The Health Advocate

ISSUE 12• December 2011

The official magazine of the Australian Healthcare & Hospitals Association

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Conference 2011

Achieving patient-centred outcomes

ALSO in this issue

- AHHA addresses the Tax Forum
- Who's moving in the health sector
- AHHA news and events

HESTA Australian Nursing Awards

2011 winners, left to right: Zena Coffey, Paul Esplin and Amanda Klahr

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HESTA Australian Nursing Awards

Nominate now and make a difference

It's said that small acts can make a big difference. This is certainly true, when it comes to the HESTA Australian Nursing Awards, because each person nominated for an award receives a certificate of congratulations.

"This gesture is an important part of the HESTA Australian Nursing Awards," says HESTA CEO Anne-Marie Corboy.

"Recognition plays a vital role in rewarding personal achievement. A certificate lets all those who've been nominated know their work is appreciated."

While only nurses, midwifes, personal care attendants and assistants in nursing are eligible to be nominated, it's important to remember that anyone can make a nomination.

"Nominations are a chance for patients, patients' families, colleagues or employers to say 'thank you', and to tell the community about their 'above and beyond' personal experience with a nurse," Ms Corboy says.

"The achievements of remarkable nursing professionals are heart-warming, inspirational, courageous and empowering — and the Awards are an avenue to share these stories."

Visit **hestanursingawards.com** for more information about the Awards, gala dinner and to nominate.

What our judges say...

The HESTA Australian Nursing Awards judging panel is made up of trained nurses, academics and industry representatives.

"Remember this is your one chance to tell us about the remarkable nurse you're nominating — so tell us as much about their accomplishments as possible."

"When evaluating nominations, I look for that extra something that makes it stand out against the rest — where the person has thought 'outside the square'. It's really important that these special qualities stand out clearly and examples are the best way to illustrate these qualities."

Unveiling the winners

The 2012 HESTA Australian Nursing Awards gala dinner takes place on Thursday 10 May. Following months of anticipation, the winners of the Nurse of the Year, Innovation in Nursing and Graduate Nurse of the Year categories will be announced.

About us

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AHHA Council and supporters

AHHA Board

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 2011-2012 Board is:

Dr Paul Scown (VIC)
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Dr David Panter (SA)
Immediate Past President
Ms Siobhan Harpur (TAS)
National Vice President
Mr Felix Pintado (VIC)
National Treasurer
Ms Kathy Byrne (QLD)
Member
A/Prof Annette Schmiede (NSW)
Member

AHHA National Council

The AHHA National Council oversees our policy development program. It includes the AHHA Board above and the following members for 2011-2012:

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Ms Helen Chalmers (SA)
Ms Rosio Cordova (NSW)
Ms Jan Currie (NT)
Dr Martin Dooland (SA)
Professor Kathy Eagar (Academic Member)
Ms Kerrie Field (NSW)
Ms Anna Fletcher (Personal Member Representative)
Mr Graem Kelly (VIC)
Ms Elizabeth Koff (NSW)
Dr Yvonne Luxford (Associate Member Representative)
Mr Andrew McAuliffe (NT)
Mr Pat O'Brien (QLD)
A/Prof Alan O'Connor (QLD)
Mr Ross O'Donoughue (ACT)
Mr Michael Pervan (TAS)
Ms Joan Scott (ACT)
Mr John Smith (VIC)
Mr Mark Sullivan (VIC)
Ms Sandy Thomson (WA)
Dr Annette Turley (QLD)
Prof Helen Lapsley (International Hospital Federation)

Australian Health Review

Australian Health Review is the journal of the AHHA. It explores health policy and management including healthcare delivery systems, clinical programs, and health financing.

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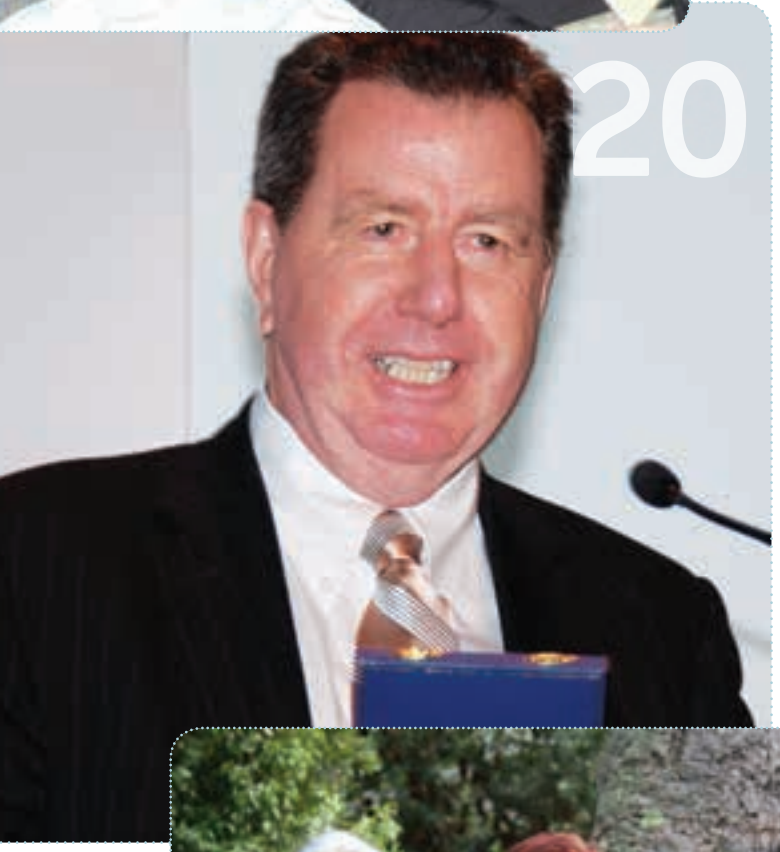

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AHHA National Councillors and Board for 2011-12

IN ACCORDANCE WITH the AHHA Constitution, all serving National Councillors are deemed to have retired from office prior to each Annual General Meeting, which was held on 13 October this year in Melbourne, during the annual Conference.

The members listed on page 3 were successfully appointed/reappointed to the Council for the forthcoming 12 months. The AHHA's governing Board is elected from Council.

Our new President is Dr Paul Scown from Victoria. Over the next 12 months, he will be supported by:

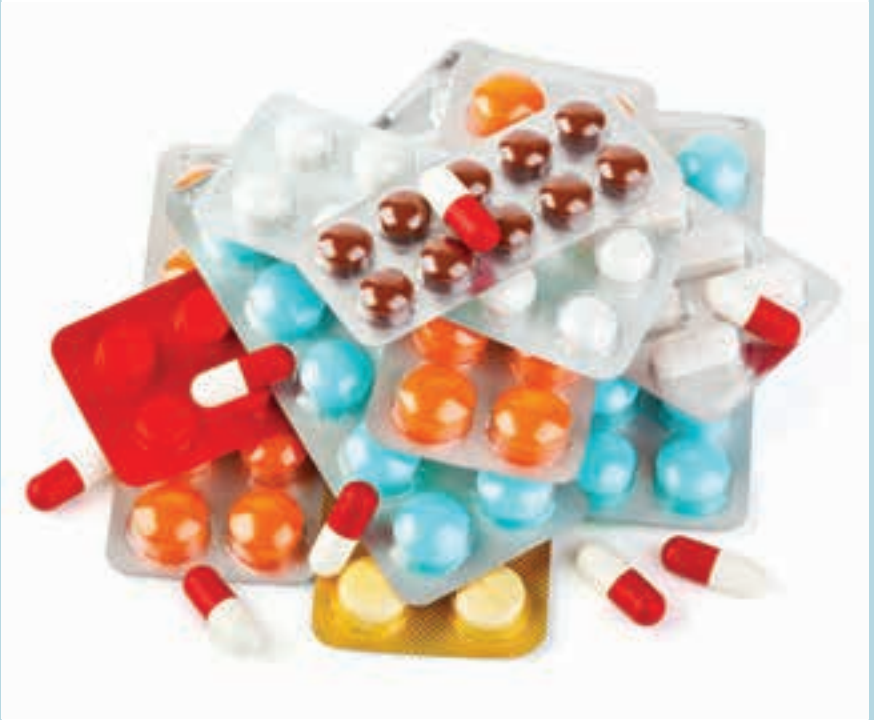
- Siobhan Harpur (TAS) as Vice President
- Felix Pintado (VIC) as Treasurer
- Annette Schmiede (NSW) and Kathy Byrne (QLD) as Members
- David Panter (SA) as Immediate Past President.

Young people still in nursing homes

YOUNG PEOPLE ARE still languishing in aged care homes, despite a government program which aimed to find more appropriate accommodation for them, according to a new study in the most recent Australian Health Review.

"The inappropriate placement of young people in residential aged care (RAC) is a problem in Australia as in many other countries. Aged care is not designed or resourced to facilitate the active involvement of young people with high clinical needs in everyday activities or support their continued participation in the life of their community" said study lead author, Di Winkler.

"Our study identified two key factors that need to be addressed in order to significantly reduce the numbers of young people in nursing homes. First, there needs to be a dramatic increase in both the range and number of supported housing options. Second, there needs to be systemic change to stem the flow of young people into RAC facilities. This will require a whole of government approach with the housing, health and disability sectors working in partnership. Without systemic change and sustained investment in alternative accommodation options, we will continue to deny young people the right to live in an environment that meets their social, emotional and developmental needs."



Australians paying more for medicines

AUSTRALIANS ARE PAYING more out of their own pockets for medicines than citizens in many other countries, according to a new study in the most recent Australian Health Review.

"Spending on medicines is rising rapidly in Australia, as in most other industrialized countries. This is due to a range of factors, including the ageing of populations, increased availability of new medicines and the rise in chronic disease," said lead research Dr Anna Kemp.

Rising costs put pressure on governments to find new ways to fund medicines. In Australia a number of policy changes to the Pharmaceutical Benefits Scheme (PBS) have resulting in consumers contributing a higher proportion of funding in direct out-of-pocket payments. There is evidence that this has resulted in access problems for some consumers, including those on low incomes and the elderly.

"We found that spending on publicly subsidised medicines by Australian patients increased from $16 per person in 1971 to $62 in 2007. Patient expenditure on all prescription medicines had risen to $134 per person in 2007 (after adjusting for inflation)." Dr Kemp said. "The findings show that the prescription medicine expenditure of Australian patients has increased substantially over recent years and that compared to other OECD countries, Australian will substantially affect access to and use of prescribed medicines, with potential risks to patient health and wellbeing. Policy makers should consider the ongoing affordability of medicine to patients, as well as to the wider community, when reviewing pharmaceutical reimbursement policy."

Hospital Pricing Authority vital for health reform

THE AHHA WELCOMED the introduction of legislation to support the establishment of the Independent Hospital Pricing Authority (IHPA), a key component of the health reform agenda.

"The IHPA will play a vital role in improving the efficiency and cost-effectiveness of our health system and its operations will be pivotal to the success of the health reform agenda", Ms Prue Power, AHHA CEO said.

"This new body will be responsible for developing a national efficient price for hospital services, advising COAG on public hospital funding issues and calculating Commonwealth funding for hospital-based training and research activities and public health programs. We believe that key to the success of this body will be its independence from government. Decisions about hospital funding need to be based on rigorous data and expert advice and not be subject to influence by the political climate of the day. Therefore, we urge all political parties to support this legislation and facilitate the establishment of the IHPA as a statutory authority."

Events & meetings

Everything you ever wanted to know about health reform

IN SEPTEMBER AND early October 2011, the AHHA hosted Branch Breakfast Events in South Australia, Queensland and NSW titled 'Everything you ever wanted to know about health reform'. Breakfast guests in Adelaide and Brisbane met with special guest Dr Tony Sherbon, Interim CEO of the Independent Hospital Pricing Authority (IHPA) and formerly Deputy Chief Executive Officer, National Health Reform Transition Office. In NSW, Sydney guests had the opportunity to hear from Mr Shane Solomon, Chair of the Independent Hospital Pricing Authority (IHPA).

Significant new legislation to establish IHPA has been under consideration by the federal parliament in recent months. Both speakers gave an overview of the new IHPA and the implications of the Council of Australian Governments (COAG) agreement on health reform that will rely on partnerships between the Australian Government and the states and territories.

