Although it is a health alliance, the organisation is a strong voice on rural and remote affairs in general. Organisations within the Alliance such as the Country Women's Association of Australia, the Isolated Children's Parents' Association and Health Consumers of Rural and Remote Australia, make sure that, in its work, the Alliance never forgets the fundamental purpose of its existence. That purpose is to make every effort to try to ensure that people living in rural and remote areas have good health, wellbeing and lifestyle opportunities.

So while there is a legitimate role for specific organisations in the Alliance to be concerned with their particular professional interests, they are also supportive of the strong focus of consumer organisations on ensuring that the work is directed at what is often called the sustainability of rural and remote communities.

Sustainability isn't just a fad

The word 'sustainability' has been given wider currency during the election campaign due largely to the Labor Government's re-badging of one of Tony Burke's responsibilities as Minister for Sustainable Population (expanded, or contracted depending on how you look at it, from Minister for Population). While initially there was criticism of this apparently subtle change, it is now the case that all the major parties agree that Australia's population policy, including as it relates to immigration, should take account of the ecological, social and economic capacity of the nation.

For its part, the Alliance has for some time tried to identify what it is precisely that makes some communities in rural, regional and remote areas 'sustainable' and others not.

The UK Government defines sustainable communities as: "... places where people want to live and work, now and in the future. They meet the diverse needs of existing and future residents, are sensitive to their environment, and contribute to a high quality of life. They are safe and inclusive, well planned, built and run, and offer equality of opportunity and good services for all."

This approach to the concept of sustainability rests not on size or location but on the quality of life offered. However, it does have implications for size – at least for changes in size. If the community is sufficiently attractive, even in the absence of intervention and support it is likely to maintain or grow its population.

One of the problems with such a definition is that it is determined by people's individual judgements. For some people, a sustainable community in these terms could be one with a primary school, pub, general store, some social, artistic and sporting capacity, and community organisations such as the CWA, Rotary and/or Lions. For others, proximity to a doctor and emergency healthcare may also be essential.

However, other people may not mind living in places that are very small – and even experiencing population loss – as long as they have access to certain basic services. The relationship between 'sustainability' and 'liveability' is therefore quite complex.

The notion that a sustainable community is one with a future that is not at risk embraces both ecological and lifestyle considerations. It is a place where people want to live and work, both now and into the future.

In the context of the health system, sustainable communities are desirable places because they provide positive social and economic determinants of health. They are places where there is the capacity to engage in healthy behaviours, meet basic life needs, and find fulfilment in social and professional spheres.

As they are pleasant and healthy places in which to live, they are able to attract and retain health (and other) professionals. They are likely to offer a good supply of jobs, access to decent education, a range of goods and services (including health services) and a reasonable cost of living.

In summary, sustainable rural and remote communities enhance the liveability, efficiencies, economy, industry diversity and vibrancy of Australia, and the health of its people. They can be contrasted with communities that cannot attract the infrastructure, services or staff they need and whose members find it more difficult to maintain a good and healthy lifestyle.

How can we help communities become sustainable?

One of the questions that challenges the rural health sector and governments is what their approach should be to communities which persistently fail to achieve an adequate level of sustainability. For most of the past 25 years governments have been unwilling to intervene in the market process by which communities grow or decline. They argue that it is hard to pick winners and losers – and it is certainly the case that today's unsustainable community could, through fresh blood and renewal, become a sustainable success story in the future.

Those of a more interventionist disposition will have been heartened by some oblique references during the election campaign to what may be seen as a de facto regional development policy. There was more or less agreement that immigration should be seen in the context of the differential needs of various regions for a larger workforce. In the mining taxation debate there were references to using tax revenues for building infrastructure in areas of great need. The National Farmers' Federation proposed a root and branch update of the remote zone tax allowance. And a general view seems to have developed that population growth should be distributed away from the congested capital cities with the Labor Party promising investment in affordable housing in a range of non-metropolitan centres. Even the proposal to reward job seekers who shift from one region to another may be seen as part of regional development.

Frequent references to Australia's 'two speed economy' remind us that there is more than one reason for rural communities to be experiencing stress. As a nation we have grown used to the ongoing and potentially corrosive challenges faced by communities that have gradually lost population and services, and have borne what is arguably an unfair share of the nation's economic adjustment. Now, at the other end of the spectrum, we hear of communities in resource-rich regions where the major challenges include the general difficulty of maintaining physical and social infrastructure development at a

pace to ensure that locals have a healthy and pleasant community in which to live. It is not uncommon to hear stories of communities in the north-west of Western Australia where the major constraint on appointing an allied health professional, for instance, is the unavailability of housing rather than what is more usually the case: the unavailability of the health professional.

