The Health Advocate

Your voice in healthcare

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A campaign to recruit more young doctors to country towns

Championing Aboriginal health research
The need for more Indigenous appointments

Empowering Communities

Encouraging participation to improve health outcomes

Optimising health and learning in our schools
Improving outcomes for refugee and other newly-arrived migrants

2014-15 Budget
What it means for health

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The official magazine of the Australian Healthcare and Hospitals Association

ISSUE 24 / June 2014

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BY DR PAUL SCOWN
Chair of the Australian Healthcare and Hospitals Association (AHHA)

New look / Same passion

The face of *The Health Advocate* may have changed but the heart of the AHHA as an independent voice in healthcare remains

This edition of The Health Advocate comes to you with a new look and an emphasis on the innovative work and activities of our members. As you will see, AHHA interests cover a wide range of areas, and in this edition, we highlight rural and Indigenous health, as well as innovations in the health and wellbeing of aged care residents, refugees and other newly-arrived migrants. Healthcare funding is also a particular point of interest, as it has been in the past few months leading up to the Commission of Audit report and 2014-15 Federal Budget, both in May.

The continuing speculation regarding possible strategies to rein in increasing health costs in the lead up to the Federal Budget was notable for its lack of evidence-based solutions. Indeed, the absence of robust evidence and broad consultation about co-payments and an increasing role for private health insurance in the delivery of public health suggests an experimental approach to public policy making which may have serious long-term consequences. Of even greater significance is the withdrawal of substantial hospital funding to the states and territories. The challenges which will face the public hospital sector are immense.

The introduction of co-payments for general practice visits and similar proposals for emergency department visits indicate a disconcerting step away from universal healthcare towards a system that privileges the 'haves' over the 'have nots'. A country that requires the injured and ill to present their credit card for payment in order to receive treatment in an emergency department is not a country that has universal health coverage.

While the Commission of Audit and the 2014-15 Federal Budget have focused on predicted increases in health expenditure, they failed to encourage a greater focus on health promotion and disease prevention, or better integration of care across the primary and acute care sectors, which are effective approaches to reducing costs and improving the health of the community.

This is just one example of why discussions about potential reforms to healthcare funding should occur in consultation with all stakeholders including hospitals, general practitioners, community health services and primary health providers. The National Primary Health Care Strategic Framework was endorsed by the Commonwealth, State and Territory Health Ministers in 2013 and promised a new approach for governments to work in partnership to address the priorities identified in the 2010 National Primary Health Care Strategy. The Framework provides a solid foundation on which to base sensible discussion about evidence-based long-term options for the delivery of sustainable primary healthcare services, and it would be sensible for governments to refer to it as they progress current reforms for Medicare Locals, or Primary Healthcare Networks as they will now be known.

At a time when health funding is under scrutiny, it is important to ensure that all financial decisions are made in the long-term health interests of society; not for short-term political gains. Medicare Locals were established to support better integration and coordination of care and this role continues to be needed. The critical roles of service coordination and access support must be retained, regardless of new models for primary health services. Anything less will result in a service vacuum which will have significant negative impacts on patient outcomes, and service costs and efficiency.

Public problems: Private solutions?, a report that was released in April and co-authored by the AHHA's Deeble Institute for Health Policy Research, Catholic Health Australia and the University of Sydney's Menzies Centre for Health Policy, outlined options to make better use of Australia's health sector resources and to improve the way public patient treatment is contracted to private and not-for-profit hospitals. The report addressed large and small-scale reforms to improve public/private contracting, such as: contracting over longer periods, setting up brokers to facilitate contracting, co-locating and sharing public and private hospital infrastructure, establishing contestable funding pools, establishing more public-private partnerships and implementing new hospital financing models. The AHHA and Catholic Health Australia led further discussions on these issues at a roundtable on 28 April in Sydney; proof of the AHHA's commitment to independent research and evidence-based policy development as well as to debate on issues that matter to the healthcare sector and are of great concern to Australia's future prosperity. ha

BY ALISON VERHOEVEN
Chief Executive
AHHA

Fostering healthy policy discussion

An overview of AHHA's activities from the past few months

In response to Health Minister Peter Dutton's call for a national conversation on achieving a sustainable health sector, the AHHA has published several policy briefings and undertaken a busy program of roundtable discussions over recent months. Events such as these are great opportunities for the AHHA to engage with some of our members, as well as to develop our policy program and advocacy work.

During the summer months, we were pleased to welcome four postgraduate students to work with AHHA to develop issues papers on policy-relevant questions. La Trobe University PhD candidate Nerida Hyett presented findings from her paper, *How rural health can be improved through community participation*, at a session in Launceston facilitated by AHHA Board Member, Siobhan Harpur. Tony Walter of Griffith University prepared a paper on mitigation and adaptation strategies for climate change in a public health context, presented at a Climate Alliance roundtable in Melbourne in April. Elizabeth Martin of Queensland University of Technology presented her issues paper on health rationing at a Brisbane roundtable on 22 May. ANU PhD student Katie Thurber's work on obesity in Indigenous children was presented at a meeting of the Social Determinants of Health Alliance in February, and will also be presented in Darwin in July. Katie and Nerida's research is discussed further on pages 22 and 32.

Together with GPNSW and Novartis, the AHHA was pleased to host Dr Martin McShane of the UK National Health Service in Canberra to speak about his experience in integrated care for those with chronic illness. We plan to continue this work with a simulation exercise later this year.

At another Canberra event, together with ANU, the Australian Medicare Locals Alliance and the Consumer Health Forum of Australia, we heard from Professor Walter Rosser of Queens University in Ontario about the changes to the provision of primary healthcare services that have occurred over the past 20 years in Ontario. These discussions will inform an AHHA policy on enrolment programs for primary care.

In early April, we held a roundtable in Sydney on finding savings in healthcare, with presentations by Professor Philip Clarke (University of Melbourne), Associate Professor Adam Elshaug (University of Sydney), Associate Professor Terry Hannan (University of Tasmania), Dr Robyn Lindner (NPS Medicine Wise) and Terry Barnes (former adviser to Tony Abbott). We plan to become more involved in the development of an Australian version of the Choosing Wisely program as an outcome of this roundtable.

A subsequent roundtable on contracting between the public and private sectors was held in Sydney at the end of April, as a follow-up to an evidence brief we co-published with Catholic Health Australia.

The reports associated with these events are published on the AHHA website, which also comes to you with a more contemporary look this month. I would be happy to discuss these important issues further with members, and look forward to having the opportunity to bring similar events to members around the country in coming months. Your suggestions for our events program would be very welcome.

Last but not least is the AHHA national conference, The Quantum Leap, which is to be held in September in partnership with the Australian Council on Healthcare Standards. This will be an excellent opportunity to progress these discussions further. We have some excellent speakers on our program, including Health Minister Peter Dutton, Professor John McDonough from Harvard University speaking on the politics of national health reform, and Joe Gallagher from First Nations Health speaking about his experience in establishing British Columbia's Indigenous health agency. I hope you can join us for this conference. ha

The Quantum Leap

Health Innovation: Making Quality Count

What?

A collaboration of the Australian Council on Healthcare Standards and the Australian Healthcare and Hospitals Association, bringing together local and international leaders in healthcare to discuss innovative strategies and programs for health service management and delivery.

When?

Tues. 9 to Wed. 10 September, 2014
(optional workshop day on Mon. 8)

Where?

Novotel, Brighton Le Sands, Sydney

To register or to find out more:

Go to www.thequantumleap.com.au/
or phone (02) 6162 0780.

2014-15 Budget wrap

State and Territory support missing as Abbott Government tears up health agreement

The recent decision announced by the Commonwealth Government as part of its 2014-15 Budget package to turn its back on the commitments in the National Health Reform Agreement has been met by universal disapproval from the states and territories. More specifically, the Abbott Government has walked away from the commitment that no state would be worse off, and for guaranteed funding of at least $16.4 billion over 2014-15 to 2019-20 and the provision of 50% of growth funding from 2017-18.

"This will have an immediate effect on the ability of states and territories to maintain their commitment to achieve service delivery standards including the national elective surgery and emergency department waiting time targets," says AHHA Chief Executive Alison Verhoeven.

Health and hospital funding will be swept up into the broader review of Commonwealth-state funding relations, to be examined in a Federation White Paper. It seems likely that the Commonwealth will revert to CPI based growth contributions and block funding arrangements.

"In the delivery of major infrastructure and services such as hospitals, two years is a very short planning cycle and the states and territories will face major challenges as they attempt to manage their health budgets."

"Certainty around sufficient funding to meet current and future health needs is critical to a well-performing health system. The public dissent being expressed by Premiers and Chief Ministers all across the country demonstrates the serious implications of this decision for patients and health services throughout Australia," says Alison Verhoeven.

How the AHHA responded to the 2014-15 Federal Budget

The introduction of co-payments will hurt those who require care the most – the elderly and those with chronic disease.

"We should be implementing systems that improve access to health care for those most in need – not creating more barriers," says Alison Verhoeven.

The Abbott Government has attempted to soften the blow of co-payments by simplifying the safety net arrangements, but the changes should have covered all health services and products, not just out of hospital services, and, it should have done more to protect individuals against the risk of excessively high fees.

Investments in bowel cancer screening, youth mental health, some rural workforce initiatives, dementia research and ongoing support for e-health are welcomed. However the lack of focus on preventive health is very short-sighted, and the medical research fund will be limited both by lack of funding clarity and its very narrow view of health.

A reduction in the number of health agencies is welcome, particularly where it reduces duplication in data collection, analysis and reporting, which has represented both a time and cost burden to the states and territories

The Abbott Government's decision to delay the negotiations on the new National Partnership Agreement for additional Adult Public Dental Services threatens to reverse the recent improvements in waiting times for public dental care. Despite resisting the closure of the Chronic Disease Dental Scheme when in Opposition, the Abbott Government has now delayed the introduction of one of the programs intended to replace it. This raises concerns about the Government's understanding of the importance of oral heath to overall health and its links with chronic disease. ha

AHHA in the news

HAVE YOUR SAY...

We would like to hear your opinion on these or any other healthcare issues. Write to us at admin@ahha.asn.au or PO Box 78, Deakin West, ACT, 2600

Suggestions for a tax grab from the ill is a sick joke

The suggestion by Treasury head Dr Martin Parkinson in April that the Goods and Services Tax (GST) might be extended to include health must be rejected unequivocally. "Proposed changes to the tax system must be undertaken not just to meet fiscal objectives, but also to meet broader social objectives," said AHHA Chief Executive, Alison Verhoeven. "GST is a broad-based tax, and doesn't discriminate between the rich and poor, those who have the advantage of good health and those who are chronically ill or frail and elderly. Adding GST to health costs would have an immediate impact on the ability of many Australians who are least advantaged to afford the health care they require."

Finding savings in healthcare: moving from theory to reality

Prior to the Federal Budget in May, many in the health sector were offering up suggestions for where the Abbott Government might find savings. Many of those options were discussed in detail at an AHHA Roundtable held in Sydney at the end of March. What became clear from discussions among participants was that experts in the field have no trouble generating long lists of potential savings options that might cut billions off the bottom line. The tough part for Government is working out which of these options it should take up and to do so in a timely manner with broad stakeholder engagement.

The Royal Dental Hospital of Melbourne goes Lean

We are delighted to announce that over the coming months, LEI Group Australia in association with the AHHA will deliver a suite of Lean training programs to staff at Melbourne's Royal Dental Hospital. This will create a core group of Lean experts working on projects to improve the cost, quality and delivery of services to their patients and other stakeholders. The success of this group will not only deliver improvements within The Royal Dental Hospital of Melbourne but will also lay down a challenge to other healthcare organisations and hospitals to follow suit, to significantly improve efficiency in patient care across the healthcare continuum.