The speakers focused on the IHPA's role in setting the 'efficient price' for activity based funding (ABF) for public hospital services and any 'loadings' to account for variations in prices. IHPA will specify all of the classifications, costing, data and modelling standards that are required to develop ABF pricing for public hospitals. The national efficient price will be used to determine Commonwealth funding to Local Hospital Networks (LHN) for the activity provided. States and territories can contribute above or below the efficient price level.

In question time, topics ranged from concerns about how IHPA will determine the criteria for defining block funded services for smaller hospitals that do not meet the ABF criteria to what constitutes a national efficient cost and how will research and training be valued. Dr Sherbon said IHPA will determine which hospital services are eligible for Commonwealth funded ABF and block grants based on the advice from states and territories. He expected the boundary between block funded services and activity based funded services will be contentious.

Dr Sherbon and Mr Solomon respectively spoke about the benefits of ABF as all governments will become much more conscious of the relative costs of providing public hospital services across jurisdictions and across LHNs. One area that will challenge IHPA is their role in resolving cross border and cost shifting disputes as they arise and Dr Sherbon admitted that cross border and cost shifting determinations will be another area of contention. ha


Shane Solomon


Tony Sherbon

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Conference 2011: Achieving patient-centred outcomes

The great healthcare challenge: developing a **patient-centred healthcare system**

THIS YEAR'S CONFERENCE was convened with a new and exciting healthcare collaboration. AHHA partnered with colleagues from the Australasian Association for Quality in Health Care (AAQHC), The Australian Council on Healthcare Standards (ACHS) and The Royal Australasian College of Medical Administrators (RACMA) to host four intense and brilliant days at the Great Healthcare Challenge Conference in Melbourne from 11-14 October 2011.

The conference theme of 'achieving patient-centred outcomes' reflects the challenges of delivering integrated care in the current reform environment. This collaboration of four of Australia's peak organisations brought together highly influential groups of clinicians, executives and academics in Australian healthcare across both public and private sectors to discuss our vision for a patient-centred healthcare system.

Pre-conference workshops

Day one was dedicated to a series of concurrent pre-conference workshops, led by eminent international and national healthcare experts. Professors Russell Mannion (University of Birmingham UK) and Jeffrey Braithwaite (University of NSW) presented an interactive and lively day focused on Organisational Culture and Healthcare Quality. From the UK Kings Trust, international guest speaker John Clark presented a workshop on 'Exploring the link between clinician engagement and patient-centred outcomes'.

A team of five eminent doctors – Andy Robertson, Andrew Johnson, Michael Hills, Richard Ashby and Paul Cullen – ran a Master Class on Disaster Management. They shared lessons they had learnt from their experiences in the past two years from the New Zealand earthquakes and Queensland floods and covered practical aspects of disaster management from health service perspectives including preparation, response and recovery.

Professor Kathy Eagar presented on the topical theme 'How to use casemix as a tool to achieve and improve patient care outcomes'. And Drs Jen Bichel-Findlay and Chris Maxwell along with Anne McIntosh challenged their participants to consider 'Measurement in Healthcare: Are we dividing apples by red herrings?'.

Conference sessions

Over the following three days, the 730 delegates listened to a range of international and local speakers and joined in an innovative program of plenary sessions, invited papers and interactive workshop presentations. The program was

structured around five key themes: leadership and vision; innovation and reform; clinical governance; technology, ICT and e-health; and appropriateness of care and patient-centred outcomes.

A number of presenters provided a national perspective and experiences ranging from national registration and accreditation, the Personally Controlled e-Health Record and leadership in health reform, to more personalised issues such as a proposed national approach to improving pain management in Emergency Departments.

The workshops and presentations in the e-technology stream provided insight and participants were enthralled with visions of the future paperless hospital as well as real examples of success such as same-day radiology reports.

Patients were at the centre of themes throughout as the following examples highlight:

Dr Susan Piper presented on acute care for children without admission, a patient-centred approach to cancer treatment planning involving multi-disciplinary teams and discharge management of acute coronary patients.

A team from University of NSW also presented ground-breaking research on vulnerable groups of patients and statistics that showed such groups need further focus in our healthcare system.

New Zealand experiences in improving patient and whaanau (family) engagement in district health boards were shared by our NZ colleagues and guest speaker Carol Bennett from the Consumer Health Forum reminded us that the consumer's voice is a valuable one at the planning table as well as the bedside.

Ministerial Speeches

The Hon David Davis MLC, Victorian Minister for Health, spoke about the need for long term planning in health reform and added that such planning was something state governments traditionally did not do well. He noted concerns that national reforms should not increase the health bureaucracy and hoped this could be avoided.

The Hon Nicola Roxon MP, Commonwealth Minster for Health and Ageing also addressed the conference. She commended participants for their delivery of strong public health and public hospital services and said she appreciated the practical advice she received from them on how to create an improved and sustainable system for the future.

The Minister particularly praised the AHHA for our strong commitment to the strength of our public health system. She thanked the AHHA for the advice she had received following the AHHA health reform simulation held earlier this year and acknowledged the appointment of two members of AHHA - Prue Power and Dr Martin Dooland - to the twelve member National Advisory Council on Dental Health.

You can read Minster Roxon's speech at http://ahha.asn.au/news/australian-healthcare-and-hospitals-association-conference-great-healthcare-challenge-achieving

Entertainment

Inspired by the Melbourne racing season, the Gala Dinner was awash with 'feathered fascinators', elegant hats and racing colours as participants joined in some high spirited frolics for the 'racing carnival'. A comedian entertained all with a video 'race' and each table backed their special horse with noisy and festive enthusiasm. The fashion parade and judging was suitably conducted with much laughter and due regard for the 'well dressed'. The prize went to a very attractive jockey!

Posters

An exceptional collection of 58 poster presentations were on display throughout the four days. The winner of the Poster Prize was Gabrielle O'Grady from The Children's Hospital Westmead NSW for Clean Hearts: Keeping Little Hearts Infection Free. The poster highlighted work by a team from the Heart Centre for Children at Westmead to reduce surgical site infection rates in paediatric cardiac patients.

Trade Exhibition and Sponsors

A comprehensive trade exhibit accompanied the conference and included displays from some of the major sponsors of the event. AHHA extends our appreciation for sponsorship for the event to: The Australian Commission on Safety and Quality in Healthcare, The Victorian Quality Council (VQC), The Health Quality and Safety Commission of New Zealand, the Victorian Managed Insurance Authority (VMIA), HESTA, Riskman International (RMI), C.Gov. and Microsoft.

Conference 2011: From the diary of Michael Pervan

New insights on **patient-centred care**

ACHIEVING PATIENT-CENTRED outcomes and delivering good health care is about people. People with a passion for providing care for others, combined with applied evidence about what works best to achieve better results. Improvement is all about combining these elements with an understanding of the relationships involved in delivering care and how those relationships can be enhanced or changed to achieve a better outcome for the patient. This is the essence of patient-centred care.

Leadership in health care is universally about this. Relationships, influenced by evidence to improve patient outcomes. The conference theme, 'achieving patient-centred outcomes', reflected the challenges of delivering integrated healthcare in the current reform environment.

It has been a tough year for the Australian health system and those working in it and in many respects, the general mood of the conference should have been quite sombre. It was most certainly not. Almost despite the impacts and noise of the reform agenda and grim budget realities, the mood of the conference was vibrant, positive, engaged and constructive.

There were many highlights and without detracting from other excellent presenters who are featured on other pages, for me firstly, it was Dr Sally Cockburn. She set the pace and enervated the conference with a rousing address about many things – but mostly about us. We all understand the challenge of patient-centred outcomes "because that is what we do and that is what we've always done". Dr Cockburn also made a point about mixed messages that certainly rang true with many of us. While there is a lot in the media about a disengaged, besieged and inefficient public healthcare system, the reality most of us experience is diametrically opposed to this view.

In my discussions with delegates it was clear that the patient was and always will be at the centre of what they do. None of the delegates attended because they had run out of things to improve or the desire to improve them. They were there to listen, to compare and benchmark themselves and their services, to present and promote their efforts and to search, as we all do, for new insights into improving the experience of our patients.

Also noteworthy was the presentation from Professor Jane Halton, the Secretary of the Commonwealth Department of Health and Ageing who provided the conference with a comprehensive overview of the national reforms of our funding, governance and reporting systems. She was surprisingly open about the challenges ahead and the complexity of implementing the change agenda.

Healthcare improvement is about relationships and making them work better for the patient by applying the evidence of what works best. If, as Fran Thorn, Secretary of Health in Victoria suggested, reform is a jigsaw puzzle, most conference delegates would agree that we can put it together. The healthcare collaboration that put this fantastic event together is an immediate example.

The theme was most eloquently expressed in the words of Ms Bev Johnson, the President of the Institute for Patient and Family Centered Care in Maryland, USA, and provided perhaps the most fitting end to a conference that focused on evidence, relationships and partnerships in care. Her presentation on patient and family centred care, and of including the patient and their family as part of the team who are caring for the patient, confirmed what we had been discussing all week.

It was also Bev who reminded us that the reason why "reform" seems to last forever is because it does. And it should! Healthcare improvement is a journey, not a destination.

The conference ended with a fabulously entertaining hypothetical facilitated by Dr Bernie Street.

At every level, and for every reason, but especially in an environment of resource and capacity reductions, oversold spin and contentious political agendas, it was wonderful to be reminded of what it actually means in practical terms to put the patient at the centre of our thinking and the care we deliver and to see so many examples of this being done across the country by dedicated, talented and amazing people.

Conference 2011: Highlights from the diary of Annette Schmiede

Highlights from this year's **keynote speakers**

CONFERENCES CAN BE an efficient way of gaining a good grasp of current industry issues as well as gaining more detail around technical topics. So that was my challenge in attending the Great Healthcare Challenge Conference 2011.

The highlights started with the opening session and a burst from Dr Sally Cockburn, aka television alter ego Dr Feelgood. Sally's speaker's notes say she likes to bring sensitive issues into the open. Well, she didn't disappoint and had many in the audience either squirming in their seats or roaring with laughter, particularly when she related the story of her bout of renal colic and subsequent diagnosis of diabetes. Her message was forceful – as healthcare workers we must not neglect our own health, as she had done.

Another Sally message was the sparkle moment – each day decide what gives your day a sparkle and celebrate the good you do.

With the audience nicely warmed up, Jeffrey Braithwaite delivered the keynote address and he was in top form. Is he the David Attenborough of the Australian healthcare sector, lifting the behavioural lid on all 600,000 Australian healthcare workers? He traversed the literature to bring us a riveting summary of the work of the last 50 years, starting with the famous electric shock obedience experiments of Milgrim who demonstrated the strength of social pressures on individuals to do the right thing. Jeffrey touched on the work of Seligman and the psychology of happiness to demonstrate the importance of relationships including those in the workplace. He talked about power and its application to be a destructive or constructive force and observed that we see too much destructive power exercised in healthcare. He finished with a traverse through studies on relationships and what we find attractive in the opposite sex, particularly when it comes to dancing. Yes dancing! The dancing avatars were the stars of the conference.

The message out of this for the healthcare sector? Health is a complex social system and it is difficult to approach change using simplistic strategies such as system restructuring. Restructuring sets up the conditions for reform – but in itself it is not reform. Also, be realistic about achieving goals because it always takes longer than you think.

A keynote address by Professor Russell Mannion from the University of Birmingham on the experience of the NHS around performance measuring was insightful. He began his talk by telling us it was Florence Nightingale who pioneered the use of statistics to gather data on performance and bring about changes in health policy and practice. He reminded the audience about the many dimensions of performance and to be clear about what we are trying to measure, processes or outcomes, and that there are many issues with both. He warned about unintended consequences and used the example of the "hello" nurses in a hospital in the US who "greet" patients and satisfy a five-hour target of seeing the patient. He drew our attention to a recent US study that found consumers rarely access and use comparative health performance data because they still rely on advice from friends and family on who to see or where to go. Physicians also relied on peer networks rather than comparative performance data.

In a panel discussion with health leaders, Tracey Batten from St Vincent's Health Australia called for real collaboration between the public and private sectors around the reform agenda remarking that they currently operate as parallel sectors. Patricia Faulkner, speaking from the COAG Reform Council perspective, posed the questions: how do you drive improvements from the data? and what is driving differences in performance across the health system? COAG has 70 performance indicators to monitor under all the national agreements.