The determinants of health and health policy

Having such broad community issues as these on its agenda means that the Alliance remains focused on the critical importance of the social and economic determinants of health. The organisation has been fond of saying that the best medium-term answer to the shortage of doctors, physiotherapists and nurses in the bush is regional development. That is, if we could spread our population and infrastructure more evenly over this wide brown land, there would be more naturally healthy and attractive places in which to live and fewer short-term and ad hoc programs to recruit health and other professionals would be required.

But in a polity in which three-year Federal Government cycles (and too much other government besides) are dominant influences on policy processes and their results, it is hard to interest politicians or the media in anything but the short-term.

Reflecting this reality, the Alliance therefore promoted several of its shorter term bids in the election campaign – many of which relate to the health sector more narrowly. It has been a difficult time due to the shortage of categorical statements from either of the major parties. The mental health lobby groups have managed to move their issues more into the spotlight, with the commitments of the two major parties now distinguished more by how their policies would be funded (in the case of the Coalition, from cuts in other parts of the health sector) than by their content.

Where's the detail on local health entities?

One of the most intriguing and critical elements at the time of writing is the extent to which the two major parties will push on with the health reform agenda into which so many interest groups have put so much time and energy. People have noted that, as Prime Minister, Julia Gillard signed off (with her Health Minister) to *A National Health and Hospitals Network for Australia's Future – Delivering the Reforms*, and that Tony Abbott has indicated he will cut the new tranche of GP Super Clinics. But what neither side of politics made clear in the election campaign is the role to be played by local entities and the related infrastructure for open accountability of public hospitals and primary care, which seems to many to be a very useful way forward.

It might be concluded that the new architecture proposed for the Australian health sector is not, after all, something in which the politicians have real confidence. If this is the case then it is likely that those two-and-a-half years' work will result in simply another generation of Area Health Services managed by the States. If this means also that the Commonwealth does not proceed to take policy and funding responsibility for primary care and aged care, many will be bitterly disappointed.

People associated with the NRHA will be among these, believing that the localisation of management and control of hospitals and primary care, within a single, unified national health system, has much in the way of benefits to offer to people in rural and remote areas. Time will tell what the prognosis is for real change in Australia's health system – and whether the 2010 election campaign was a bump in the highway or the beginning of a no-through road. ha

> Time will tell... whether the 2010 election campaign was a bump in the highway or the beginning of a no-through road.

A National Hospital Network

Maybe this is something we can all agree on, says Alison Choy Flannigan

BY THE TIMe this article is published the outcome of the August 2010 Federal election will be known. The general concept of a more locally managed public hospital structure as part of a National Hospital Network currently enjoys bipartisan support.

Understanding the Agreement

On 20 April 2010, COAG agreed, with the exception of Western Australia, to sign the National Health and Hospitals Network Agreement (NHHN). One of the most significant changes will be the requirement that existing health services will become smaller (or in some cases larger) Local Hospital Networks (LHNs).

The NHHN suggests that the aim of the LHN's is to decentralise public hospital management and increase local decision-making to better meet local needs. The agreement states that ideally LHNs are to consist of a single or small group of public hospitals and other health services with a geographical or functional connection.

The LHN's will be run by a Chief Executive and Governing Council. Governing Council members will be appointed under respective State legislation by State Health Ministers. Each LHN's CEO will be appointed by the Governing Council, with the approval of the State Health Minister or their delegate, and will be accountable to the Governing Council.

LHNs will be responsible for:

- negotiating and agreeing with the relevant State Government a LHN Service Agreement and any necessary adjustments;
- managing the LHN's budget as determined by the LHN Service Agreement;
- developing a strategic plan for the LHN, and implementing an operational plan to guide the delivery of the services, within the agreed budget under the LHN Service Agreement;
- providing to States sufficient information regarding actual service levels delivered to enable them to inform the Commonwealth of the payments to be made; and
- receiving Commonwealth funding for delivery of services from the Funding Authority in that State as agreed under the LHN Service Agreement.