Health system changes must include a strong public health sector

In February, the AHHA welcomed Health Minister Peter Dutton's commitment to a national conversation about modernising and strengthening Medicare, and ensuring a strong performing public health sector, operating effectively and efficiently in partnership with the private sector. As the peak national body for Australia's public hospitals and health care providers, the AHHA gave notice it will play an active role in this conversation.

Bear Cottage gets a dose of royal treatment

As part of their whirlwind tour of Australia, the Duke and Duchess of Cambridge visited Bear Cottage; an initiative of the Children's Hospital at Westmead and the only children's hospice in New South Wales. As guests of the Sydney Children's Hospital Network, the pair received insight into the journeys that patients, families and staff continue to undertake and the role of play and music therapy in the healing process. As a gift to help remember their visit, the Duke and Duchess were presented with an artwork of nearby Manly Beach made up of fingerprints from Bear Cottage children, families, staff and volunteers.


Royal visit to Bear Cottage. Image courtesy of AUSPIC.


Royal visit to Bear Cottage. Image courtesy of AUSPIC.

Improved dental care must remain a top priority

A group of eight national health organisations, including the AHHA, have reiterated their support for continued investment in improved dental health, particularly for children and those who rely on public dental health services. The 2013 National Partnership Agreement and the Child Dental Benefits Schedule are both aimed at improving access to affordable dental care. Tony McBride, Chair of the Australian Health Care Reform Alliance, said that dental care has been one of the Cinderellas of the public health system until now. "The new programs are widely welcomed as enabling much greater access to children and also to adults, many of whom wait up to three years for dental care," he said.

Hospital efficiency: Quality patient outcomes must be a goal, not just cost cutting

The variable cost of providing health services across Australia has again been highlighted by a Grattan Institute report. In response, AHHA Chief Executive Alison Verhoeven said that the cost variation between hospitals shows that there is potential for more efficient service provision, however the drive for efficiency cannot be at the expense of quality. "Public hospitals are already very focused on improving efficiency and value for money as Australia's healthcare system moves toward more use of activity-based funding and greater transparency and accountability", she said. ha

BY DR ANNE-MARIE BOXALL
Director, Deeble Institute for Health Policy Research, AHHA

Finding savings in healthcare

Moving from theory to reality

In a tough health budget environment, many in the health sector have offered up suggestions for where the Abbott Government might find savings. Some of these options were outlined in an article published in Croakey in April. They include:

- cutting the price paid for generic drugs and encouraging substituting brand name drugs with generics;
- expanding the range of tele-health services that can be funded under Medicare;
- ensuring treatments listed on the Medical Benefits Schedule are effective and offer value for tax-payers, thus reducing use of those that are shown to be wasteful; and
- reducing the price paid for prosthesis, such as hip and knee replacements.

These options and more were discussed in detail at a roundtable, hosted by the Australian Healthcare and Hospitals Association, on options for finding savings in health and improving quality in healthcare. What became clear from discussions among participants was that experts in the field have no trouble generating long lists of potential savings options that might cut billions off the bottom line.

The tough part for Government is working out which of these options it should take up and doing so in a timely manner with broad stakeholder engagement.

Roundtable participants discussed some of the challenges governments face when trying to move debates about savings from theory to reality. The political fallout that results from cutting (or reducing) funding for programs, services or treatments that are currently available is the most obvious challenge, and the one at the forefront of most politicians' minds. Participants at the roundtable had some suggestions on how to make this easier for politicians, and more likely to succeed.

One suggestion was to ensure there was a clear, well-thought through stakeholder engagement process and media strategy around any proposed change prior to announcing it. Participants recalled the previous government's attempt to change the price paid for cataract surgery and how, very quickly, those adversely affected by the change (ophthalmologists) managed to 'capture' the media story, and the hearts and mind of the public. Because the government of the day did not appear to have anticipated how the story would play out in the media, or the strategies the ophthalmologists might use to win over public support, it was on the back foot even despite having a strong economic rationale for making the proposed cuts.

Many participants at the roundtable were in favour of expanding the use of rigorous economic evaluations of services funded by government — for example, the processes used to inform decision-making on individual items on the Medical Benefits Scheme (MBS) or drugs on the Pharmaceutical Benefits Scheme (PBS). However, they recognised that a purely 'technocratic' approach to decision-making was not going to be enough in a highly political area like health. They also acknowledged the large volume of work required, and the apparently slow progress being made in reviewing items and acting on review findings.

One option canvassed by roundtable participants that might de-politicise decision-making to some degree was to establish an organisation external to government with the capacity to carry out both the technical (assessments of relative value) and consultative processes (bringing together academic experts, stakeholders and consumers) required to make rational — albeit difficult — decisions in healthcare. The National Institute for Health and Care Excellence (NICE) in the United Kingdom is one international example of an organisation with the capacity to perform both these roles. Another is the Pharmaceutical Management Agency in New Zealand.

A second, and possibly more feasible option, in a time when governments are seeking to reduce the number of health

agencies, rather than grow more, is a program similar to the Choosing Wisely model which is in place in the United States.

Extensive engagement amongst clinicians, academics, peak bodies and consumers, overseen by a coordinating committee, has resulted in the identification of many inappropriate and low-value healthcare practices.

Such a movement adapted for Australian circumstances could help build a savings culture in health, with strong buy-in for the change process.

The most complex but rewarding suggestion roundtable participants discussed as a way for de-politicising decision-making about health funding was about engaging clinicians. They pointed out that many of the decisions that affect the cost (and outcomes) of healthcare are made by individual clinicians at the point of care – while hovering over the patient's hospital bed, talking to the patient in the GP surgery, or visiting the patient in their home or residential aged care facility.

Out of everyone in the health sector, clinicians have the greatest capacity to influence overall costs of care. For government to find and deliver savings in healthcare, they must find ways of engaging clinicians in the decision-making process about budgets and savings. Clinicians, however, are often the most difficult people to consult because they are working all over the country, and at all hours of the day and night, treating patients. They also tend to be the most difficult people to convince that things should be done differently. While all workplace cultures and traditions can be hard to change, clinical cultures can be particularly rigid. They are, for example, fairly hierarchical, making it difficult for younger clinicians to make the case for change to their superiors. Because so much of clinical practice is art rather than science (take bedside manner, for example), it can be difficult to convince clinicians to change established practices that they think work well.

Out of everyone in the health sector, clinicians have the greatest capacity to influence overall costs of care. For government to find and deliver savings in healthcare, they must find ways of engaging clinicians in the decision-making process about budgets and savings.

Finding ways to engage clinicians is not easy. However, roundtable participants pointed out one approach that should definitely be avoided. Foisting changes on clinicians from 'on high' (changes such as new rules about what drugs can be prescribed for whom and when, or targets for hospital length of stay) will nearly always cause resentment and often result in push-back from clinicians. Because clinicians have a lot of autonomy when making decisions about patient care, they are also easily able to thwart attempts from non-clinicians to exert control over them.

The challenge of engaging clinicians, however, is not insurmountable, as one roundtable speaker pointed out. He explained that with the growing complexity of clinical decision-making and information available to inform it, clinicians are having to rely more and more on automated tools and support systems to help them make decisions. This creates an important opportunity for governments to collect vital data about the process of clinical care. If these data were analysed and used to show clinicians how they could make changes that would improve patient care, there would be a strong motivator for change, and clinicians would be engaged because most constantly strive to deliver better quality patient care. ha

BY SHANE SOLOMON
Chair, Independent Hospital Pricing Authority

Activity-based funding

How far have we come?

A key component of the National Health Reform Actt 2011 (NHRA) included improving public hospital efficiency through the use of Activity-Based Funding (ABF) based on a National Efficient Price (NEP).

ABF is a way of funding hospitals whereby they get paid for the number and mix of patients they treat. This type of funding model aims to improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.

The NHRA established the Independent Hospital Pricing Authority (IHPA) to determine the NEP for public hospital services where the services can be funded on an activity basis. It also formulated a National Efficient Cost (NEC), which is used when ABF is not suitable for funding, such as in the case of small rural public hospitals.

The NEP and NEC serve two key purposes. One is to determine the Commonwealth funding contribution to Australian public hospitals according to either hospital activity levels or, in the case of small rural hospitals, an allocation of block funding. The second is to provide jurisdictions with an independent benchmarking tool to measure the efficiency of public hospital services in their state or territory.

The NEP and the NEC Determinations are based on the annual National Hospital Cost Data Collection and the National Public Hospital Establishment database. IHPA examines the average cost of providing each hospital service across the country. Based on the evidence of costing data, loadings are made for services where there is an 'unavoidable cost', such as rural location of patient residence and Indigenous status.

Three years on from the NHRA, significant work has taken place and key achievements have been made in establishing national ABF for Australian public hospital services and delivering an annual NEP and NEC. IHPA recently released its third NEP and second NEC Determinations. For the first time, from 1 July 2014, Commonwealth funding for most public hospital services will be directly determined by ABF.

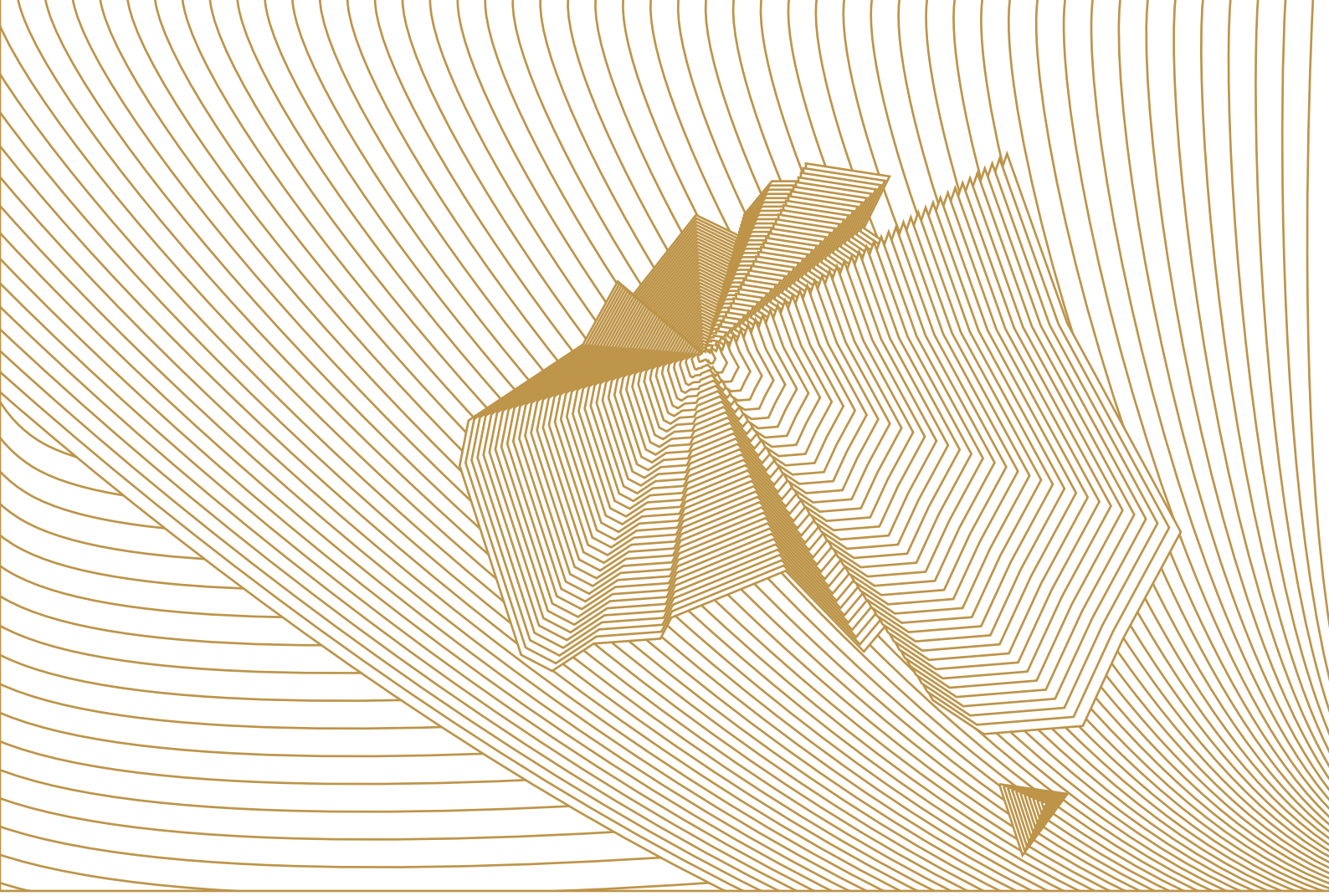
The achievement of a nationally consistent approach to ABF is the result of wide and thorough consultation with the Commonwealth, state and territory governments, as well as peak bodies, health associations and other stakeholders. This is done through a program of work that results in the annual publication of IHPA's Pricing Framework for Australian Public Hospitals Services.