The final keynote address from John Clark continued the leadership theme, particularly medical leadership. John Clark, from the Kings Fund UK, was previously the Director of Leadership at the NHS Institute for Innovation and Improvement. He posed a question that seems high on the health reform agenda: how do we get clinicians, particularly doctors, more engaged? He talked about the link between medical engagement and organisational performance. When doctors feel valued and engaged the organisation is likely to perform well across many indicators. He warned that while structure was important it is not the answer. Rather, emotional engagement is also needed. He talked about the need for clinicians to feel like shareholders, not just stakeholders.

In conclusion I would say that the conference measured up to my performance criteria: a great overview of all the issues and thought provoking detail around the current hot topics.

Managing to the **efficient price**

A review of the workshop led by **Stephen Duckett**

THE FIRST STAGES of a national approach to activity based funding have already begun. Preparatory work is under way in terms of identifying the classifications that will be used to describe various aspects of hospital activity and other aspects of system design. The first operational phase of the new system commences on 1 July 2012, giving clarity about relative Commonwealth and state/territory funding shares and payments to hospitals for in-patient, out-patient and emergency department activity.

Although some states have been using casemix funding for almost twenty years, even in these states there will be changes: a move to a common national approach to setting prices might change the perceived relative efficiency of some hospitals. The new Independent Hospital Pricing Authority has only been in place a couple of months and many aspects of the new system are yet to be developed. But that doesn't mean hospitals can't begin to prepare for what it will be like in the new regime. For this reason, the Australian Healthcare and Hospitals Association (AHHA) and La Trobe University convened a workshop in Melbourne on 'Managing to the efficient price', run by casemix expert Professor Stephen Duckett.

The workshop's 70 attendees heard presentations by Professor Duckett and others on both the policy intent and context of the national implementation of activity based funding and practical strategies that can be used by managers if the hospital they manage is identified with an 'efficiency challenge'.

Although key aspects of funding design at the national level are unknown, and the way the states and territories will function as 'system managers' is also unclear, common strategies are available. In the first two transition years of the new system, the emphasis will be on transparency: of the Commonwealth and jurisdictional contributions and whether a particular hospital is seen as efficient or not, using the new national measurements. Clearly for hospitals identified as inefficient, some preparatory work will need to be taken. The consequence of being identified as 'inefficient' for state funding of the hospital is unknown at this stage.

The real implications for all hospitals come from the post 2014 system implementation. From 1 July 2014 the Commonwealth will fund 45 percent of the costs of growth in both the efficient price (because of inflation, technological change) and in activity, at the efficient price.

The workshop canvassed strategies relevant to both the transition and the post-2014 period. These strategies included examining the quality of recording (to ensure that the hospital is getting full credit for all the activity it actually provides), and examining reasons for length of stay or cost differences. Strategies relevant to both hospitals that had patient-level costing data and those that don't were discussed.

It is planned to run the workshop in other states in early 2012. ha

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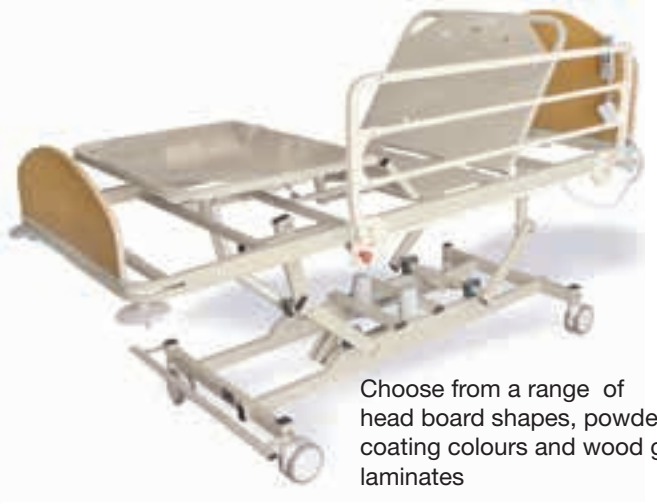

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Mick Reid
Sidney Sax Medalist 2011

The Australian Healthcare and Hospitals Association was delighted to announce **Mick Reid** as the recipient of this year's prestigious **Sidney Sax Medal**

THE SIDNEY SAX Medal is awarded each year to an individual, active in the health services field, who has made an outstanding contribution in the field of health services policy, organisation, delivery and research.

Mick Reid has been an outstanding leader in our health system for over three decades. He has spent most of his working life in the health and human services industry and has made a rich and varied contribution to it. He has a national and international reputation as a public sector manager, as a reviewer of health systems, as a reformer of health agencies and as a planner of health services.

Mick understands well the complexities of the Australian health system with its competing demands between high-tech specialist medical care on one hand and primary and preventive health care on the other. He also knows that resources are needed to ensure equitable distribution of services while also focusing on disadvantaged groups such as Indigenous Australians and those with mental illness.

From working with Indigenous people on Bathurst and Melville Islands, to reforming state hospital systems, to consulting on behalf of the World Health Organization for governments around the world, Mick has demonstrated an exceptional ability to implement major system changes which result in improved resource management and better health outcomes for all.

Mick's career continues to take fascinating tacks into some of the most important and influential roles in our health system. He has achieved much in these roles with intelligence, vision and good humour and compassion. Mick has been described as an effective, well-connected change agent. Colleagues call him a tough negotiator, a thinker and a doer, a straight shooter, and a political animal.

The AHHA recognises Mick's distinguished career and joins with his many friends and colleagues throughout the health system to congratulate him on his achievements. This award acknowledges his outstanding contribution to health care in Australia and around the world. ha

Dr Bill Coote
Life Membership

The Board of the Australian Healthcare and Hospitals Association had great pleasure in awarding **Honorary Life Membership** of the Association to **Dr Bill Coote**

HONORARY LIFE MEMBERSHIP of the AHHA is precious, awarded only rarely and in recognition of a significant, long-term contribution to the Association as well as to healthcare in Australia.

In announcing this award, Dr Paul Scown, AHHA President, highlighted Dr Coote's impressive career and valuable contribution in diverse areas of health care in Australia.

Bill graduated from the University of Queensland with an MBBS in 1973 and, for nine years from 1976, ran a rural general medical practice in the Gold Coast hinterland area. In addition to his medical duties and raising a family he was elected a member of the Beaudesert Shire Council and completed a Bachelor of Economics.

In 1987 he was appointed manager of the Federal AMA's medical economics department and was involved in the development of the Commonwealth's first major package of measures to support rural practice - the Rural Incentive Program. For six years from 1992, Bill was CEO of the AMA's national office, coordinating the development and promotion of AMA positions on a wide range of issues.

Bill then spent two years as senior policy adviser in the office of the Minister for Health, Dr Michael Wooldridge, and was involved the management of a wide range of complex health policy issues. In 2001 he was appointed the inaugural CEO of General Practice Education and Training Limited (GPET), which established a network of 'Regional Training Providers' across Australia.

From 2006, Bill was self employed as a consultant focussing on health policy and financing issues for numerous national medical and hospital organisations. He has recently been a member of a panel assessing applications for funding under several Government General Practice infrastructure programs. In November he was appointed Director of the Professional Services Review by Minister Roxon.

Bill has been a valuable friend of the AHHA and has made important contributions to our policy development. ha

Dr Owen Curteis
Life Membership

The Board of the Australian Healthcare and Hospitals Association had great pleasure in awarding **Honorary Life Membership** of the Association to **Dr Owen Curteis**

HONORARY LIFE MEMBERSHIP of the AHHA is rare, awarded only when the recipient has demonstrated a significant, long-term contribution to the Association as well as to healthcare in Australia.

In announcing this award, Dr Paul Scown, AHHA President, outlined the valuable contribution that Dr Curteis had made to so many areas of health care in Australia.

Dr Owen Curteis is one of the AHHA's longest serving friends, having been actively involved in our Association since 1981. He was a national councillor to our predecessor, the Australian Hospitals Association, for more than 20 years during which time he served as President of the NSW Branch. Since 2001 he has been the AHHA's representative on the Asian Hospital Federation and was for four years our representative on the International Hospitals Federation.

Owen graduated in Medicine from the University of Sydney in 1960 and undertook his residency and registrar training at the Mater Misericordiae Hospital in North Sydney and the Repatriation General Hospital at Concord. In all he spent some 25 years at Concord, 15 of those as Chief Executive Officer. In 1989 he was appointed Chief Executive Officer of the Western Sydney Area Health Service and remained in that position for the next seven years. In 1996 Owen took the extraordinary step of re-entering clinical medicine and was appointed the senior medical officer for the Brisbane Waters Private Hospital.

Owen has been Chairman of the NSW Branch of Royal Australian College of Medical Administrators and was a member of the Federal Council of the College for more than ten years. For twelve years he was a member of the Board of Australian Council of Hospital Services. In addition to these appointments, Owen has been an executive member and Treasurer of the Postgraduate Medical Council, member of the Minister's Health Advisory Council, member of the Board of the Ambulance Service of NSW and a director of various health credit unions. He has been a stalwart supporter of the Health Services Association of New South Wales and was its President for two years.

Owen Curteis enjoys enormous respect and regard throughout the entire health system across Australia, encompassing virtually every professional discipline. He has recognition among all his peers as an "honest broker", a person who can be relied upon to comment openly and frankly on issues affecting the health system, without fear or favour. Apart from his outstanding intellect and understanding of the health system, his unreserved sincerity and integrity encompasses everything he does and everyone he works with. People at all levels relate and respond to him accordingly.

QUESTEK INTRODUCES AUSTRALIA'S FIRST WiFi NURSE CALL SYSTEM

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For over 25 years Questek have designed, manufactured and installed state of the art nurse call systems and have provided over 450 Aged Care Clients a system they can rely on. Questek recently introduced their new WiFi wireless nurse call system, a system that is based upon the 802.11 WiFi standards. This new technology changes the way nurse call systems will be installed worldwide and is an Australian innovation. With WiFi the possibilities are endless and installation is a breeze, wireless takes the headache out of installation and gives more flexibility than ever before.

Using WiFi makes sense. More and more facilities are installing WiFi networks for Resident internet access or staff data access and now that same network can be used for nurse call, staff duress, video and voice. One network can do it all. Why would you run cables for multiple services when all your systems can be converged onto one simple to install and simple to manage WiFi network?

The future is here and the future is wireless.

Questek nurse call is the way of the future, not only can it raise alarms when Resident's need help but it can raise alarms for temperature, movement and egress. A nurse call system that can monitor temperature output of thermostatic mixing valves (TMV's), fridges and ambient air, as well monitor resident and staff location is only the beginning. The Questek system interfaces to asset management systems and gives greater understanding of asset utilisation as well as optimisation. The Questek system will save facilities thousands of dollars in operations each year by automatically checking TMV's and air conditioning, reporting any abnormalities directly to facility maintenance. The savings in electricity alone by alarming when an air conditioner is either over or under temperature is amazing.

Staff time is often wasted looking for assets or even Resident's, with the Questek WiFi system staff can pinpoint the item or person they are looking for on an interactive floor plan. Gone are the days of wandering the corridors looking for a spare wheelchair, now you can see where they are right on the screen. By using perimeter monitoring, staff can now be notified if a Resident is trying to leave the building unassisted and can intervene before an issue arises. Resident safety is increased without having to make the facility a fortress. These simple time saving ideas are only the tip of the iceberg, the future of Aged Care is here and the system that makes life easy is Questek.

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QUESTEK AUSTRALIA

Respectful and adaptable

Australians on the move in Asia

Australian healthcare executives and professionals are **well regarded overseas**

AS MOST EXECUTIVES in the hospital and healthcare sector recognise, to select the most suitable candidate for specialist executive, professional or academic positions it is now almost de rigueur to undertake a global talent search.

As well as assessing qualifications, personal attributes and leadership skills, a specialist global recruitment process must also take into account more subtle cultural traits in the candidate, such as appropriate sensibilities to the different social environments of the position.

Wayne Bruce, CEO of executive search firm Ccentric Group, places many Australian candidates in senior positions throughout the Asia-Pacific region, particularly in hospitals and healthcare universities.

"In many Asian countries Australians are perceived as strong candidates," says Wayne. "Australian executives and professionals are highly regarded because they are seen to park their egos at the door; to be culturally adaptable and sensitive. And of course, more often than not, the candidate is also highly skilled."

