



The Health Advocate

ISSUE 3 • APRIL 2010

The official magazine of the
Australian Healthcare & Hospitals Association

Your voice in public healthcare

It happens: Death in hospitals

Ken Hillman
discusses the issues

Designing better facilities

Ian Forbes on
innovations resulting
from Public Private
Partnerships

Member profile

Home Support
Services and
their work in the
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Aged and end of life care *Can we do better?*

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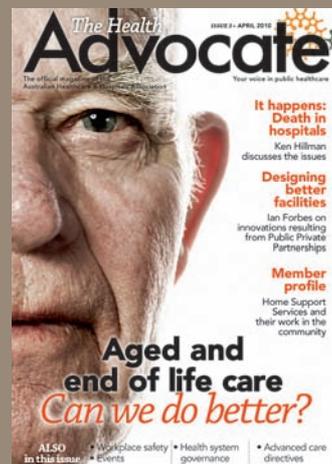
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DR DAVID PANTER

President of the
Australian Healthcare and
Hospitals Association

President's report

With an election year upon us, 2010 is going to be an interesting time for us all, with both sides of politics promising reform of the health system

WELCOME TO 2010 and our third issue of *The Health Advocate*! We've already seen a lot of activity around the health debate in this election year. One key health policy — the Government's proposed changes to the private health insurance rebate — has already provided a trigger for an early election and has established some clear battle lines in Federal politics. The Opposition has put forward a 'kernel' of an idea for hospital boards in two states which risks fragmentation if not backed up with a clear policy framework for the whole system. This kind of debate will certainly galvanise the public at least.

The Australian Healthcare and Hospitals Association (AHHA) is always twice as busy in an election year. As the only national body fighting independently for the strongest public healthcare sector possible, we have our work cut out for us. Some positions are clear and unequivocal, such as the absolute need for more funding for public hospitals and other services. There can be no question about the ever increasing demands on the public sector, and the knowledge that expenditure by Government is not keeping pace.

But there are areas that are open to much debate and discussion about the best path forward. These include ways of changing healthcare practice to ensure patients are held at the centre of a system built around them, how to make care happen in the most appropriate setting, and the best mechanisms for funding and governing the whole health system to achieve these goals. This is something the AHHA has long been grappling with — and you can find a summary from our Executive Director, Prue Power on page 44 of this issue.

All of these discussions are still occurring in the context of Government negotiations over their recently announced health reform plan, and no publicly disclosed health reform policy from the Opposition (at least beyond NSW and Queensland). At the time of writing, interest groups, the media and the public had finally welcomed the first announcement

from the Rudd Government of its plans to reform health — starting with public hospitals. It's as though we know we're waiting for something big, assuming almost everyone will be disappointed, and the Federal Government delivered with a proposal for more national influence and funding combined with more local decision making. All the while, the States remain engaged in the system, and all governments are now in the process of negotiating over the acceptance or rejection of the plans. The Australian public seems relieved that there is finally some action in this area. Still, it seems all sides of politics are in for a bumpy ride during their election campaigns.

In light of heightened public attention to health, this issue of *The Health Advocate* has a focus on one of the most significant drivers of the system today and in decades to come — ageing and end-of-life care. We know that a lot of Australians die in hospitals when they would prefer to spend their last days at home or in a non-hospital setting. Everyone has to die at some point, we just happen to be doing it at higher ages. As we get older, there are increasing co-morbidities and chronic disease that make coordinated, ethical and compassionate care absolutely critical.

As a society and as health professionals we need to overcome some of the more difficult concepts around mortality and quality of life, and actually start talking openly about it as consumers, professionals and family members. Medical advancements since the mid-20th century have been so significant, and continue to be revered for their capacity to keep us alive for longer, that it seems to come as a shock that we do actually have to die.

I hope that you gain some helpful insights from the excellent articles, contributed from all areas of the health sector. We hope that you engage with us throughout this landmark year. With so many fantastic opportunities, including our high-level workshop series in June, regular Think Tanks and the Congress in my hometown (Adelaide) in September, you won't miss a minute of the action. You never know, we may encounter some real change for the better!

ha

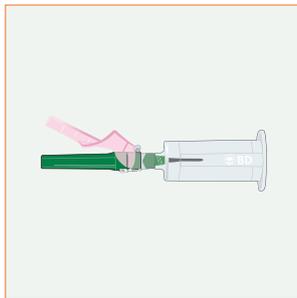
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Media coverage and issues of interest to the AHHA

In the news

Healthy public role

Letter to the Editor – The Age, 13 February 2010

MICHAEL ROFF ("Private health rebate helps the public system", Online, 9/2) misrepresents the findings of the Productivity Commission's inquiry into public and private hospitals. Contrary to Mr Roff's claims, the Commission found that public hospitals are efficient and provide good value to the community. In fact, the Commission stated that the efficiency of public and private hospitals is, on average, similar.

Mr Roff also claims that private health insurance rebates help reduce demand on the public system. This is false because, first, people who drop their private health insurance when prices increase are generally the affluent and the healthy. Second, given the fixed number of doctors and nurses, a shift in demand to private hospitals attracts health care providers away



from public hospitals. Private hospitals are an important part of our health system. However, they are not, and never have been, a substitute for public hospitals. All Australians rely on a high quality and accessible public system that provides essential

services not provided by private hospitals, such as care for complex patients, accident and emergency services, paediatrics and hospital services in rural areas. As numerous health economists have found, the billions being used to fund the private

health insurance rebate would deliver much greater health gains if used to fund health services directly.

Prue Power, Executive Director, Australian Healthcare and Hospitals Association, Deakin, ACT



Ringling in the election year!

▶ **THE AHHA** welcomes the early attention to healthcare in this election year. It will be a flagship issue, but one we must all exercise caution over when we vote for the next government. We always expect a mix of interesting ideas, left-field discussions, feverish allusions and simplistic 'solutions' that appease the public but do nothing to actually change how the whole system can function.

The AHHA has been working on a suitable approach to system reform of governance, incorporating financing sources and mechanisms, reporting and accountability, and moving decision-making and planning closer to the local level. Remarkably, these principles have been reflected in the Government's proposals announced on 3 March. The Coalition put forward its first health idea in February to implement government-

appointed boards for the larger hospitals in Queensland and NSW. While we are certain the Coalition will have more fully developed proposals than this (of course, there are 10 million other people in the country), it concerns the AHHA that such knee-jerk responses to real issues in hospitals and healthcare can gain traction. For a discussion of the Government proposals, see Prue's summary on page 44.

Unfortunately for the public healthcare sector, a second run

through the Senate for proposed means testing of the Private Health Insurance Rebate was rejected. The AHHA has been vocal over many years about the need to redirect the massive amount of public funds spent annually on the rebate to health services themselves. This chance was lost again, with hospitals missing out on a boost of \$1.9 billion from the projected savings that would have resulted from the entirely reasonable means testing of the rebate.

Events & meetings

AHHA events provide the opportunity to openly discuss the **big issues**

Think Tanks

▶ THE AHHA holds regular Think Tanks on key issues with expert speakers, which run on Chatham House rules and are limited in the number of available seats, giving participants the freedom to discuss issues openly. This was particularly important for our last Think Tank of 2009 (with the Productivity Commission's David Kalisch) and the first for 2010.

David spoke in more detail about the Commission's study

into the comparative costs in the public and private health sectors. This work confirmed that costs are generally similar across the sectors — the public sector is more cost effective in its most frequent services (medical, emergency) while the private sector has efficiencies for its specialties (surgical services). The AHHA was pleased that Dr John Deeble was able to provide significant support to the Commission, following his Chalmers Oration that explored similar issues. For a copy of the Oration, contact the AHHA at admin@aushealthcare.com.au.

Our first Think Tank of 2010 was an opportunity to collaborate with Palliative Care Australia to discuss end-of-life care in acute settings, during which Professors Ken Hillman and Jane Ingham gave excellent and sobering insights to the decisions facing clinicians.



Branch Seminars

▶ SINCE THE last issue of The Health Advocate, the AHHA has held Branch Seminars in Brisbane, Canberra and Adelaide. In each of these Seminars, our presenter was the Chief Executive of the state health department – Mick Reid, Mark Cormack (prior to becoming CEO of Health Workforce Australia) and Tony

Sherbon. Each speaker gave local context to national health reform plans and insight into the high-level discussions. There are clearly concerns held by members, but they can see there are pathways through the political quagmire to an improved health system.



Left-right: Dr Lyn Roberts, Lyn Dimer, The Hon Warren Snowdon, Traven Lea and Dr Andrew Boyden

Indigenous Parliamentary Roundtable

▶ IF AND WHEN Indigenous Australians with acute coronary episodes reach hospital, they have fewer procedures and poorer outcomes than the rest of the population. A forum at Parliament House in Canberra on 24 November examined existing data, looked at the reasons behind lower intervention rates, and canvassed policy options to close this gap in health outcomes, believed to be a significant contributing factor to the broader life expectancy gap. The forum and policy options are the result of a joint initiative between the Heart Foundation and AHHA, aiming to close the gap in hospital intervention rates. Then Director of the Heart Foundation's Aboriginal and Torres Strait Islander Program, Traven Lea, said that in-hospital fatality and procedure rates for Indigenous Australians are far worse than for other Australians.