The Pricing Framework is released prior to the NEP and NEC Determinations to provide transparency and accountability by making available the key principles and policies adopted by IHPA to inform the Determinations.As part of this program, considerable work has commenced to refine and add to the classification systems in order to allow for more accurate costing and to include more hospital services in the ABF mix. This includes work with the National Mental Health Commission, health departments across all jurisdictions, as well as clinicians, professional organisations, mental health carers and consumers, to develop a classification system and pricing approach that will support contemporary models of mental healthcare. Work has also commenced to develop a classification for teaching, training and research.

To build on these initial achievements, there must be ongoing consultation and collaboration to improve the pricing process and create a more accurate, transparent and sustainable funding system. This, in turn, will drive efficiency, quality, and better value for public money.

IHPA will release its consultation paper for the 2015-16 Pricing Framework in June 2014 and encourages submissions from all interested parties.

For more information about Activity Based Funding and IHPA, please visit www.ihpa.gov.au. ha



Maintaining an international standard of care

Australian Council on Healthcare Standards (ACHS) retains prestigious international accreditation

Following an independent assessment by the International Society for Quality in Health Care (ISQua) in October last year, ACHS received the exciting news in March that it has maintained its ISQUa accreditation for another four years.

ACHS has achieved an outstanding result in the ISQua International Accreditation Programme according to the ISQua surveyors. Only two formal recommendations were made in the surveyor's assessment of ACHS against the International Standards for Healthcare External Evaluation Organisations, Third Edition.

Addressing ACHS staff at the summation conference back in October, ISQua accreditor Tricia Doré said at the time that "it is highly unusual for an organisation such as ACHS to receive only minimal recommendations, with a small number of improvements to consider, and this is a commendable reflection on the organisation."

"We have been very impressed with the level of improving quality across the six Standards, and the number of improvements that have been made in the organisation since the last survey."

Ms Doré also praised ACHS staff commitment to quality improvement, stating that the results of the survey were a reflection of the organisation's approach to teamwork.

To be an approved accreditor for the Australian Commission on Safety and Quality in Health Care's (ACSQHC) National Safety and Quality Health Service (NSQHS) Standards, ACHS is required to be accredited with an international accreditor.

"As Australia's largest healthcare accreditor, it is important for us to set a high standard when it comes to accreditation, and a lot of work has been undertaken over the last four years to ensure there has been continuous quality improvement in what we provide to our members," ACHS Acting Chief Executive Dr Lena Low said.

"We were delighted with the early advice given by the surveyors and then having this recently confirmed with the full report from ISQua, written and approved by the ISQua Board."

The organisational assessment to the ISQua standards takes place every four years. ACHS will now address the actions it will undertake to meet the two recommendations. ha

Image courtesy of the Council of Ambulance Authorities.

BY GREG MUNDY
Former Chief Executive Officer
Council of Ambulance Authorities

Uncovering hidden value in ambulance services

Initiatives to improve pre-hospital care and transport

The ten public ambulance services that comprise the membership of the Council of Ambulance Services all aim to improve the health of the communities they serve by providing high quality pre-hospital care and associated transport services. This emergency health care response provides layers of value to patients, the community, the health system and governments.

There are a number of dimensions to this:

- **operational efficiency** — containing the costs of services delivered;
- **service efficiency** — delivering the most cost-effective services to meet patients' needs; and
- **health system efficiency** — contributing to the overall cost-effectiveness of patient care from a system wide perspective.

Public ambulance services in Australia and New Zealand are working hard on all of these. One such initiative is the use of statistical models and tools to predict peaks, troughs and the likely location of demand for ambulance services. This makes it possible to use the available resources to maximum effect.

Another area of focus is the development of alternative pathways for 000 callers so that emergency calls receive an emergency response, but that less time-critical calls may be dealt with by other responses. These may include an ambulance response but without the use of 'lights and sirens'; referral to other agencies, for example specialist drug treatment agencies; or by the provision of qualified health care advice over the telephone.

Providing advanced life-saving treatment to patients before and during their transport to hospital is a clear priority for ambulance services in Australia and New Zealand. Such treatment has been shown to significantly improve the patients' chances of survival and to reduce their disability resulting from a critical health episode. Apart from the obvious value to patients and their families, such treatments can also significantly contribute to national productivity if they increase the likelihood of a return to work and reduce demands on family carers.

The use of ambulance capacity to deliver urgent primary care services, particularly in rural areas and out-of-hours, is yet another way that that ambulance services are working to improve frontline healthcare services. Initiatives such as Community Paramedicine and Urgent Community Care have the potential to prevent some patients' health issues from escalating; divert some patients from hospital Emergency Departments by treating them on the spot; and maintain the skills of paramedics in areas where emergency cases are less frequent. Re-directing patients with less urgent or less acute care needs to destinations other than Emergency Departments is important as it results in patients receiving the care they need more quickly and reduces the pressure on Emergency Departments at critical times.

A major factor impacting on all of these initiatives is that demand for ambulance services is increasing steadily in all jurisdictions. This is leading ambulance services to consider and refine the way they respond to different types of cases. These experiences, and the learnings from them, are shared through the CAA and its network of Australasian committees and forums.

An important corollary of this work is refining the way we measure the performance of ambulance services with a progressive shift away from process and activity measures, such as time, towards patient (and system) outcomes such as pain reduction — reported for the first time in the 2014 Report on Government Services — and survival to hospital discharge for cardiac patients, in train.

The Council of Ambulance Authorities is a key vehicle for facilitating the cooperation between services that support developments such as these. ha

BY ELIZABETH KOFF
Chief Executive Officer
Sydney Children's Hospital Network

Optimising health and learning in our schools

How a project initiated by the Sydney Children's Hospitals Network is helping to improve the health and education outcomes for refugees and other newly-arrived migrant students in New South Wales

An innovative refugee project initiated by the Sydney Children's Hospitals Network has won a series of accolades, including the Building Partnerships Award at the New South Wales (NSW) Health Innovation Awards and the Premiers Award for 'Delivering Quality Customer Services'.

The Optimising Health and Learning Project is a partnership between public education and health services. It aims to improve early identification of, and intervention for, health issues likely to impact on the learning of refugee and other vulnerable newly-arrived students to Australia. This has been done through the provision of early health assessments at Intensive English Centres (IECs) in NSW high schools, as funded through the National Australia Bank Schools First Seed Award and Local and State Impact Awards.

The two IECs trialled for the project were Beverly Hills in South West Sydney and Evans in Western Sydney, where health assessments were conducted for more than 200 newly-arrived refugee and other vulnerable migrant students over a two-year trial period.

Partners in the project include Sydney Children's Hospitals Network, South Eastern Sydney and Western Sydney Local Health Districts, Beverley Hills and Evans IECs, South Eastern Sydney and WentWest Medicare Locals, Menai and Evans High Schools, NSW Refugee Health Service, South Eastern Area Laboratory Services and SydWest Multicultural Services.

Many newly-arrived refugee and migrant students have not previously had access to preventative health and early intervention services, such as those offered to children in Australia before they start primary school. Further still, prior to the project commencing, less than 20% of refugee students in Greater Western Sydney received health screenings on arrival.

Many newly-arrived refugee and migrant students have not previously had access to preventative health and early intervention services, such as those offered to children in Australia before they start primary school. Further still, prior to the project commencing, less than 20% of refugee students in Greater Western Sydney received health screenings on arrival.

Many of the health conditions experienced by students — such as vision impairment, hearing loss, and iron and vitamin deficiencies — can easily be identified and treated through routine health screening and linkage with GPs. Yet, upon arrival in Australia, the biggest obstacles that new students face are language difficulties and a lack of knowledge about local healthcare services.

By improving access to school-based health assessments, the Optimising Health and Learning Project can reduce the disadvantage experienced by refugee and newly-arrived migrant students and improve their ability to integrate and succeed in mainstream schooling.

IECs are ideally placed as supportive environments within the community to bring together a range of health services to these students, their parents and their siblings. The established relationship that IECs have with students and parents also enables effective follow-up of identified health issues.

Experienced Registered Nurses are responsible for conducting the health screenings in the IECs, with the assistance of qualified interpreters. Conducting the assessments in this way helps to introduce students and their families to the Australian healthcare system, link them with service providers who speak their language, and provide supported follow-up for students with identified health issues.

The main activities of these IEC health assessments are outlined here as follows:

Left to Right: Dr Chris Elliot (Sydney Children's Hospital), NSW Health Minister Jillian Skinner, Lisa Woodland (South-East Sydney Local Health District), Dr Karen Zwi (Sydney Children's Hospital), Dr Melissa Kang (Western Sydney Local Health District) and Vivianne Challita-Ajaka (South-East Sydney Local Health District). Image courtesy of the Sydney Children's Hospital Network.

- nurse-led screening clinics for hearing, vision and general health;
- provision of information about health and health services to parents;
- linkage of students and their families with local GPs;
- on-site blood collection service for refugee students;
- referral of students with identified health conditions to appropriate services;
- intensive follow-up support for at-risk students;
- provision of professional education;
- information and support to local GPs; and
- hospital tours for students and families.

Over the two-year trial period of the Optimising Health and Learning Project, 80% of refugee students required medical follow-up for a range of health conditions, with most students having at least two conditions identified. All students requiring follow-up have been linked with a local GP and/or specialist health service. Those students identified as having complex health needs, and who need multiple referrals to different service providers, have often required support and transport for them and their parents to attend follow-up appointments.

Since the trial commenced, students have been shown to be more engaged, confident, energised and focused on their learning. There has also been a significant increase in the strength and number of relationships among partner schools, health services and related services.

In identifying both the healthcare needs of, and benefits to, newly-arrived student communities across two different IECs, the Optimising Health and Learning Project has demonstrated that it is an effective model that can be successfully transferred to different geographical areas, each with their own set of health, education and non-government partners.