John Duke has recently completed a three-year term as Chief Operating Officer at Bangkok Hospital Medical Centre, which followed six years as Executive Director at the Mater Hospital in Sydney for St Vincent's and Mater Health.

"There have been many international people who have not survived culturally in Bangkok," says John. "However, Australians are very well received because the Thais perceive that 'Australians are similar to Thais'. I'm not really sure what that means, but perhaps we just embrace their culture and are respectful.

"Culturally it is very different and I'm sure I made many mistakes. But if you are respectful of a culture and try to embrace it, then I find it's very rewarding. When you get right down to it, I find that people are basically the same and everyone wants to be recognised for what they do, to be treated fairly and to have pride in their job, company and country."

Language is an issue, nonetheless. "Although English is spoken at a high level in the organisation, talking to workers was difficult. So I had 200 Thai lessons while I was there – and they appreciated the effort I made, if not the result!"

The professionalism of Australian hospital and healthcare systems and processes – as implemented by our overseas health professionals – also is a positive advantage, according to John.

"The organised state of the Australian hospital system really helped us advise Bangkok Hospital. The payment models, the analysis of data by clinical classification systems (DRGs or diagnosis related groups), the movement into research in the private sector, as well as other more basic efficiencies, were all seen as sensible steps to take in the private health sector in Thailand. They embrace and are thirsty for information and change."

Conversely, John has been most impressed with the Thai approach to their own health system. "We were refreshed by the desire at Bangkok Hospital to deliver exceptional quality and holistic care, the team approach to work and the support that you receive (and give) as a member of their company. We also celebrated or grieved together with friends and workers alike."

Wayne Bruce says both North and South Asia will only grow as a career destination for Australian healthcare and hospital professionals.

"There's a strong interest in employing Aussies, particularly in Malaysia, Singapore and Thailand. Vietnam also needs hospital staff – and we find our candidates are really interested in positions there.

"Generally, there are burgeoning private hospital systems in Asia, which is both a good thing for the countries' development needs and for senior candidates.

He warns there are variations in pay levels and conditions from one country to another, plus there's taxation considerations concerning whether one remains an Australian resident or not. (There are great benefits too, in Singapore and Hong Kong for example, with tax rates 20 percent or lower).

Wayne says Malaysia is also a favoured potential destination for candidates. "The country has established health and life sciences as one of just 10 NKEA or National Key Economic Areas for growth and prosperity. The opportunities in Malaysia are second-to-none." ha

HUGH LINEY
CCentric Group

Nine hard months before rural bliss a reality

AUSTRALIA IS ALSO a favoured destination for overseas health and hospital professionals or academics, with as many as 15 percent of potential candidates from the UK expressing a desire to work here.

Professor Jane Farmer was appointed last year as Head of School, Faculty of Health Sciences at La Trobe University's Rural Health School in Bendigo, leaving her previous position as Chair of Rural Health Policy and Management and Co-director of the Centre for Rural Health at the University of the Highlands and Islands (UHI) in Inverness, Scotland.

"I'm a rural health academic and Australia is the home of rural health research, so I thought a stint here at some point in my career would be important," she says.

"I wanted to see what rural health research was like in another country. I think it's hugely important for an academic who is ambitious to have worked abroad – working abroad is the real thing, whereas visiting fellowships are just visits."

Jane says the professional challenges of leaving Inverness and coming to Australia are just huge.

"Professionally, I have had to take on board all of the intricacies of Australian Higher Education, of regional Australia, and of course, healthcare. Healthcare is a completely different system, while higher education is scarily similar (fundamentally with no money anywhere really). Luckily I find regional Australia really interesting.

"The staff and my team at La Trobe are truly amazing. I have never met such a hospitable group and some incredibly competent people. That has made it bearable and I have learned a huge amount. One year on, I feel I have hugely grown in character and in my knowledge of managing a department."

However, Jane emphasises there are lots of differences and some obstacles to overcome in such a monumental move.

"The biggest challenge was getting permanent residency – that took nearly a year and involved lots of evidence for the Department of Immigration. It was quite a strain. Getting a house, a mortgage, a car, a school, health insurance, in just six weeks, while having a really challenging job was very stressful.

"But it was much easier for me than for my family. My daughter (16) was very stressed for about nine months and prone to bursting into tears; at the same time she kept telling me she realised it was character building.

"My partner David was a student nurse and had to wait six months to start the second year of his course. He tried exceptionally hard to get some casual work, but it took nine months to find something. Now he loves everything."

And Jane's number one lesson from the career move?

"Patience! It took nine months to feel truly 'at home'. Now it's all good though – Bendigo is like Inverness, but with great coffee, wine and sunshine."

Medical engagement: No longer an optional extra

Doctors should be encouraged to be involved in **management, leadership and service improvement**

IN AUSTRALIA, LIKE many other countries, the current health reforms will require even greater engagement of doctors in leadership if improvements in access, quality, safety and productivity are to be realised. Activity Based Management will require executives to work even more closely with clinical and particularly medical colleagues to reduce variations in practice, quality, outcomes and efficiency.

Clinical or medical engagement has become an oft-used, but rarely defined, term and few hospitals have active strategies. From experiences in Australia, USA and the UK, I suggest that medical engagement is about changing the culture of a practice, department, service or hospital where all doctors, as practitioners, are keen to be actively involved in management, leadership and service improvement and where executives genuinely seek opportunities to encourage doctors to lead improvement initiatives. Essentially it is about getting doctors to become more like "shareholders" than "stakeholders".

Spurgeon, Clark and Ham (2011) report on a study in the UK where a clear relationship between medical engagement and quality of care, clinical outcomes and financial performance has been established. For many years we have known that poorly performing hospitals were often typified by having low engagement of doctors in leadership but this UK study provides strong evidence for the need to work harder at creating opportunities for doctors to be more involved.

In parallel with many policy-makers recognising the importance of doctors being more engaged, so the medical profession itself is redefining the role of a good doctor. Many medical professional and regulatory bodies have adopted a variant of the CanMEDS framework (Canadian), which defines a good doctor as not only a clinical expert but also as a professional, communicator, collaborator, manager, health advocate and scholar.

This has led to the medical profession

JOHN CLARK
Senior Fellow,
The King's Fund, London
Director, Institute of
Health Leadership,
WA Health

in the UK, through a combination of professional, regulatory, educational and service support, to incorporate leadership and service improvement competences into undergraduate and postgraduate curricula. A Medical Leadership Competency Framework (MLCF) has been developed which incorporates a range of relevant leadership competences for all medical students, postgraduate doctors and specialists. Indeed this Framework has now been extended to all clinical professionals and forms the core for a new Leadership Framework applying to all NHS staff. The Health Workforce Australia Innovation and Reform Strategic Framework for Action (2011-2015) similarly identifies the need for a nationally consistent leadership competency framework for all health professions.

This new focus on service improvement and systems thinking is proving to be very attractive to an increasing number of doctors and many are now keen to take up to a year out of their specialty training to undertake a clinical service improvement fellowship. This approach has proved very successful in the UK and Victoria Health over the past few years. WA Health will be introducing up to ten similar opportunities for doctors early in 2012.

Stimulating doctors and indeed other clinical professionals at an early stage in their education and careers will have a profound effect on how they see their roles. In future, we should see all professionals recognising their responsibilities as being to incorporate improvement as well as delivery of high quality and evidence-based care.

The responsibilities of whatever form of governance Local Health Networks and Medicare Locals assume in the different jurisdictions should include a focus not only on community engagement but also staff engagement, particularly clinical. Explicit strategies of medical engagement should be developed with clinical staff that provides a "compact" between the governing body and clinicians. We might take a leaf out of the McLeod Regional Medical Center (USA), winner of the 2010 American Hospital Association McKesson Quest for Quality Prize where the engagement of medical staff has been a key feature of their cultural change. At McLeod, a 450-bed hospital with a mainly independent staff of 400 doctors, they have managed to develop an organisational approach based on "physician-led, data-driven and evidence-based".

The King's Fund Commission on Leadership and Management in the NHS (May 2011) stressed the importance of a distributed style of leadership with management and leadership needing to be shared between managers and clinicians and to be equally valued by both. The duality or pairing style of leadership (ie clinician and manager) at all levels of a health organisation is proving to be a highly effective way of leading a service or organisation. The Fund will be developing this initial work with a further Inquiry into leading engagement, particularly of medical staff to be published in May 2012.

The initiatives outlined above of postgraduate trainee doctors taking time out of their specialty training to undertake clinical service fellowships and to attain agreed set of relevant management, leadership and service improvement competences suggests that we need to think again as to how appropriate parts of some of our undergraduate and postgraduate education and training for all health professionals and managers should be reassessed; there is clearly scope for some rethinking on this as clinical professional bodies redefine roles and curricula.

Doctors moving into leadership roles have often been challenged by peers with statements about going to "the dark side". This is unhelpful and what is now needed is the creation of organisational and system cultures where more doctors at all levels move to the "centre stage". Greater engagement in the overall leadership of a service will realise some significant improvements in quality, clinical outcomes and efficiency. It cannot be left as an optional extra.

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LCHS making gains in **Koorie engagement**

Collaboration the key to improving health outcomes among the **Koorie community**

Family and community members participate in the Elders Camp organised by LCHS at picturesque Wattle Point on the Gippsland Lakes

BEN LEIGH
CEO
Latrobe Community
Health Service

LCHS Carer Support Coordinator Vida Wallace (centre) with Gunnai Kurnai Elders Gloria Whalan (left) and Joyce Hood (right) at this year's Wattle Point Elders' Camp

LATROBE COMMUNITY HEALTH SERVICE (LCHS) in the eastern Victorian region of Gippsland has found a collaborative approach is working well in extending their services to the Koorie community.

"We tend to think of core health issues whenever the subject of Koorie health comes up," says Ben Leigh, LCHS Chief Executive Officer. "But there are a lot key services that are missed in this approach."

Ben highlights Carer Services as an example of a service that is sometimes overlooked but provides tremendous benefits for the local Koorie community.

"Our Carer Services team meets and supports people in the Koorie community who are carers. Our Koorie Liaison Officer works with members of the community to help break down barriers that may be preventing Koorie people accessing our services," says Ben.

LCHS understands that caring for someone is not always an individual effort in the Koorie community and that it can be shared by many people – often this is done by the Elders who may be supporting several people at a time. Part of the approach of LCHS is to find new avenues to deliver their services to the Elders who may also have carers themselves.

A typical and successful event is the annual Elders camp at Wattle Point in East Gippsland. The camp was held in April this year and 37 people attended the outdoor setting. This is the third year of the camp and the number of Elders attending each year is increasing.

The camp provides an opportunity for Elders and their carers throughout Gippsland to have a break in a beautiful, relaxing location. Importantly, the Elders enjoy the opportunity to catch up with long-term friends and family members who may live in other towns. Some have commented that they like the camp as they are coming together for a happy event in contrast to the community gatherings that often occur when someone passes away.

"Our Carer Services staff arrange and attend these events. They present information about our programs and help link clients and carers into other LCHS services," says Ben.

LCHS believes the key is to spend the time to build a relationship with the community rather than just supply information. It has been important to demonstrate this commitment to the local Gunnai Kurnai people. LCHS worked with a local Koorie woman and educator at GippsTAFE to develop a cultural awareness training package for all existing staff. This has been rolled out over the last twelve months and is now embedded in orientation for all new staff.

These efforts are proving successful in building the relationship and extending the services accessed by the Koorie community.

LCHS district nurses were invited to do a health check day at the Koorie Elders Planned Activity Group (PAG) in Traralgon. On the initial visit it was seen that an ongoing service could assist in changing the health outcomes of these clients. The district nursing service now provided to this group of elders ranges from occasional blood pressure and sugar tests to full health assessments and chronic disease referrals.

Gloria Whalan is a member of the Koorie Elders PAG and she had this to say about the district nurses visits:

"I didn't know it existed till I was invited along to the weekly Koorie Planned Activity Group. I had always been stuck at home raising my kids and my foster kids. My husband left me when I was 27 with six kids aged from 1-9 years. I never went to the doctors much, because when I grew up you only ever went to the doctor if your foot was about to fall off!

"When I met the nurses they taught me how to look after my health properly. I know I can ring the nurses anytime and ask a question or get a home visit.