LHNs will also be responsible for:

- employment of LHN staff in line with remuneration and employment terms and conditions established by State governments in workplace relations agreements;
- local implementation of national clinical standards to be agreed between the Commonwealth and States on the advice of the Australian Commission on Safety and Quality in Health Care;
- local clinical governance arrangements;
- providing information to States at their request, for the purpose of enabling the relevant State to provide information and data; and
- maintaining accountability under and subject to State financial accountability and audit frameworks.

In early August this year, NSW Health released a Discussion Paper – Health Reform in NSW – containing its proposals for how LHN's should be distributed throughout NSW. The opportunity to make submissions on the Discussion Paper finished on 1 September, 2010, so unfortunately we do not yet know the overall response.

The Coalition's plan

The Coalition's "Plan for Real Action on Hospitals and Nursing" includes a developing a community-controlled public hospital system by transferring managerial decision making from centralised bureaucracies to community boards.

ALISON CHOY FLANNIGAN
Partner in Health, Biosciences and Pharmaceuticals at DLA Phillips Fox

Interesting times ahead

It would appear that the possibility of having a National Hospital Network of more locally managed public hospitals is high. Potential legal and other issues include:

1. Legislation throughout the States and Territories will need to be reviewed and amended to enable the new structure;
2. Appropriate governance arrangements and dealing with conflicts of interests;
3. Potential liability of members of the Governing Council/Community Boards;
4. The levels of delegation, functions and responsibilities of the Governing Council/ Community Board;
5. Measures to deal with non-performance of a Governing Council/Community Board;
6. Measures to deal with disputes within the Governing Council/ Community Boards;
7. Dealing with existing contractual relationships, including procurement and infrastructure contracts;
8. The role of organisations in the private sector (such as Affiliated Health Organisations) who currently operate public hospitals or provide, under contract, public health services; and
9. The transition of the employment of staff, particularly those staff who are currently deployed across a number of facilities.

The Plan states that community boards should include prominent community representatives with financial and management expertise. Boards should also include senior representatives of the local medical, nursing and allied health staff.

Boards will appoint hospital CEOs who would be responsible to the board rather than to the Director-General. With the CEOs, the local boards would set hospital budgets. Their selection and payment would be a matter for the States.

According to the policy, each major referral hospital, and its associated hospitals, should have its own board. In other instances, a small cluster of hospitals could come under a board. Details of which hospitals would fall under which local boards would be worked out with the States and local communities.

It's fair to say we are preparing for interesting times ahead!

For more *information, please contact Alison Choy Flannigan on 02 9286 8629 or by email at alison.choyflannigan@dlaphillipsfox.com*

Become an AHHA member

Help make a difference to health policy, share innovative ideas and get support on **issues that matter to you**

FOR MORE than 60 years, the AHHA has upheld the voice of public healthcare. The Association supports your access to networks of colleagues. It provides professional forums to stimulate critical thinking. It facilitates a collective voice across Australia and develops innovative ideas for reform.

Network and learn

As a member, you have access to regular professional development activities and to networking opportunities with colleagues across Australia through our stimulating and innovative events. You also receive the *Australian Health Review*, Australia's foremost journal for health policy, systems and management (paper copy and online), our new magazine *The Health Advocate*, up-to-the-minute news bulletins and other professional information.

AHHA values your knowledge and experience

Whether you are a student, clinician, academic, policy-maker or administrator, the AHHA values your skills and expertise.

The AHHA reflects your views and gives them a voice. Your ideas will help shape the AHHA's policy positions and our highly influential advocacy program.

Our focus is on improving safety and quality for patients and consumers in all healthcare settings. To do this we are working to achieve better service integration; enhanced information management systems; efficient financing models; targeted performance measures and benchmarking; and a sustainable and flexible workforce.

Your knowledge and expertise in these areas are valuable and you can have direct input to our policy development.

As a member, you and your organisation play a role in reforming the public healthcare sector by contributing directly to the AHHA's leading edge policies. We develop policies that reflect your views. Join our think tanks or participate in our national seminars or conferences. Our voice is authoritative and influential. It is heard via our high-level advocacy program and extensive media exposure.