The strategic planning group for the project is currently seeking funding to expand the pilot to eight IECs across metropolitan Sydney. This would enable the model to:

- reach over 1,200 newly-arrived students and their families per year;
- capture the majority of refugee high school students newly-arrived to NSW; and
- evaluate the long-term cost effectiveness of this approach. ha

BY DAN MINCHIN
General Manager East Coast
Silver Chain Group

Partnering to provide more palliative care

Silver Chain Group offers new services in New South Wales and Queensland

The Silver Chain Group is a recent addition to the New South Wales and Queensland health and community care landscape, working with local public sector, not-for-profit and private providers to improve lifestyle choices and support people to live independently at home for as long as possible.

In New South Wales, we've brought our community-based palliative care experience acquired in Western Australia and South Australia to launch palliative care services in partnership with eight Local Health Districts (LHDs). These include South Western Sydney, Western Sydney, Sydney, Nepean Blue Mountains, Illawarra Shoalhaven, and Rural and Regional Local Health Districts' Hunter New England, Mid North Coast and Northern New South Wales. South Western Sydney LHD is the contract holder for the five metropolitan LHDs and is using its Triple I (Hub) to coordinate and centralise the intake process to ensure ease of access for referrers. Silver Chain is the contract holder for the three rural and regional LHDs.

The aim of the service is to provide additional care to people being supported through their end of life stage at home, and it is part of NSW Government's plan to increase access to palliative care. The service runs under the Palliative Extended Care At Home (PEACH) model developed and piloted by South Western Sydney LHD. Silver Chain's role in the partnership involves supplementing the care delivered by each LHD's community-based specialists palliative care team.

The Silver Chain palliative care service commences at the end of life, with the intention of reducing hospitalisation and giving carers more confidence and time to support their loved one in the home. Evening visits are provided by specialist palliative nurses, in addition to clients and carers being able to access support via telephone or video between the hours of 11pm and 8.30am every day. Personal care or respite for carers is also available during the day.

We are passionate about supporting people's last wishes and we anticipate that we'll support approximately 4,000 people to die in dignity at home over two and a half years. This program is an example of how palliative care can be extended by introducing a wraparound service to complement the great work that has already been done by the specialist palliative care teams across Local Health Districts.


Image courtesy of Silver Chain Group

In Queensland, we are partnering with local provider RSL Care and Telstra Health to deliver Hospital in the Home (HITH) services on behalf of Queensland Health. It is one of Queensland's first community-based public-private partnerships and we're incredibly proud to be part of HITH's expansion in the State.

Silver Chain has extensive experience delivering HITH services, operating Silver Chain Home Hospital in Western Australian since 2009. It is a large scale program available throughout metropolitan Perth, and we provide approximately 110 virtual 'beds' as an alternative to hospital based acute care for conditions that often lead to hospitalisation.

Similarly, our HITH services in Queensland provide hospital level treatment at home under the care of a medical practitioner for acute conditions including skin, urinary tract and lung infections, plus blood clots in the legs and lungs. The service is available 24 hours a day, seven days a week to patients from Brisbane Metro North Hospitals including Royal Brisbane Women's Hospital, Prince Charles Hospital, Redcliffe Hospital, and Caboolture Hospital. It has also recently expanded to the Sunshine Coast and is available to patients from Nambour Hospital, Caloundra Hospital, Maleny Hospital, and Gympie Hospital.

It is available by referral only but since launch earlier this year, we've delivered care to 80 patients in Metro North Hospitals in Brisbane.

Both the palliative care (PEACH) program and HITH services are exciting partnerships between the government and non-government sectors, working closely together to provide a greater level of support to clients and their families and carers

By working in partnership, we can deliver a greater impact on the community, increase access to services and ultimately improve health and wellbeing outcomes for Australians. ha

Reshaping health and care across Australia

The Silver Chain Group is one of the largest not-for-profit health and community care providers in Australia, assisting over 87,000 people in their homes each year.

With 120 years' experience the Silver Chain Group is committed to caring for people at home and to helping shape the future of health and community care across Australia.

Our services improve lifestyle choices and support people to live independently at home for as long as possible, improving their overall quality of life and wellbeing.

We also work in partnership with hospitals, doctors and other health care providers to provide a seamless transition to care in the community.

For more information visit
www.silverchain.org.au

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Silver Chain

Palliative Care Online Training

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Do you want to make a real difference in end-of-life care? You're not alone...

Whether you work in aged care, acute or primary care, chances are, at some stage, you'll find yourself caring for someone with a terminal illness.

Every person's needs are unique and sorting your way through the emotional and social stresses faced by a dying person and their family can be difficult.

A new online training program has been developed to help health professionals who provide palliative care to aged persons in the community. The modules will help you develop your skills and confidence, so that the next person you care for at the end of their life will benefit from your experience.

The four online training modules have been developed to help you to:

- Reflect on the needs of people and their families as they approach the end of life;
- Build your screening and assessment skills;
- Develop confidence in having end of life conversations, especially around Advance Care Planning;
- Invest in your own self-care and build resilience;
- Connect you to a wider network of experts who can support and assist you.

Why do the training?

- **It only takes a few hours to complete online;**
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For more information, contact Terrie Paul, the Director of JustHealth Consultants, by emailing tpaul@ahha.asn.au or by phoning 02 6162 0780.

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BY FELIX PINTADO
Chief Executive Officer, Royal Freemasons.
Pictured with Noeline Brown, Ambassador for Ageing

More tablets for the elderly

How portable technology can improve mental health and wellbeing in aged care

Tablets — not the oral medicines that immediately come to mind, but the easy to hold, easy to use for web browsing, email and photo-sharing kind of tablets — are just one of a range of new ideas that are transforming aged care facilities for the better.

If not being turned on its head, aged care in Australia is in the middle of being turned on its ear. What a time to be part of this sector; to observe the powerful will for change and the enormously beneficial outcomes that are evident. The new focus on in-home care to provide a healthier and happier environment at home for longer; the new aged care reforms from 1 July — which will enable more equitable and higher quality aged care services for all; the changing attitude on the needs of the individual in aged care to be recognised as 'an expert' on oneself and all that it entails for our own health and wellbeing.

These are just a few of the exciting changes that are being led by organisations like Royal Freemasons, a major Victorian provider of aged care services.

Royal Freemasons is unique in that it has been serving the aged community since 1867, with the full continuum of aged care services and with an added commitment to providing for Victoria's most needy.

The central focus of the organisation has been on innovation together with excellence in care. Hence, it has been instrumental in staying at the forefront of trialling and adopting new ideas in aged care in line with emerging social attitudes, quality care standards and wellness techniques. This is all done with an emphasis on respecting individual needs and enriching the lives of customers.

Efforts to increase the use of personal computers and internet devices — to improve connectivity of clients with family and friends — has been a key objective at Royal Freemasons. While some clients are already well supported by family with personal computers and tablets, the majority are not. Consequently, a strategy has been put in place, commencing late last year, to fundraise for tablets that could help make clients feel more connected and engaged, intellectually and socially, as well as provide a source of great enjoyment. More than $30,000 has been raised so far. This money is being used to purchase iPads, to be deployed via a library style sharing regime. This regime will be supplemented by volunteer trainers who will bring clients up to a level of being able to search the net, receive and share email and photos, and so on.

The Commonwealth Government's current campaign to promote positive ageing has four areas of focus, one of which is highly relevant to this activity. The four areas are: staying physically active; eating well; keeping in touch with family, friends and community; and avoiding falls at home. The Government has also established its very first Ambassador for Ageing — the much loved and well known actor, Noeline Brown. She is a vocal advocate of 'keeping in touch with family, friends and community' and strongly supports the Royal Freemasons strategy. To show her support, Ms Brown officiated at the Royal Freemasons 'Homes Open Day' in March, at the Coppin Centre in Melbourne.

The Government's broader message about positive ageing is clearly designed to help us stay in our own homes longer, hence building as productive and cost effective a community as possible. The importance of keeping in touch with family, friends and community is applicable, whether in one's own home or in an aged care residence.

The Victorian Government's 2012 VicHealth Indicators Survey found that older people who use social media feel more connected to their families: two thirds of people over 75 years of age agreed that it helps them spend more face-to-face time with family. This was the highest level of agreement among any age group. The survey also found that our oldest residents are the most likely to reap mental health and wellbeing benefits from regular internet use. This is the reasoning behind Royal Freemasons' plan to encourage all residents to get on board with this activity.

It is important to remember, though, that technology is just one demonstration of emerging activities designed to stimulate body and mind, as well as provide enjoyment for residents, regardless of their life stage and need. Clearly, there are other ways to engage residents, as exemplified by a popular program at the Coppin Centre, in which dementia patients are able to enjoy the centre's resident hen enclosure.

With all the new activities occurring in aged care at the moment, Royal Freemasons is an exciting place to be. We are continuing to attract enthusiastic research partners to build knowledge and tools around improving patient care and wellbeing. These developments will not only benefit our own customers, but will ultimately be shared and enjoyed more widely across the aged care community. ha


iPad

BY NERIDA HYETT
PhD Candidate, La Trobe University;
Deeble Institute Summer Scholar

Rural health and community participation

Empowering country residents to improve their health and wellbeing

Rural Australians tend to experience poorer health than their city counterparts. This is due to a number of factors, including difficulties accessing timely and affordable healthcare, growing ageing populations, and higher rates of chronic disease.

Rural Australia is a vast and diverse geographic region, where there is good health and prosperity, as well as significant disadvantage. Community participation is one strategy that may improve rural health and related social, health and economic issues that impact rural places.

There are examples of where community participation has positive results for health and wellbeing – here in Australia and overseas – including with Indigenous communities. These suggest that community participation contributes to the health and wellbeing of residents, by increasing social cohesion and active citizenship, and improving health program delivery by tailoring services to the local context.

That said, community participation is a complex social process, and there are challenges that need to be considered.

Rural health services, like other Australian health services, are currently implementing a whole range of publicly funded community participation initiatives. In many cases, this is in response to new legislation, primarily the second of the National Safety and Quality Health Service Standards – 'Partnering with Consumers'. Primary health care reform, which identifies 'partnering with communities' and regional needs assessment as primary objectives, is also currently being rolled out through Medicare Locals and Local Health Networks.

These policy directives stipulate that consumers and stakeholders need to be included in the planning and delivery of healthcare. However, relevant literature shows that there is little guidance for practitioners and health executives for how to coordinate community participation initiatives.

The purpose of *How can rural health be improved through community participation?*, a report that I produced in conjunction with the Deeble Institute and other researchers at La Trobe University, is to provide evidence on how community participation can be facilitated in a way that is likely to benefit rural residents and places. The report provides new, preliminary evidence from an ongoing research project, outlining several strategies for informing rural health policy and practice utilising community participation initiatives. Strategies outlined in the report include:

Gather local knowledge from local people

A comprehensive understanding of local context is required to facilitate participation at a community-level; this involves gathering experiential and tacit knowledge (lived experiences), as well as scientific knowledge.

Use a dynamic, multidimensional approach rather than a single method

A combination of high and low intensity participation methods, tailored to the local context helps increase community involvement; for example, through community meetings and social media. Such multidimentional approaches are more effective than methods used in isolation.

Leverage existing community assets and capacity

Identify what partners, assets, and esources exist, and direct funds at leveraging this to maximise outcomes and value of investment.

Utilise paid community leaders

Paid community leaders are necessary to reduce volunteer burden and barriers to volunteering, as well as for building trust and legitimacy. Work with existing leaders and provide honorariums and incentives to acknowledge time and efforts involved in facilitating participation.