The Honourable Warren Snowdon, Minister for Indigenous Health, Rural and Regional Health, made time to speak to those in attendance.

The final paper will be presented to the Minister in April and the AHHA and Heart Foundation are moving forward with the campaign. The paper is available from the AHHA – send us an email at admin@aushealthcare.com.au.



Mick Reid, Director General of Queensland Health

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GREG MUNDY

Chief Executive Officer
of Aged and Community
Services Australia

The spirit of aged care

Greg Mundy shares the perspectives of Aged and Community Services Australia

THETASKS of aged care and the services the sector provides are relatively well-known. Residential aged care, which at any one time looks after around 170,000 older people, is a visible presence in our suburbs and often graces different pages in our daily newspapers. Community care – looking after people in their own homes – is less visible and less well-known by those members of the public outside of its clients and their families, yet it cares for up to one million people every year. ACSA's members are active providers of retirement village accommodation with around 45,000 units of housing for older people. These services form the core tasks of our aged care industry.

They don't stand alone: as the National Health and Hospitals Reform Commission (NHHRC) put it, the health and aged care systems are like two giant interconnecting cogs. They also correctly noted in their Interim Report, that aged care is not only about healthcare as most people would perceive it. It's also about supporting older people's lives by assisting with tasks of daily living and facilitating social engagement. These are elements of a broad definition of health but far removed from wound care and medication management.

My list is not exhaustive either. Aged care providers are also involved in hospital avoidance programs, post-acute care programs and providing services to younger people with a disability, to name just a few.

What links the various tasks or services that aged care providers undertake in the \$10 billion aged care industry is their purpose. The purpose of aged care is to assist older people to live the most self-directed and satisfying lives that they can in their remaining years. This is the spirit of aged care, its heart.

It is in this spirit that ACSA has responded to the NHHRC (see agedcare.org.au). How can we equip our aged care system to respond to the diverse needs of our growing aged population, flexibly and sustainably? How can we facilitate smoother connections between aged care services and the other supports that older people may need such as primary health care and hospital care? How can we transition from our current, rather rigid system? How can we best address the challenge posed by the coming increase in demand in the context of a finite workforce? In ACSA's view we won't be able to meet the challenges of caring for an ageing population by doing more of the same.

Our aged care system is already feeling the strain. Aged care providers are finding it increasingly difficult to build new aged care homes or renovate existing ones on the current policy settings. Aged consumer organisations and providers agree that this needs to be addressed but our adversarial political system is blocking lasting solutions. Community care services are becoming increasingly thinly-spread as the subsidies fail to keep pace with the cost of providing services. Providers in

they will give the Productivity Commission a reference to progress reform of aged care. The Prime Minister has given public recognition to the challenges of an ageing population (which we should celebrate as a triumph of human achievement!). This is an advance on the mantra of the previous ten years of denying that there are any problems that can't be dealt with by short term patches. It's not action, though, and action is what we need to continue to provide quality

Our job in aged care is to help people get the most out of the later stages of their lives

many parts of Australia, particularly those affected by the mining industry, find it very difficult to recruit and retain staff in the face of the wages paid to the miners. Access to GP services by the residents of aged care homes has been difficult for over a decade and will not be fixed without attention to the financial incentives to GPs to provide this service.

We have been encouraged by an increasing degree of recognition by the Australian Government that change is needed. They have indicated that

services to older people.

Longer term reform is vital and should not be blindly rushed, but we also need action in the short term to stop the decline in the real value of aged care subsidies and to enable residential care providers to resume building.

Our job in aged care is to help people get the most out of the later stages of their lives. To do this we need good relations with other parts of the care system and the right sort of support from governments. These are our challenges in 2010 and beyond. 



ROD YOUNG

Chief Executive Officer of
the Aged Care
Association of Australia

Aged care - problem or passing mirage?

Rod Young shares the views of the Aged Care Association of Australia

The Commonwealth funded aged care program currently provides services to approximately 170,000 residential care recipients and 48,000 community care recipients. Just over 70 million bed days of care are provided each year and approximately 530 million medication administration events occur each year in residential care alone.

It's estimated that the number of persons in care will rise from 218,000 to approximately 370,000 by 2031. The interface between this group of very frail older care recipients and the acute hospital sector is an important one that needs to be handled expertly and sensibly by both service providers. Any service failure in either domain can have severe consequences for the care recipient. In particular, where inappropriate or poor management of a person in this care group occurs, the cost escalation that can flow from serious chronic illness and disability should prompt strategies to prevent such outcomes.

There are examples of good dialogue and inter-relationship arrangements between hospitals and aged care providers (fine examples being the Gold Coast

Hospital aged care provider interface in south east Queensland) and other tentative engagements mostly being driven by innovative general practice networks.

It is estimated that there are 39,000 transfers from residential care into the acute sector, many of which are short term emergency admissions. AIHW has estimated that roughly 8,000 of these admissions are preventable due to either medication adverse events or capacity of residential care staff to undertake complicated clinical management. There is an urgent need for significant improvement in communication channels between residential care and acute hospitals in order to achieve a number of underlying objectives, namely to:

- prevent unnecessary admissions;
- improve the clinical capacity and proficiency of residential care staff;
- provide a range of educational opportunities for acute sector staff to better understand the needs of aged care patients – in particular those suffering from dementia – and the constraints under which aged care services must operate;
- improve the information flow, particularly that surrounding medication regime from

residential care into acute care and from acute to residential care; and

- implement a discharge summary electronic documentation process to better inform staff in each setting about the diagnosis and prognosis of the patient/ resident on transfer.

In addition, there are 55,000 new admissions into residential care each year, with approximately 60 per cent or 33,000 of these being transfers from acute hospitals into residential care. The flow of information at the time of a transfer from acute to residential is often

and older in Australia will increase to approximately 1.2 million people by 2045. The needs of this group, whether being cared for in the residential care setting or an acute treatment setting, are unique and demanding and if Australia is to provide quality services in either setting it will be essential that care services are effectively resourced to achieve quality outcomes. But more particularly, our care/clinical providers need training and education in understanding the nature of diseases that impact this very elderly population; and in choosing the most appropriate

The number of persons aged 85 years and older in Australia will increase to 1.2 million

poorly managed. The same issues surrounding medication regime, diagnosis and prognosis outlined above are just as relevant to a residential care service receiving a new admission from an acute setting as a person being transferred between care settings.

It is generally accepted that the number of persons aged 85 years

form of care and service for persons in this age group, especially those living with a cognitive impairment.

Aged care stands ready to work cooperatively with the acute care sector to achieve improvements in the efficiencies of our programs. In this way we can deliver better care outcomes and avoid unnecessary clinical interventions. [ha](#)



CLARE KARIBIKA

Director of Continuing Quality Improvement, King Faisal Hospital, Rwanda

Rwanda's Clare

The many challenges and rewards of making your career and life in another country

CLARE KARIBIKA graduated in general nursing from the Cumberland College in 1983 and subsequently worked at the Royal North Shore and the Royal Hospital for Women in Paddington.

Clare met Louis, a Rwandan who was studying at the University of Newcastle. Like many of his compatriots he was passionately patriotic and determined to return to his country after his studies. Unsure of Clare's willingness to move there, they didn't marry until February 1994. They married in Australia and honeymooned in Zimbabwe, Uganda and Rwanda.

To Clare and Louis' horror, on return to Australia, the news of the commencement of the April – July 1994 genocide filtered through.

Both felt a determination to help the country. Louis returned for a visit in 1995 and resettled his parents in Rwanda – they had been living in exile in Uganda. Clare and Louis returned in 1998, with two young sons for a four month visit, to a country still struggling with high community tensions and poor infrastructure. National infrastructure had been destroyed by the retreating Hutu army and its supporters. Most stores stocked bars of soap and candles only.

Clare applied for a position at the King Faisal Hospital and was appointed Unit Manager for Critical Care, while Louis, an information systems specialist, was appointed to a senior position in the Ministry of Finance.

Clare's work at the hospital continued over the years. She became Director of Nurses Services and held this position for eight years. She is now the Director of Continuing Quality Improvement, co-ordinating the hospital's program for international quality accreditation.

She both managed and taught over the years, contributing significantly to turning the facility into the tertiary teaching hospital it is today.

Training of nurses was initially on-the-job, with Clare working in each ward on a day-to-day basis. To address the need to build local capacity, she has worked with the institutions that train nurses and has arranged for nurses to be trained in Kenya. The lack of standards and regulation is now being addressed with the establishment of a National Nurses and Midwives Council and improvement of the programs offered by the national training institutions for nursing and midwifery. Funding is an ongoing challenge along with managing demand.

The aftermath of the 1994

genocide is still evident today with post traumatic stress cases both in patients and staff, and continuing issues of trust between the rival groups. As doctors become better educated and trained as specialists (many of whom have studied abroad), there is the challenge of educating nurses to the required level of specialisation to support them.

Capacity-building remains the biggest hurdle and while the hospital has made extraordinary progress, there is still a long way to

There is an ongoing need for skilled medical people – nurses, medical GPs, specialists and many allied health professionals and administrators – to build capacity. People who are prepared to contribute their skills both to patient care and to building the skills of the local staff. If you are interested in a short visit as a volunteer or a stint of six months or more there are opportunities for you to really make a difference.

