The Health Advocate

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Mirror, mirror on the wall
How Australia's health system fares in international comparisons

Continuity of midwifery care
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The official magazine of the Australian Healthcare and Hospitals Association

ISSUE 26 / October 2014

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Contents

The Health Advocate

Issue 26 / October 2014

In depth

Briefing

From the AHHA desk

PAUL DUGDALE
Chair of the Australian Healthcare and Hospitals Association (AHHA)

Leaps and bounds

The AHHA celebrates innovative ideas at The Quantum Leap 2014 and welcomes its new Board and Council

Allow me to introduce myself as the new Chair of the AHHA. My name is Paul Dugdale. I am Director of Chronic Disease Management for Canberra Hospital and Health Services and Director of the ANU Centre for Health Stewardship. By profession, I am a public health physician and have worked in policy, general practice, hospital administration, teaching and research.

For several years, I have been engaged with the AHHA as facilitator for our policy think tanks and strategic planning days. With the AHHA being the peak lobby group for public hospitals as well as primary health and community-based health services, it is an honour to become its Chair. We have the experience, commitment and drive to build on what works and lobby for improvements in our health system, and I look forward to working with our staff, Board, Council and broader membership over the coming year to help make this happen.

We have farewelled Felix Pintado and Siobhan Harpur from the Board with gratitude for their services. Immediate Past Chair Paul Scown remains on the Board along with Kathy Eagar, Deborah Cole (Treasurer) and Elizabeth Koff (Deputy Chair). We welcome new Board members, Gary Day, Walter Kmet and Lesley Dwyer.

There have also been recent changes to our Constitution that have clarified the nature of membership and the makeup of our Council. The changes should facilitate a deepening of our membership in a way that deals well with recent and future organisational change in our health systems, including the creation of Local Health Networks. A list of AHHA Council members is available on our website at www.ahha.asn.au/governance.

I would particularly like to extend a welcome to the Medicare Locals who have joined AHHA recently, and I look forward to supporting and representing the primary and community health services sector in the transitions the Commonwealth has embarked on.

Aside from changes to our Board and Council, September was a busy month for the AHHA as a whole, with our annual Congress, The Quantum Leap, held in partnership with the Australian Council on Healthcare Standards in Sydney on 9-10 September. This year's conference theme — Health Innovation: Making Quality Count — drew a number of international and local speakers, each presenting a fresh perspective on a range of healthcare issues. Key themes were: technology, evidence-based service development, service redesign, safety and quality, workforce and training. Two of the conference speakers have features in this issue of *The Health Advocate*. First is Bronwyn King, who provides an introduction to the Tobacco-Free Investment Initiative. Second is Bill Moss AM, who writes about new ways of approaching and governing medical research and his experience as the Founder and Chair of the FSHD Global Research Foundation.

In addition to sparking discussion about the future of healthcare in these kinds of areas, The Quantum Leap also offered time to reflect on achievements that have already come to pass through the awarding of the Sidney Sax Medal. The 2014 medal was awarded to Professor Judith Dwyer, celebrating her more than 20 years of hard work towards shaping Australia's health system, especially with regards to improvements in Aboriginal Health Services.

We have the experience, commitment and drive to build on what works and lobby for improvements in our health system, and I look forward to working with our staff, Board, Council and broader membership over the coming year to help make this happen.

This edition of *The Health Advocate* continues to celebrate the wide-ranging activities of our members and their efforts to respond to the many emerging issues in the health space; from reducing the prevalence and burden of heart disease in Indigenous communities to developing hospital playground facilities for children living in regional areas. AHHA members are active across the healthcare spectrum, as the following pages demonstrate. ha

The Quantum Leap, 2014.

AHHA in the news

HAVE YOUR SAY...

We would like to hear your opinion on these or any other healthcare issues. Send your comments and article pitches to our media inbox: communications@ahha.asn.au

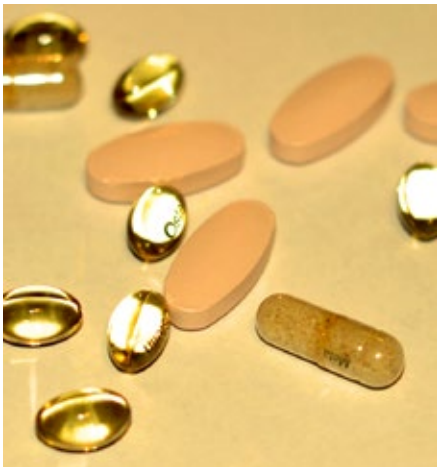
The Quantum Leap Indigenous Scholars

The AHHA was proud to join with HESTA and the Australian Council on Healthcare Standards in presenting two Aboriginal and Torres Strait islander students with The Quantum Leap (TQL) Scholarships at our conference, held in Sydney on 9 and 10 September.

Michael Lawler of La Trobe University and Dianne Crawford of Deakin University were the inaugural winners of the TQL Scholarships and were presented with their awards by Federal Health Minister, the Hon. Peter Dutton MP, during the conference dinner on Tuesday 9 September.

Michael is currently studying dentistry and, pending completion of his studies, will be the first Indigenous dentist to have graduated from La Trobe University. Dianne is currently studying nursing at Deakin University and balancing the busy demands of bringing up two children.

The AHHA would like to congratulate both Michael and Dianne on their achievements and wishes them the best of luck with their studies into the future.



Better solutions are neeed for those with chronic health issues to access affordable, integrated care.

The Quantum Leap Indigenous scholars pictured with Federal Health Minister, the Hon. Peter Dutton MP.

After Hours Primary Care Services Review

In its submission to the Department of Health's Review of After Hours Primary Care Services, the AHHA emphasised that after hours primary care must be affordable and accessible for all.

"We welcome the government's review of after hours services, however while we understand the need to conduct this review prior to the commencement of tendering for Primary Health Networks, respondents have really only been able to put their two cents worth in due to the very limited response allowed and the very short timeframe," said AHHA Chief Executive, Alison Verhoeven.

"Unplanned and poorly integrated after hours services can result in increased pressure on Emergency Departments and acute care services, which are both costly and not always appropriate," Ms Verhoeven said. "A whole of health system perspective needs to be taken, to ensure integrated care remains at the heart of service delivery regardless of when care is needed. The AHHA looks forward to further opportunities to contribute to this important review."

A productive, healthy country needs health policy for all

Better solutions are needed to help those with chronic illness access affordable and well-integrated care, and a narrow focus on solutions led by private health insurers will not assist the millions of Australians who don't have private health insurance. "While we are supportive of the development of innovative strategies to achieve better patient outcomes, government policies must take into account the needs of all Australians, not only those who can afford private health insurance," said AHHA Chief Executive, Alison Verhoeven.

"The AHHA is supportive of the trials currently underway in Victoria and Western Australia which are aimed at the delivery of timely, cost-effective care to both privately insured and non-insured patients. The AHHA values the interest of private health insurers in getting this right for their policy holders, though the challenge rests with the Health Minister to get this right for all Australians, not just those with the means to pay," Ms Verhoeven said.

AHHA welcomes new Board Chair: Paul Dugdale

The AHHA is proud to announce the appointment of its new Chair, Dr Paul Dugdale, elected unopposed at the organisation's AGM in Sydney on 8 September. Dr Dugdale is currently the Director of Chronic Disease Management for Canberra Hospital and Health Services, Associate Professor of Public Health at the Australian National University (ANU), and Director of the ANU Centre for Health Stewardship.

As well as welcoming Dr Dugdale to his new position as Chair, AHHA Chief Executive Alison Verhoeven acknowledged the work of outgoing Chair, Dr Paul Scown, who has been involved with the AHHA for the last 20 years. "Dr Paul Scown has led the AHHA with considerable skill and insight as we have navigated several years of health reform. With even more work to do in health reform, the AHHA will be well-positioned to taking a leading role with Dr Paul Dugdale at the helm," Ms Verhoeven said.

Dr Scown was also very positive about AHHA's future. "We're in safe hands with Paul Dugdale as the new chair, and it's terrific to refresh the Board and welcome new members to both the Council and Board," he said.

New AHHA Chair, Dr Paul Dugdale (left) with outgoing AHHA Chair, Dr Paul Scown (right).

More Australian action needed on Ebola crisis

In September, the Public Health Association of Australia (PHAA) and the AHHA called on the Australian Government to step up its response to the growing international Ebola crisis. This came as estimates from the US Centers for Disease Control and Prevention (CDC) predicted that as many as 8,000 people in Sierra Leone and Liberia would be infected with the virus by 30 September.

"Australia is lagging behind the US and UK after further commitments from these countries to provide funding and resources to stem the outbreak," said PHAA CEO, Michael Moore.

AHHA Chief Executive, Alison Verhoeven, said the CDC data must be a wake-up call to wealthy countries like Australia. "While the Australian Government has committed some support, we have not done nearly enough to address this major humanitarian crisis. We do not want to see over a million people infected by January. AHHA and PHAA are urging the Government to show true international leadership and respond with the generosity for which Australians are renowned," Ms Verhoeven said.


Mary McDonald, Department of Health, speaking at the Senate Select Committee on Health, 2 October 2014.

Support for Senate Select Committee on Health

On 19 September, the AHHA announced its support for the establishment of the Senate Select Committee as an opportunity for health policy, administration and expenditure to be considered on a whole-of-system perspective.

"As the voice for public healthcare in Australia, we recognise the value and need to work with the whole sector in better integrating care and in supporting better outcomes for all patients," said AHHA Chief Executive, Alison Verhoeven. "We have encouraged the Committee to take a wide view in their investigations and to include aged care, community care, private health providers and services, non-government organisations and the providers working in these groups. An integrated health system should be the main driver in order to provide proper patient centred care when people become unwell."

The AHHA's submission also highlighted the importance of investing in prevention and wellness activities, as well as appropriate financial incentives and funding structures which serve to reduce waste and inefficiency, and which support continual system improvement. The overarching message was that healthcare should be affordable, accessible and adequate for all Australians regardless of their means. ha

ALISON VERHOEVEN
Chief Executive
AHHA

A healthy debate about funding?

Federalism White Paper flags new debate about heath funding

After more than six years of national health reforms, health and political leaders across the country continue to debate the shape of Australia's health system. Of particular discussion is how it should be funded and the extent to which this should be a responsibility of the different tiers of government.

The reform agenda of recent years has driven substantial change at state and territory level, including a heightened focus on safety and quality, public accountability for performance, the centrality of primary care, and devolved governance structures. However, the new structural reforms process being initiated by the Commonwealth opens up new questions about Commonwealth-state responsibilities.