Use specific strategies to include marginalised community subgroups

Marginalised groups find it difficult to participate with traditional methods. The development of creative and respectful strategies with community leaders will help facilitate participation by these groups.

Adopt shared decision-making processes to improve outcomes and experience for the community

Participation is more meaningful for the community when decision-making responsibilities are shared. An equal, co-operative partnership that promotes knowledge sharing is more likely to result in locally-specific, practical solutions for healthcare improvement.

Community health services and networks have an important role to play when it comes to implementing these strategies. Initial efforts should focus on conducting a comprehensive assessment of local assets and resources, building partnerships between existing community services, and leveraging existing avenues for community involvement, such as local schools and community groups. Community health services and networks may, however, benefit from the eventual creation of a jointly-appointed, paid community leadership position to work across services. This would help avoid duplication of effort and overcome barriers of over-consultation and volunteer fatigue.

For community participation to be effective, the policy environment underpinning it has to be one in which public engagement is both promoted and prioritised. In rural Australia, this includes the use of current budgets in new and flexible ways to contract and pay for health services that promote community-designed solutions. Implementation of health reform can also be supported by focussing Government grants and tenders on proposals that best display community participation initiatives. ha

Dr Candice Baker, a doctor working in rural Victoria, says "you can be anything you want as a country GP." Dr Baker is pictured sharing a happy moment with a young patient. Image courtesy of Tony Wells, Rural Health Workforce Australia.

BY JO-ANNE CHAPMAN
General Manager of Programs
Rural Health Workforce Australia

Young doctors encouraged to go rural

A campaign by Rural Health Workforce Australia

A wise woman once told me that rural practice isn't a life sentence, it's a life opportunity. This is the message we're hearing now from the increasing number of young doctors who are taking an interest in rural medicine. They are discovering that it really is a case of choose your own adventure, with the chance to add specialties such as anaesthesia, obstetrics and paediatrics to your bow as a country GP.

Rural general practice itself is full of variety and is a great choice for people who want to make a difference. By living and working in country communities, doctors can learn so much, help so many, as well as broaden their professional horizons.

There are, of course, side benefits such as working close to home, the affordability of real estate, and the sense of connection that comes with being part of a community that values the expertise of resident health professionals. Above all, GPs are a critical part of the frontline 'team' that sustains the health and wellbeing of country people.

As more medical students emerge from the training pipeline, our national network is keen to show them how good life can be professionally, and personally, in the country.

That is why we are running the Go Rural campaign, which is targeted at students and early career doctors.

The campaign, which started in March, is based around a series of events in every state and the Northern Territory where participants get to meet rural doctors, visit rural communities and be taught emergency skills.

There is some serious money on the table as well. The Federal Department of Health, which sponsors Go Rural, offers incentives up to $120,000 for doctors to relocate to rural areas.

To emphasise these points right across the country, the Go Rural campaign is underpinned by a partnership between Rural Health Workforce Australia and its network of not-for-profit Rural Workforce Agencies: the New South Wales Rural Doctors Network, Rural Workforce Agency Victoria, Health Workforce Queensland, the Rural Doctors Workforce Agency in South Australia, Rural Health West in Western Australia, Health Recruitment Plus Tasmania, and the Northern Territory Medicare Local.

These agencies bring Go Rural to life and are there to help young doctors make the move. The agencies have strong connections to rural communities and organisations throughout Australia, and are very experienced at supporting health professionals and their families make the transition to a new life in the country.

It is also reassuring to see so many rural doctors getting behind Go Rural. This is hardly surprising; they know how important medical students and young doctors are to the future and the wellbeing of country communities. That is why some of the best training occurs in rural centres — where everyone is a welcome member of the team.

To find out more about the campaign, visit www.rhwa.org.au/gorural ha

The Rural Workforce Agency Network

RHWA is the peak body for the Rural Workforce Agency Network which attracts and supports health professionals to work in rural and remote communities. Across Australia in 2012-2013, the RHWA-RWA network:

- Recruited more than 650 new doctors, nurses and allied health professionals for rural communities and Aboriginal Medical Services;
- Facilitated 194,000 patient services via outreach specialist teams;
- Supported 5,800 rural doctors and 2,000 rural practices;
- Handled 12,000 inquiries from health professionals;
- Arranged locum relief for 1,000 rural doctors, so they could take a break;
- Supported 1,800 rural doctor families;
- Provided crisis support to 81 doctors; and
- Engaged hundreds of medical, nursing and allied health students in positive rural experiences such as rural high school visits, Rural Health Club activities and Go Rural career events.

2013 Sidney Sax Medallist

A profile of John Smith

A lifelong commitment to high quality health services in Australia, and particularly in rural communities, has been acknowledged by the AHHA, in its awarding of the Sidney Sax Medal for 2013 to John Smith.

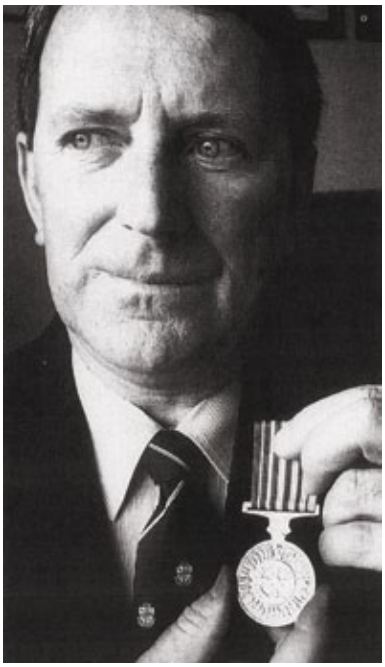
The award recognises outstanding achievement in, and contribution to the development and improvement of the Australian healthcare system — and while there are many very dedicated professionals who are worthy of such recognition, John Smith stands out in the crowd.

Starting his career in the banking sector, John subsequently made a transition to the health sector, earning a Graduate Diploma in Health Services Management and a Master's Degree in Health Administration.

For 30 years, John was Chief Executive Officer of the Nhill Hospital, after which he was appointed Chief Executive Officer of the West Wimmera Health Service.

John has played an active leadership role throughout his profession, being elected to the Division 4 Council of the Victorian Hospitals' Association in 1974, marking the beginning of a long and beneficial partnership. He was Chairman of that Council from 1988 to 2002.

In December 1993, John was elected Chairman of the Victorian Hospitals' Association Honorary Board of Directors, the first district hospital Chief Executive Officer to hold that position. He led the Association through a restructure and was appointed Chairman of the Board of Directors of the Victorian Healthcare Association in



Opposite page: John proudly displaying his Public Service Medal (1991); John at the launch of the Mira Medical, Community and Allied Health Centre (2013); John receiving Australiasian Reporting Award (2003); John (2010). This page: John with a young trainee at a West Wimmera Health Service Christmas party (2011); John named as a finalist for CEO of the Year at the Equity Trust Awards (2008); John receiving his Diploma in Health Service Management (1989).

November 1995. John continued in that position until 1997, after which he was appointed as the President of the AHHA, a role that he maintained until 2000. He has also served on the Board of Directors of the Victorian Hospitals Industrial Association, to which he was appointed in 1993.

John's rural expertise gained him a place on the Executive Committee of the Co-ordinating Unit for Rural Health Education Victoria from 1995 to 1997. This group honoured John with the inaugural Rural Health Award for Significant Achievement in May 1999.

John's extensive experience has seen him serve on many state and federal committees. His knowledge of the health sector, and of rural health in particular, has earned him a reputation as a valued government adviser. John has also been a surveyor for the Australian Council on Healthcare Standards (ACHS) from 1982. Since then, he has surveyed hospitals throughout Australia and New Zealand. He represents the AHHA on the Council, and is currently the vice-president of the ACHS.

In 1991 John was one of four Victorians awarded a Public Service Medal in the Australia Day Honours. This was a proud achievement for a man who has a wealth of knowledge that he willingly shares with those who seek his counsel. It was also a testament to his determination for rural communities to have equitable access to quality health services. Despite working and living in the Wimmera, a four hour drive to Melbourne never deterred him from accepting positions on committees and working groups to further the cause of rural health services.

John has taken every opportunity to represent the views and the needs of communities to peak bodies and government representatives and in doing so has gained the utmost respect of his adversaries as well as his allies.

There is no doubt that John Smith has the interests of rural communities at heart and works with the utmost commitment to ensure that their future is assured. It is with this sentiment, and with recognition of his contributions across the healthcare sector, that the AHHA is pleased to award John the Sidney Sax Medal for 2013. ha

Winners announced at national nursing awards

Recogition of the exceptional work of Australian nurses

A mental health nurse, a graduate nurse assisting the elderly to live in their homes and an innovative Cape York-based infant safe sleeping program received the highest honours at the 2014 HESTA Australian Nursing Awards held in Sydney in early May.

Now in its eighth year, the annual nursing awards recognise nurses, midwives, personal care attendants and assistants in nursing in the three categories of Nurse of the Year, Outstanding Graduate and Team Innovation.

HESTA Chair, Angela Emslie, said the awards were a chance to recognise the work of Australian nurses and learn about some of the successes and innovations emerging from the nursing profession.

"The judges were very impressed by the dedication and professionalism of all the 15 finalists who are making a real difference to people's lives and tackling some of our most intractable social problems," she said.

"Our award recipients have not only demonstrated extraordinary care and compassion in the course of their work; they have gone above and beyond what is expected of them. HESTA is proud to honour the work of these outstanding individuals and nursing teams."

Nurse of the Year was awarded to Steve Brown of NorthWestern Mental Health, Victoria. This award was in recognition of Steve's role in implementing the Police Ambulance Clinician Emergency Response (PACER) system to improve the crisis management of people living with mental health issues.

The Outstanding Graduate award went to Zoe Sabri of the Royal District Nursing Service in Springvale, Melbourne. Zoe's has worked tireless to assist elderly clients to continue to live safely in their own homes.

The Team Innovation award went to the Apunipima Pēpi-pod® Program based at Cape York Health Council in recognition of their work to reduce the rates of Sudden Unexpected Death in Infancy among Aboriginal and Torres Strait Islander communities.

Together, the award recipients share $30,000 in prizes, courtesy of long-term HESTA awards supporter, ME Bank.

Running at the same time as International Nurses Week, the awards were a timely reminder for members of the public to thank a nurse for their wonderful contribution to the health and wellbeing of the community. ha

Left to right: Zoe Sabri; Steve Brown; Professor Jeanine Young (of the Pepi-pod Program team). Image courtesy of HESTA

Image courtesy of Merri Community Health Service.

Community outreach keeping people well

Innovation at Merri Community Health Service

A HHA member, Merri Community Health Services (MCHS) has secured a $125,000 workforce innovation grant from the Victorian Department of Health to deliver multidisciplinary back pain management n a community-based setting.

MCHS will be working in partnership with Melbourne Health to establish transition programs from hospital to primary care, with the introduction of advanced practice back pain clinics at MCHS sites.

This will bring many benefits including timely access to services within the community, reduced demand on hospital wait lists, and improved workforce capacity in community health to accept referrals and manage back pain clients who are currently being referred to a hospital setting.

Community health centres play an important role in delivering preventive health services aimed at keeping the community well. The MCHS Healthy Eating and Lifestyle Program 'HEAL' is a permanent fixture in the range of services being offered by their Primary Health Care Program.

HEAL is the result of a fruitful partnership between Moreland City Council and MCHS, offering ongoing community access to high quality information and support for healthy eating and increased physical activity.