On both professional and personal levels, Clare has faced

The aftermath of the 1994 genocide is still evident with post traumatic stress cases

go in all fields. Australians have contributed to building skills, including Clare and three other Australians, as well as one New Zealander. One Australian is into her fifth year, heading up the nurse training in Internal Medicine and other cross-cutting elements, such as Infection Control and Pain Management. Forty-five Australian health professionals from Operation Open Heart visit each November and perform open heart surgery on some 30 children. A similar group comes from the USA each April to treat adults.

many challenges over her time in Rwanda. Louis died in an accident eight years ago, three weeks before the birth of their daughter. Yet Rwanda is a country with big dreams and its leadership is determined to achieve these. It is physically beautiful, safe and free from corruption. Through all this, Clare has maintained her commitment to the country.

Clare can be contacted on ckaribika@gmail.com if you would like to make a contribution to a worthy goal: building the health services of the new Rwanda. 



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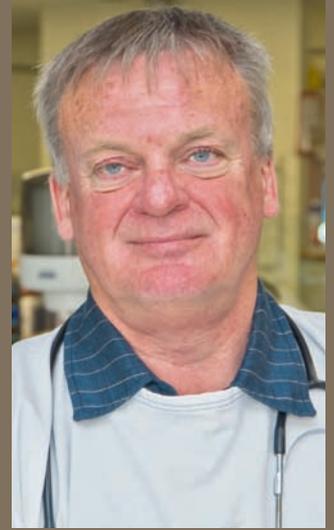


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KEN HILLMAN

Professor of Intensive Care and Director of the Simpson Centre for Health Services Research, University of NSW

Diagnosis of Dying

Ken Hillman discusses the difficulties around end-of-life care in hospitals



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More than half of all Australians now die in acute hospitals. The way death and dying is handled in our society has changed markedly over the last few decades.

Around the middle of the last century many illnesses were dealt with in the community by general practitioners. Then there was an explosion in what modern medicine could offer; new drugs such as antibiotics, chemotherapy and drugs to treat severe cardiac and respiratory problems; diagnostic machines which could pinpoint problems anywhere in the body; complex surgical procedures; non-invasive inventions to unblock arteries, stop bleeding and refashion heart valves; and sophisticated machines in intensive care units (ICUs) which could keep a body "alive", even when there was no hope of recovery. There are reports of the newest miracle drugs and life-saving procedures almost on a daily basis. Is it any wonder that society is given the impression that death may soon be a thing of the past?

Medicalised death

The reporting of medical advances is reinforced by TV programs that almost invariably show patients being saved by astute doctors and high technology. A recent study showed that, according to every US medical drama aired over several months, survival after cardiac arrest in acute hospitals was approaching 80%. The real figure is more like 10% and many of those die soon after discharge from hospital.

Although ageing, dying and death are inevitable, they are somehow buried (excuse the pun) among reports of new diets, gyms and plastic surgery. Interestingly, our news is full of distant deaths as a result of wars, accidents and natural disasters but there are few images of a peaceful and natural death involving an old person that we can all relate to.

In the 1950s, similar to the dying process now, the birthing process was medicalised. Women usually had their babies in a specialised obstetric hospital. The baby was removed from the mother and placed in a room with other babies. Fathers not only were not permitted to be at the birth, they could only view their child, along with all the other babies lined up in the

large room, through glass windows.

Acute hospitals are now the flagships of health care. They contain the technology and expertise necessary to sustain life. When serious illness strikes, people ring the ambulance. In Australia, ambulance personnel do not have discretionary powers to not take a patient to the nearest hospital, even if it is beyond doubt that there is nothing that the hospital could offer and the patient was naturally and inevitably dying. Usually the ambulance delivers the patient to the emergency department where they are rapidly assessed and, if necessary, life-saving treatment commenced. Emergency departments are geared for resuscitating and packaging patients. In an emergency situation, there is little time to decide whether further treatment is appropriate or not. Even if the patient has expressed a wish not to have invasive treatment at the end-of-life, there are many "ifs and buts" around that statement. What if the patient has a cardiac rhythm which is causing a low blood pressure and a decreased level of consciousness and, when cardioverted, the patient immediately returns to normal and is discharged from hospital soon after? What if the patient has fallen off a ladder and broken ribs but with life support treatment in intensive care, they make a full recovery and are discharged home to lead a normal life after a week in hospital?

These are difficult challenges with serious implications for patients and their carers. As a result, staff in the emergency department usually commence resuscitation and manage patients. They are then admitted to hospital; either to a general ward or to a specialised unit such as a coronary care unit or ICU.

Determining prognosis

The question of prognosis now begins to have more meaning. It is often difficult at the initial stage of treatment to be certain of the prognosis. However, if the initial resuscitation has been successful, it is a good time to stand back and assess more accurately the situation.

Many other factors can now be considered including: the age of the patient; the underlying medical problems; their physical and mental functional state; as well as the nature of the acute illness that necessitated their admission to hospital. The wishes of the patient, if



There are real challenges facing the system, not least the prospect of an ageing population and the great demands this will inevitably place on the system.

advanced directives have been discussed, can be a powerful factor in deciding whether further active treatment should be contemplated.

In a younger population, the severity of the acute illness which precipitated the admission is the most important factor in prognosis. In older patients, the acute problem responsible for hospital admission may be relatively trivial but the patient, because of their underlying health status, may only require a small insult to suffer a life-threatening illness. One of the major challenges for medicine is that it is difficult to accurately measure the underlying reserve of an older person. It is often a surprise to relatives to be told that their loved one has a high chance of dying. They often respond by saying something like – “but they were perfectly well yesterday”. The extent of ‘reserve’ and the definitions of ‘futility’ can often only be evaluated in retrospect.

And so, when there is doubt about prognosis, a titrational approach is often used. Where there is significant uncertainty, it may be, after discussion with the patient and/or their close ones, that it is appropriate to trial a course of aggressive and invasive therapy, even escalating to life support machines. This needs to be accompanied

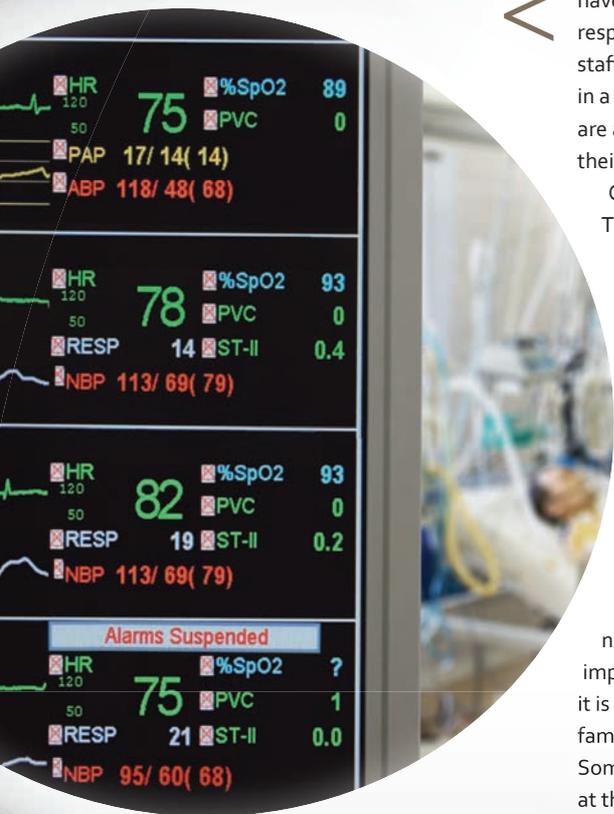
by transparent and honest discussion about the strategy. There may be rapid improvement and the patient may live with no long term consequences of the serious illness. However, more often than not, a state of equilibrium is reached. The drugs and machines are keeping the patient alive – there is neither improvement nor worsening in the condition. It is then that serious questions arise about the value of sustaining ‘life’ in those circumstances. Apart from the broad issue of ‘ethics’; there is the suffering of the patient, suffering from the tubes and devices necessary to sustain life; as well as the fear from being unable to communicate because of the tube in the patient’s throat.

Difficult decisions

In this situation, several predictable challenges arise. The patient is usually unconscious as a result of sedation or the illness. Relatives are left with decisions about

continuing active management. Relatives may perceive the whole decision of life or death rests with them. The law is not clear around this issue and probably for good reasons. It is not black and white. Many would consider it unfair to give the responsibility of life or death to the closest relative. Moreover, physicians do not have to continue to institute what they consider futile and cruel treatment. An experienced physician in intensive care will not make the relatives make this decision alone. They will state that despite everything being done, their relative is dying and that further measures would be futile. They usually state that it is not a decision that either the relatives or they





have to make; the patient has made it by not responding to conventional measures. Usually staff and relatives work through this process in a constructive way, where grief and sadness are acknowledged and they are reassured that their loved one will not suffer any pain.

Occasionally, a different discussion occurs. The relative knows that the drugs and machines are keeping the patient alive; they know that if they are withdrawn, they will die; they argue that miracles happen and demand that active treatment is continued until death naturally occurs. The problem is that 'natural' death sometimes is not allowed to take its 'natural' course.