"My daughter became very unwell with terminal cancer and I didn't know what to do so I rang up Vida who works for LCHS in Carer Services as she has helped me in the past. She recommended palliative care. The nurse who does PAG also does palliative care, so I could tell my Linda how nice everyone was and this reassured her. They provided us with all the equipment we needed to make her comfortable. We really wanted Linda to be at home surrounded by her family, not in a cold unfamiliar hospital. Caring for Linda at home gave the family the ability to visit her at anytime and the family made a roster so someone was with her at all times.

"I think the nurses coming to our group have helped the Koorie community. Before, no one knew what services were available and they just kept their health problems to themselves and just put up with it." ha

DR PAUL SCOWN
President of the Australian Healthcare and Hospitals Association

President's view

I am proud to be the **new President** of the AHHA and to announce the establishment of a **Health Services Policy Research Institute**

I AM PROUD to be writing to you as the new President of the AHHA. The AHHA appoints its National Council at each Annual General Meeting and the Council then elects the governing Board from its membership. You can see a list of our Councillors for the forthcoming 12 months on page 3.

The AHHA has a vital and important role in the health sector. As the outgoing President, Dr David Panter, noted in his report to the AGM on 13 October, the AHHA's exposure and reputational standing continues to strengthen and governments now draw regularly on our experience and expertise for policy advice. I have been a keen member of the Board as Vice-President since 2003 and am now very much looking forward to being at the helm of this go-ahead organisation.

Our work over the next 12 months will be undertaken by three Directorates in the Secretariat, structured to undertake:
1) Policy development, networking and advocacy;
2) Health services policy research; and
3) Membership and business activities.
The AHHA's current policy and advocacy priorities include:

- issues related to the National Health Reform. Our particular focus in the next few months is on the governance and funding of community health and rural and remote services;
- refugee employment in heath;
- oral and dental health. NB: our work in this area has led to Prue Power and Martin Dooland being appointed to the government's peak Dental Advisory Committee;
- Private Health Insurance, where we are working with Professor John Deeble to support means-testing the PHI rebate.

The AHHA is proud to announce the establishment of a Health Services Policy Research Institute. The Institute will be underpinned by a collegiate partnership between academic organisations and health service providers. The Institute will make a real difference in the landscape of health services research, policy development, implementation and evaluation in Australia and has the capacity to influence health services delivery both here and internationally. It will develop and implement evidence-based policy and effect knowledge translation for the benefit of the healthcare sector and the Australian community. Its goals are to:

- stimulate and improve the national capacity for commissioning and conducting health services policy-relevant research and testing health policy hypotheses;
- improve the Australian public healthcare system by ensuring health policy development and implementation are based on independent research and analysis informed by input from key managers and clinicians in health services;
- promote effective liaison between researchers and health services; and
- collaborate with similar research organisations both nationally and internationally.

To support the Institute, the AHHA has incorporated Academic Membership into the Association with the same benefits that apply to our core Institutional Members. There is no doubt that this new endeavour will contribute positively to broadening the scope of the AHHA over time. Our Membership and Business Directorate is responsible for a growing membership and the establishment of the AHHA's Just Health Consultancy, providing (among other things):

- Governance training;
- Activity based funding consultancies and training;
- Organisational improvement consultancies;
- Professional conference organisation; and
- Mediation and arbitration services.

Please keep reading this section throughout 2012 for regular updates on these activities. ha

Note this date in your diary…
24–27 September, 2012

How does our health system measure up?

Reporting on performance: the views of consumers, providers and regulators

Sofitel Sydney Wentworth

A collaboration of the Australian Council on Healthcare Standards (ACHS) and the Australian Healthcare and Hospitals Association (AHHA)

How does our health system measure up?

Reporting on performance: the views of consumers, providers and regulators

Following the success of **The Great Healthcare Challenge** in 2011, the Australian Council on Healthcare Standards (ACHS) and the Australian Healthcare and Hospitals Association (AHHA) will again join forces in 2012 to bring you – **How does our health system measure up?** ***Reporting on performance: the views of consumers, providers and regulators.***

Whether you are a clinician, a manager or finance officer, you are required to measure and assess your outcomes. The National Health Reform will put this part of your job **under the microscope**.

How do we measure individual patient outcomes or population health status? How do we relate financial performance to both utilisation and quality? Do we collect and link our data efficiently to reduce the red tape burden? How will the National Standards, mandatory from 1st January 2013, influence our administrative and clinical priorities? How will the national entities such as the National Health Performance Authority (NHPA), the Australian Institute of health and Welfare (AIHW) and the Independent Hospital Pricing Authority plus their state counterparts rationalize their roles? How will they incentivise good performance?

This conference will discuss these questions and highlight the views of key stakeholders.

We will answer the key question – "Are we really a high performing health system?"

Who should attend?

This conference will appeal to a wide cross-section of the public and private healthcare sectors across rural, regional and metro areas. If you work in a healthcare facility or department as a clinician, a clinical leader, a manager or executive, a finance officer or an information officer you will find this conference useful and stimulating.

Register your interest at:
admin@ahha.asn.au

International experience

DR PATRICK BOLTON
National Councillor of the Australian Healthcare and Hospitals Association

AS A REGULAR columnist for *The Health Advocate* I am encouraged to write articles that build on the theme for the edition. Unfortunately, my international experience in health is limited and so I'm left reflecting on a mix of ideas that come to mind when I think about health care in an international context.

One such issue is how much Australia spends on health and whether that really is the best use of our limited resources. It is well known that we fall towards the top, but within the pack, of OECD nations on healthcare expenditure per capita. For that, it is generally recognised that we get a pretty good healthcare system. Not one without opportunities for improvement, but value for money on the outcomes, so long as one ignores the clamour of dissatisfaction that seems to come from most stakeholder groups.

What follows from this is whether it is worth investing more in our health system - given the law of diminishing marginal returns - and even whether we should consider disinvesting in health so that we can invest in other areas where we get a better return. One area that comes to mind is in reducing greenhouse gases and global warming. I reckon investment there is likely to provide greater health and welfare benefits than the same investment in health. Another potential area for investment is in supporting the health and welfare of less advantaged people, either overseas or at home.

Investment that supports health in third world countries is more effectively spent on infrastructure than directly on health services. One of the lessons learned from overseas through the work of Marmot and Wilkinson is the significant role that equity appears to play in determining the health of nations once basic infrastructure needs have been met. The health of the people of Costa Rica is better than the health of black Americans, notwithstanding that the former earn around 10 percent of the latter. The reason for this is thought to be the greater social equity in which the people of Costa Rica live. So, another area that we might want to reduce investment in healthcare in favour of would be greater equity and social inclusion within Australia.

It's not necessary to go overseas to find people whose health status is comparable to that of the third world. The health of Australian Aborigines remains behind not only that of other Australians, but also behind that of Indigenous peoples living in other countries settled by Europeans, such as the US and Canada. While issues remain, those countries have had considerable success in addressing health problems among their native peoples over the last 30 years, something Australia has yet to successfully emulate.

Another issue that comes to mind when thinking about health in an international context is Australia's apparent excessive use of acute hospital beds. There is a respectable body of opinion that argues that this is a data artefact. The magnitude of the issue and the potential savings, if it really exists, suggest that robust analysis and debate about this would be worthwhile.

As a doctor working in Australian hospitals I used to acknowledge the data, but wonder which of the patients I was seeing I could realistically not admit. I am coming around to the view that the role of hospitals should be to support patients whose dependency needs cannot be met by less intensive models of care. This model makes nursing requirements the main determinant of hospitalisation. The corollary of this is that, in general, the medical needs of patients for diagnosis and treatment could be managed through alternative logistic arrangements if the healthcare system were engineered to support them.

A related issue, which perhaps lends credence to the notion that Australia does have more acute hospital beds than it needs, is data from the US, which suggests that up to one third of medical procedures are unnecessary. The main determinant of the provision of medical services in that context appears to be the supply of doctors providing those services, rather than proxies for patient need. This has to be a target for productivity improvement in an increasingly resource constrained and accountable healthcare system.

It's tempting to comment on the internationalisation of the health workforce. On the one hand I am not sure how important that is to Australia. The barriers, particularly to doctors, to entering Australia remain

What can we learn from **international healthcare** models to **benefit Australia?**

high. On the other hand, I am perplexed by the failure of the much-vaunted increased number of health graduates to materialise over the last five years. I accept as a matter of fact that the universities are turning them out, but I still face shortages of junior doctors in my pleasantly located inner metropolitan teaching hospital. If they are not going overseas I am not sure where they are going!

The last international issue I want to mention is reform. I noted in one of my first columns for *The Health Advocate* that the UK and New Zealand experience had been that reform was hard to stop once it had been started. The health reform genie has escaped from the bottle in Australia. Given the unclear and probably equivocal effects of the first round of reform, a second round seems inevitable. But, if overseas experience is to be relied upon, that is no more likely to solve our problems than the first attempt.

I guess the bottom line about overseas experience is that we need to learn from it so that it can be applied for our own benefit. ha

Conference culture

Philip Darbyshire asks if there is a future for **healthcare conferences**

AS THIS YEAR'S CONFERENCE season hits full swing, should we be concerned for the future of our conference culture in health care?

The conference calendar may seem as busy as ever but for many nurses and midwives, and especially clinicians, it seems that being able to attend professional conferences is becoming more of an obstacle course and an achievement than a professional expectation. As the 'Impacted Nurse' website asked recently about conferences: "Is there a bedside nurse in the house?". The answer is: "Not nearly as frequently as there should be".

There are several forces at play here. On the one hand, there are some hospitals and health services who seem to see any kind of professional development or continuing education as a drain on the budget and a detraction from 'essential services' rather than an investment in service quality. (Take a bow Queensland Health for your PDP for Nurses and Midwives of up to $2,500 per year). When budgets are tight, an almost

PHILIP DARBYSHIRE
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Monash University
Adjunct Professor,
University of Western
Sydney

sub-cortical executive response is to cut back on education and of course conferences. Even the language that we use feeds into this downgrading. Staff apply for 'Conference Leave' as if this were a holiday they were taking instead of an integral part of their professional practice. They may then be granted 'permission' or 'approval' to attend. Such largesse is touching. For many clinicians it is also light years away from the NHHRC vision of our future health workforce being 'modern, learning and supported'.