HEAL is currently being run out of MCHS' Bell Street site in Coburg and is an eight week program consisting of a one hour information session about healthy eating and lifestyle, followed by a one hour session of tailored exercises.

Increasing numbers of participants are being referred to HEAL programs by their doctor as it helps patients with chronic disease management, such as diabetes or cardiovascular disease, or as a preventive program for those with significant chronic disease risk factors, such as hypertension. ha

Championing Aboriginal health research

BY JOAN CORBETT
Adjunct Associate Professor of Public Health, University of Canberra

A need to encourage more Indigenous appointments in academic and leadership roles

It is a rare treat to have the opportunity to learn from someone who has as much history, integrity and political understanding about Aboriginal health as Pat Anderson.

Pat has seen and done many things in her time. Growing up in Darwin and returning there much later to run one of the bigger Aboriginal Medical Services, Danila Dilba, Pat has gained deep understanding of what is needed and what works. She has been an effective advocate and educator, particularly in health and education fields, from Darwin to Melbourne and to international forums including the United Nations in Geneva.

Pat's appointment at the University of Canberra (UC) is something of an innovation. As a first at the institution, proudly introduced by the Faculty of Health with support of the Deputy Vice-Chancellor of Education, Nick Klomp, it is hoped that similar appointments of Indigenous academics and leaders will follow in other faculties.

Pat is not shy as an innovator. She has been involved in many campaigns and debates and has taken part in critical stages of activism for Aboriginal rights and representation. She has spoken with, and influenced many, government ministers in her time; working tirelessly to make a difference for coming generations of Aboriginal people.

Perhaps her most often quoted role has been as co-author (alongside Rex Wild, QC) of the challenging report to the Northern Territory Government, known as *Little Children are Sacred*.[1] This was the report that is readily linked to the Howard Government's Northern Territory Emergency Response (NTER). As a report, its recommendations are worth re-reading — even if little of what was done in the NTER related to them. It is an important public policy story for others to tell, and part of the long history of chop and change in Australia when dealing with marginalisation and disadvantage for Aboriginal and Torres Strait Islander people.

Another of Pat's contributions — one that is arguably more important — is as a champion and leader in Aboriginal health research.

Australia's national institute for Aboriginal and Torres Strait Islander health research, the Lowitja Institute, is the only research organisation in Australia solely focused on the health and wellbeing of Aboriginal and Torres Strait Islanders. As Chair of the Lowitja Institute Board for many years, Pat has helped change the way such research is conducted and valued.

Named in honour of Dr Lowitja O'Donoghue, the Institute brings together world-leading researchers, policy makers and experts in cutting-edge service delivery, enabling health research collaborations that will make a real difference to people's lives. The Institute is

Pat Anderson with Tom Calma. Image courtesy of University of Canberra Media.

Pat Anderson.
Image courtesy of
the Lowitja Institute.

a national first and its Congress, held in mid-March this year, attracted great speakers and press interest.

In her part-time role at UC in 2014, Pat will contribute to learning, course development, and some public debate about current issues. These range from 'Close the Gap' to the history of Aboriginal Community-Controlled Health Organisations (ACCHOs) — most commonly known as Aboriginal Medical Services, NACCHO (the national voice for ACCHOs), and the work of the Lowitja Institute. Pat will also convene a public seminar on Constitutional reform, which she believes is vital but must be well-handled and supported by both sides of Australian politics; a view shared by Tom Calma, Chancellor of UC.

In a lecture recently for second year UC Public Health students, Pat enlightened all about the role Aboriginal Medical Services played in shining light on what is now termed the 'Social Determinants of Health'; a well-known concept in contemporary healthcare across the globe. The simple idea of a holistic approach to health was always there in the ACCHOs, from Redfern in the early 1970s onward. It was just practical to take into account the circumstances affecting a person or family's living, working, community, relationships, culture, values and resources and not only to look at any illness at hand. While this approach was not rocket science for ACCHOs, it was indeed influential. One such influence was on the writing of the Declaration of Alma-Ata by the World Health Organisation in 1978, which was informed by Aboriginal representatives working alongside other drafters to explain what underpinned the ACCHO approach.[2]

Many may not realise that some of the most significant global debates on public health have been so well informed by Australia's Aboriginal experience. It has certainly come as a surprise to many students and academic staff at UC. Clearly, we have a lot to learn from history, and would do well to have more informed voices guiding us along the way. ha

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BY KATIE THURBER
PhD Candidate, ANU;
Deeble Institute Summer Scholar

Soft drinks / hard evidence

Reducing soft drink intake could have health benefits for Indigenous children

Obesity rates are elevated among Indigenous, compared to non-Indigenous, Australians, beginning as early as childhood.[1] If this burden of childhood obesity and related chronic disease continues to increase, the gap in life expectancy is set to widen, not to close. Thus, early childhood is an opportune time to prevent the development of obesity.

Most programs addressing obesity focus exclusively on individual behaviours, such as physical inactivity and diet, but they have had limited success. There is no doubt that diet and other health behaviours influence childhood weight status, but these behaviours are inextricable from the context in which they occur. Programs need to focus on a broader set of social, cultural, economic, and environmental factors (described as social determinants hereafter) if we are to successfully halt this epidemic among Indigenous Australians.

In 2008, the World Health Organisation recommended that countries to adopt a social determinants approach to improve health equity. Australia has not yet formally acted upon these recommendations; and despite the significant financial investments in Indigenous health, little of this funding has specifically targeted the social determinants of health.[2]

As part of his 2014 Closing the Gap report, Prime Minister Tony Abbott stated that progress against the Closing the Gap targets has been disappointing and that a change of direction was needed. He said 'for the gap to close we must get kids to school, adults to work …'[3] Achieving these objectives means we would begin addressing some of the social determinants of health: education and employment.

The Australian Capital Territory (ACT) Chief Minister and Minister for Health Katy Gallagher called for obesity prevention efforts to move beyond the health portfolio, towards a coordinated effort across arms of government. This requires action on the food environment, schools, workplaces, urban planning, and social inclusion. As part of her plan, Gallagher banned soft drinks in ACT public schools.

To date, there has been a limited evidence base to guide the development of programs and policies for obesity prevention among Indigenous children. It has long been recognised that the social determinants of health are important; however, empirical evidence quantifying these relationships is lacking. This knowledge gap can be filled using the Longitudinal Study of Indigenous Children (LSIC), a national study managed by the Australian Government Department of Social Services.

Case study: data on soft drink consumption in LSIC

Soft drinks (referring to sugar-sweetened beverages including soft drinks, cordials, and sports drinks) are a prime example of an obesogenic food; they are high in sugar and devoid of nutrients.

Australia is one of the top ten consumers of soft drink globally and, on average, Indigenous children consume soft drink in even higher quantities than the overall Australian population.[4] Thus, reducing soft drink intake could have significant health benefits for Indigenous Australians. It is important to understand how the broader context influences children's soft drink consumption, and to use this knowledge to develop effective programs for obesity prevention.

We examined the association between a broad range of factors and soft drink consumption in LSIC among 1,282 children aged three to nine years. These data demonstrate that this individual choice was strongly influenced by the broader context.

In 2011, 51% of children had consumed soft drinks the day preceding their interview. Children were more likely to consume soft drinks if they experienced disadvantage at the individual and neighbourhood level.

The odds of consuming soft drinks were significantly higher for children:

- whose mothers had lower levels of education;
- who experienced housing instability;
- who lived in more urban areas; and,
- who lived in disadvantaged neighbourhoods.

These findings provide quantitative evidence on the association between the social determinants of health and an individual behaviour. If programs and policies are to successfully change health behaviours and outcomes, they must address the social determinants of health — the context

structuring individual behaviour.

The increased odds of consuming soft drink in urban, compared to remote, areas does not indicate that soft drink consumption is not an issue within remote areas; this is indeed still a problem. However, this analysis has uncovered a problem of increased soft drink consumption among Indigenous children within more urban areas. This is unsurprising given the burgeoning availability of soft drinks in urban areas; for example, from 24-hour petrol stations, convenience stores, supermarkets, and fast food outlets. With the continuing urbanisation of the Indigenous population, this is important to address.

It has long been recognised that the social determinants of health are important; however, empirical evidence quantifying these relationships is lacking.

Promising programs and policies

While there is very little in the way of formal evaluations, it is important that new programs and policies build upon existing ones that have demonstrated success and acceptability within Indigenous communities. Before expanding policies and programs to different settings, however, it is critical to ensure that the programs are transferable. Programs need to be founded on strong relationships with the community, and tailored to meet local needs and priorities. For example, members of a remote community in the Anangu Pitjantjatjara Yankunytjatjara Lands developed a new store policy due to concern over the consumption of soft drinks.[5] This policy removed the three top-selling soft drinks from their community store, halving the community's sugar intake from these beverages.

Although limited in empirical evidence, sports and recreation programs also offer a promising avenue for obesity prevention. Successful sporting programs encourage physical activity and healthy diets in a fun, culturally relevant, community-based way, and link to other services such as health checks or educational development.

The impact of the recent soft drinks ban in ACT public schools on children's soft drink consumption and weight status should be evaluated. If proven successful, this policy could be expanded to other settings across Australia, particularly disadvantaged urban areas. However, this policy in isolation will not solve the epidemic of childhood obesity for Indigenous children. This will also require actions addressing poverty, education, and housing; these factors all shape a child's ability to engage in healthy behaviours.

Conclusions

This analysis of LSIC provides quantitative evidence on the importance of addressing the social determinants underpinning individual health behaviours that influence the risk of obesity. Because these factors are not confined to the health portfolio, policy development should occur across portfolios including housing, education, employment, social welfare, and community development. The broader benefits of such programs should be considered when weighing the cost: the implications for the wellbeing of Indigenous Australians, and for health equity generally, are undoubtedly striking. ha