Perceptions in the community are often around miracle drugs and procedures capable of prolonging death indefinitely. That death is no longer a natural outcome of life. It is rare that this impasse occurs for more than a few days but it is uncomfortable for hospital staff and the families. Mistrust and antagonism can occur. Sometimes there are unresolved family issues at the heart of the matter. Often, it is just the

chronically affected and coming near the end of its use-by date, being supported by various drug combinations. But illness involves many organs failing simultaneously, and during that process, affecting each other's function. They cannot be looked at in isolation when things begin going seriously wrong. As a result, the patient is the subject of 'committee' medicine, where each specialist tries to optimise the function of their own organ without necessarily looking at the patient as a whole.

This has made the diagnosis of dying difficult for specialists. When the patient deteriorates on a general ward, they are increasingly subject to a system first described in Australia and commonly known as the Medical Emergency Team or MET concept. It comprises a way of recognising at-risk patients early and then responding rapidly to their needs. Unfortunately the system picks up patients who are naturally and inevitably dying as well as those where further active treatment is appropriate. As a result, because the intensive care specialist is involved in the response they are increasingly making the diagnosis of dying, because they are the ones who decide whether further active management would influence the outcome of the patient. Their job is made more difficult when, before they see the patient, specialist colleagues ask patients and relatives, "Do you want everything done?" Phrased like that, relatives often feel that, of course, they would want everything done. What is not explained well is that any further active treatment will be futile and, therefore, not appropriate.

In summary, management of end-of-life in acute hospitals is often inappropriate and cruel. Nevertheless, there are pressures to place people at the natural end of their life on a conveyer belt from their home to the hospital and from there into an ICU to spend their last days connected to machines when there is no hope of recovery. The reasons why this has happened are complex and include: societal expectations about what modern medicine can offer; the fragmentation and specialisation in medicine; the reluctance of doctors to discuss death and dying; lack of community resources to support the dying and their carers in the home; the low profile of palliative care; and fear of litigation. This is creating enormous problems for society in terms of the increased cost of healthcare as well as unfair burdens on patients and their carers when their dying process is not managed appropriately. 

We must not sit back and wait for the Federal Government to tell the States what to do, but instead ensure that the necessary discussions take place.

pure grief at having to accept the inevitability that their loved one will die.

It can also be difficult for some to distinguish between euthanasia as opposed to withdrawing and withholding treatment on patients whose life is temporarily being supported by technology. Euthanasia is the deliberate taking of life, whereas withdrawing existing therapies or withholding potential therapies is done when there is no hope of survival.

Committee medicine

End-of-life issues are increasingly occurring in patients being managed on general wards outside specialised ICUs. This is often the result of increasing specialisation in medicine. Doctors become experts in one part of the body without necessarily seeing it in the context of the whole person. Their organ may be

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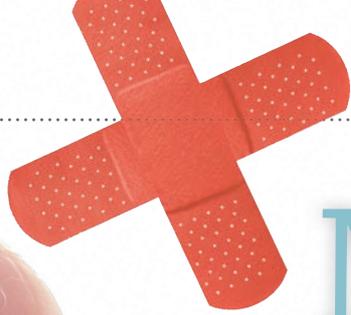
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Making the workplace safer

Sharps safety and needlestick injury prevention

h EALTHCARE professionals and other organisations in the healthcare sector have formed a coalition to address the issue of sharps safety and needlestick injury prevention in the healthcare workplace. Every needlestick or sharp object injury at work is a foreseeable hazard to healthcare employees in Australia. The elimination of workplace hazard and risk is a fundamental principle of occupational health and safety legislation. The risk of occupational exposure to blood borne pathogens from a needlestick or sharp object injury can and must be eliminated.

Background

In Australia, it has been estimated that at least 18,000 nurses and other healthcare employees suffer needlestick and sharp object injuries every year. Numerous studies have shown that approximately 50 per cent of needlestick injuries are not reported, with rates of under reporting ranging from 40 per cent to 80 per cent. Therefore the actual number of injuries to healthcare professionals is likely to be in excess of 30,000 per year.

A 2008 report on occupational exposures of Australian Nurses [ASCC 2008] found that needlesticks and other sharps are identified as high risk occupational hazards by 43.5 per cent of nurses. The report also shows that one

It has been estimated that at least 18,000 nurses and other healthcare employees suffer needlestick and sharp object injuries each year.



in nine nurses had at least one needlestick or other sharps injury in the previous 12 months. These injuries generate significant cost for the Australian healthcare system and can result in great stress for the injured healthcare workers and their families.

Global picture

Many overseas jurisdictions have already mandated the implementation and use of safety engineered needles and other sharps in medical workplaces.

However, Australia has yet to adopt a nationally consistent approach to the use of safety engineered medical devices (SEMD) in healthcare settings either through prescriptive legislation or policy. Guidelines, awareness and education campaigns and other non-legislative initiatives alone have generally proven ineffective in the prevention of needlestick and sharp object injuries in healthcare.

Jan's story

Behind the statistics are the personal stories.

"In January of 2002, I had a needlestick injury at work while taking blood from one of my HIV patients. It happened in a split second and changed my whole world."

Jan's story was enough to move participants into action when they heard her speak at a Parliament House healthcare roundtable held in Canberra in March 2009.

Jan had just taken a blood sample from one of her regular patients who was HIV positive, when he suddenly became unwell. Her attention was momentarily diverted and the sharp tip of the needle pierced her hand. Two months later, Jan was diagnosed with occupationally acquired HIV.

The diagnosis changed her life. She had to give up her job, endure months of debilitating drug therapy and had to come to terms with the fact that her life and those of her family had changed forever.



Australia trails behind its contemporaries in taking concerted and consistent action to address the ongoing issue of needlestick injuries at work.

Coalition approach

The recently formed Coalition for Needlestick Injury Prevention in Healthcare has broad-based membership including the Australian Infection Control Association, Australian Nursing Federation, Infection Control Plus Pty Ltd, Medical Technology Association of Australia, Royal College of Nursing Australia, and the Royal College of Pathologists of Australasia.

The aim of the Coalition is to ensure that all healthcare employees in Australia are protected from the hazard of occupational exposure to blood borne pathogens from needlestick and sharp object injuries and the subsequent risk of acquiring a potentially life threatening blood borne disease such as hepatitis B, hepatitis C or HIV/AIDS.

Independent studies show that the majority of needlestick and sharp object injuries are preventable through the implementation and use of SEMD combined with relevant education and training programs for healthcare employees.

The Coalition believes that the action required is three-fold, to:

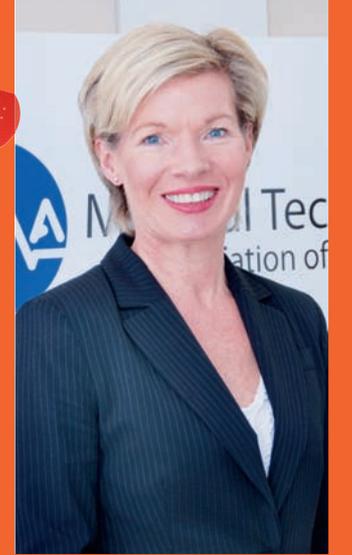
- Improve the education and training of all healthcare employees and other stakeholders on the importance of sharps safety and needlestick injury prevention;
- Require a standardised national system for monitoring and reporting of occupational

exposure to blood borne pathogens; and

- Incorporate into occupational health and safety standards/legislation and into healthcare safety and quality standards, the mandatory use of safety engineered medical devices in our healthcare system.

The provision of a safe and healthy working environment is a fundamental right of every employee in Australia. The safety of all healthcare employees must be viewed as paramount and is everyone's responsibility.

Let's not forget that safety for healthcare employees is as important as patient safety. [ha](#)



ANNE TRIMMER

Chief Executive Officer of the Medical Technology Association of Australia on behalf of the Coalition for Needlestick Injury Prevention in Healthcare



Images: iStockphoto

Innovation under Public Private Partnerships

An architect's view

t HIS PAPER REFLECTS research undertaken to examine claims that innovations have been made in the architecture of hospitals procured under the Public Private Partnerships (PPP), and the earlier British version of Private Finance Initiatives (PFI). The research methodology used was to examine literature published regarding PFI/PPP hospitals in the years from 1997 to 2009 and through interviews and an email survey of architects and managers involved with the PPP process. As the model for hospital PPPs is predominantly a Commonwealth country approach, only people in the United Kingdom (UK), Canada and Australia were involved.

The context of the British PFI/PPP design process

The history of PFI/PPP is integral with the history of hospital development in UK. Although there is a history of private and public interrelationships with Australian hospitals the formulation of PPP as it is structured in Australia today is essentially based on the British model.

Hospital building in the UK is characterised by post-war shortages and a stock of old buildings, many of Victorian era, which were unchanged well into the 1970s. As technological change increased, a number of alterations and additions occurred, but the kind of complete redevelopment with innovations seen in the mid 1970s at the Greenwich and the Oxford Radcliffe Hospitals were few and far between. After the 1974 oil crisis the public spending virtually stopped and then through

the 1980s projects dragged on incrementally over many years.

By the 1990s the Thatcher Government realised that hospital infrastructure was in a desperate state and despite a new recession they had to close the gap. Using the private sector philosophies so famous for Thatcher's era, the logical conclusion was to prevent another public borrowing spree by treating hospitals as commercial developments, built and maintained by the private sector and 'leased' by the government National Health Service for 25 to 30 years. The Private Finance Initiative (PFI) was initially offered to hospital trusts (the public hospital fund-holders) as an alternative way of obtaining capital through the private sector. Later under a Labour Government the process was refined, made more systematic and renamed Public Private Partnerships (PPP); suggesting private and public sectors working together in long term partnerships.