We have had some guidance on what shape these might take through the various reviews that have been undertaken, for example, the National Commission of Audit report and the recently released Federalism issues paper. We have also seen some actions taken through the Commonwealth budget process, for example:

- the replacement of Medicare Locals with new Primary Health Networks;
- closure of agencies such as Health Workforce Australia and the Australian National Preventive Health Agency;
- cessation of national partnership agreements;
- discontinuation of agreed provisions in growth funding for hospitals;
- the impending merger of the national performance reporting and monitoring agencies;
- budget measures such as co-payments; and
- the development of a medical research fund.

Earlier this year, the Prime Minister announced that work would begin on White Papers on Reform of the Federation and Taxation aimed at reviewing the sharing of powers and revenue between the Commonwealth and the states and territories. Health and hospitals funding are key areas of focus, with both the Prime Minister and the Health Minister flagging their position that the states and territories run hospitals and therefore have responsibility for funding them.

Health and hospitals funding form key areas of focus, with both the Prime Minister and the Health Minister flagging their position that the states and territories run hospitals and therefore have responsibility for funding them.

The recent rulings by the High Court of Australia on the Williams case regarding the Commonwealth funding of school chaplaincy programs also provides some guidance on possible shifts in funding and responsibility for health and hospitals. Essentially, the High Court found that the Commonwealth had a role in providing services which directly benefited individuals, rather than broader program delivery. Thus, the provision of a Medicare benefit to an individual would be in Commonwealth scope, but the provision of a hospital service in its entirety would not (of course, this overlooks the fact that the Commonwealth currently does deliver a hospital service in Tasmania, something that happened under the watch of Prime Minister Abbott when he was Health Minister).

The risk for the health sector is that structural reform will be driven by fiscal reform, without full engagement with the health sector. This work, both at Commonwealth and state and territory levels, will be led by central agencies, so it will be critical for the health sector to look at opportunities for engaging, influencing and participating in debate.

Issues which we will likely see canvassed are possible changes to GST, including increasing the percentage, and/or extending it to food and health. State and territory revenue raising capacity and a re-definition of the income tax sharing arrangements will also be topics of interest.

And as the Commonwealth and the states and territories continue to debate responsibility for funding health, we are

very likely to see further cost-shifting to individuals, and thus opportunities for greater roles to be played by private health insurers and providers. This is very much in line with the current Government's ethos that individuals and the private sector should play a greater role in taking care of themselves.

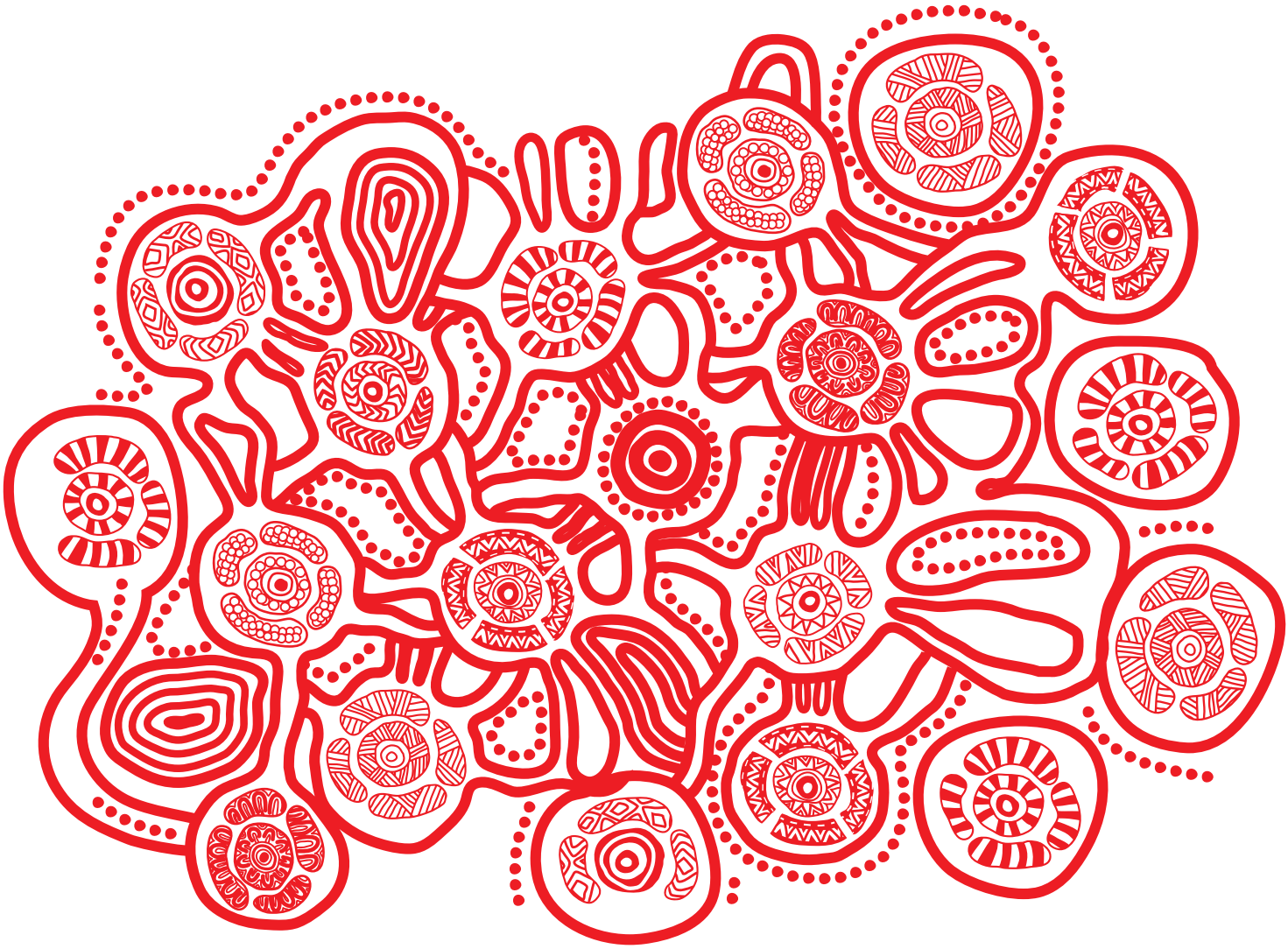
Notwithstanding the Federalism White Paper, we already have seen Commonwealth decisions which impact on funding flows to state and territory health departments. The move away from guaranteed funding growth related to achievement of performance targets, to one tied to CPI and population increases, has a particular impact on activity-based funding.

Changed funding arrangements and the merger of the national health data agencies will inevitably mean changes in performance reporting arrangements. It is unlikely that the Commonwealth will have the same interest in collecting hospitals and healthy communities data if they have a reduced financial relationship with the states and territories.

Further, their capacity to collect and agilely report data will be further constrained as the agencies are streamlined into a single entity; and the need will decrease, particularly given states and territories are already reporting more timely and broader data, sometimes even in real time.

This represents a potential opportunity for the health sector, particularly at state and territory level, to take a greater role in collecting, shaping and using health data. There is also a real opportunity to address some of the very large gaps in health data. For example:

- to shift the focus beyond outputs, performance and accountability, to outcomes, quality and improvement;
- to enhance the collection and reporting of primary care data;
- to work more collaboratively with private health insurers and providers to link their data with public data, and to encourage them to stop hiding behind commercial confidentiality, particularly given they are major beneficiaries of the public purse. ha



The graphic above is an excerpt from the Heart Foundation's Reconciliation Action Plan Artwork, created by Riki Salam, the Creative Director at Gilimbaa.

Reducing heart disease in Indigenous communities

Carrie Sutherland and **Vicki Wade** from the Heart Foundation discuss how the Lighthouse Hospital Project, jointly conducted with the AHHA, is helping reduce the prevalence and burden of heart disease among Indigenous people

Aboriginal and Torres Strait Islander peoples are dying from cardiovascular disease (CVD) at twice the rate of non-Indigenous Australians. This high mortality rate is largely avoidable. For example, it has been estimated that if Aboriginal and Torres Strait Islander peoples achieved the same level of cardiovascular health as non-Indigenous Australians, the life expectancy gap could be closed by six and a half years.

In 2010, in an effort to decrease the unequal distribution and burden of heart disease in Australia, the Heart Foundation and the AHHA published a report, titled *Better Hospital Care*, which described the disparities and opportunities for improving care for Aboriginal and Torres Strait Islander peoples experiencing heart attack. The report, as well as subsequent publications, have identified that best practice healthcare for Aboriginal and Torres Strait Islander peoples requires culturally-safe integrated services, with a visible Aboriginal and Torres Strait Islander workforce, to ensure continuity and delivery of patient-centred care.

In 2012, the Heart Foundation and the AHHA received funding from the Australian Government Department of Health and Ageing to scope a national, innovative 'Lighthouse Hospital Project' to improve the care of Aboriginal and Torres Strait Islander peoples experiencing Acute Coronary Syndromes (ACS) by sharing the knowledge, skills and experience developed by exemplary 'Lighthouse' hospitals. This was achieved by documenting the key elements of past or current initiatives that improve the patient journey for Aboriginal and Torres Strait Islander peoples with cardiovascular disease (and specifically ACS).

The aim of the project was to reveal some of the exemplary work being undertaken across Australia within this context in order to highlight some positive practices and collate and analyse key elements of these initiatives. While the project originally referred to better 'hospital care', it was clear that improving the journey for Aboriginal and Torres Strait Islander peoples with ACS involved a broader range (and in some cases, innovative use) of other care settings.

Since securing further funding, Phase 2 of the Lighthouse Project has commenced, and will run from 2013 through to 2016. The goal of Phase 2 is to provide health practitioners with the practical tools to ensure Aboriginal and Torres Strait Islander peoples receive clinically-appropriate treatment, delivered in a culturally-safe manner, irrespective of the health service they attend. By incorporating the findings and lessons from Phase 1, it is hoped that Phase 2 will act as a means to change traditional cultural and structural work practices that are seen as barriers to quality care for Aboriginal and Torres Strait Islander peoples with ACS.

The main goal of Phase 2 is to develop, implement, evaluate and refine a quality improvement toolkit for health practitioners in acute care to address disparities and improve outcomes. The toolkit complements the recently developed performance dataset ESSENCE, the National Goal and Standards for the management of Acute Coronary Syndrome, the Aboriginal and Torres Strait Islander Health Performance Framework, and the Aboriginal and Torres Strait Islander Patient Quality Improvement Toolkit for Hospital Staff.

Hospitals will also be encouraged to undertake quality improvement activities relevant to their local needs and communities as well as work with other healthcare services to address issues relating to the return of patients to the community, transfer of records, access to cardiac rehabilitation and on-going secondary prevention. These services include Medicare Locals, GPs, Community Health Services and Aboriginal Medical Services.

In adopting this coordinated approach, the project retains a national focus, with Lighthouse Hospital Project sites located across the healthcare spectrum — from larger teaching hospitals to smaller regional hospitals, as well as a range of healthcare facilities across rural and urban settings. The toolkit will first be trialled in eight hospitals, with a comprehensive evaluation to be undertaken on the appropriateness and usability. Feedback will then be gathered from the hospital staff to refine a final version of the toolkit. An economic analysis will also be conducted to determine the appropriateness of use by hospitals across Australia.