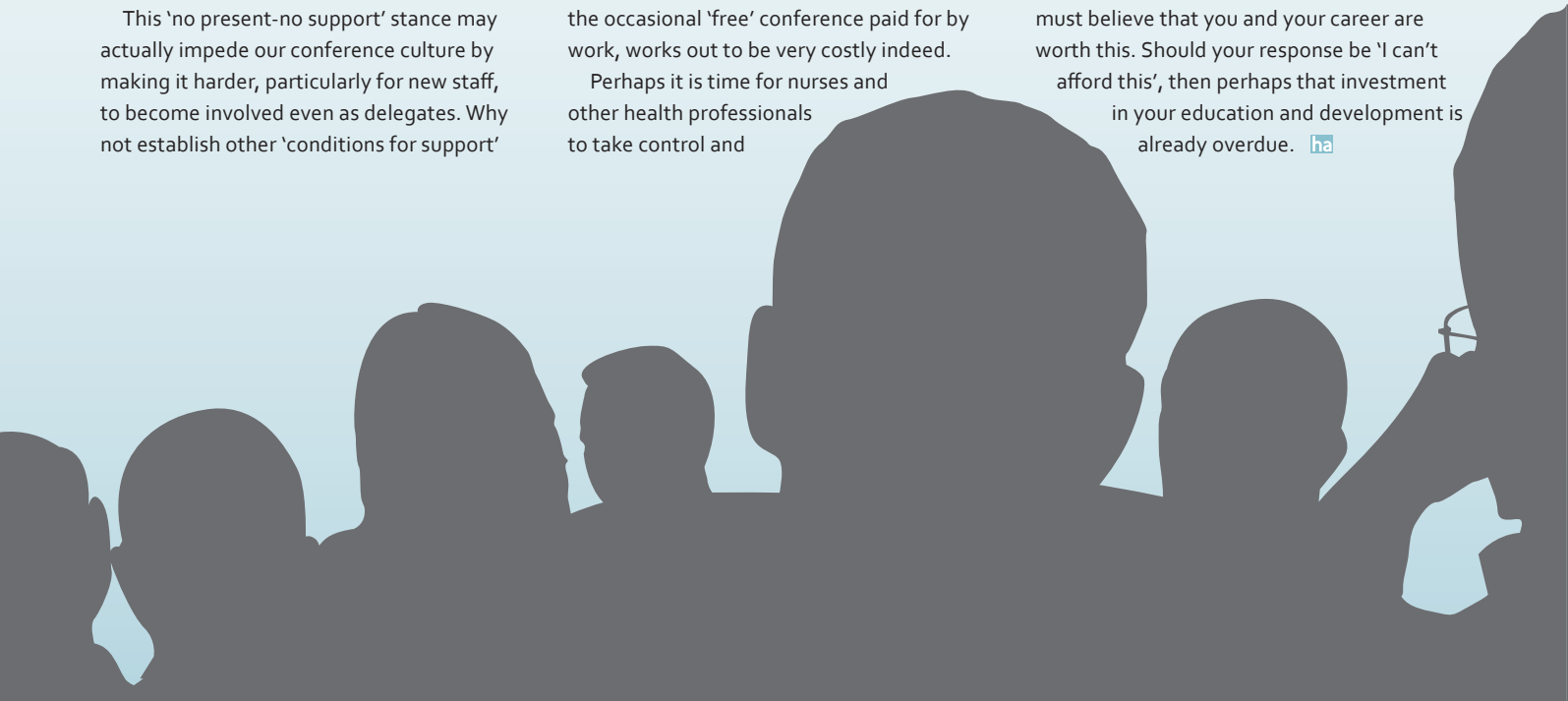
Nor are our universities all that different. While conference attendance is regarded as more of an expectation in academia, schools of nursing want bang for their bucks and so conference support funding is often dependent upon applicants presenting a paper (and don't hold your breath if you have chosen the conference world's shockingly undervalued poor relation - the poster). Small wonder that conference organisers often try to cram in as many concurrent sessions as they possibly can when talking to 10 people for as many minutes can constitute 'delivering a paper at an International Conference' and thus secure some support.

This 'no present-no support' stance may actually impede our conference culture by making it harder, particularly for new staff, to become involved even as delegates. Why not establish other 'conditions for support' that will enable and promote conference participation? Ask that every experienced clinician who attends takes a new RN from the ward or unit with them. Insist that every educator takes a keen student with them and mentors them in the art of 'conferencing'. Expect every manager to take one of their 'rising stars' and help them network.

Nursing's history and culture of dependence has hardly helped matters. Traditionally nurses expected 'the hospital' to provide and pay for all of their professional development. We have paid a high price for this Faustian bargain. I have lost count of how often nurses have told me that they would have loved to attend this or that conference or meeting but 'weren't allowed to' because 'the hospital' or their health service would offer neither funding support nor 'days off' to attend.

Many nurses have effectively handed over responsibility for their own professional development and continuing education to their employing organisation. Why on earth should nurses continue to allow a line manager somewhere the power to determine what conferences, events or meetings they should attend? Within this dependency deal, the occasional 'free' conference paid for by work, works out to be very costly indeed.

Perhaps it is time for nurses and other health professionals to take control and responsibility for their ongoing education and development. What may look at first blush to be an expensive stance can soon feel both empowering and liberating. Rather than being beholden to the whims and favours of your managers, make the decision now that your professional development is too important for such abdication and that these decisions should be in your hands. I almost 'tithe' a percentage of my income each year and use this for my ongoing development. Clinical nurses and nurse educators could do likewise and should look on this five or 10 percent 'education slice' of their salary as liberation money. Surely as a professional nurse, you must believe that you and your career are worth this. Should your response be 'I can't afford this', then perhaps that investment in your education and development is already overdue. ha



Lissa Smith
Director of 360health

Managing to the efficient price

Lissa Smith believes the momentum behind activity based **funding is growing**

A COLLECTIVE MOMENTUM TO embrace activity based funding (ABF) was demonstrated by those who attended AHHA's recent 'Managing to the Efficient Price' seminar led by Professor Stephen Duckett, Professor of Health Policy at La Trobe University.

Although some healthcare systems are more advanced than others in adopting casemix and costing methodologies, this shift from historic budgeting to ABF is truly transformational within the Australian public hospital system.

At its core, ABF is meant to provide a simple, transparent means to purchase efficient healthcare services with our taxpayer funds. It should provide public hospitals with equitable payment for delivering patient services. While there is a fundamental understanding of casemix funding based on Australian Refined Diagnosis Related Groups (AR-DRG), there remain many unanswered questions regarding the Independent Hospital Pricing Authority's (IHPA) approach to cost weights for variables such as population mix, locality, research and teaching, capital investment and wage differentials. There is also ongoing speculation regarding everything from block grants, to the states' ultimate funding approach, to whether the adoption of ABF will create perverse incentives.

As a result, much energy is being placed on better understanding all of these dynamics and complexities, especially as they relate to acute, emergency department, subacute and out-patient services. ABF will create an entirely new set of business issues, including the need for systems and a knowledgeable workforce that are required to support and deliver the associated clinical coding, auditing and analytics.

But, as Stephen Duckett reminded us, ABF is only one means to impact quality and cost. As an industry, we have a unique opportunity to take the health reforms to heart and not only focus on cost weights and casemix, but embrace mechanisms that impact utilisation and meet community expectations as well.

While listening throughout the day to presentations on costing models and auditing protocols, I kept reminding myself that, day-in and day-out, taxpayers and patients do not really relate to these cost and business complexities. Nor should they. From their perspective, they simply expect to receive efficient services that provide the best possible outcomes. Arguably, our greater collective challenge will be not only to define 'efficient' in the context of current service delivery, but also within the context of meeting consumer expectations for the adoption of emerging and mobile technologies, personalised medicine and the desire to age independently at home.

To that end, the move to ABF will provide stronger uniformity across public and private hospital data sets. While this first phase will shift our industry to funding linked for actual service provided, I am hopeful that we leverage this expanded wealth of health informatics to design new service delivery models, delivering even stronger quality and efficiency.

Taking quality improvement seriously

Benchmarking is key to improving quality and safety says **Jane Thompson**

Jane Thompson
Senior Research Officer,
Women's Hospitals
Australasia

BENCHMARKING CLINICAL CARE processes and outcomes with peers is one of the important tools available to a women's health service seeking to assess the quality and safety of the maternity care they deliver.

As a service to its members, Women's Hospitals Australasia (WHA) undertakes a number of benchmarking programs. These include annual benchmarking of maternity clinical indicators as well as of activity and costing data.

Since 1997, WHA has been collecting and analysing a set of maternity indicators. These indicators have been developed and refined by WHA, taking account of their relevance, the capacity of members to collect valid and reliable data, and competing demands on organisations. Members are provided with a summary of results in WHA's report Benchmarking Maternity Care and are able to make comparisons with similar services beyond state or district boundaries.

Ranking hospitals in terms of their performance on a set of clinical indicators can be problematic without due regard for contextual factors such as casemix and size. As an aid to member hospitals to assess their performance relative to other members and adjust for greater proportionate random variation in smaller hospitals, WHA introduced funnel plots for relevant indicators.

In a funnel plot, a target for each indicator is set and control lines (two and three standard deviations) constructed around the target. A hospital whose performance indicator lies anywhere between the target and the control lines (regardless of its ranking) is considered to be 'in-control', while one whose performance indicator lies more than three standard deviations away from the target, warrants closer scrutiny.

Further, key clinical indicators are now reported separately for selected primiparas (women 20-34 years old, giving birth for the first time, singleton pregnancy, cephalic presentation, gestation 37-41 weeks). Selected primiparas are relatively homogeneous with respect to risk factors for interventions and outcomes, so comparisons across hospitals are less likely to be confounded by casemix differences if they are confined to this stratum of women.

Currently WHA collects 40 maternity clinical indicators. With more than 1 million births now recorded in the dataset over a number of years, analysis of particular clinical practices and outcomes both between hospitals and over time is possible.

For example, 6.6 percent of women who gave birth vaginally in 2009-10 in WHA member hospitals had forceps used as the final method of birth. There was considerable variation between hospitals (0.7 percent to 13.3 percent). Data for this indicator have been collected for 10 years. In 2000-01 the percentage was 6.9 percent, then declined to a low of 3.8 percent, in 2005-06. Since then, percentages have steadily increased each year to the current percentage.

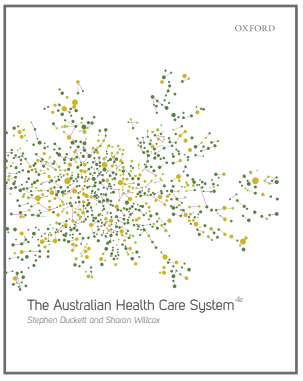
WHA introduced benchmarking of activity and costing data in 2009. The data are made available to members via a web-based portal. This system enables members to compare themselves against peer organisations in areas such as length of stay for specific procedures and costs of provision of particular services. Members are also able to generate individualised charts and tables to more closely examine particular areas of interest.

WHA continues to strive to provide relevant services to our members and our benchmarking programs are highly valued. With the implementation nationally of activity based funding for hospital services, the ability of members to now evaluate service activity and costs is particularly important.

Most importantly though, members need to respond appropriately where the data indicate that their practice differs significantly from peers. In 2010, WHA initiated an evaluation project to explore the ways in which member organisations use the benchmarking data and, in particular, whether they had initiated any changes in management or clinical practice in response to comparative review of indicator results. The project identified considerable variation in how members responded. Participating hospitals made a number of recommendations regarding the reporting of the data including providing individual hospital reports summarising their performance relative to peers on selected indicators.

WHA is a national not for profit body of hospitals providing maternity and other women's health services. It supports both generalist and specialist hospitals and health services to achieve excellence in clinical care of women and babies.

Book reviews



Stephen Duckett and Sharon Willcox
Oxford University Press, 2011
RRP $83.95

The Australian Health Care System

I am fortunate to be able to review the latest edition of a text I last reviewed in 2008. At that time I praised the text as 'providing useful insights and a deeper understanding of the issues that confront the future direction and delivery of health services in this country'.

On initial inspection, the text has undergone a significant facelift in regards to layout, style and approach. Also pleasing is the addition of useful summaries at the start of each chapter; key terms; and further reading lists and useful websites at the conclusion of each chapter. These enhancements take this edition to a new level.

In addition to the chapters that focus on frameworks for analysis; the Australian population and its health; financing health care; the health workforce; departmental and intergovernmental structures; hospitals; public health; primary and community care; pharmaceuticals; and policy challenges for the Australian health care system, the authors have included three new focus areas:

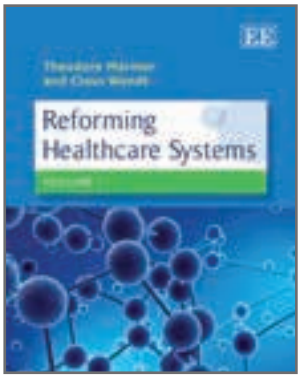
- Primary care services;
- Specialised health services; and
- Aged care and disability services.

Further enhancing this edition are case studies that assist the reader to link theory and practical aspects. This is particularly useful for the student or casual observer of Australia's complex health system.

An inclusion that has strongly enhanced the fourth edition is the addition of a commentary by the authors at the end of each chapter that examines future reform directions. This approach nicely concludes each chapter, encouraging the reader to consider where Australia's system of health care may be heading in the future.

In 2008 I wrote that The Australian Health Care System, was a 'useful addition to any library as well as a staple for students needing to more clearly understand the complexities and challenges of the Australian health care system'. At the time of the initial review I reviewed the text through the eyes of an academic. This time around I review the text from the perspective of a senior health executive. I can attest that this text is still as relevant today as it was in 2008. Additionally, with the fourth edition enhancements, this text is equally pertinent to the student, the academic and the practitioner. As was the case in 2008, this is a must-have text.

Reviewer: Dr Gary E Day, Senior Associate Editor – Australian Health Review.



Theodore Marmor and Claus Wendt (Editors)
Edward Elgar Publishing
RRP US$730 (Two-volume set)

Reforming Healthcare Systems

Choosing articles to include in an edited collection that examines international health system reform is doubtless a daunting task! This two-volume collection includes 55 articles spanning the period from 1975 to 2009. Volume II, the subject of this review includes 28 articles covering almost the last two decades (1992 to 2009), grouped under six broad themes: cross-national lessons; the role of the market in health care; health policy retrenchment; the principle of solidarity; priority setting and rationing; and the consequences (both intended and unintended) of health system reforms.