Immediately this enabled hospital trusts to seek developments by private consortia that raised funds, designed, built and importantly, maintained these needed facilities under long-term contracts for 25 to 30 years. Governments in all countries using PPP insisted on competitive bidding between consortia to ensure probity. A process that became incredibly expensive with costs borne by the consortia. Responsibility for the risks of the development, construction cost and time, as well as the risk for ongoing facility management



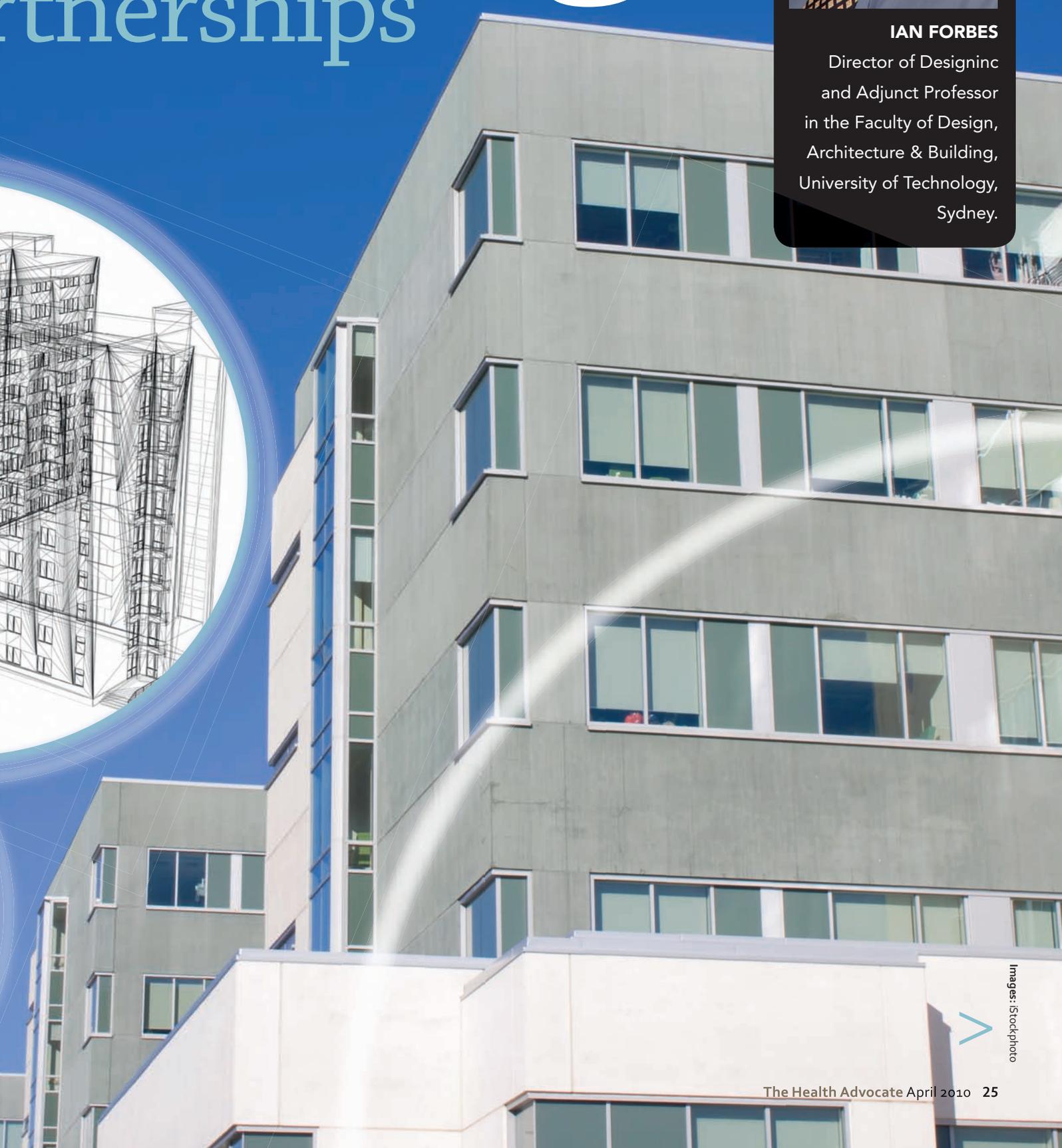
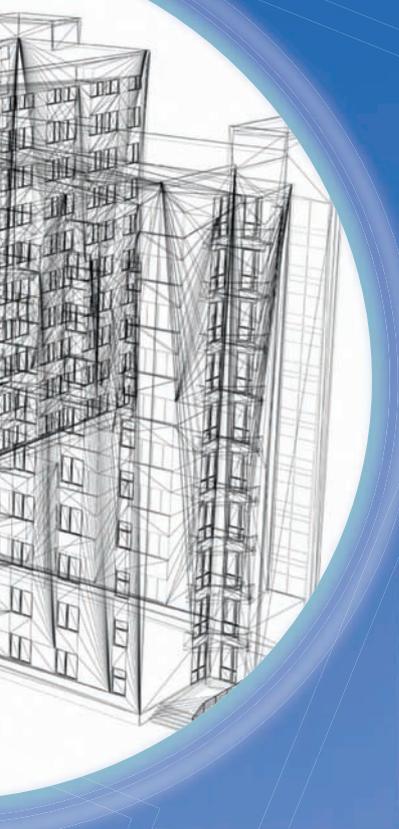
in design

Partnerships



IAN FORBES

Director of Designing
and Adjunct Professor
in the Faculty of Design,
Architecture & Building,
University of Technology,
Sydney.



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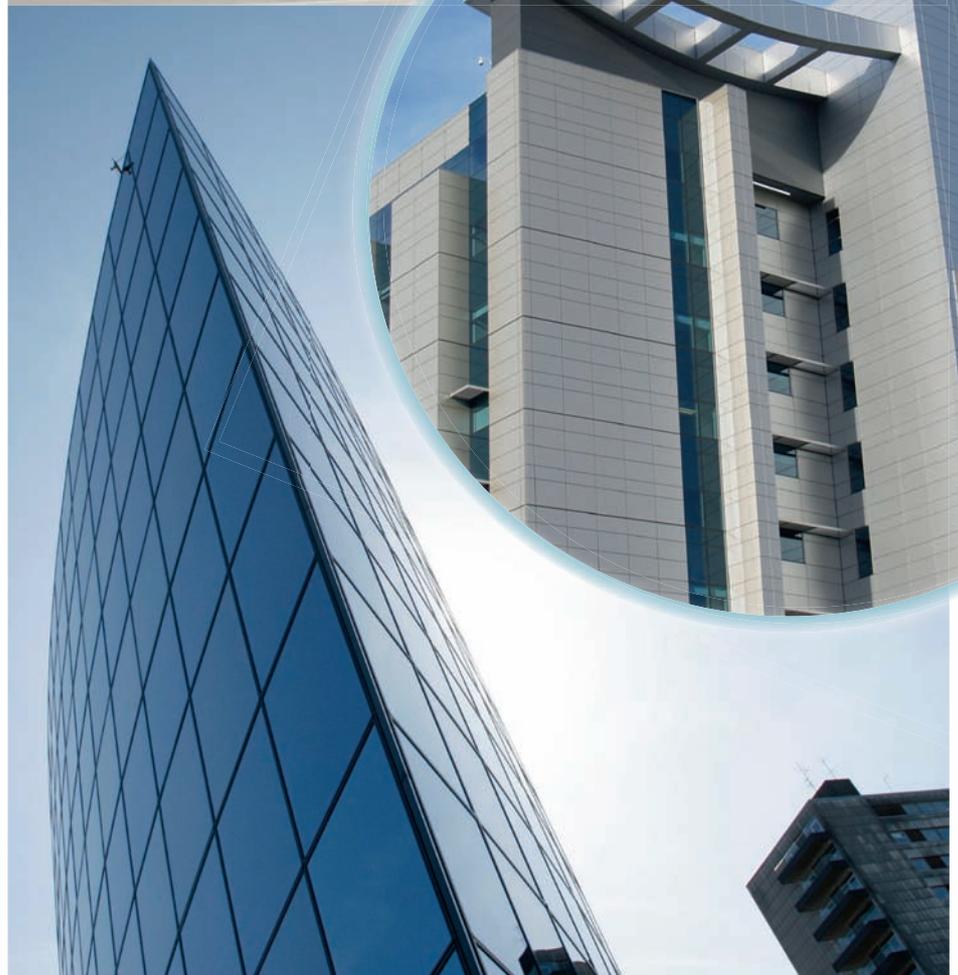
services, passed out of government hands to the private sector consortia. It was also believed that the construction industry would gain from supply chain integration and consolidation into larger units through this process although this seems not to have happened. Long-term contracts would guarantee private investment in these projects and major international investment groups were pleased with the idea of being able to take equity in public sector areas not previously available.

As evidence of success, the Royal Infirmary Hospital of Edinburgh had waited 50 years to be redeveloped, but under PPP was completed in several phases from 2002 to 2003 within a total project time of seven years. British Government statistics show that between 1997 and 2008 there were 139 projects approved under the PFI/PPP procurement regime with an expectation of an annual expenditure for the year 2009-2010 to top £2.25 billion. It is widely agreed that the objective of closing the gap in UK is clearly being achieved. In Australia, governments have followed the lead and where several billion dollar replacement hospitals looked too much for state treasuries, the PPP has been invoked to enable them to be developed now.