In the end, it is hoped that that the Lighthouse Hospital Project will help Aboriginal and Torres Strait Islander peoples to achieve the same level of cardiovascular health as non-Indigenous Australians and, ultimately, contribute to closing the mortality gap. ha

Sidney Sax Medallist 2014

The AHHA congratulates **Professor Judith Dwyer**

Following on from the awarding of the 2013 Sidney Sax Medal to John Smith, the AHHA is now proud to announce Professor Judith Dwyer as the Sidney Sax Medallist for 2014.

Formerly a CEO of Southern Health Care Network in Melbourne, and of Flinders Medical Centre in Adelaide, Judith has worked in the Australian health system for more than 20 years in a range of community, hospital and government settings. She is currently Professor of Health Care Management at Flinders University in South Australia, having worked in the same department for the last eight years. Prior to starting at Flinders, Judith was the head of the Department of Health Policy and Management at La Trobe University's School of Public Health.

In 1998, Judith received the Inaugural Australian Medical Association Women's Health Award. By 2006, she had become part of a team awarded a $3million grant by the National Health and Medical Research Council to assess transition care for older Australians. That same year, Judith was awarded seed funding by Flinders University for the development of a collaborative research project on family-centred care for Aboriginal people in Adelaide.

Numerous projects since then highlight Judith's research passion for health system governance and design and, in particular, on the delivery and improvement of Aboriginal health services.

It is this enthusiasm that has earned Judith a role as a Research Program Leader for the Cooperative Research Centre for Aboriginal and Torres Strait Islander Health. In addition to this role, Judith serves as the Deputy Chair of the Board of the Cancer Council of South Australia, and as a member of the Board of the National Cancer Council.

As an active contributor to AHHA activities over the years, Judith has been involved with the Australian Health Review and has written regularly for The Health Advocate. She has also been an AHHA conference speaker on many occasions.

While Judith was unable to accept the medal at this year's Quantum Leap conference in person, Professor Kathy Eagar provided an acceptance statement on her behalf. "This is a singular honour, and I am truly delighted to receive it," Judith said. "It is a real privilege to join the impressive list of former recipients of this medal, many of whom I have worked or sparred with over the years, in the joint pursuit of better health and health care for Australians or simply in the quest to win the argument."

In her acceptance, Judith also took time to reflect on the award's namesake. "I had the great pleasure of spending a little time with Sid Sax when I was a young health policy and management enthusiast and he was the chair of the Australian Institute of Health and Welfare. He was a generous and wise advisor on anything to do with health policy and programs, or the careers of young managers."

While Judith understands more can, and should, be done to improve Australia's public health system, particularly for Indigenous Australians, she is also grateful at the relative affordability and accessibility of care we have here compared to some other nations. With the prospect of co-payments on the horizon, and continuing debates around healthcare funding and potential commercialisation of services, Judith reinforced the ongoing importance of the AHHA's voice in health policy debates. "In times like these, the role of the Australian Healthcare and Hospitals Association is critical," she said. "There is now, once more, much to be done in defending Medicare and the principle of universal access that has served the Australian community so well." ha

Images – opposite page, top to bottom: Judith with Ms Joanna Shen and Dr Arthur van Deth at the Graduation for Master of Hospital Administration and Master of Health Administration awards (April 2012); Judith at a meeting with colleagues of The Overburden Project, Dr Uning Marlina and Ms Kim O'Donnell (Aug, 2009). This page: Judith discussing the Managing Two Worlds Together project with colleagues (Jan, 2012). All images courtesy of Flinders University.

BRONWYN KING
Radiation Oncologist; Peter MacCallum Cancer Centre and Epworth Healthcare

Little question re: big tobacco

Understanding the importance of super fund investment decisions and engaging medical specialists in broader health-related conversations

The tobacco industry causes nothing but harm and, as a radiation oncologist, I have seen that harm first hand. It is almost impossible to overstate the devastating consequences of tobacco use on individuals, their families and the community, not just in Australia, but around the globe — with tobacco accounting for approximately six million deaths per year.

Smokers face a 50% risk of dying early as a result of their tobacco use. Of the 17% of Australians who smoke, studies show that the majority regret that they started smoking and have tried to give up at least once.

When I accidentally discovered that I was investing in tobacco companies via my superannuation fund, I felt extremely disappointed. I did not want to be a part of the tobacco epidemic. I did not want my money to support tobacco company activity. I knew that my colleagues would be similarly concerned. Moreover, I suspected that the Australian community would be disappointed to learn that it had an estimated combined total of $8.5 billion dollars invested in tobacco via superannuation.

After receiving the support of the then CEO of Peter MacCallum Cancer Centre, Craig Bennett, I began a process of engaging with the executives, investment teams and directors of Australian superannuation funds. At first, I concentrated on the funds that provide services for health professionals, as tobacco divestment seemed a logical and compatible fit. Then I started working with government related funds, followed by funds that represent workers from a wide range of industries.

When I accidentally discovered that I was investing in tobacco companies via my superannuation fund, I felt extremely disappointed. I did not want to be a part of the tobacco epidemic.

In the middle of 2012, and after two years of engagement, the First State Super Board made the decision to divest approximately $200 million of tobacco holdings from across all investment options. It was a great moment for the cause and created discussion and momentum within the superannuation industry. Soon after, several other large superannuation funds followed suit. And with that, the Tobacco-Free Investment Initiative was underway.

Since that time, there have been another 16 large Australian superannuation funds that have decided to divest tobacco stocks, bringing the total amount divested to more than $1.2 billion dollars. There is still a lot more work to do, but it is encouraging to know that the Australian superannuation industry is listening. I am currently working with another 30 superannuation funds, as well as some of the big Australian banks.

What started as a 'side project' has slowly developed into a significant body of work that continues to advance. I am extremely fortunate to have the support and advice of a growing number of highly influential individuals from the superannuation industry, in particular Mr. Michael Dwyer AM — the CEO of First State Super — who has helped me open doors that I could never have opened myself. It has been an unexpected and surprising journey.

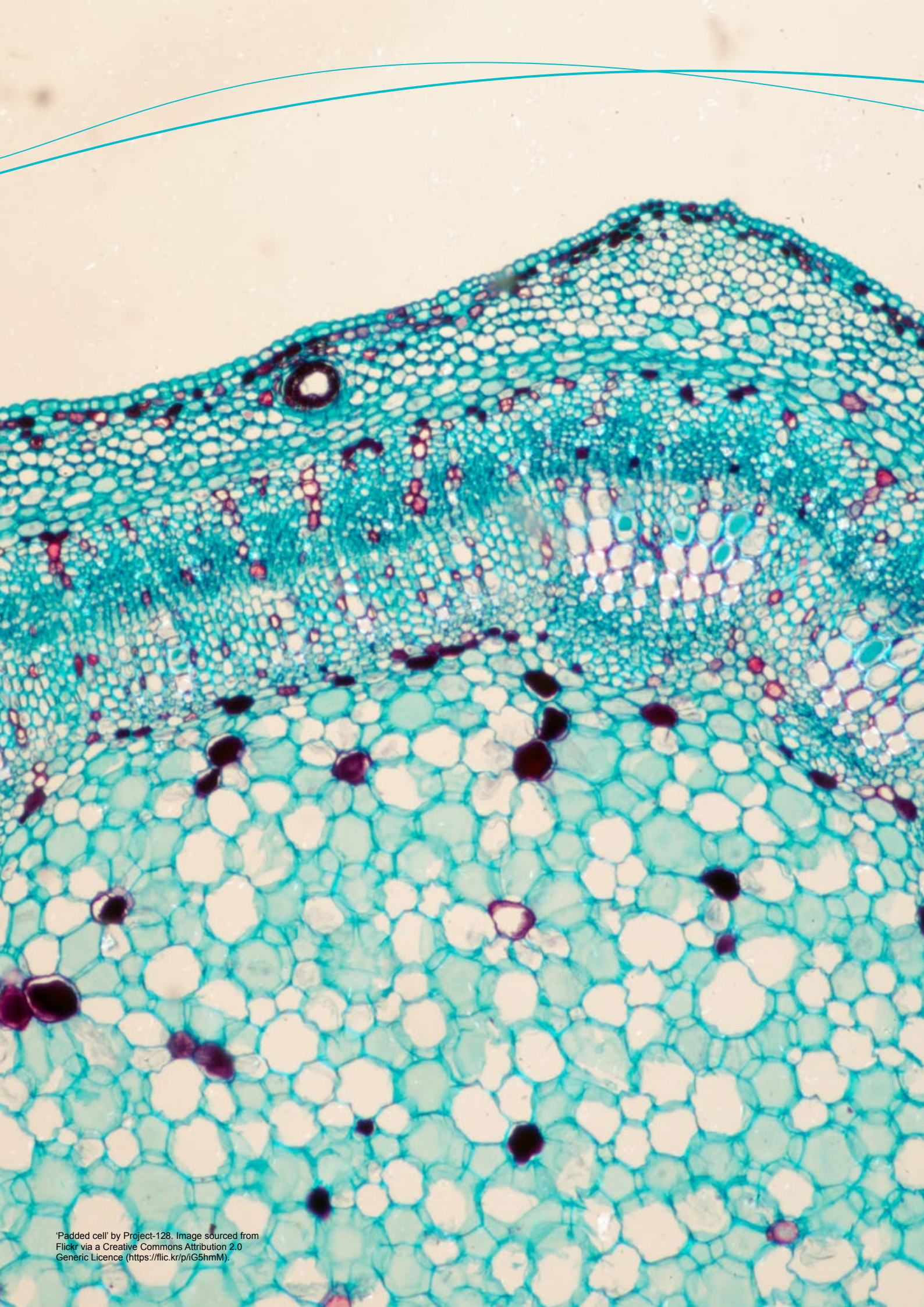
In addition to my clinical work, I am now a passionate advocate for public health policy and tobacco control. This has made me much more aware of the positive impact that is possible when medical specialists engage in broader health-related conversations.

If we fast-forward 10, 20 or perhaps 30 years down the track, Australians will no doubt look back in disbelief, wondering how a situation could arise where so much of their money was being invested in the tobacco industry.

At present, the Australian financial system is completely entangled with tobacco. It will not always be like this. It's simply a matter of bringing this issue to the attention of those who can instigate meaningful change and helping them to navigate a solution. Australia has led the way on many tobacco control initiatives. It is my hope that this will be the next one. ha

Bronwyn King was a speaker at the AHHA-ACHS Quantum Leap 2014 conference. Shortly after, in October, her leadership was recognised in the Australian Financial Review / Westpac 100 Women of Influence Awards.