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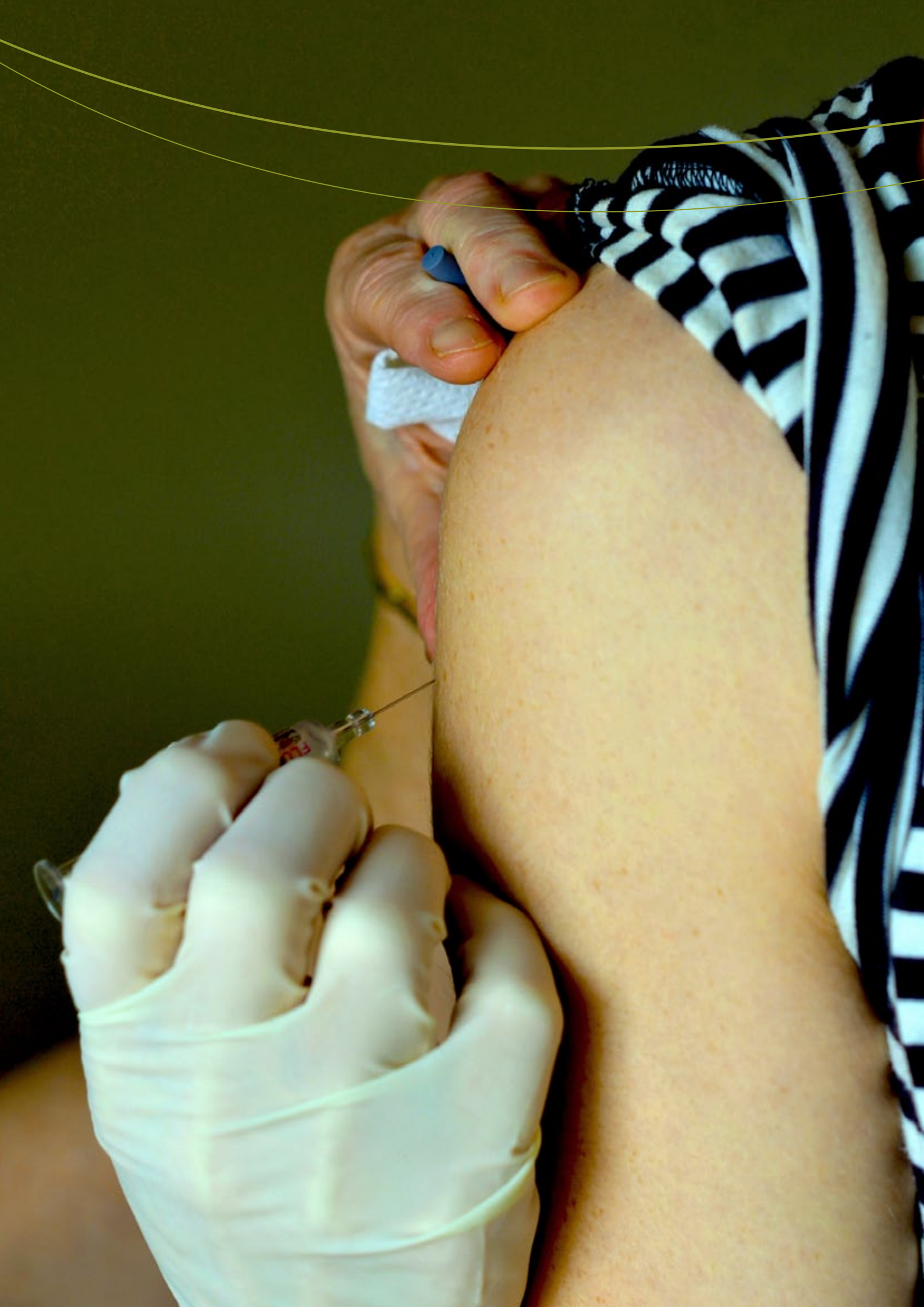


BY DR STEPHEN LAMBERT
Medical Epidemiologist
Queensland Health

A 'measles-free' Australia

What exactly does that mean?

On 15 March 2014, Australia was one of four countries in the Western Pacific region, along with China, the Republic of Korea and Mongolia, to be declared 'measles-free' by the World Health Organisation (WHO). What a terrific achievement for public health and medicine for the entire Pacific region.

WHO have declared Australia is in a measles elimination phase. But what does this really mean? In the first instance, it is probably easiest to say what it doesn't mean: it doesn't mean we will never see measles in Australia again.

Disease elimination is defined as the reduction to zero of the incidence of a specified disease in a defined geographical area as a result of deliberate efforts, with continued intervention measures required to maintain that status.

In practical terms, this is an exciting and substantial public health achievement. However, in terms of clinical application, our measles-free status simply serves to move the goalposts.

It does not mean our work in measles prevention or the battle for immunisation is over; the total eradication of measles requires an ongoing, global effort.

Measles is the most contagious of all infectious diseases, and whilst we have an excellent vaccine — we could not have achieved elimination without one — the measles virus will exploit any weakness in population immunity.

Measles elimination means we no longer have our own circulating strain of measles; a strain that remains in the background, constantly circulating in our community. The absence of an endemic strain means, by definition, that the only measles we see in Australia is now imported or due to local spread from an imported case. Maintaining our elimination status will be an ongoing effort, particularly whilst we continue to have measles outbreaks in our region.

For example, the Philippines has been battling a measles outbreak, which began at the end of 2013, that has resulted in more than 15,000 Filipinos contracting the disease and 23 deaths.

Travellers to the region have also been affected by the outbreak. The Centers for Disease Control and Prevention (CDC) in the United States (US) has confirmed that there have been 13 cases of measles in US residents returning from the Philippines so far this year. The CDC reports 'most of these cases were among unvaccinated children younger than two years old.'

Japan reported a spike in cases in January this year, with at least 17 cases imported from the Philippines. It is also believed that other travellers from Canada, New Zealand, and the United Kingdom have contracted measles in the Philippines.

In Australia, already this year we have seen 177 cases of measles across the country, with 17 of these found in Queensland. Of the cases in Queensland, a third were imported from the Philippines.

As seen in 2013 in Queensland, the importation of measles into the community can have broad-ranging and devastating effects. In one outbreak alone, 37 people fell ill from contact with one case of measles at the Woodford Correctional Centre.

Given the incredible speed at which measles can spread, the impact of an outbreak in a confined space, such as a correctional facility, would have been horrific. Luckily, through isolation and proactive immunisation of inmates and staff, a secondary outbreak was prevented. Control of the outbreak was achieved through the rapid deployment of immunisation teams, with immunisation of hundreds of prisoners and staff being identified within 36 hours of the outbreak.

But what we can learn from the measles-free status is that, definitively, there would be no cases of measles in Australia if cases were not introduced to the community from overseas.

Australian Health Ministers are exploring the best ways to increase immunisation rates, particularly in children, but we must also look at how the importation of diseases can be prevented. This means also targeting adults who travel to and through the South-East Asia region where measles is particularly prevalent (as well as to the United Kingdom and parts of Europe).

This requires all levels of government and other bodies working collaboratively to raise awareness of the need, not just the importance of, vaccination prior to travel to certain destinations.

However, while a lack of awareness is one way to explain the number of imported cases of measles, we must also examine other causes. Cost and access are two likely leading causes. The Queensland Government funds two doses of measles vaccine for anyone born in or after 1966, who is not up-to-date.

Regardless, making sure that you are protected against measles before your trip is an essential part of travel planning. ha

Cut the clutter & get your hospital back into shape

A quick guide to Lean Method (5S)

Lean Thinking is about applying good process management to improve efficiency, maximise resources, and achieve brilliant results. As part of the joint Lean Healthcare Certification initiative of the AHHA and LEI Group Australia, *The Health Advocate* will present a series of international case studies that demonstrate the benefits of Lean Healthcare across the healthcare continuum.

The first in this series is the University of Colorado Hospital in Denver, written by Kelley Williamson — Director of Information Systems at University of Colorado Hospital.

The University of Colorado Hospital Lean project was submitted as part of the Leading Edge Group Lean Healthcare Green Belt project and was subsequently included in the LEI Group Australia's parent publication, 'Applying Lean in Healthcare — A Collection of International Case Studies'.

The project was based on a strategic decision to move the hospital campus to another location. One of the first steps was to survey employees to determine what issues they were experiencing around the move. They identified the following high-level issues:

- **Low employee morale** — the change in campuses was been made without explaining why and resulting merged units had never been together before;
- **Low employee opinion scores** — the low scores were attributed to the change and transition that employees were experiencing;
- **Staff involved in day-to-day administrative issues** — keeping them from focusing on process issues that have existed at the hospital for many years; and
- **Low room cleanliness and workstation scores**.

The hospital chose 5S because it was a simple but highly effective tool that would help in the removal of waste from the work environment through better workplace organisation, visual communication, and general cleanliness. The five pillars of 5S are defined as Sort, Set in order, Shine, Standardise, and Sustain.

Implementing Lean

The 5S project was named 'Clean Sweep - Out with the Old, in with the New to Become a More Efficient U'. A timeline was put in place to educate, train, and implement the 5S Clean Sweep project in a 60 day timeframe. A number of tools, techniques and games were deployed.

During the 60 day timeline, the transition team needed to educate managers and train employees. They used a monthly transition committee meeting to update the managers. The Clean Sweep project was seen as a creative and engaging event that would involve all employees in cleaning up waste and creating a workplace that everyone would be proud to work in. The second phase was to train all employees. This involved creating a brochure explaining what 5S and how it would be used in a hospital setting (see Fig. 1).

The following were the steps taken to implement the 5S Clean Sweep project:

1. Design and approve all forms, including the blue tag form and equipment removal tag form (see Fig 2).
2. Email all employees and managers, asking for nominations for Clean Sweep volunteers (see Fig 3).
3. Develop the metrics to be measured in order to analyse the return on investment.
4. Design a crossword puzzle in STAT (the online UCH newsletter) in order to educate staff about the project
5. Create a Test Your Clean Sweep IQ program in STAT
6. Create a calendar of events for each floor/clinic/unit involved in the project

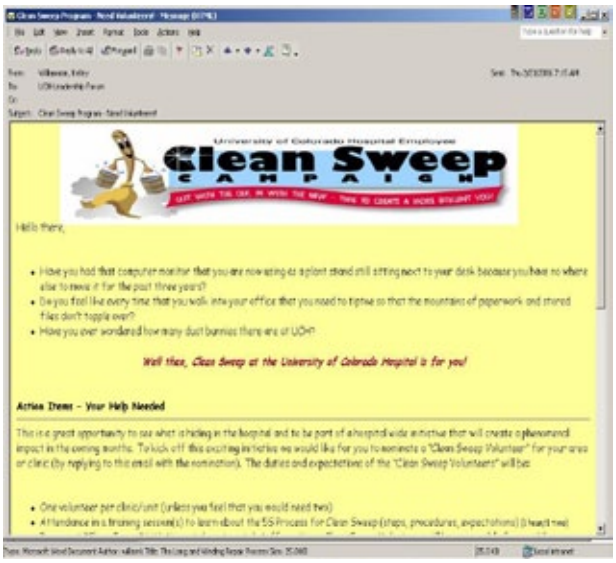
Results and Lessons Learned

UCH leadership praised the project for being innovative and producing cost savings for the hospital. After the program was delivered successfully, leadership at the hospital voted to hold two more Clean Sweeps and one virtual Clean Sweep (cleaning up computer files, Microsoft Outlook, etc.).

Employees were involved in the day-to-day process by implementing Lean tools that enabled the hospital to increase revenues by reusing supplies and by reducing waste, and to increase employee satisfaction scores

BLUE TAG

Category	Equipment Other		
Item Name			
Asset #			
Quantity	Units:	Value	$
Reason - Circle choice	1. Not needed 2. Defective 3. Use not known 4. Other		
Disposal by:	Department/Unit		
Disposal Method:	1. Discard 2. Return to Vendor 3. Move to storage site 4. Other	Disposal Complete (signature)	
Today's Date:	Posting Date:	Disposal Date:	
Blue Tag File #			



Clockwise from the left: Fig 1. Clean Sweep campaign brochure; Fig 2. Blue tag form; Fig 3. Clean Sweep campaign email. Images courtesy of the University of Colorado Hospital

in value and trust in management. Other quantifiable benefits associated with their 5S campaigns were increased quality and safety; standardised and consistent work practices; reduced storage costs; reduced cycle times, changeover times, and down time; reduced patient waiting and queue times; streamlined and efficient administrative processes; improved teamwork; decreased medication errors and healthcare-acquired infections.

The 5S Clean Sweep project was the beginning of the Lean initiative for the hospital. As a result of this project, another Lean project was instigated specifically for the operating room theatres. This particular project involved a closer examination of:

- **Doctor preference cards** — because doctor preference cards were not being completed by all the surgeons, leading to higher room turnover and inefficient setup of operating room theatres;
- **Room turnover** — because operating room theatre turnover was shown to be between 45 and 60+ minutes, well above the national average for turnover, which is approximately 29 minutes;
- **Sterile processing** — because surgical equipment sterile processing was shown as taking too long for surgeries that were back to back; and
- **Pre-surgery procedures** — because patients were being asked the same questions multiple times, causing patient dissatisfaction. ha



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The Australian Healthcare and Hospitals Association (AHHA), formerly Australian Healthcare Association (AHA), is the independent membership body and advocate for the Australian healthcare system and a national voice for high quality healthcare in Australia.