Membership Fees 2010/11

Student	Australian: $195	Overseas: $262
Personal	Australian: $262	Overseas: $360
Associate*	Australian: $1050	Overseas: $1430

*Companies providing products and services to healthcare providers

Institutional Members (Australian healthcare providers)		
Gross Operating Expenditure (x 1,000,000)		
Equal to or greater than:	**Less than:**	**Membership**
$0	$10	$1,690
$10	$25	$3,380
$25	$100	$7,890
$100	$250	$16,900
$250	$400	$22,500
$400	$550	$27,900
$550	$700	$34,600
$700	$850	$39,500
$850	$1000	$45,100
$1000	$1500	$62,000
$1500	$2000	$78,900

*Fee includes GST - valid from July 1, 2010 to June 30, 2011

Image: iStockphoto

For more information:
www.aushealthcare.com.au
E: admin@aushealthcare.com.au
T: 02 6162 0780
F: 02 6162 0779
A: PO Box 78
Deakin West, ACT, 2600

2011 Membership Applications and Renewals

Australian Healthcare & Hospitals Association

Tax Invoice

PO Box 78 Deakin West ACT 2600 **t:** +61 2 6162 0780
ABN: 49 008 528 470 **f:** +61 2 6162 0779
E: admin@aushealthcare.com.au

	Australian	Overseas
Student*	☐ $195	☐ $262
Personal	☐ $262	☐ $360
Associate	☐ $1050	☐ $1430

Institutional ☐ _____

(See 2010/11 fee scale)

*Documentation required to verify status as a student. All prices for Australian membership include GST and are in Australian dollars.

Member Details

Name _____

Position _____

Organisation _____

Postal address _____

Suburb _____ State _____ Postcode _____

Email _____

Institutional members may specify an IP address: _____

eSubscriptions (optional)

☐ **E-Healthcare Brief** - The key news and AHHA updates edited by the AHHA team (twice weekly)

☐ **AHR Preview** - A reminder to check online for the next *Australian Health Review*

Payment Details

Amount in AUD$ to be paid by cheque or credit card (maximum for credit card payments: $2000).

☐ **Cheques** should be made payable to Australian Healthcare & Hospitals Association

☐ **Bank Transfer:** Details available from admin@aushealthcare.com.au

☐ **Credit Card Payments:**

☐ American Express ☐ Diners

☐ Mastercard ☐ Visa Amount _____

Cardholder Name _____

Card Number _____

Expiry _____ Validation Number _____

Authorised Signature _____

This membership form becomes a tax invoice upon completion and payment.

Please retain a copy for your records

Trade news

Information from suppliers in the **healthcare industry**

Grow your super

YOUR super is an investment in your future but the basic amount your employer contributes to your super on your behalf (known as Super Guarantee or SG contributions) may not be enough to support you when you retire.

Fortunately, you don't have to rely on just the contributions made through your employer.

1. Government co-contribution

Finding extra money to contribute to your super can be hard.

So, imagine getting a dollar-for-dollar match for your after-tax super contributions – up to $1,000! Well, that's exactly what the government may do to help eligible members boost their super.

Set up a pay deduction to make regular contributions each pay period or make extra contributions by direct debit, BPay or cheque. Go to ***www.hesta.com.au/contribute*** for more information and the full eligibility conditions.

2. Make a salary sacrifice

Salary sacrifice contributions are simply a portion of your before-tax salary paid into your super. This means the amount is subject to contribution tax of 15 per cent, rather than your income tax rate. These contributions also reduce your taxable income. However, unlike after-tax contributions, they are not eligible for the government co-contribution.

If you're under 50 you can have up to $25,000* in before-tax contributions, including salary sacrifice and your employer's SG amounts. For those aged 50-plus this amount doubles to $50,000* (until June 2012, when it will revert to the $25,000 threshold).

To take up this option, ask your employer to set up a salary sacrifice arrangement.

For more information about growing your super savings go to ***www.hesta.com.au/contribute*** or call 1800 813 327.

Remember, making voluntary contributions now means you may have more money to do what you want later in life!

*Any contributions in excess of these limits will be subject to total tax of 46.5%. Issued by H.E.S.T. Australia Limited ABN 66 006 818 695 AFSL 235249 regarding HESTA Super Fund ABN 64 971 749 321. It is of a general nature and does not take into account your objectives, financial situation or specific needs. You should look at your own financial position and requirements, and consider our Product Disclosure Statement before making a decision about HESTA – free call 1800 813 327 or visit ***www.hesta.com.au*** for a copy.