As one would expect to see in a retrospective of health system reforms over the last two decades, there are articles examining some of the major developments: the rise (and fall) of the internal market in England; the role of perceptions in fuelling the regulatory backlash against managed care in the US; and the attempts to implement managed competition with varying degrees of success in some European countries.

There are also one or two timeless gems that retain their power to educate and inspire successive generations of health policy reformers. An example is Bob Evans' classic 1997 'Going for the Gold' article that eloquently examines the self-interest underpinning much advocacy for the introduction of market-based reforms in healthcare systems. The equally erudite Donald Light cuts through with his incisive analysis that most of the benefits arising from the introduction of managed competition in the English National Health Service were attributable to the growth in purchasing experience, while most of the costs arose due to competitive contracting.

For an Australian audience interested in identifying reform lessons, there are some 'light bulb moment' insights. Bevan and Robinson's 2005 examination of English reforms identifies the chasm between the policy rhetoric and what was actually implemented. Citing Machiavelli, they compare the challenge of implementing major health system reforms as being akin to an 'army in occupation', fighting against the prevailing structural forces of powerful groups interested in maintaining the status quo, resulting in a pallid version of announced reforms. (The NHHRC vision of voluntary enrolment for Australian patients springs to mind as a local example of this

We **review three new books**: a look at the complexities and challanges facing the Australian healthcare system, a collection of articles examining healthcare reform and a patient's view of their journey with cancer

policy-implementation challenge).

As Australia moves towards more 'local control' in its health system with the introduction of Local Health Networks and Medicare Locals, it is also timely to remember the warning by Morgan and Freeman (in their examination of regionalisation trends in European health systems) that decentralisation allows governments to distance themselves from hard choices.

However, what is missing in Volume II is accompanying commentary by the editors that synthesises or integrates the lessons from these articles. The 28 articles in Volume II are presented in their original format (as published in various health policy journals), with no discussion by the editors about why these particular articles were selected. Beyond grouping the 28 articles under the six themes, there are no insights available as to how the editors view the different perspectives of their selected authors or how to 'resolve' the contrasting arguments and evidence presented on a range of health system reform approaches. The Volume II contents mentions that Volume I contains an introduction to both volumes, but this was not available to the reviewer so it is unknown to what extent the editors have shared their expertise in commenting on the selected articles. Given the length of both volumes, it would have been preferable for each volume to be self-contained.

Added to this limitation is the reality that at the publisher's price of $US730 for the two-volume set, this collection is simply out of reach for most of its likely audience – health system policy makers, academics and practising health professionals interested in understanding the dynamics of health system reform. Given that most of the articles are available to anyone with access to a good academic library, the market for this edited collection is likely to be limited.

A final issue is that the historical flavour of this edited collection is likely to be problematic for readers unfamiliar with the most recent health system reform developments in particular countries. Many of the American articles predate the passage of the 2010 reforms moving the US towards almost universal health insurance coverage, while the recent flurry of English health reform announcements, 'pauses' and revised reforms are similarly unexamined. This book does serve the important purpose of reminding us of from where we came, but sheds less light on where we might be going!

Reviewer: Sharon Willcox, Adjunct Associate Professor, Department of Epidemiology and Preventive Medicine, Monash University and former Commissioner, National Health and Hospitals Reform Commission

Geoff and Grace Goodfellow
Wakefield Press
RRP $29.95

Waltzing with jack dancer. A slow dance with cancer

It is a privilege to share the patient experience of health care service delivery as a health professional. It is a private, emotional and personal experience which we, as health professionals, are but one small component. We need to have professional distance in a very confined and intense space and yet, be human and respect proximity.

Geoff Goodfellow, the author of this book about the lived experience of his cancer treatment and his embrace of the inherent contradictions in living with cancer, has reminded me of that (and more). He writes in open form poetry which, for those of us more used to templates, checklists and procedures, gave me pause for cynical thought as I compared styles of writing. He came up trumps, I should add!

His poems are surprising and the contradictions abound: Geoff Goodfellow is a working class man and a poet, a boxer with sensitivity, a touring speaker with humility, a man with cancer and a sense of humour. A tough man brought to tears by chemotherapy. His life is one of contradiction: a man who smoked up to sixty cigarettes a day and exercised religiously twice daily. When his weight becomes a treatment issue, he reminds us of the importance of his weight as a boxer. Contradictory, congruent, confounding!

His poems start with a simple scenario, the set up. They include his perceptions and descriptions with sparse, clipped prose. Then he gives an insight into what it means with a short, sharp literary clip around the ear for the reader. Just like a boxer, just like a man fighting cancer with every ounce of his welterweight.

I was surprised at how much I enjoyed Geoff Goodfellow's style. He has something of a cult following in Australia although his cancer treatment caused him to cancel his ninth tour of Tasmania.

The book of poems is written in collaboration with his daughter, who is similarly gifted as a writer. She adds her story to the book. It is a story of family love and of confounding those around them. These are not writers to be pigeonholed easily and their writing gives a beautiful insight into this cancer journey. This book is a poignant reminder to us as health professionals to see the individual and respect them as the owner and controller of their story.

By the time I'd finished this book I had a new perspective on hospitals and the care we deliver.

Reviewer: Tess Dellagiacoma

AHHA adresses the Tax Forum

AHHA CEO, **Prue Power addressed** the Australian Government **Tax Forum** held in Canberra on 4-5 October 2011

THE COMMONWEALTH has put in place a series of major tax reforms aiming to build a stronger, fairer and simpler tax system. The focus of the recent Tax Forum was to identify ways to make the most of the opportunities through tax changes so that Australia is able to sustain a fair and equitable tax and transfer system, including the provision of public healthcare services.

All Australians have the right to universal health care that provides:

- equity of access to the healthcare system; and
- healthcare services of high quality, delivered by skilled professionals, that are appropriate and responsive to their needs and coordinated across all settings.

Australia should have national healthcare policy solutions that are socially, economically and environmentally sustainable. Our national healthcare services must be efficiently and adequately resourced to ensure sustainability and safety. An important foundation to this goal is an Australian tax and tax transfer system that adequately and appropriately funds the public health system. The tax system should ensure simplicity and efficiency and reduce the financial burden especially for low-income earners and pensioners.

AHHA supports key opportunities to introduce changes to:

Superannuation policy

The recommendation of the Australian Government's Final Report of the Australia's Future Tax System Review (Henry Review) proposes that superannuation be taxed at a taxpayer's marginal rate of tax less a rebate. This will ensure greater equity and encourage couples to invest separately in the superannuation account of the lower income earner. Financing such changes can be achieved through taxing superannuation at a person's marginal tax rate and redirect investment in superannuation away from high income earners, who can afford to invest more in superannuation than low income earners.

Security and sustainability of pensions and income for the aged

According to the AIHW, in 2009-10, people aged 55 years and over accounted for 53.7 percent of 8.6 million admissions for patient care in Australian hospitals. There should be simplification of concessional offsets for Age Pensions and removal of relevant offsets; however this needs to be matched with adequate increases for senior pensions that guarantee the health and wellbeing of recipients.

Increasing the tax on tobacco

The AHHA supports increasing the tax on tobacco. While smoking rates in Australia have fallen by about 24 percent over the past two decades about 17 percent of Australians continue to smoke daily. And smoking remains the single most important cause of ill health and death in Australia[1].

Increasing taxation on tobacco should continue to fund programs for health prevention and smoking cessation.

Medicare Levy Surcharge and Private Health Insurance

It is important that the Australian community understands the costs and funding of the health system. At the same time complex taxation arrangements for the Medicare levy and structural tax offsets should be simplified. The recommendations of the Henry Review that the Medicare levy surcharge and assistance for private health insurance should be reviewed as part of the tax and non-tax policies relating to private health insurance is supported.

A gradient rate of Medicare levy payments based on how much people can afford to pay as part of their taxed earnings would provide greater equity. Health costs should be more transparent and the revenue from the Medicare levy, whether it is separate or within a personal income tax, be allocated to health expenditure.

Read the full AHHA submission to the Tax Forum at http://ahha.asn.au/publication/submissions/tax-forum-submission

References

1 Australian Institute of Health and Welfare - Cardiovascular Disease Australian facts 2011

Photography by AUSPIC,A tax plan for our future - www.futuretax.gov.au, The Treasury

Who's moving?

Readers of The Heath Advocate can track **who is on the move** in the hospital and health sector, courtesy of the AHHA and healthcare executive search firm, Ccentric Group.

MATHEW DALY is moving on from his position as Chief Operating Officer of the Southern Clinical Cluster, NSW, to become Secretary of the Department of Health and Human Services, Tasmania.

Christina Mitchell is also moving - but internally at Monash University - from Head of School, Biomedical Sciences to become the Dean of the Faculty of Medicine, Nursing and Health Sciences.

Professor Michael Reade has been appointed to the inaugural Chair of Military Surgery and Medicine at the University of Queensland.

On the national scene, **Professor Chris Baggoley** has been appointed Australia's Chief Medical Officer, while **Louise Sylvan** has been appointed permanent Chief Executive Officer of the Australian National Preventive Health Agency (ANPHA).

Margie Hepner, CEO of Stanhope Healthcare Services, is off to Australian Home Care as the Executive General Manager Community Services.

John Duke has returned to Australia as Regional Manager, Health Care NSW. John was previously at Bangkok Hospital Medical Centre, Thailand.

Damian Hiser has moved from being State Manager at Healthcare Australia to National Business Development Manager for Domain Principal.

Donna Markham has been appointed General Manager-Allied Health at Southern Health. Donna was previously Acting Director-Allied Health with Southern Health. Donna replaces **Athina Georgiou** who now assumes the role of CEO of Queen Elizabeth Centre.

John Fogarty is also on the move from his position as CEO at St John of God, Ballarat to become Executive Director Hospitals, Aged Care and Community Services at Mercy Health.

Head of Acquisitions, IMG Recruitment, **Kristin Carney** becomes General Manager, Radiation Oncology Associates, NSW.

Mary Bonner, formerly General Manager, Health Services at Waikato District Health Board has recently moved to Capital and Coast District Health Board as CEO.

Graham Renwick, National Services Manager at Southern Cross Hospitals, New Zealand makes the big journey to Domain Principal as State Operations Manager in sunny Queensland.

Linda Sorrell is the new CEO of the Australian and New Zealand College of Anaesthetists. Linda was CEO of Melbourne Health.

In another Trans Tasman move, **Shaun Drummond** shifts from the position of COO of Capital and Coast DHB in Wellington, New Zealand, to Western Health in Victoria as its COO.

If you know anyone in the hospital and health sector who's moving, please send details to the Ccentric Group: editor@ccentricgroup.com.

Ccentric Group
Executive Search Specialists

Trade news

Information from suppliers in the **healthcare industry**

Are you at risk?

Did you know that during surgical procedures, 92% of glove punctures go unnoticed ? Double gloving offers protection from the consequences of cross-infection and reduces the risk.

If you are double-gloving with the Biogel Puncture Indication System, you are choosing a solution that has been specifically engineered to show a change in colour contrast following a puncture. If a puncture occurs you have an immediate visual warning in the presence of fluid. If the outer glove is punctured, fluid penetrates between the two gloves and a dark patch alerts the wearer to the puncture. To facilitate donning, the dark coloured underglove has a smooth surface which allows you to quickly and easily don the overglove. The Biogel Puncture Indicator System is available both in a synthetic and latex range.

Double gloving is a recommended practice by the Australian College of Operating Room Nurses (ACORN) .

Why put yourself at risk?

Maffuli N. et al. J Hand Surg 1991; 16(6): 1034-7
ACORN standards for perioperative nursing, Australian College of Operating Room Nurses, 2004.