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BY PHILIP DARBYSHIRE
Director, Philip Darbyshire Consulting;
Professor, Monash / Flinders Universities

The 'thankless professions'

Regulating and engaging with health practioners in an age of consumer choice and social media

If you complain about your 'thankless job', blame the Australian Health Practitioner Regulation Agency (AHPRA) for making it official. Poor AHPRA. If they had crewed the Titanic, they would have sunk it twice. Close on the heels of last year's Social Media Guidelines debacle comes their attempt to blow off their remaining foot. Their latest 'Guidelines for advertising regulated health services' have provoked such a firestorm of criticism from social media, health professionals, patient advocacy groups and more, that only a complete re-think and re-write (and *not* in three years' time) is likely to recover AHPRA's credibility.

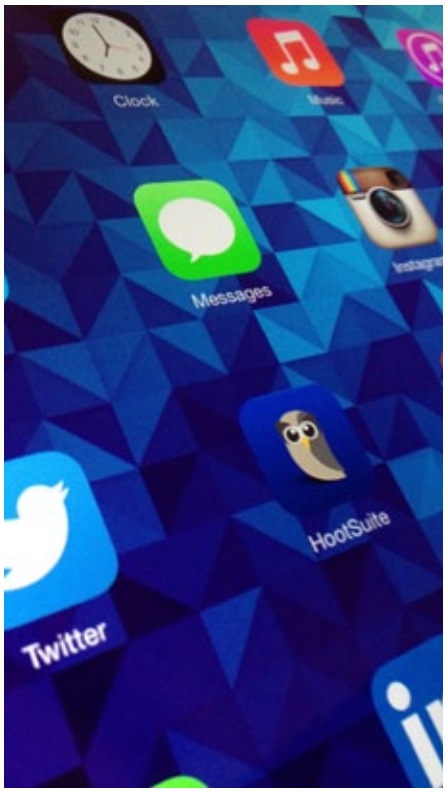
Once again, people have been blindsided by these guidelines, despite AHPRA's claims of 'consultation'. Like many others, I don't remember an email, or letter, or, heaven forbid, any reaching out via social media. AHPRA's view of 'consultation' in 2014 is positively myopic. The Daleks consult and discuss more successfully than AHPRA.

But it is the substance and implications of these advertising and testimonial guidelines that gall. Rather than try to appreciate and navigate the complex 'new world' of social media, patient power, health marketplaces and more, AHPRA has reached for the 'too hard basket', rolled over at the first sight of Section 133, and dumped blanket testimonial prohibitions on health professionals. These would be laughable, were they not so potentially serious.

In essence, AHPRA expects health professionals to now become the paranoia police of patient and professional opinions. We are to watch over social media, lest anyone compliments us. AHPRA say, in all seriousness, that 'a practitioner must take reasonable steps to have any testimonials associated with their health service or business removed when they become aware of them, even if they appear on a website that is not directly associated and/or under the direct control or administration of that health practitioner and/or their business or service. This includes unsolicited testimonials.'

Fail to do this and you can be fined $5,000 if someone says something complimentary about you online.

What AHPRA (and Section 133) are so afraid of is hard to fathom. It's not hard to inform health professionals that if you lie, cheat and behave unethically in this domain, AHPRA will come down on you like a ton of bricks. Essentially, don't lie in testimonials and adverts; don't fabricate them; don't pressurise patients into providing good ones; don't bribe people to praise you; and don't make outrageous or bogus claims that you can't substantiate. In a nutshell, bring the same professionalism and ethics to your advertising and testimonials that you bring to your clinical practice.



AHPRA, however, inhabit a regulatory twilight zone where social media hasn't happened; where all health professionals are equal and defined only by their qualifications and 'office details'; where marketing and promotion is like a bad smell underfoot; and where the entire patient empowerment and 'health consumer's voice' movement of the last decade is a mirage.

This latter concern is perhaps the most telling. The level of condescension and the patronising tone towards patients and public is almost prehistoric. Apparently a testimonial 'can distort a person's judgement' as they 'choose' their health practitioner. The reason why it is a 'judgement' is because patients and families will weigh up testimonials – along with word of mouth, personal impressions and numerous other 'intangibles' that are way beyond the scope or imagination of AHPRA's regulatory pall.

There is a glint of optimism here. As I write this, AHPRA has at last begun to engage with health professionals on this issue via social media. AHPRA is tweeting! If they can build on this trust and engage genuinely with health professionals, then we can salvage something worthwhile from this episode. Now that would be something to advertise. ha

Who's moving

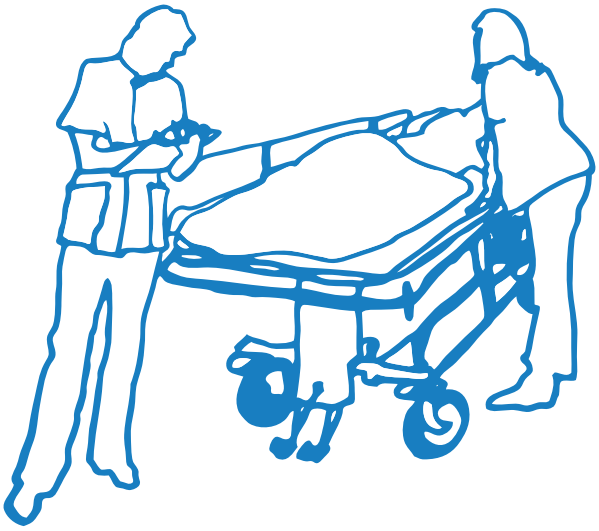
Readers of *The Health Advocate* can track who is on the move in the hospital and health sector, courtesy of the AHHA and healthcare executive search firm, Ccentric.

John Martin, previously Regional Manager with Dr Jones & Partners in Adelaide, has moved to Adelaide Cardiology as their General Manager.

Eileen Hannagan, Executive Director of the Epworth Hospital Richmond, is moving north to Sydney as CEO of The Chris O'Brien Lifehouse.

Vincent Borg has moved within Epworth HealthCare, from his role as Executive Director of Epworth Eastern Hospital to Executive Director Rehabilitation and Psychiatry.

John Fogarty has moved from Mercy Health as Chief Operating Officer to bcome the new CEO at St John of God Murdoch.



Tracey Batten, formerly the National CEO of St Vincent's Health Australia, is moving to the United Kingdom to join Imperial College Healthcare NHS Trust as CEO. Taking up her position is **Toby Hall**, who was the CEO of Mission Australia prior to joining St Vincent's.

David Alcorn moves south to Melbourne as the new Executive Director of Royal Melbourne Hospital.

Leaving her position as the General Manager of Services Delivery and Clinical Practice with Cancer Australia is **Sue Sinclair.** Sue will be joining the ZEST Health Group in a consulting and strategy role.

Kimberley Pierce has moved from the Sunshine Coast University Private Hospital, where she was CEO, to take up a position with Gold Coast Hospital and Health Service as the General Manager of Diagnostic, Emergency and Medical Services.

The Royal Women's Hospital in Melbourne has a new CEO, **Susan Matthews**, who has migrated from Canada where she was Chief Nurse and CEO at the Niagara Health System in Ontario.

Naomi Dwyer is moving to Adelaide to become the CEO of the Women's and Children's Health Service. Prior to this new appointment, she has been the Chief Operating Officer at Gold Coast Hospital and Health Service.

Tracey Scott leaves Epworth Healthcare, where she was Group Manage of Strategic Development, to take up as position with Monash IVF as General Manager of Victoria.

Previously with Medibank Private, **Cindy Shay** is moving to HCF as the Chief Benefits Officer.

Meigan Lefebure is moving to Domain Principal Group as State Manager of Victoria, having worked as a consultant since leaving Jewish Care Victoria.

Steven Schultze is looking for the sunshine, becoming the State Manager of Queensland for Healthcare Imaging Services, leaving Ramsay Healthcare where he was CEO of Kareena Private Hospital.

Marlene Kong joins the Kirby Institute as Program Head of Aboriginal and Torres Strait Islander Health. Before the move, Marlene was working at the South East Sydney Public Health Unit. ha

Ccentric Executive Search

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

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Help make a difference to health policy, share innovative ideas and get support on issues that matter to you – join the AHHA

The Australian Healthcare and Hospitals Association (AHHA) is the only independent national peak body advocating for universal and equitable access to high quality healthcare in Australia.

With over 60 years of engagement and experience with the acute, primary and community health sector, the AHHA is an authoritative voice providing: strong advocacy before Ministers and senior officials; an independent respected and knowledgeable voice in the media; and a valued voice in inquiries and committees.

By becoming a member of the AHHA, you will gain access to AHHA's knowledge and expertise through a range of research and business services.

The Deeble Institute for Health Policy Research was established by the AHHA to bring together policy makers, practitioners and researchers to inform the development of health policy. In joint collaboration with seven university partners and health service members, the Institute: undertakes rigorous, independent research on important national health policy issues; publishes health policy Evidence Briefs and Issue Briefs; conducts conferences, seminars, policy think-tanks and workshops; and helps policymakers, researchers and practitioners connect when they need expert advice.

In addition to this guidance in health policy and research, the AHHA offers various business services through JustHealth Consultants. This is a national consultancy service exclusively dedicated to supporting Australian healthcare organisations at state, regional, hospital and community levels and across various sectors. Drawing on the AHHA's comprehensive knowledge of the industry, JustHealth Consultants provides expert skills and knowledge in areas including: corporate and clinical governance training; strategy and business planning advice; organisation design and improvement; health services planning and program evaluation; and board induction training.

In partnership with the LEI Group, the AHHA also provides training in 'Lean' healthcare which delivers direct savings to the service provider and better outcomes for customers and patients.

To help share important developments across these various health research, policy wand training spheres, the AHHA also publishes its own peer-reviewed journal (*Australian Health Review*), as well as this health services magazine (*The Health Advocate*).

To learn more about these and other benefits of AHHA membership, visit www.ahha.asn.au ha

Join us at The Quantum Leap

Register now at www.thequantumleap.com.au

This conference, a collaboration of the Australian Council on Healthcare Standards and the AHHA, is set to cast an in-depth review of various approaches for improving the quality, efficiency and provision of healthcare, locally and internationally. Such innovations are a welcome addition to the heated discourse currently surrounding Australia's health funding arrangeents.

One of the international speakers is John E. McDonough, a professor of public health practice at the Harvard School of Public Health and Director of the new HSPH Center for Public Health Leadership. Between 2008 and 2010, John served as a Senior Advisor on National Health Reform to the U.S. Senate.

Joe Gallagher will also be presenting. He is of Sliammon First Nation ancestry and serves as the Chief Executive Officer for the First Nations Health Authority, Vancouver, Canada. Involved since the beginning, Joe is responsible to provide senior-level coordination and leadership to the implementation of tripartite and bilateral health plans and agreements.

Professor Roopen Arya, who is Director of London's King's Thrombosis Centre and Lead Clinician and Deputy Clinical Director of Haematological Medicine at King's College Hospital, will also deliver a keynote speech.

So, too, will, Mark Britnell, a partner and Head of Healthcare, Europe & UK for the advisory firm KPMG since 2009 and the former Director-General for Commissioning and System Management for the National Health Service (NHS) of England (July 2007-September 2009).

To hear from these and other experts in health, register for *The Quantum Leap* today! ha

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The Quantum Leap

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