Designed and Engineered in Australia for Australians

UNIQUE Care
Manufacturer of Quality Care Products

UNIQUE Care specialises in manufacturing and direct sale of medical and aged care beds. Mark and Wendy Hardcastle (owners) are proud of their company's rapid growth over the past 10 years. Their string of innovative products, coupled with their impeccable reputation for customer service, has made Unique care a leader in the marketplace.

SafeCare Floor Bed

Australia's best selling SafeCare Floor Bed is now even better. The redesigned bed is packed with the latest in safety features, but perhaps the most important addition is the new optional folding feature. Seven minutes is all you will need to fold or unfold this impressively engineered SafeCare Floor Bed.

HomeCare Bed

At last, a home care bed that supports the care givers as well as the patient without that institutional look. These attractive beds come with solid timber sides, headboards and footboards and are available in a wide selection of timber stains.

Unique Care beds are fully manufactured and assembled in Australia. For more information on Unique Care extensive range of products and accessories, visit **www.uniquecare.com.au** or call us on (03) 5248 8369.

Howard Wright wins top Australian International Design Award

HOWARD Wright's M8 intensive care medical bed has won its fourth design award by winning the top award at the Australian International Design Awards.

To date, the M8 has also won the prestigious international iF design award, a Red Dot design award from the Germany-based Red Dot Institute, and an award in the Best Design Awards run by the Designers Institute of New Zealand.

With a design philosophy of "making human care easier", what's innovative about the M8 is that it allows for a wide range of medical procedures to be performed on the bed without the need to transfer the critical care patient.

Unique design features include the ability to convert the bed into a full cardiac chair and the inclusion of a full radiolucent deck enabling X-ray and C-arm imaging capabilities without moving the patient.

The award is one of the world's most renowned design assessment programmes, recognising product design and innovation excellence. The judges were impressed by the attention to detail with the bed – from the aesthetics, materials and functionality through to safety and comfort for all users.

Contact:
Howard Wright Limited, PO Box 2786, Taren Point, NSW 2229
T.: 1800 120 727
www.howardwrightcares.com

HOWARD WRIGHT

HEALTHCON 2010

Multiple Dimensions of Healthcare

22-24 September Adelaide Hilton

View program and register online at www.ahhacongress.com.au

Snippets
The **last** word

Health Workforce Australia takes steps forward

IN EARLY AUGUST, Health Workforce Australia (HWA) appointed key senior executives to help take forward the work of the authority. The Executive Directors move to HWA in Adelaide with a depth and breadth of experience that will bring new vision to the task of health workforce planning.

The appointments are:

- Mr Ian Crettenden, Executive Director of Information, Analysis and Planning – Ian managed the Education, Indigenous and Migrant Statistics Branch at the Australian Bureau of Statistics;
- Professor Liz Farmer, Executive Director of Innovation and Reform – Liz was Dean of Medicine at the University of Wollongong;
- Mr Craig Jordan, Executive Director of Corporate and Finance – Craig was Chief Financial Officer for the Therapeutic Goods Administration; and
- Ms Jane Sloane, Executive Director of Communications, Stakeholder Relations and Marketing – Jane's background includes managing the International Women's Development Agency and the Media Centre for the Sydney Olympics.

At the time of writing, the position of Executive Director of Program Management remained unfilled.

For more information on the backgrounds of the appointees and the work plan of Health Workforce Australia visit their website at **hwa.gov.au**.

Indigenous Allied Health body launched

In July, the Minister for Indigenous Health, Warren Snowdon launched Indigenous Allied Health Australia Inc.