Pushing for a ban on big tobacco investments.



BILL MOSS AM
Founder and Chairman
FSHD Global Research Foundation

Sowing the seeds of change

Rethinking the way we govern and approach medical research funding

Some people say change is too hard, others are just scared of change. Some simply oppose change for political benefit. Still, everybody can drive the agenda for innovation. You can change the world. I know I have done it many times. In fact, if you don't change it, others will. And you may not like the outcome. The one thing that is certain is that change will happen. But before you can change the world you need to know what will work and what will fail.

In my book, *Still Walking*, I talk about the need for change with regards to research education and solutions. Solutions without research and education rarely succeed.

One area that certainly needs more research, and indeed, smarter solutions to instigate profound change in people's lives, is disability care. In this day and age, why is it that an electric wheelchair costs more than a car? And why are there not more products widely available?

The National Disability Insurance Scheme is a very significant development for Australia in this regard, and something that I will keep a close eye on. During my 23 years as a senior Macquarie banker and the time since, I have felt firsthand what it is like to battle through persistent discomfort and pain, and face constant barriers as someone living with a physical disability.

I entered the world of disability slowly due to Facioscapulohumeral Dystrophy (FSHD), an inheritable muscle disease that affects as many as 1 in 7,500 people. It is characterised by the progressive weakening and loss of skeletal muscles, for which there is currently no known cure or effective treatment.

Despite its relative prevalence compared to some other chronic conditions, FSHD research remains underfunded, with no public funding in Australia and marginal funding for programs overseas.

Since leaving the banking sector and setting up the FSHD Global Research Foundation, I have applied the same corporate governance, the same protocols that I used in the financial world, to the Foundation world. Essentially, this means when giving money to medical research, I don't think of it as a donation, I think of it as an investment. Something that can be monitored and that can generate returns.

Some people say change is too hard, others are just scared of change. Some simply oppose change for political benefit. Still, everybody can drive the agenda for innovation. You can change the world. I know I have done it many times. In fact, if you don't change it, others will. And you may not like the outcome. The one thing that is certain is that change will happen.

In adopting this financial mentality, I'm very proud to say that, at the moment, our foundation can boast that 100% of all tax-deductible gift receipts received since 2007 have gone into medical research projects.

Setting up the FSHD Global Research Foundation has actually led to a major change in funding for this particular disease. We recently introduced an innovative new app that anyone can download that can track every donation that's ever been made to the Foundation. The donor can see precisely which scientific research project their money has gone toward, and are able to track the progress of that research. This is very exciting, and a world first.

Although it is just one example, the FSHD Global Research Foundation shows that it is really important to change and innovate, especially when considering how to generate funding for research projects. You can't stagnate, you've got to change if you want to be world's best at whatever you do.

While Australia may not be world's best in health, if we want to achieve such a title, then we've got to be prepared to change. And the only way we can change is to get people into a room and talk about real-world health issues, make people aware of the latest research, and try and educate people so that they can then come up with new solutions to the ever-growing list of health problems. That is precisely why organisations like the AHHA are so important; they foster discussions around emerging health issues among policymakers, researchers and healthcare professionals. ha

Bill Moss AM was a speaker at the AHHA-ACHS Quantum Leap 2014 conference.

Ms Hartley-Jones preparing to get 'dunked'. Image courtesy of Cairns and Hinterland Hospital and Health Service.

1.2 million reasons to smile

Far North Queensland Hospital Foundation raises funds for new playground facility

After almost nine years in the making, the Far North Queensland Hospital Foundation is now one step closer to making the state-of-the-art Paediatric Playground at Cairns Hospital a reality.

News of the Foundation having reached its $1.2 million target for the building project was announced in June by Cairns and Hinterland Hospital and Health Service Chief Executive, Julie Hartley-Jones, alongside the Foundation's Chair, Ken Chapman.

Ms Hartley-Jones went on to congratulate Mr Chapman on the Foundation's efforts, and those of the broader community, on reaching this milestone. "I have been with the Health Service for more than five years and this campaign has been on the cards since well before then," she said. "The Foundation has put everything into making this a reality – I am thrilled to be here today to share in the celebrations."

There is no reason why children living in regional areas like North Queensland shouldn't be afforded the same benefits as their city counterparts.

A large reason behind the Foundation reaching its $1.2 million target was actually Mr Chapman's push to get the public involved in Sea FM's Dunk The Boss fundraiser, run as part of the region's Give me 5 for Kids campaign. "We had just $40,000 to go so I issued a challenge to the community, I would match donations dollar for dollar up to $20,000 until we hit our mark," he said. "The response really was overwhelming, I can't thank everyone enough who contributed; not just in that final week, but throughout the years. Whether the support was cash donations or in-kind, it was a major fundraising effort in financially hard times and we couldn't have done it without the community."

Ms Hartley-Jones, who took part in the Dunk The Boss challenge to support the cause, said she couldn't have asked for a better result. "The quality of life for sick children and their families throughout the Far North will improve as a direct result of this new facility," she said. "They can finally have a dedicated area where they can escape the isolation of a hospital ward."

Local design firm CA Architects volunteered their services for the playground. "When you think of the sick kids who are usually feeling pretty awful, stuck inside being prodded by strange people all day, you can't help but want to be a part of something that can bring a little sunshine and fresh air into their time at the hospital," CAA spokesperson Stuart Withrington said. "In the design, we have tried to create spaces full of light and life, giving the kids and their families a welcome break from the artificial world inside."

In spite of its name, this is far from your typical playground. "We are not just talking about a set of swings and a slippery dip, this will be a state-of-the-art facility unlike anything we have seen," Mr Chapman said. Aside from having the highest quality play equipment and being completely wheelchair accessible, the area will have inbuilt infection control and all the necessary mechanisms needed to accommodate any illness or disability. There will also be a pool room, a classroom, a dedicated area for arts and crafts, as well as a covered performance stage.

These features mean that the facility will be more than a bit of fun; it will produce real benefits for patients and beyond. As multiple studies have shown, giving sick children the opportunity to venture outside the wards into the fresh air, and to play, can greatly improve their overall wellbeing. And when the children are happier, it dramatically improves the overall experience of families and hospital staff as well.

While playgrounds of this scale are quite common in larger metropolitan hospitals, Ms Hartley-Jones said that there is no reason why children living in regional areas like North Queensland shouldn't be afforded the same benefits as their city counterparts. ha

Ms Hartley-Jones completely soaked. Image courtesy of Cairns and Hinterland Hospital and Health Service.

Mirror, mirror on the wall

How does the Australian health system fare in international comparisons? The AHHA's **Bronia Rowe** and **Linc Thurecht** take a look...

The Australian healthcare system has recently been ranked fourth amongst 11 developed countries, while also having the third lowest per capita health expenditure, according to a recent report.

The report, entitled Mirror, Mirror on the Wall, was released by The Commonwealth Fund in June. It provides a comparative analysis of health systems in Australia, the United States (US), Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland as well as the United Kingdom (UK).

Drawing on survey data on patient and physician experiences and ratings of various aspects of care, the elements analysed and reported on included: Quality of Care (effective care, safe care, coordinated care and patient-centred care); Access (financial burden and wait times for services); Efficiency (health expenditures and administrative costs); Equity; and Healthy Lives (mortality associated with medical care, infant mortality, and life expectancy at age 60). Information on health outcomes also informed the analysis.

In comparison with the other countries studied, the Australian health system ranked second on Quality of Care, fourth on Healthy Lives and Efficiency, fifth on Equity, performed well in the delivery of services to people with diabetes, and with providing written instructions to chronically ill patients. Despite being ranked fourth overall (behind the UK, Switzerland and Sweden), and ranking in the mid-range for most of the other elements, there are a number of key areas that we can improve upon.

For example, Australia was ranked eighth for access, and under the contributing elements, ninth for cost-related problems and sixth for timeliness of care. Only Canada and the US ranked after Australia on financial barriers to accessing care, and indeed the US was seen to do better than Australia in providing timely care.

Addressing accessibility challenges stands out as the priority challenge for Australia on a comparative basis. This finding is especially relevant for Australia moving forward, given the considerable emphasis on healthcare cost sustainability and recent Government announcements made in relation to containing, or better managing, healthcare costs.

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The introduction of co-payments on GP services, pathology and diagnostic imaging, as well as the pausing of indexation on MBS items, the Medicare levy surcharge and private health insurance rebates, is intended as a health budget savings measure and for investment of these savings into the Medical Research Future Fund.

In relation to sustainability, however, it is important to note that, in this comparative study, the UK ranked first, providing universal health care through their National Health Service, and the US, with a greater reliance on private health services, ranked last. This suggests that a system providing majority Government funded services is best able to contain health system costs for both funders and consumers.

Expenditure on health in Australia is growing with an ageing population, an increasing burden of chronic disease, and with advances in medical technologies. Yet what the Mirror, Mirror on the Wall report

shows is that Australia's per capita spending is low relative to other developed countries. It also highlights that not everyone is able to equally access healthcare in a timely and affordable manner.

The introduction of co-payments for GP visits, pathology and imagining services, in addition to an increase in Pharmaceutical Benefits Scheme co-payments, would compound this problem further; disproportionally impacting on people at the lower end of the income distribution. Price signals may moderate government expenditures on health, but it is not clear that this will achieve the best health outcomes; neither for the individuals concerned, nor for the long term interests of the health of all Australians. The changes to future Commonwealth contributions towards the funding of hospitals will also inevitably lead to an increase in hospital waiting lists.

A notable additional finding is that the lower the performance on equity measures, the lower the performance on other health system measures. While Australia is currently ranked relatively well in this area, many of the 2014-15 Federal Budget proposals are likely to impact on the ability of disadvantaged Australians to access the health system in the future. As noted in the Commonwealth Fund Report, "When a country fails to meet the needs of the most vulnerable, it also fails to meet needs for the average citizen."

Undoubtedly, an efficient system that makes best use of resources is critical.

However perhaps Australia should be looking at these results more closely, asking how the health conversation can be refocused to contain or reduce out of pocket costs and improve timeliness and accessibility of care for all users of the system while maintaining our strong record for high quality care and good health outcomes. Perhaps, as a first step, we should be asking ourselves: "Where do we want to be ranked in the next Commonwealth Fund report, and what do we need to do to reach that goal?" ha

The Commonwealth Fund

The Commonwealth Fund is "a private foundation that aims to promote a high performing healthcare system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults." The Fund's full June 2014 Mirror, Mirror on the Wall report is available at www.commonwealthfund.org

Open disclosure needs to become common practice.
Image courtesy of Impress Design / Australian Commission on Safety and Quality in Health Care.

LUKE SLAWOMIRSKI
Program Manager – Implementation Support, Australian Commission on Safety and Quality in Health Care

Fostering better communication for better care

The Australian Open Disclosure Framework

Australians have an excellent healthcare system staffed by highly qualified, dedicated and hard-working people. Nevertheless, healthcare involves a level of risk, and sometimes things don't go to plan.