What were the claims made about design under PPP?

Architects involved in PFI/PPP projects claim the innovations in the design of PPP hospitals should be derived from the integration into one team of all parties responsible for the outcome of the building solution. In particular the presence of the facilities management (FM) firms was important. This meant that decisions about the cost of materials, finishes, fixture and fittings could be made as genuine life-cycle costing decisions¹ not the lowest initial cost, usually imposed to meet treasury-determined budgets and funding policies. With PFI/PPP the lower the 25 - 30 year net present value (NPV) the better the deal offered by the government through the tender process.

Another example at the Royal Infirmary project 2 was the introduction of higher quality finishes reducing maintenance costs. Adding basement service tunnels with extra lifts meant additional costs upfront to achieve a more efficient material distribution system. To improve the life of the fixtures they purchased prefabricated toilets of a higher quality rather than using in situ construction.



Many early innovations were in engineering service systems, and projects were able to report energy savings as well as improved physical environments for patients and staff. Most often the innovations were with their facades, the clustering of the buildings and the overall appearance of the buildings. They have taken a more commercial concern for image. Comments from architects, however, suggest this is the easiest area to achieve change where as clinical innovations are hard to measure or determine outcomes. We are currently seeing the same types of innovation in non-PPP hospital designs. Apparently despite the life-cycle cost philosophy, the lowest overall capital cost was still being sought to make the bid competitive and the best financial deal is what drove the winning solutions.

Have the PPP design processes produced better hospitals?

It would appear from evaluations of PPPs³ that there are many disincentives to good hospital design. This failing apparently comes from attempts during the tender stage to increase efficiency sought by the facilities managers, but not necessarily to improve the hospital's clinical operations. Authors believe the focus of concerns during the PPP design process, including projects in Australia, has not been with challenging clinical design aspects that reduce government operating costs. That is not a cost that the consortia must bear. What this suggests is that achieving better health outcomes through better facility design is left to the "tenant" and depends on how well the future operating expectations have been described. It would seem that the whole reason for why the facility has been developed has been missed in the PPP process.

In the PPP tender, the brief, which has traditionally been the essential guiding document in design, was not always able to be thoroughly tested with the client user groups before tenders closed. This still holds despite the increased interaction with the consortia teams in recent projects. In major hospital projects in Australia, where there is no PPP, considerable operational innovations have been achieved by continuing clinical interaction, often moving away from the brief's



There is no doubt that an amazing number of hospitals have been built in the UK in a short period of time since the PFI process began.

initial clinical operational models. This lack of consideration for local facility-specific solutions has been consistently cited as a major problem with PPP design outcomes.

Apparently the lack of incentive, but importantly the lack of time during the PPP's frantic and incredibly expensive bidding process, meant no examination was encouraged that might lead to operational innovations for fear of delays. Solutions are based on current best practice, not evidence-based design and tenderers address the letter of the brief, regardless of the document's quality or comprehensiveness. It would also seem that although achieved in some cases, there has been no great incentive to make the physical environment more healing and supportive, especially when it might clash with facility management's concerns for the cost of the facility.

What is the future for PPPs?

There is no doubt that an amazing number of hospitals have been built in the UK in a short period of time since the PFI process began. Similarly in Australia stalled projects have moved forward under PPP. However, it is only now that health system questions are being asked about what should have been built and in what locations. It is clear that only minimal operational and clinical efficiency innovations have occurred in the large number of UK PFI/ PPPs. Clearly the quality of designs achieved

have mostly been in their built form, while the clinical solutions depended on how informed the health planning design teams were and how many new operational ideas were possible to incorporate during the probity-driven tendering process.

PPP/PFI was initially seen as a solution by governments who were limited in funds and borrowing capacity, either real or politically perceived. Closing the hospital backlog gap was a high priority internationally but now the quality of the product achieved is raising questions about whether this process can produce all of the innovative outcomes desired. It is important for Australian governments to consider whether the impetus that created the PPP phenomena in the UK still holds true in Australia today before deciding to commit to further such hospital developments.

1 *The Role of Lifecycle Costing in Capital Investment in Healthcare Facilities (2007)* eds: Barrie Dowdeswell and Jonathan Erskine: Report for the European Health Property Network.

2. Stark D, (2006) *Healthcare Procurement Methods in Design & Health VI: Future trends in Healthcare Design* edited by A. Dilani. Stockholm: International Academy for Design & Health. pp93 – 98

3. Scher P, (2004) *An Eye on PFI HD - Hospital Development* Wilmington Media Ltd: London, April. 



DR PATRICK BOLTON

Associate Professor and Vice President of the Australian Healthcare & Hospitals Association

Respecting patients wishes

Patrick Bolton gives us his combined medical and legal insight on **Advanced Care Directives**

IT IS widely accepted that the increasing cost of healthcare is unsustainable. It is known that the greatest part of the cost of healthcare to individuals arises in the last few months of life. An examination of end-of-life care might suggest opportunities to improve the efficiency of healthcare.

Advanced Care Directives (ACDs) or Living Wills provide one such opportunity. An ACD is a statement which sets out a person's desires regarding medical treatment in the event that the person cannot do so as a result of disease or injury.

Surveys consistently show that around two-thirds of adult Australians would complete an ACD if supported to do so. Between 70 and 95% of Americans have indicated that they would prefer no treatment to aggressive treatment where their prognosis is limited. Acknowledging that "no treatment" should properly be read as "being made comfortable", these data suggest that ACDs represent a significant opportunity to better focus the use of health resources and meet the expressed needs of patients. Disturbingly, there are some data that people who have had an ACD are less likely to die than those who have not. High cost, high

complexity healthcare may not be beneficial, at least for patients at the end of life.

There is legislation supporting the use of ACDs in all states except Tasmania and NSW. The legislation in all states except Queensland provides for the operation of the common law ACDs. In this respect, the 2009 NSW Supreme Court decision in *HNEAHS v A* is of national importance because it confirmed the common law right of a person with an ACD to have the ACD complied with. The Court found that a failure by a healthcare worker to adhere to an ACD could amount to the tort of assault. The legal doctrine of precedent means that one would expect this decision to be applicable in other Australian jurisdictions.

The case drew out the tension between historical rights: On the one hand the interest of the state in the lives and health of its citizens. On the other, the right of an individual to autonomy and self-determination. Review of the legal cases which consider ACDs reflects this tension. There are legal cases in which my personal interpretation of the facts leads me to believe that the person completing the ACD would not have wished for active measures in the circumstances that arose,

although the court disagreed. In some of these the court has not upheld the ACD, sometimes for reasons that I think have more to do with values than logic.

I recall being surprised to discover a healthy 70-year-old who did not want antibiotics if she had pneumonia requiring intubation, notwithstanding the probability of a full return to her current condition with therapy. The patient was not depressed or suicidal. On discussion, it was clear that she simply felt that if death without treatment was relatively painless she was happy to accept that her number was up.

it inapplicable. It may not be possible for an ACD to be framed specifically so as to capture every possible eventuality. The court in *HNEAHS v A* encouraged healthcare workers to seek the assistance of the court in interpreting ACDs in this circumstance.

The rise of ACDs and the decision in *HNEAHS v A* create some challenges for healthcare providers. Firstly, how do you document that a patient has an ACD so that this information is available to clinicians in a timely manner? This is particularly important when we know that this information needs to be

Surveys consistently show that around two-thirds of adult Australians would complete an ACD if supported to do so.

The main issue that courts and others grapple with in the interpretation of ACDs is the applicability of a generally expressed ACD to unforeseen specific circumstances. The question is whether the actual circumstance is sufficiently different to the one the person had anticipated when they were making their ACD as to make

available and prominent in an unanticipated arrest situation. Secondly, how do you support staff who may have provided care consistent with an ACD but contrary to their own values, or conversely have breached an ACD in order to provide care consistent with their values, and perhaps those of the hospital and/or broader community? 

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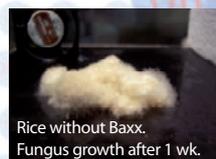


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 - MRSA, C.DIFF(SPORE FORM) AND NOROVIRUS

The right care for the elderly

Enhancing the interface between **aged**, community and acute health settings to achieve **better care**

aS OUR governments tell us that the health care system is under pressure to meet the needs of an ageing population, the media continues to report that older patients are stuck in hospital as they have nowhere to go and that wards are full of elderly people taking up beds. The burden of ageing on the health care system and burgeoning

costs has become a political agenda. Have we failed our older citizens by blaming them rather than taking a more responsive role in working to provide creative solutions to meet their ongoing needs?

We know that Australia has an ageing population, people are living longer and the birth rate has dropped. Ninety per cent of health care is spent in the final few years of

our lives. It is a challenge to provide the right infrastructure and the right workforce to cater for the ongoing care needs of older people in the midst of evolving technology, rising consumer expectations, and an increase in chronic disease.

The pressures on health services across community and hospital settings are numerous, including the expectation that

increasing the number of beds in ED and acute care will solve the problem. As a colleague recently commented, what we do "is to torture the elderly to prolong the inevitable". The elephant in the room in health care is about deciding where health care intervention is required to support life and where support for care at the end of our lives would be more appropriate.