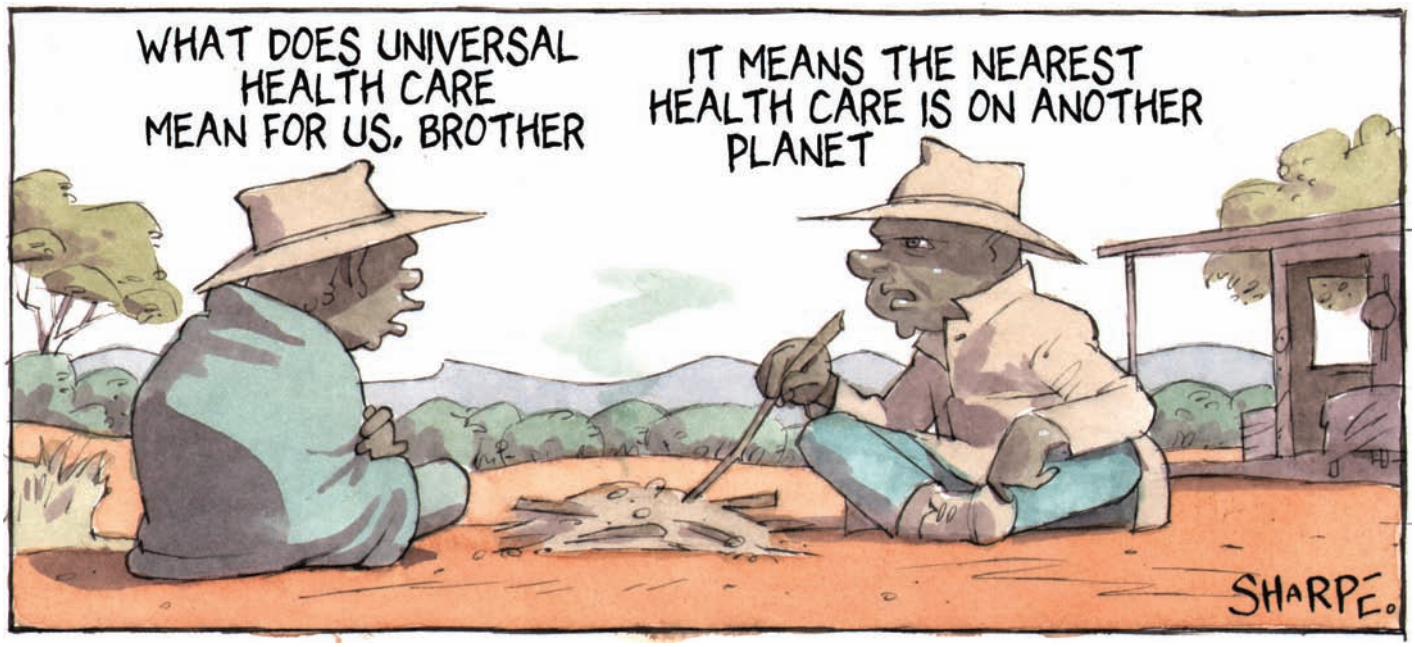
"[The organisation] brings Indigenous allied health professionals such as physiotherapists, dieticians, occupational therapists and optometrists, and students in these professions, together for the first time, giving them support and representation at a national level," he said

"This is crucial, because ultimately it will strengthen the Aboriginal and Torres Strait Islander health workforce and encourage more students to take up careers as allied health professionals."

Indigenous Allied Health Australia will:

- help build the skills of the existing Indigenous allied health workforce by providing them with the necessary resources and learning opportunities to build a long and successful career;
- play an important role to develop and contribute to Aboriginal and Torres Strait Islander health policy and planning; and
- work with the nation's universities to increase the number of opportunities being provided to Indigenous students and ensure they have the support they need to succeed.

For more information on Indigenous Allied Health Australia visit their website at ***indigenousalliedhealth.com.au***.



Reduce the risk of needle-stick injuries

Sandoz have a number of injectable products available with hangers.

Key advantages of using Sandoz products available with bottle or vial hangers

- **Removing steps in the production process**

  Removing the need for drawing the solution from the vial & injecting into the infusion bag reduces the handling of needles and minimises the risk of needle-stick injuries and administration errors.

- **Reducing the preparation time & eliminate the need for infusion bags**

  Reducing the preparation time provides efficient healthcare work practices.

  Cost effective solution by minimising waste and materials.

Find out more about the Sandoz product range and contact your Sandoz Regional Business Manager.

hospital.division@sandoz.com or Call 1800 SANDOZ

SANDOZ

A healthy decision

At Fresenius Kabi, your priority really is our priority.

With a focus on the provision of high quality and best in class therapeutics, technology and service, Fresenius Kabi strives at all times to support healthcare professionals in their endeavours to address the needs of patients.

FRESENIUS KABI
caring for life

Fresenius Kabi Australia Pty Ltd ABN 39 109 383 593 **Address:** 964 Pacific Highway PYMBLE NSW 2073
Tel: 02 9391 5555 **Fax:** 02 9391 5505 **Email:** info@fresenius-kabi.com.au **Web:** www.fresenius-kabi.com.au
PFKC 4031 BBK 12/09