Open disclosure is a dialogue about healthcare incidents that resulted in patient harm between the clinical team and patients, their loved ones and/or carers.

Failure to acknowledge and openly discuss harmful incidents, or to do so inadequately, can lead to additional and unnecessary pain, grief and confusion. If done well, open disclosure can be of significant benefit for those affected.

The quote below from a patient's mother illustrates how open disclosure can help a loved one to understand, and come to terms with, an incident that resulted in harm:

"Before the open disclosure process I blamed the hospital, I blamed myself, I blamed everybody. The guilt was just so raw with me. My own guilt, the guilt that I'd let my son down, and the blame that I needed to pass on to the hospital … all of that. Since the open disclosure, I know for a fact that measures have been put in place so that this doesn't happen again ... the open disclosure process actually lifted a great weight off my shoulder. I didn't feel like it was about guilt any more. It was about acceptance."

Open disclosure can also benefit clinicians and staff, who are often referred to as "second victims" of patient harm. The following quotes are from two healthcare providers who have experienced open disclosure first hand.

"We had a massive case — an absolutely horrendous situation. Then we went through an open disclosure process … and the whole thing turned into the most amazing, positive experience."

"I think in some ways staff are relieved because there is a plan. They can say 'this is what we are going to do with this family'."

The benefits of good open disclosure can also translate into quality improvement in the broader ecology of clinical practice. This can manifest in several ways. All high-quality health service organisations have transparent processes, and a relentless focus on continuous improvement. Open disclosure is a key marker of a health service's transparency, and how ready it is to learn from patient harm.

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A patient's unique perspective about incidents can also be harnessed to improve practice. This valuable information is best captured through the open disclosure dialogue.

Finally, the process of preparing for and conducting open disclosure helps to develop and equip staff with effective communication skills — a fundamental element of good clinical practice.

The Australian Commission on Safety and Quality in Health Care (the Commission) recently released the Australian Open Disclosure Framework (the Framework). The Framework provides a national basis for open disclosure policy and practice, and replaces the previous national Open Disclosure Standard.

The Commission views open disclosure as an essential element of good practice. The Framework approaches open disclosure as a key part of ethical and patient-centred care rather than an organisational risk management strategy or a legal protocol. It firmly prioritises the needs of patients, their loved ones and carers, as well as the needs of staff in a health service's response to a harmful incident.

The Framework has been endorsed by Australian Health Ministers, and several clinical colleges and associations. Implementation of open disclosure policy and processes is a requirement for health services seeking

accreditation under the National Safety and Quality Health Service (NSQHS) Standards.

The Framework comprises two parts. The first is organisational preparedness. This provides the context and scope, and describes the necessary requirements for open disclosure to be implemented and practised across all healthcare settings. It describes the eight principles of open disclosure, and provides an outline of key considerations regarding patients, staff and the organisational culture.The second part of the Framework comprises open disclosure practice. This describes the elements of conducting open disclosure from the identification and assessment of a harmful incident, planning and preparation, through to the dialogue itself, including the apology, follow up and documentation. It emphasises that open disclosure is a dialogue that can take place over several meetings and may span a considerable amount of time.

A patient's unique perspective about incidents can also be harnessed to improve practice. This valuable information is best captured through the open disclosure dialogue.

The Framework also deals with the legal aspects of open disclosure, and how to measure open disclosure for internal, quality improvement purposes.

The Commission has developed a suite of resources to assist clinicians and health services to practise open disclosure in various settings. These include process flowcharts, sample surveys, a template for measuring and reporting results, a guide to "saying sorry", checklists, frequently asked questions and information for patients.

A guide to assist small practices to implement and practise open disclosure is also available. This document is recognised as an accepted clinical resource by the Royal Australian College of General Practitioners (RACGP). ha

The quotes provided here are taken from formal evaluations of open disclosure undertaken by the Commission. For more information, visit www.safetyandquality.gov.au/our-work/open-disclosure/

New Australasian clinical indicator report released

Analysis of healthcare performance from 2006 – 2013

Australia's most statistically-detailed national Clinical Indicator report, with expert commentary analysis on the overall performance of 731 healthcare organisations for the last eight years, was released in Sydney on 9 September.

The *Australasian Clinical Indicator Report 2006 - 2013 (15th edition)*, published by the Australian Council on Healthcare Standards (ACHS), presents a rich analysis of healthcare performance in Australia.

ACHS President, Adjunct Associate Professor Karen Linegar, said the report presents an overview of the ongoing changes in levels of performance in 2013 for the 415 public and 316 private healthcare organisations who contributed almost 30,500 data submissions to present an overview on their performance.

"With the improved level of contributing healthcare organisations from 690 in 2012 to 731 in 2013, this has ensured we have an even stronger statistical base," she said.

"ACHS are delighted with the strong responses from over 40 medical colleges, specialist societies and health associations who have demonstrated their support for the ACHS's Clinical Indicator Program that builds an aggregate picture to illustrate where improvement has occurred, and most importantly, where the potential for future improvement lies."

"Developed by clinicians, for clinicians, the 22 sets of Clinical Indicators that contain nearly 300 rate-based indicators are an invaluable tool to encourage the recording of current individual performance and from this build an aggregate view of where the entire group of healthcare organisations stands, to reveal where the different performance levels lie."

Notable improving trends over the eight year period include:

- Hospital Infection Control: major attempts to reduce infections are working with a significant decline in infection rates over the last eight years;
- Emergency Department triage goals: the proportion of patients seen within the recommended time in all Triage categories has improved over the last eight years, with categories 2-5 reaching their highest level in 2013;
- A strong increase in the proportion of pregnant women receiving an appropriate prophylactic antibiotic when delivering from 64% in 2008 (start of data collection) to 92.5% in 2013; and
- The proportion of radiation oncology waiting times exceeding 14 days has reduced from 36% to 28%.

Notable deteriorations, where the potential to make improvements exist, are:

- The proportion of mental health admitted patients whose Emergency Department waiting time exceeded 4 hours increased from 44% to 55%;
- Seclusion of mental health patients increased, with the percentage of inpatients having seclusion for more than 4 hours now 50%, compared with 40% in 2006; and
- The proportion of inpatients admitted with pressure injuries increased from 0.08% in 2007 to 0.49% in 2013. ha

'Local Media' by Bob Mical. Image sourced from Flickr via a Creative Commons Attribution 2.0 Generic Licence (https://flic.kr/p/imkZUX).

Raising the standard

The AHHA's **Dominic Lavers** looks at how the Australian Press Council is helping to ensure positive relationships between patients and the media

The Australian Press Council's recently released new Specific Standards of Practice for media practitioners wishing to contact patients in hospitals or residents in other care facilities have been welcomed by the health sector.

The Standards, which were developed in consultation with representatives from the media and the public and private health sectors, aim to help facilitate media contact with patients while respecting the health, dignity and privacy of those people and their families.

The Standards, which were developed in consultation with representatives from the media and the public and private health sectors, aim to help facilitate media contact with patients while respecting the health, dignity and privacy of those people and their families.

The Consumers Health Forum (CHF) CEO, Adam Stankevicius, said the Standards set out a workable guide to cover the sensitive and potentially fraught issue of media contact with hospital patients.

"Obviously the rights of patients to speak to the media if they choose must be upheld," Mr Stankevicius said. "But there have been cases in the past where reporters have made unacceptable intrusions to the bedside of stricken patients or devastated families.

"With modern capabilities like smart phones and micro recorders and cameras, reporters can avoid detection and invade the patient's privacy against the best interests of that patient.

"CHF believes the new standards, about which CHF was consulted, establish a reasonable middle ground, making it clear to media managers and reporters what's acceptable in approaching patients, while also providing protection for patients who might or might not want to speak to media."

Similarly, West Moreton Hospital and Health Service (HHS) Chief Executive, Lesley Dwyer, said the Standards were a positive move by the Press Council in ensuring patient privacy.

"We commend the Australian Press Council for establishing standards of behaviour for journalists, photographers and other media practitioners," Ms Dwyer said.

"At West Moreton HHS, we enjoy a productive relationship with our local media. West Moreton HHS adheres to statewide policies around media management, which focuses on our patients' rights to privacy and the protection of their confidential information."

The Standards will be applied by the Council when considering any complaints made to it about the behaviour of journalists, photographers and other practitioners in print and online media.

Press Council Chair Professor Julian Disney said the Standards have been well received, and that he is pleased with the cooperation the Press Council is getting with the dissemination of them within the media industry and health sector.

"The Standards have been developed after extensive consultation with representatives from the media and the public and private health sectors, including the Australian Healthcare and Hospitals Association," Professor Disney said.

"Their main aims are to help prevent inappropriate contact by journalists with a patient who is in a vulnerable position and to prevent unreasonable exclusion of journalists from hospitals. They also aim to promote a co-operative approach between journalists and hospitals, and to prevent undue intrusion by journalists on other patients and hospital staff." ha

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The Australian Press Council was established in 1976 and is the principal body that issues and monitors Standards of Practice for the publication of news and comment in Australian newspapers, magazines and associated online material. It is also the principal body that considers complaints about coverage of news or comment across this range of publications. The Council currently receives about 700 complaints each year.

Many complaints result in a correction, apology or some other action being taken due to the involvement of Council staff. Where the complaint cannot be resolved without a formal adjudication, the publisher is required to publish the adjudication promptly and with due prominence.

KATHY BELL
Chief Executive Officer; Australian Primary Health Care Nurses Association

All in a pickle over health assessments

Recognising the value of primary care nurses

Throughout July, Government officials issued a series of statements aiming to clarify the Medicare billing rules relating to health assessments, with each statement being met with growing concern from health groups.

The drama began at the end of June when Medicare Australia issued an announcement, stating that the time general practice nurses spend contributing to health assessments could not be legally claimed under the relevant Medicare Benefits Schedule (MBS) items. This was contrary to widely accepted practice, based on previous and explicit advice from Medicare that nurse time could be counted in such a way.

It's not hard to see why Medicare's June announcement caused enormous disquiet. General practices across Australia, with well established team approaches to chronic disease screening and management, felt as though the rug had been pulled out from under their feet.

The ability to claim for the nurse contribution to health assessments is what has long underpinned the business case that enables practices to deliver high quality preventive care at a reasonable cost. Telling practices that — apparently — this would have to stop was always going to cause a stir. This is because the Practice Nurse Incentive Program (PNIP) subsidy on its own would not be sufficient to support a viable nurse workforce in many practices. And without the PNIP to complement health assessment billing, practices would need to seriously contemplate cutting back on their nurses.