Older people have different health care trajectories that are influenced by where they live, their age and health status including mental illness and or chronic disease. Older people's entry into health care, community services and residential aged care fluctuates depending on the system's ability to respond to their care needs at any given time. For example, being admitted to hospital via an emergency department has become a default for care due the increasing complexity of older people's health care needs and the lack of capacity to set up and maintain supportive care environments in community and residential aged care sectors.

Health care reform based on a community oriented primary care sector is integral to providing flexible and receptive care. This means working with and forming partnerships

between the profit and not-for-profit community services, building greater flexibility into health care models and working with older people to help them determine their own pathway of care in older life. For example, an older person with respiratory problems that fluctuate should find it easy to have: oxygen at home, additional home help in those weeks when breathing problems exacerbate, phone and email linkages to general practitioner, pharmacist and specialist to monitor symptoms and adjust medication, in addition to the usual visits to the doctor and physiotherapist to manage symptoms early and prevent deterioration.

There is also strong capacity for the broader service provider network (community and residential aged care) to be drivers with health services in providing this care. The development of multidisciplinary and intersectoral service approaches that manage risk and/or restore health and function of individuals can work to avoid admissions to emergency departments and subsequent admission to hospital. Current service models in NSW such as Healthy at Home and ComPacks have been innovations that engage with the service provider network outside health services. They provide case management and brokerage funding models



LORRAINE LOVITT

Leader of the NSW Falls Prevention Program at the Clinical Excellence Commission



BRONWYN WILKINSON

Director of Catch Consulting



< with the ability to be flexible and responsive to need. These services are based on short term interventions to address service gaps until the usual services are available to support the client long term, and case management which assists people and carers to develop self-directed short, medium and long term plans of care. This is followed by assistance to navigate the service system and facilitate the provision of restorative and proactive care. Case managers ensure continuity of care, integration of service provision and a collaborative care plan that fosters effective communication between the person, carers and all providers in the service sector. This can lead to better decision-making and agreements for ongoing care needs when an older person is coming towards the end of life.

Mr S, a 76 year old man had been in hospital for 6 weeks and had declined a hostel placement. He wanted to go home but there were no services in place and the hospital team were concerned for his safety at home. He had dementia and no family support. He had refused to sign documentation for respite or any other service referral. A Community Options case manager visited him in hospital and he agreed to accept ComPacks support as a way of getting home safely. The case manager met him when he arrived home and he refused any help. After several weeks of twice-weekly visits to build his trust, he agreed to have safety rails installed for the bathroom and front and back steps. He also agreed to assistance for heavy cleaning. Soon after, he received dementia support services to have meals prepared and bills paid. The case manager made contact with his GP as he agreed his health was deteriorating and his self-medicating preferences were not bringing an improvement in his health. Finally, he agreed to a referral for a Community Aged Care Package (CACP) and he is successfully living at home with his needs monitored by his GP and through CACP services.

Enhancing the interface between aged, community and acute care settings requires investment in:

- A single point of contact, as opposed to multiple options, that enables direct access for people and carers to appropriate services, early intervention and information. These contact points accept referrals from general practitioners, chronic care service providers, hospitals and residential aged care services;
- IT infrastructure that enables providers to communicate with each other and share



When we are older we'd like to be involved in discussion about our health care, and to access coordinated short-term services and ongoing care if required

information about documented assessments and care plans supporting service needs; and

- Improved coordination of care, to utilise health assessment, case conferencing and care planning with general practitioners and other service providers. The benefits are proactive monitoring, early identification of signs of deteriorating health, physical or psychosocial function, which trigger early assessment and short-term care coordination or additional service provision. The timely outcome of this approach is to relieve the person's and carers' anxiety and stress with a plan of care that promotes wellbeing.

When we are older the way we'd like things is pretty straight forward: to be involved in discussion about our health and care options, and to access well coordinated short-term services and ongoing care if required. We would like a system to support periods

of acute illness and chronic illness through self-care and management to maximise our functional status and accommodate impairment. In fact, we want to be treated with respect by a system that can support care that manages illness and end-of-life care, not too late and very well. [\[12\]](#)



The Intergenerational Report



JUDITH DWYER

Professor of Health Care Management at the Flinders University School of Medicine

Judith Dwyer asks, can baby boomers change the health and aged care future?

AS AN ageing baby boomer myself, perhaps I should declare my interest. Like most people, it's not my ambition to be a burden on the health and aged care systems, although I confess to an increasingly intimate relationship with the pharmaceutical industry – all in order to stay healthy, mind. It's good to see that the doomsday approach of the first *Intergenerational Report* (2002) – 'we're about to drown in millions of pesky empowered oldies' – has been toned down a bit in the latest one (2010).

But the projections are still scary. Health and aged care spending, plus increased pension payments, remain the major future pressures on the federal budget, with Federal health spending estimated to almost double in GDP terms over the next 40 years (from 4% to 7.1% by 2050); Federal aged care spending more than doubles (from 0.8% to 1.8%); and age and service pensions increase by almost half (from 2.7% to 3.9%). Total national Government spending goes up by only 1.1% of GDP over the 40 years (that is, of

course, a lot of dollars), but together, health, aged care and pensions grow to be nearly half of that total Federal spending. The main shrinking sectors are defence and education.

But don't leap to the conclusion that we really ought to send every third baby boomer out to the desert to die cheaply – less than half of the predicted increase in spending is due to population growth and ageing combined. The rest comes from 'demand for higher standards of care' and 'rapid technological innovation' (p51) which presumably benefit everyone, not just the oldies.

There are two important omissions in the report's extensive modelling of our health and aged care futures. Firstly, for the frail and bewildered aged, there is an assumed trend away from low-care residential places to community care (with a matching increase in the costs of support for carers) – let's hope they're right about that. But there is no recognition of caring responsibilities as a barrier to workforce participation by older

people (p30) – Treasury needs to talk to older women more.

Secondly, the projections of hospital costs appear not to include any thought of change to the admission rate of older people, particularly those over 85, for whom it is desperately high. We need to do more than hope that they're wrong on that one. While it's not for Treasury to figure this out, it would be pretty awful if we are not able to do anything in the next 40 years to change the way that we deal with the last years of life.

themselves and, for different reasons, no-one else was able to speak for them. They seemed destined to stay there – not a good place or way to die. Given the choice, I think more than half of us would rather be that one who could and did decide.

Here is where the baby boomers might pay their way – we might be able to seize more control of our endings, and achieve gentler good nights than our elders are currently allowed. And that means more focus on making Advanced Care

We might be able to seize more control of our endings and achieve gentler good nights.

I will never forget seeing a group of five elderly 'long stayers' on a visit to an adult ICU – all of them were going to die; and only one was conscious. That one had declared her intention to stop treatment and she was on her way home. The others were not able to speak for

Directives* workable, and more provision for timely serious discussion with one's healthcare providers. Activism may again be required, but we're good at that – provided we get to it while we can still remember what it was.

*See Patrick Bolton's article in this issue. [ha](#)



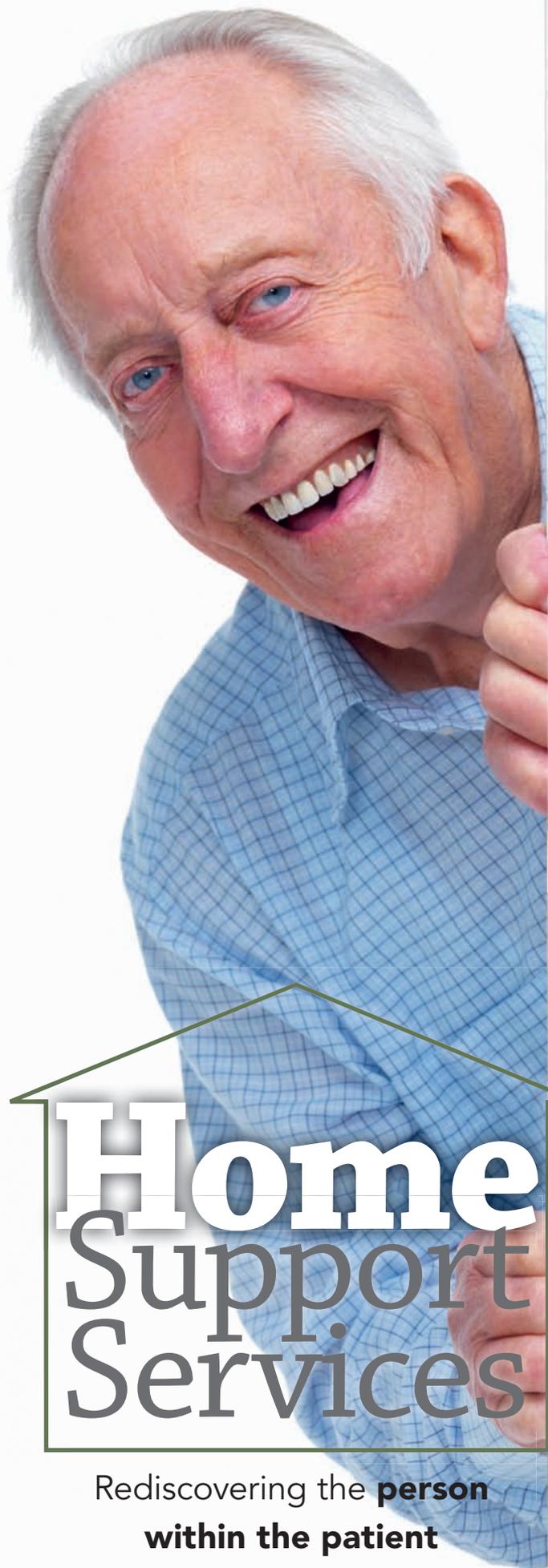
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Home Support Services

Rediscovering the **person within the patient**



VIRGINIA BULLOCK
Managing Director of
Home Support Services

traditionally speaking, patient care has been based on the identification, treatment and management of disease; the medical model. A patient visits their local clinic or emergency department with a set of symptoms and these symptoms are consequently analysed, diagnosed and treated. The patient returns home with their diagnosis and six months later re-presents to the clinic or ED with the same set of symptoms; the true cause of their presentation not resolved.