Breakthrough technology to dramatically enhance care

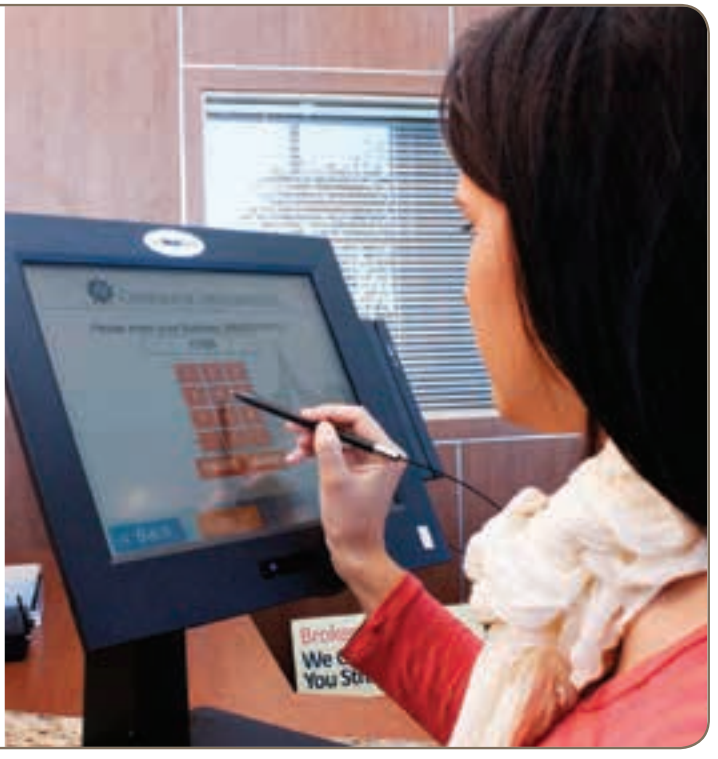
Australia's healthcare sector has begun implementing a new web-based technology, Q-Flow, to ensure quality of care is at the core of the patient experience.

The patient scheduling technology extends beyond queue management to enable surgeons and other hospital staff to accurately monitor the time they spend with each patient to improve patient scheduling and reduce waiting times.

With remote patient check in capability, the system can send a text message in the instance of appointment delays to avoid patients having to wait. Surgeons and other staff can also check appointment schedules and patient flow from a smart phone, bringing a new level of accessibility to the healthcare industry.

In Australia, the Q-Flow system, distributed exclusively by The NEXA Group, currently assists staff at Victoria's Cabrini Medical Imaging Department to manage 100,000 procedures annually.

The system has also been installed at The Prince Charles Hospital in Queensland as part of a major upgrade. Here it will manage the majority of people entering the hospital, from patients to visitors and those attending for tests.



Sharing information, preventing infection

As an integral part of the highly successful *Not On My Watch** infection prevention program, Kimberly-Clark has launched an exciting online community known as Kimberly-Clark's ***HAI WATCHDOG**** Community, this dynamic online program will:

- Serve as an environment where healthcare professionals can learn from one another about HAI prevention and improve their practices
- Encourage participants to exchange HAI information with their peers via online discussions.

As an important part of this online community, healthcare facilities will be allowed to enter Kimberly-Clark's ***HAI WATCHDOG**** Awards Program. This prestigious online recognition program will:

- Allow facilities to enter HAI prevention programs or initiatives that they have implemented
- Be judged by an independent panel of healthcare experts
- Reward the most successful entries with educational grants and/or with healthcare industry and local community recognition
- Include a Clinician's Choice award allowing online voting by healthcare professionals.

NEW

Making Safety Safer℠*

The healthcare industry has come a long way in preventing needlestick injuries and their potential dangers. Even so, blood exposure during a peripheral IV insertion is still a factor – and a risk – to healthcare workers and patients.

Now blood exposure does not have to be "part of the job". BD Insyte™ Autoguard™ BC with Blood Control Technology is proven to reduce the risk of blood exposure by 95 percent.[1]

Ninety-eight percent of clinicians stated they had no risk of blood exposure during insertion when using BD Insyte™ Autoguard™ BC,[1] which means:

- Less risk of blood exposure to bloodborne pathogens
- Reduced need to clean up blood spills
- Less need to worry about stopping blood
- The potential to reduce add-on costs for clean-up supplies.

In addition to these benefits, the push-button shielding technology is proven to reduce needlestick injuries by 95 percent.[2]

For more information, please contact your BD Account Manager, or call our Customer Service Team on **1800 656 100**.

**Versus non-blood control safety IV cannula.*

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Reach your retirement goals with HESTA

AT HESTA, we're committed to supporting you reach your retirement goals. After all, we have had more than 20 years experience in the health and community services sector.

We deliver our finance education and advice services in easy to understand language, using real life examples. Led by CEO, Anne-Marie Corboy, our role is to inform you about your options – so that you can build a better retirement savings balance, whether you're 25 or 65.

We now have more than 700,000 members, 98,000 employers and $17 billion in assets. Our size means we can offer many benefits to members and employers. These include: low fees; a fully portable account; easy administration; access to low-cost income protection and death insurance; limited financial advice (at no extra cost); super education sessions and transition to retirement options.

In addition, we provide access to a range of great value products and services such as health insurance, banking and financial planning. HESTA is also at the forefront of super innovation: we are the first major superannuation fund in Australia to introduce a sustainable investment option and to assess fund managers on their after-tax investment returns.

For more information go to **hesta.com.au** or free call **1800 813 327**.

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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 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.

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Membership Fees 2011-2012

Student	Australian: $205	Overseas: $275
Personal	Australian: $275	Overseas: $378
Associate*	Australian: $1103	Overseas: $1502

*Companies providing products and services to healthcare providers

Institutional / Academic Members (Australian healthcare providers)		
Gross Operating Expenditure (x 1,000,000)		
Equal to or greater than:	**Less than:**	**Membership**
$0	$10	$1,775
$10	$25	$3,549
$25	$100	$8,285
$100	$250	$17,745
$250	$400	$23,625
$400	$550	$29,295
$550	$700	$36,330
$700	$850	$41,475
$850	$1B	$47,355

*Fee includes GST - valid from 1 July 2011 to 30 June 2012

For more information:
W: www.ahha.asn.au
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T: 02 6162 0780
F: 02 6162 0779
A: PO Box 78
Deakin West, ACT 2600

2011-2012 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@ahha.asn.au

	Australian	Overseas
Student*	☐ $205	☐ $275
Personal	☐ $275	☐ $378
Associate	☐ $1103	☐ $1502

Institutional ☐ _____

(See 2011/12 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 _____

Phone _____ 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)

☐ **AHHA Events Newsletter** - Regular notification of upcoming AHHA events including the annual Congress

Payment Details

Amount in AUD$ to be paid by credit card, bank transfer or cheque.

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

☐ **Bank Transfer:** BSB 062 900 Account 008 00811 AHHA

☐ **Credit Card Payments: (Please note – an additional 3% processing fee applies)**

☐ 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 contact us on admin@ahha.asn.au if you requie further proof of purchase.
Please retain a copy for your records.

Snippets
The **last** word

What's been happening since we last met?

DR TONY SHERBON was appointed the acting Chief Executive Officer of the interim Independent Hospital Pricing Authority (IHPA), starting on 1 September 2011. Under the National Health Reform Agreement the interim IHPA will be responsible for critical aspects of a new nationally consistent approach to activity-based funding of public hospitals, until legislation is passed to create the IHPA as a statutory authority.

September also saw the establishment of a new e-mental health expert committee, which will advise on the rollout of the nation's first mental health online portal and virtual clinic. The rollout of these new online initiatives will be considered by the expert committee in its development of Australia's first national e-mental health strategy.

The plan charting the path for national health reform implementation was released. The plan shows how the benefits of health reform - increasing the sustainability of public hospitals, delivering unprecedented levels of transparency and accountability, less waste and significantly less waiting for patients - will be achieved. It outlines the plans and milestones to be met in achieving health reform across a range of areas.

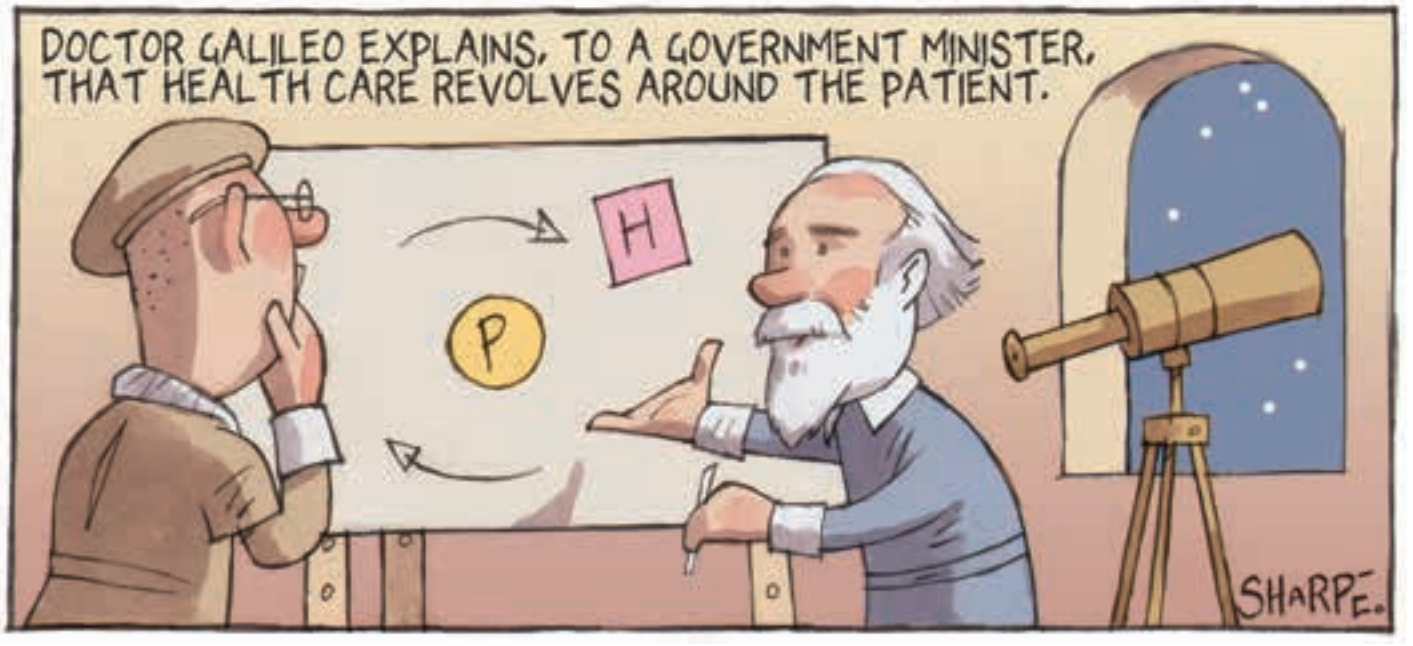
The finalised plans for Australia's secure, efficient e-health system were released. The Concept of Operations for the personally controlled electronic health record (PCEHR) system is a fundamental part of the move from paper-based records to secure e-health records. It describes the implementation plan and consultation pathways for Australia's electronic health system, its structure, how it will work, the security and privacy principles, and the many expected benefits of e-health for patients, carers and healthcare professionals.

Minister Nicola Roxon announced the Chair and members of the National Lead Clinicians Group, which will provide advice on priorities and strategies to improve patient care, promote evidence based clinical practices and assist with the prioritisation and implementation of clinical standards. The government is also working with states and territories to establish Local Lead Clinician Groups across the country to strengthen the involvement of clinicians at the local level.

In October Dr Tony O'Connell was appointed Director-General of Queensland Health. He will be responsible for driving the government's commitment to health reforms, including the creation of Local Health and Hospital Networks for the community and run locally.

Minister for Mental Health and Ageing, Mark Butler, announced the single largest investment in grants for health and medical research in Australian history. The Australian Government is providing $674 million for 1,140 grants to support researchers, research projects and research institutions Australia-wide. This investment, through the NHMRC will ensure that Australia continues to expand the frontiers of health and medical research.

At our highly successful Congress in Melbourne the AHHA Board was delighted to announce that Dr Paul Scown had been elected as the AHHA's new President. Siobhan Harpur was elected as Vice-President while Felix Pintado was re-elected as Treasurer. The AHHA Board also welcomed two new members, Kathy Byrne and Annette Schmiede. The AHHA Council, which has members representing all states and territories, welcomed new members Kerrie Field, Elizabeth Koff, Andrew McAuliffe and Kathy Eagar who takes up a new position as Academic Council Member.



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