If fewer nursing staff were on hand to deliver health assessments, leaving GPs to undertake large numbers of health assessments on their own, the result would be patient block and far higher overall cost to the system than currently exists. The fact of the matter is, though, that few GPs actually have the time, or the inclination, to do wholesale health assessments. This is particularly true for those tricky 75-plus assessments, which often mean observing the elderly managing in their home environment.

If fewer nursing staff were on hand to deliver health assessments, leaving GPs to undertake large numbers of health assessments on their own, the result would be patient block and far higher overall cost to the system than currently exists.

Without nurse involvement in this, and indeed all other areas of care, health assessments could thus soon be endangered.

Perhaps the most confusing part of this whole notion of diminishing the contribution of nurses is that it runs counter to the Commonwealth's stated strategy of supporting quality primary health to keep people well, and thus, out of hospital and out of residential aged care.

The outcry from health groups around this contradiction led to subsequent announcements from the Department of Human Services. These implied — but did not explicitly state — that nurse time could be counted in billing MBS. At the same time, however, Medicare hotline operators were giving very explicit advice to general practices who were calling to query the matter: that nurse time could not be counted. Not surprisingly, mass confusion ensued.

Eventually, the issue settled down once it became clear that the Government's intent

Health assessments in the the home. Image courtesy of APNA.

was that practices should continue with a 'business as usual' approach, and that the contribution of nurses should count in billing for health assessments. These kinds of health checks, done with proper evidence-based assessment tools, ensure that a consistent level of primary health information is collected and risk identified.

The extent of the nurse as a partner with the GP in health assessments will vary from practice to practice and may depend on the training and skill of the nurse in performing particular types of health assessments. The nurse role in health assessments, usually determined between a GP and nurse as part of a team approach to care, might include documenting current health issues; updating medical histories; documenting measurements; undertaking depression scores and mini mental state examinations; nutrition, mobility and falls risk assessments; collating information regarding referral and appointments to other health professionals; and checking medication compliance and use of complementary medications. Health education may also be undertaken at this time. The collated information is presented to the patient's GP for further review and intervention as required.

Adherence to the Royal Australian College of General Practitioners' record guidebook, *Quality health records in Australian primary healthcare*, along with observing the general practice standards as they apply to record keeping, should help ensure that practices have sufficient evidence to demonstrate they have complied with the necessary government requirements in relation to MBS billing for health assessment items. As with all care attendances, good record keeping is essential, and each clinician is legally responsible and accountable for their own record keeping and for meeting the Medicare criteria for billing purposes by the GP provider. All practices should have systems and protocols in place to ensure they meet these requirements.

Hopefully, the confusing statements from different arms of government have not led to any retrograde steps in practice. Because the picture is clear: utilising nurses to work with GPs on health assessments makes sense. It enables GPs to focus their time and skills on the areas where they are most needed, including acute care and high-end chronic disease care. This supports high quality, efficient, and cost-effective primary care. ha

RANJANA SRIVASTAVA
Medical oncologist, writer and educator
Monash Health

Coping with Cancer

Empowering patients to become active participants in their own care

Cancer Council Australia estimates that this year, more than 125,000 people will be diagnosed with cancer and roughly 40,000 will die of the disease. Essentially, cancer is a public health issue and the flip side of us living longer as a society. As our screening and detection methods improve, more people are being diagnosed with cancer; with some remarkable leaps in management, many more people are also surviving cancer. This means it is important to talk openly about the issues surrounding cancer, not just the physical toll but also the psychological and emotional aspects of it. Patients and carers must feel empowered in order to tackle the illness and all its implications.

In a lot of cases, part of dealing with cancer also means thinking and talking about end-of-life care. The first step to doing this is acknowledging that death is an inevitable part of life. As a society, we are typically disinterested in death and dying and even superstitiously believe that the mere mention of it invites bad news. But if death is inevitable, then it helps to discuss one's personal philosophy, goals of care, and wishes for end of life care. These directions do not have to be absolutely concrete but simply having thought about them is important. A patient who has engaged in such a discussion with the doctor or a loved one also does family members a favour by removing the burden of decision-making from their shoulders.

My book, Dying for a Chat, addresses the importance of having these conversations early. When I started working as a doctor, these discussions were rare. But we've since come a long way. Now, some doctors and patients are willing to talk about what happens when medicine reaches its limitations. We still have some way to go, but there is a momentum for change and it is being driven by consumers: our patients.

Learning to communicate well with patients about sensitive and critical matters, such as the wish for resuscitation, ceasing active medical intervention, transitioning to palliative care, is a learned skill although for a long time we thought that communication skills were intrinsic. Hospitals must invest in training professionals to become confident in having these conversations, realising that the outcome cannot be measured as quickly as some others.

Some patients are not yet ready to confront end of life issues although they know they will have to. Others have travelled further along the trajectory and ask for a frank discussion of prognosis. Honesty must be balanced by compassion and sensitivity.

Public hospitals are the portal of care for the majority of Australian patients so they play a fundamental role in promoting compassionate care as well as educating our patients and mentoring future generations around health education and health promotion. They are already doing some innovative things in the area of cancer and end-of-life care and more will be done with time.

But we do need to keep our eyes on the ball. Learning to communicate well with patients about sensitive and critical matters, such as the wish for resuscitation, ceasing active medical intervention, transitioning to palliative care, is a learned skill although for a long time we thought that communication skills were intrinsic. Hospitals must invest in training professionals to become confident in having these conversations, realising that the outcome cannot be measured as quickly as some others. A change in culture takes years to effect.

Strengthening palliative care services is important as we deal with an ageing society, which is suffering from a host of chronic ailments. Although people frequently look upon cancer as a terminal illness, there are many other conditions, including end-organ failure and severe emphysema, which portend a poorer prognosis. Palliative care needs to reach out to not only cancer patients but also others in need of supportive care. The introduction of palliative care is often beneficial to patients even as they receive active treatment for some illnesses. Therefore, palliative care should not be seen

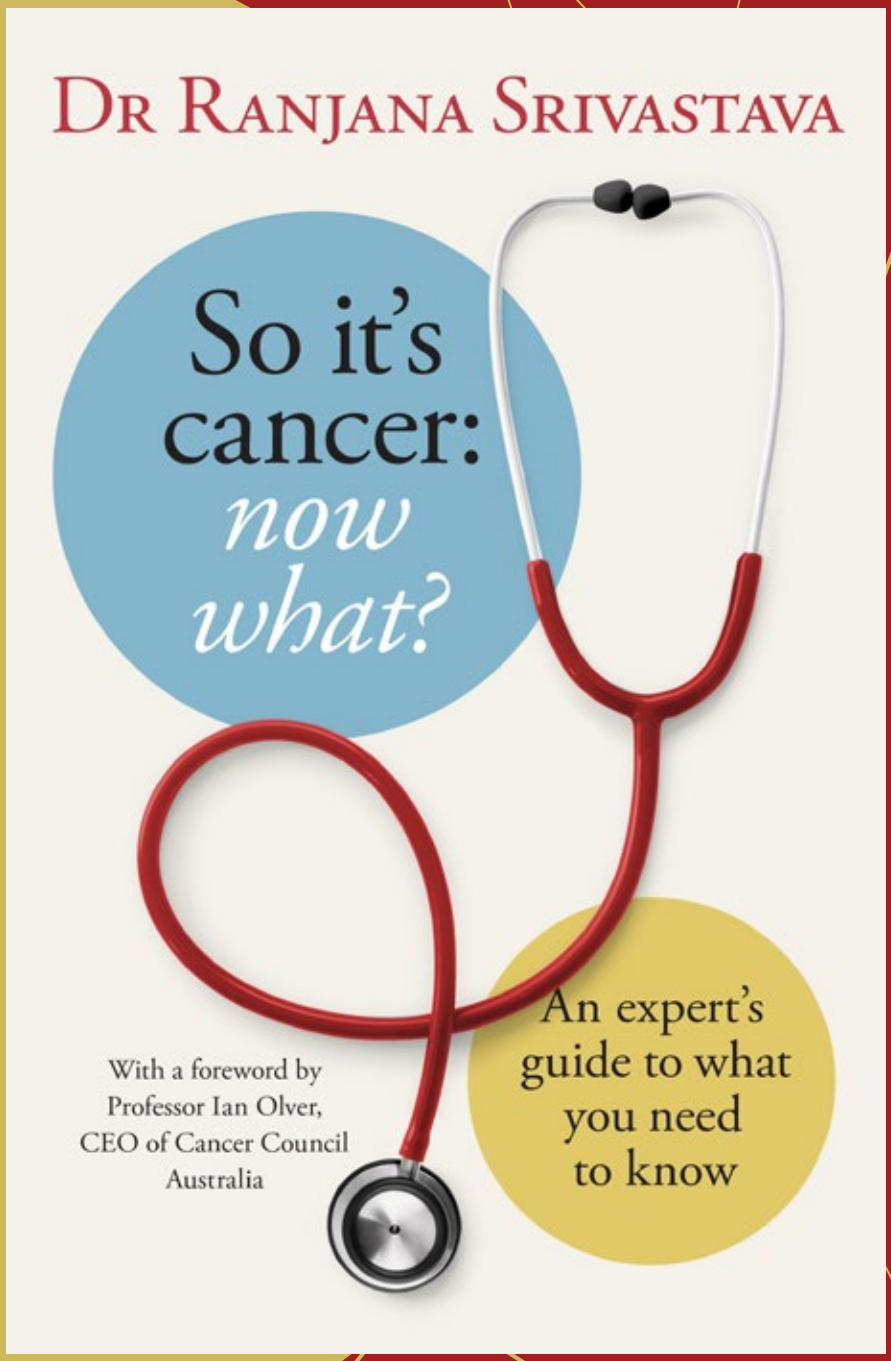
as a failure of management or a last resort.

Empowering patients to see their care in a new light is the central theme of my new book. So it's Cancer: Now What? Is an extension of the work I do with individual patients, empowering them to feel like a partner in decision-making. The central theme of the book is that, although the mere mention of cancer is frightening, patients can regain control of their lives by being an active participant in their care. This, of course, means understanding basic concepts, asking lots of questions, and believing that one is entitled to plain-language explanations of difficult subjects in cancer management.

When one is diagnosed with cancer so much attention is usually devoted to treatment options that vital issues such as diet, exercise, changed sexuality, altered body image, carer support and children's issues take a back seat. But cancer never affects one person, the whole family unit is thrown into the vortex.

I illustrate this, as well as my advice to patients and carers, with real-life stories. These make patients aware that they are not alone in facing difficulties or feeling vulnerable and hopefully provide them with the tools to deal with their own troubles. ha

***So it's cancer: now what?* can be purchased directly from Penguin Books Australia and other leading bookstores.**



Midwifery students at GCUH.
Image courtesy of Griffith University.

JENNIFER FENWICK
Professor of Midwifery and Clinical Chair
GCUH & Griffith University

Continuity of midwifery care

Student-led clinic guiding women through pregnancy and beyond

The evidence is now overwhelming; the best way for all women to be cared for during pregnancy, birth and early parenting is by having access to their own midwife.

Providing women with continuity of midwifery care — also referred to as having a 'known midwife' — facilitates the development of longitudinal relationships between women and midwives. This relationship becomes both the context and method by which quality care is delivered. In essence, the midwife is the case manager. They are the constant across the continuum of childbirth ensuring the woman has access to the appropriate people and resources she needs.

The positive benefits of this 'known midwife' model, both in terms of the short and long term outcomes for women and their newborns, are numerous. For example more women go into labour naturally, use less forms of chemical pain relief such as epidurals, have a normal birth, breastfeed and are happier with their experience.

This kind of woman-centred, continuous care by midwives across their full scope of practice is what underpins Griffith's Bachelor of Midwifery Program. Griffith's industry partner, the Gold Coast University Hospital (GCUH), also considers this a fundamental aspect of quality maternity care provision; evidenced by its collaboration with the university in the establishment of a student-led midwifery clinic.

Held at the GCUH, the weekly antenatal service allows the students — who are taught and supervised by Griffith midwifery lecturer-practitioners — to develop knowledge and understanding of the woman's physical and emotional needs within her own family context. This in-depth care is made possible precisely because women are partnered with the same student midwife across their pregnancy.

Aside from this continuity of care, the clinic also provides a platform for students to use their critical thinking skills as well as to develop clinical competence and confidence. In addition, students learn to work in collaboration with other healthcare practitioners who may also play a key role in the woman's care, such as obstetricians, neonatologists, physicians, physiotherapists and/or allied health workers. The students also support women through the process of giving birth and follow up with them during the postnatal period.

The service provided by the clinic is as much about meeting each woman's individual needs and preferences as it is about doing the physical aspects of care such as taking blood pressure, assessing growth and listening to the baby. Working in partnership with women is mutually beneficial to both the woman and the midwife and increases the likelihood that the woman will perceive her birth experience as safe and satisfying and feel better prepared for the transition to motherhood.

Importantly, the student-led continuity of care clinic is just one of a number of clinical initiatives seeking to address the fragmentation of maternity service provision. Restructuring services to reflect best practice and better meet childbearing women's needs is a high priority for both Griffith University and GCUH. Traditionally, once registered, midwives have been restricted to working in only one area of practice. Not only is this a waste of their skills and expertise but perpetuates an ineffective and inefficient way to deliver quality maternity care.

Childbirth is a normal but significant life event. For both these reasons, women need to be supported to have their babies close to home and in their own communities. Such a focus on primary care is important, because healthy women grow healthy babies and thus create strong foundations for a healthy society.

The Griffith-GCUH partnership hopes to rectify this issue by facilitating best practice; supporting and nurturing women whilst providing the midwives of the future with a solid understanding of the importance and benefits of continuity of midwifery care.

Childbirth is a normal but significant life event. For these reasons, women need to be supported to have their babies close to home and in their own communities. Such a focus on primary care is important, because healthy women grow healthy babies and thus create strong foundations for a healthy society. ha

Generating headspace

Raising funds and awareness of mental health and general wellbeing for the youth of the **South Eastern Sydney Medicare Local** region

Veteran staff at South Eastern Sydney Medicare Local (SESML) often reminisce about the days where, as a Division of General Practice, they dreamt of a *headspace* centre for their region. They lobbied for it, fought for it, and hoped that one day it would become a reality.

Now, not only has the dream become true, it's multiplying. In February this year, *headspace* Miranda opened its doors, providing a much needed space for young people in the Sutherland Shire to access information, support and services. But, SESML hasn't stopped there. In mid-2014, *headspace* Hurstville opened its doors, providing young people in the St George area with a safe place to access the services and support they need.

As the lead agency of both *headspace* centres, SESML — along with a dedicated team of consortium partners — is working hard to address the needs of young people in the community. In carrying on the work of *headspace* across the country, the centres support people aged 12-25 years, and their families, particularly in the areas of:

- general health;
- mental health and well-being;
- alcohol and other drugs services;
- education and employment support; and
- sexual health services.

Young people are invited to visit *headspace* no matter how big or small their problem may seem. Issues can range from mental health, drug and alcohol issues, sexual health, or even just a feeling of being down, worried or stressed. The services provided by *headspace* are free and confidentiality is always respected.

Operations Manager across the Miranda and Hurstville centres, Lesley Pullen, speaks very highly of *headspace* staff. "We pride ourselves in providing a friendly, comfortable and caring environment for local young people," she said. "We have some extremely well qualified, experienced staff who are always ready to listen to and work with young people in need."

headspace Miranda has been working with local fundraising group, Step Ahead, to raise awareness and funds for young people with mental illness through Step Ahead's inaugural walking event, held on Saturday 11 October. Proceeds from the walk — which coincides with Mental Health Week — will go to *headspace* Miranda.

Hayley Turpin, sister of Richelle Turpin who lost her battle with mental illness earlier this year, said the walk will provide an opportunity to raise much-needed funds for young people in the Sutherland Shire community but also honour the memories of those lost to mental illness.

Because of the stigma still surrounding mental illness, many young lives are cut tragically short because people are not seeking the help they need. The goal of both Step Ahead and *headspace* is to create a community where mental illness is openly discussed and help is readily sought.

For more information about the Step Ahead walk, go to www.stepaheadwalk.com.au ha

Staff at *headspace* Miranda. Image courtesy of South Eastern Sydney Medicare Local.

Jubullum community members receiving their training. Image courtesy of North Coast NSW Medicare Local.

Communities hungry for first aid training

North Coast NSW Medicare Local seeing benefits with its First Aid in Aboriginal Communities program.

North Coast NSW Medicare Local (NCML) is providing a new first aid training program — First Aid in Aboriginal Communities — across the North Coast through Aboriginal Land Councils. So far, 13 Land Councils have signed up.

The training is being administered through the NCML's Vulnerable and Disadvantaged Communities Program.

Gugin Gudduba Aboriginal Land Council, based at Kyogle, was one of the first to receive the training. Its CEO, Ron Randall, took part in the one-day course.

"Mike Johnston, the trainer, has extensive experience and Aboriginal people always appreciate learning from someone with experience; we aren't interested in learning from someone just out of uni. Mike really made the material come alive with songs such as Staying Alive during the CPR training but, above all, he made learning first aid fun," Ron said.

Ron also said that Mike covered a huge amount of material in one day, but that everyone enjoyed it and got a lot out of it. "They've got the confidence and skills to go back to their communities and help out when an emergency comes up. Sometimes it can take time for medical help to arrive, so it's important for community members to be able to respond when things happen."

Particularly helpful, in Ron's opinion, was the section on recognising symptoms of diabetes, a condition which affects so many in the Aboriginal community. A diabetic himself, he understands the value of knowing about type 2 diabetes and getting checked out by a GP if you suspect you might have it.

Another great endorsement of the scheme is the fact that, of the eight participants in the Kyogle first aid course, seven said they would like regular and further first aid training. And the training is already paying off.

Down in Coffs Harbour, one first aid training participant was especially chuffed that he was recently able to make use of his new skills when one of his clients fell to the ground shaking. While a co-worker thought the client was having a stroke, the first aid trainee assessed the client as having a seizure and was able to provide immediate care while his co-worker called an ambulance.

Further benefits will soon be felt in other locations and health areas as well, with NCML facilitating mental health first aid training throughout North Coast Aboriginal communities. ha

Roger Downham at work. Image courtesy of Chris Crerar, Tasmania Medicare Local.

Coaching your way through to better health

A mission to reduce impact of type 2 diabetes and find healthcare savings from **Diabetes Tasmania**

Roger Downham is not really what you'd think a typical person with type 2 diabetes looks like. He displays none of the modifiable risk factors associated with the condition, and yet he was diagnosed with the disease at the age of 59.

Working as a farmer for the majority of his life, Roger runs sheep, cattle and crops at a property in Richmond, Tasmania. He is regularly active, eats well and does not smoke or drink. Basically, Roger could not have done more to lessen his chances of developing diabetes.

It is not altogether surprising, then, that Roger's GP did not view him to be an immediate candidate for the condition. "My GP was quite surprised that the results came back positive for type 2 diabetes because I am so lean and fit," Roger said. Nonetheless, the risk that Roger would develop type 2 diabetes was high; a combination of his age, gender and recent history of elevated blood sugar levels.

Beyond 35 years of age, the likelihood of developing type 2 diabetes, as well as heart disease and stroke, starts to increase. Men are particularly at risk of these diseases, as are people of Aboriginal, Islander, Maori, Asian or Middle Eastern descent. Essentially, everyone becomes at risk of type 2 diabetes as they get older.

Although the risk can be curbed, it cannot be fully eliminated. Luckily for Roger, his GP was well aware of this and made sure that Roger was tested and diagnosed, and that he has since undergone treatment for his diabetes. Part of this treatment has been through The COACH Program® offered by Diabetes Tasmania.

Primarily a telephone-based service, The Coach Program® provides clients with nutritional coaching from accredited dieticians working specifically in the field of diabetes. This specialised training enables the dieticians to identify treatment gaps; that is, treatment that should be delivered according to national guidelines but, for whatever reason, is lacking.

After identifying the gaps, coaches work with clients over three to six sessions to educate and advise them on how best to rectify the gaps and reduce their risk factors while they continue to work with their usual doctor to manage the disease. Through coaching, participants are encouraged to take more of a lead role in their health by asking doctors to measure their risk factors, discuss the results, and work together to achieve improvements in the future. They are also encouraged to ask for guideline-recommended prescription of medications.

Coaches also advise clients on lifestyle changes that they can make themselves; namely through diet, exercise, smoking and alcohol consumption. Clients' doctors can then monitor the effect of such lifestyle modifications through regular measurement of blood glucose and cholesterol, blood pressure, waist measurement as well as any medication dependence.

Roger's personal coach was Minke Hoekstra. "Roger was already in pretty good health when he entered The COACH Program® but there were a few things we could do to help him get his cholesterol readings down and improve his heart health," Minke said. "All in all, he's a great example of a regular bloke whose diagnosis of diabetes could have been missed because of his seemingly good health. Fortunately, it was picked up and now the chance of complications has been reduced for Roger."

The flexibility of The COACH Program® means that it can be delivered anywhere in Tasmania, and that it can run outside regular business hours. The implications of such a flexible — yet, highly targeted — initiative are significant, as demonstrated by an independent assessment which found that a $350,000 investment in the program created a $1.5 million saving for the public health system over three years. These figures show that a relatively small investment in preventative healthcare can return tremendous savings; not just in fiscal terms but also in terms of health and quality of life. ha

The COACH Program® is funded by the Tasmanian Department of Health and Human Services and is available to all Tasmanians who are at high risk of developing type 2 diabetes, have pre-diabetes or have been diagnosed with type 2 diabetes. For more information on the program, please contact Diabetes Tasmania on 1300 136 588.

BEN FIELDING
Chief Executive Officer
St Vincent's Hospital, Melbourne

Oh, what a lean feeling!

Hospital patients to benefit from Toyota's expertise

Here at St Vincent's, we are committed to innovation and we are always open to new ways of delivering the best patient care. We have led the way in Victoria's Redesigning Hospital Care Program, especially in the way we have engaged clinicians directly within the redesign team. Toyota Australia is a world renowned leader in innovation, particularly in lean management techniques. With this combined emphasis on progressive thinking, there is a good fit between the two organisations.

While our industries are very different, we both have an aim to be the best at what we do with a relentless pursuit of excellence and impact. Staff at St Vincent's are delighted to benefit from Toyota's wealth of knowledge in this area, and in terms of lean techniques. The automotive giant's efforts to streamline the hospital's processes have already proved invaluable in improving the services provided to our patients.

As part of its initial engagement with St Vincent's, Toyota Australia worked with the hospital's pharmaceutical division to improve the way it prepares pre-packaged medication for approximately 1,000 patients each week. By applying concepts from the world renowned Toyota Production System, the time taken to pack each script from start to finish was drastically reduced from 210 minutes to 34 minutes.

This is really significant for us, because we are continually striving to improve our patient care. The changes have drastically reduced double-handling in our pharmacy, which means staff are working more efficiently. In turn, this means that patients can get their medication much more quickly, and that they spend less time in the waiting room.

We are also in the process of analysing the whole patient journey, aiming to streamline the entire patient visit so that there's less time between steps with regards to treatment; for example, between arriving at the clinic, and seeing the doctor.

As the project has just begun, we don't yet know what time savings might be made. What we do know is that we were able to make significant system improvements in our pharmacy, and that we're hoping to be able to find similar time savings for our cancer patients.

Typically, there are many steps or clinical decisions involved in a cancer patient's treatment visit to hospital: undergoing blood tests, waiting for the results, receiving chemotherapy or other treatment. This can add up to an hour between events. By reviewing the current system and streamlining the process, Toyota Australia and St Vincent's aim to reduce the time between events to just 20 minutes. This means that patients spend less time in the hospital and more time at home with their loved ones.

While St Vincent's is always open to innovation, we know that we're not the only ones with good ideas. We will continue to embrace opportunities for improvement and we encourage others to do the same. ha

Left to right: Max Yasuda, Toyota Chairman; Ben Fielding, CEO of St Vincent's Hospital, Melbourne; Prof Patricia O'Rourke, CEO, St Vincent's Public Hospitals; Dave Buttner, CEO Toyota Australia. Image courtesy of St Vincent's Hospital.

Toyota Australia will continue to work with St Vincent's until the end of 2015 as part of its $15 million development program that is partly funded by the Federal Government. The program involves 20 dedicated Toyota employees working with local suppliers and at least one non-automotive entity each year to increase productivity in the workplace.



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The Australian Healthcare and Hospitals Association (AHHA), 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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For more information on pricing and registration please contact: 02 6162 0780
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CHRIS CARTER
Chief Executive Officer
Inner North West Melbourne
Medicare Local (INWMML)

Our region, our people

Regional health check shows the importance of primary healthcare

Our second annual health check of inner north west Melbourne has given us the opportunity to get a great overview of the major health issues facing our region.

Brought together in the second edition of the *Our region, our people* report, these insights show that, while several of the key health concerns in our region stay the same as in our previous report, a number of emerging issues are taking centre stage.

Our region, our people shows that the prevention and management of chronic disease, particularly type 2 diabetes, remains the number one priority in our region.

Rates of diabetes in our region and deaths caused by the disease are above Australian averages. As diabetes is a complex condition that can often lead to severe complications, this means we need to be putting even more effort into supporting local doctors to help manage the condition in the primary care setting, where patients have the best chance of maintaining their quality of life.

The results are more encouraging in relation to cancer, with deaths caused by cancer dropping substantially since they were last reported. All cancer deaths in our region fell from 99.3 per 100,000 between 2003-07 to 93.8 per 100,000 between 2008-12.

The importance of primary care to these sorts of improvements is an underlying theme throughout the report, which provides a detailed snapshot of the mental, physical and emotional health of people living in the local government areas of Melbourne, Moonee Valley, Moreland and Yarra, as well as the socio-economic factors that influence their health outcomes.

Flinders St Station, Melbourne CBD. Image courtesy of INWMML.

The report is the culmination of a year-long Comprehensive Needs Assessment (CNA) process involving the analysis of hundreds of primary and secondary data sources, along with the invaluable input and support of our expert advisory panel and board. It reveals the five most pressing health issues in our region are prevention and management of chronic disease, coordinating care across systems, health literacy, mental and emotional health and wellbeing and alcohol and other drug use — all areas where the primary health care system plays a central role.

The importance of primary care to the major health issues in our region would come as no surprise to the hundreds of local doctors, specialists, nurses and allied health professionals who deal with these issues every day.

We hope that the release of this report can assist their crucial work, both by helping practitioners identify the population health issues facing their practice and by informing the policies and priorities of key health stakeholders in our region.

Full copies of the report, as well as snapshots of each priority health area, are available at www.inwmml.org.au/media. ha

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

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.

The Honourable **Brownyn Pike** is Western Health's new Board Chair. Her previous roles include being Health Minister and Education Minister in the Victorian Government.

Mr **Bruce Levy**, who has more than 30 years of experience in healthcare, is the new Board Chair of Silver Chain Nursing.

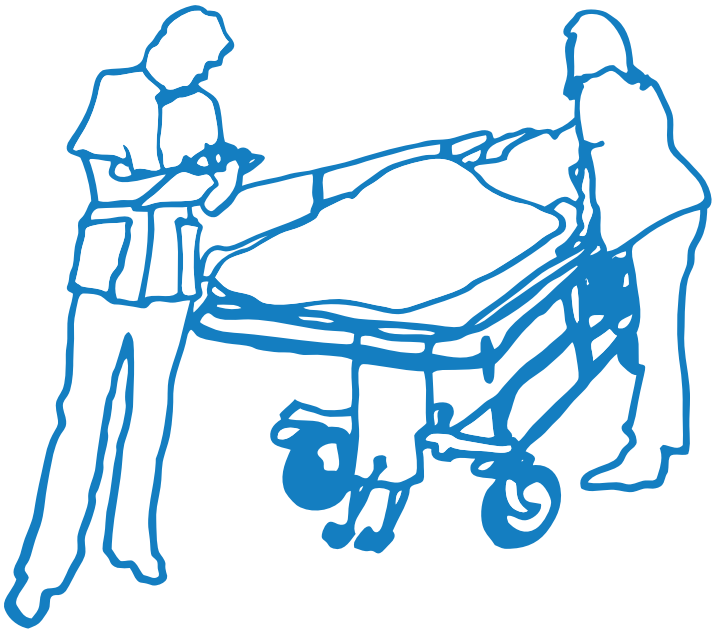
Professor **Graham Schaffer**, former Executive Dean of the Faculty of Engineering, Architecture and Information Technology at the University of Queensland, is moving to La Trobe University to be the inaugural Pro Vice Chancellor of the College of Science, |Health and Engineering.

Professor **Anthony McGrew** will be the inaugural Pro Vice Chancellor of the College of Arts, Social Sciences and Commerce at La Trobe University. Professor McGrew is moving to Melbourne from Glasgow where he has been Executive Dean of the Faculty of Humanities and Social Sciences at Strathclyde University.

Dr **Mark Brown**, currently the Executive Director Oral Services at Metro North Hospital and Health Service, will be the new Chief Dental Officer at Queensland Health following the retirement of Dr Rhys Thomas.

Dr **Sam Henson**, former Associate Dean for International and Partnerships, is now the Head of the Ballarat Campuses of the Federation University Australia.

Professor **Peter Klinken** has been appointed as the new Chief Scientist for Western Australia, having previously worked as at the University of Western Australia.



Ms **Tonina Harvey** is moving to South Western Sydney Local Health District as General Manager Drug Health. She was previously the General Manager of Community Services at Paraquad.

Professor **Steve Chapman**, currently the Vice-Chancellor of Heriot-Watt University in Scotland, will become the new Vice-Chancellor of Edith Cowan University in early 2015.

Dr **Nancy Huang**, National Manager of Medicine Insights for NPS MedicineWise, is moving to Australian Unity as the Medical Director of Remedy Health.

Professor **Tim Stokes**, from the University of Birmingham, has taken up the Elaine Gurr Chair of General Practice at the University of Otago's Dunedin School of Medicine.

Ms **Sophie Najjarin**, formerly with Westmead Private Hospital, has moved to Waratah Private Hospital to become their Clinical Services Manager.

Professor **Paul Brunton** will be moving from the Leeds' School of Dentistry to New Zealand to become the Dean of the School of Dentistry at the University of Otago.

Dr **Wayne Hsueh**, who was the Deputy Executive Director of Medical Services at Tasmanian Health Organisation South, is undertaking the position of Director of Medical Services at Shellharbour Hospital.

Ms **Margot Mains** is moving from the Northern Adelaide Health Network to be the new Chief Executive Officer for Illawarra-Shoalhaven Local Health District.

Dr **Kathleen Atkinson**, Executive Director of Medical Services at Murrumbidgee Local Health District, is moving to Far West Local Health District as the new Executive Director of Medical Services. ha

Become an AHHA member

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 an 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 sectors, 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 our 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 onferences, 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*). ha

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

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Who we are, what we do, and where you can go to find out more information from us

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The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation, the protection of its assets and the quality of its services. The 2014-2015 Board is:

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Ms Elizabeth Koff
Deputy Chair
Dr Deborah Cole
Treasurer
Dr Paul Scown
Immediate Past Chair
Prof Kathy Eagar
Academic Member
Prof Gary Day
Member
Ms Lesley Dwyer
Member
Mr Walter Kmet
Member

AHHA National Council

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

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Ms Gaylene Coulton
Prof Gary Day
Dr Martin Dooland AM
Dr Paul Dugdale
Ms Learne Durrington
Ms Lesley Dwyer
Prof Kathy Eagar
Mr Nigel Fidgeon
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Ms Sue Wright
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Project Manager, JustHealth
Mr Daniel Holloway
Communications Officer
Mr Dominic Lavers
Communications Officer

Australian Health Review

Australian Health Review is the journal of the AHHA. It explores healthcare delivery, financing and policy. Those involved in the production of the AHR are:

Prof Andrew Wilson
Editor in Chief
Dr Anne-marie Boxall
Managing Editor
Dr Simon Barraclough
Associate Editor, Policy
Prof Christian Gericke
Associate Editor, Models of Care
Dr Lucio Naccarella
Associate Editor, Workforce
Dr Caroline Hadley
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