It goes without saying that the classification and treatment of illness is absolutely fundamental to patient care. But by reducing the patient to a biomedical nomenclature of their symptoms, we run the risk of overlooking the root cause of the presentation – the underlying psychosocial, environmental or behavioural aspect that may be causing that patient to re-present in our already overburdened healthcare system.

The medical model in perspective

For illnesses which are isolated events in a patient's life and for which medical or surgical intervention is the only option, the medical model remains necessary. However, as our lives become increasingly complex, so too do our health complaints. As a result, it is no longer enough to simply address the physical symptoms of our illnesses when the underlying cause of these symptoms

is often intrinsically linked with the extenuating circumstances of our lives.

The medical model, which has dominated healthcare for so many years, has little room within its framework for the impact of social, psychological and behavioural dimensions on a person's broader healthcare issues. To appropriately address a patient's needs and stop the cycle of unnecessary GP and hospital presentations, one cannot isolate the home support structure, environment, mental health status, psychosocial and family situation. These areas are interrelated, and require equal attention to understand what our patients need to continue to safely manage within their own homes.

Moving forward

Investigating the medical model verses holistic care debate demonstrates that Australia is moving away from the traditional view; partially due to limited resources and an ever increasing demand for hospital services. Consequently, the role of a more holistic framework of care is becoming increasingly accepted as a preferable mode of care delivery.

The health reform agenda supports this shift with recommendations built on a framework moving towards community-based hospital avoidance programs with an increased focus on the holistic model. This framework affirms the value of service integration, the delivery of wellness and targets comprehensive health service providers to ensure the best opportunity for improved outcomes.



Rediscovering the person within the patient

Before a holistic framework of care can be implemented we need to learn to listen; to rediscover the person inside our patient. This involves not only addressing physical anomalies but devoting time to unravelling the layers of psychosocial and environmental factors which may be contributing to a patient's illness. Furthermore, we need to listen not only to their immediate concerns, but to what they will need to ensure their health and independence is maintained well into the future.

By truly listening to our patients and implementing a care plan based on a holistic assessment, we reintroduce the concept of patient-centred care. We are able to uncover the root cause of a patient's problem and implement a range of targeted interventions to surmount it. By doing so, we increase the probability that patient will achieve and sustain a positive health outcome.

Home Support Services (HSS) and its

community-based provision of hospital avoidance care are at the heart of the government's health reform agenda reducing pressure on the hospital system through the delivery of holistic care across three states; South Australia, Queensland and New South Wales (northern area). At HSS, the philosophy of patient care is centred on holistic assessment and care delivery; discovering, addressing and treating the root causes behind a patients' presentation to hospital or community healthcare setting.

Case Study: Edith

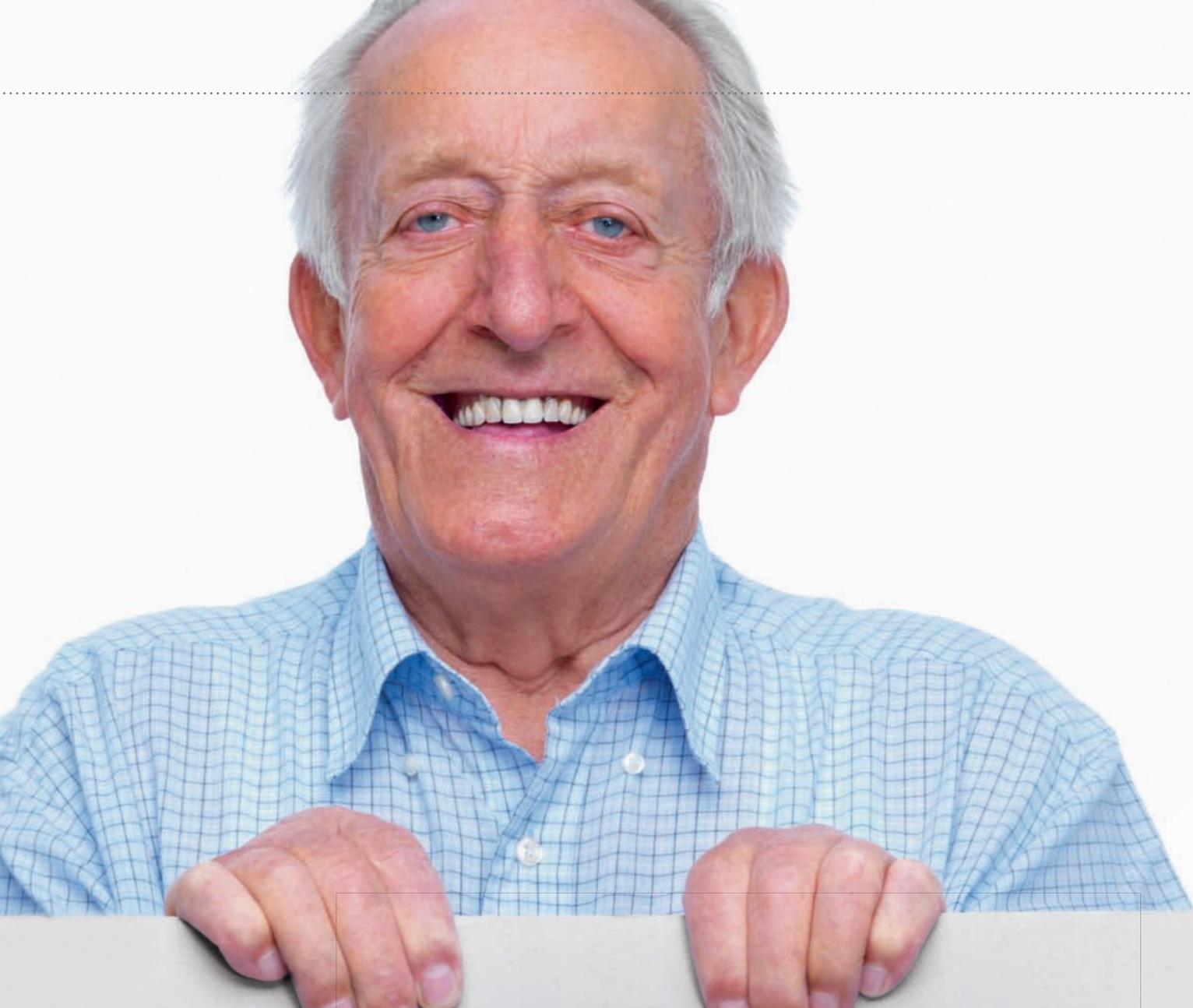
Edith is an 84 year old lady who presented to the ED with a soft tissue shoulder injury after a fall at home. A fall is never just a fall. It requires a detective approach to find the root cause. It has to be put into the context of a broader framework of the person's environment.

Edith wanted to go home, and was referred to HSS. As is often the case within this age group, Edith presented with co-morbidities: a history of falls over the past six months plus a diagnosis of

Parkinson's disease. The multiple falls meant that Edith was anxious and frightened and it was not just a matter of providing a walking frame, shower chair and some pain relief while the immobilised shoulder heals. A comprehensive look into what caused the fall in the first place was required.

To prevent Edith from extending her time in ED, HSS needed to provide the immediate actions of supportive mobility aids, visits for clinical care as well as meal preparation, shopping and personal hygiene as needed. Work was then done on discovering the cause of the fall.

It was determined that the fall was due to dizziness from the Parkinson medications and deteriorating vision. Edith received an assessment from a Registered Nurse Specialist in Parkinson's disease and suggestions and strategies were made to slightly alter the time the medications were due to fit into Edith's daily routine which would minimise the dizziness. These actions together with a pharmacy review, referral for a vision review, a call alert and more regular GP visits facilitated Edith to remain as independent as possible without further falls.



Case Study: John

HSS was contacted by a mental health community service for assistance with John, a 51-year-old gentleman with major depression. John had been placed on new medications. He lived alone, displayed some anti-social behaviour and became very anxious with any change.

The mental health community service key worker who visited weekly had noticed his anxiety was increasing and they were concerned he was entering a manic phase. The key worker did not think it was in John's best interest to go to ED or hospital as this would increase the risk of an exacerbation of a manic episode but realised he did require his regular medication. HSS was asked to visit twice daily starting that evening to settle John's anxiety, support with medication prompting and assist the new change transition.

Due to his anti-social behaviours, the coordination of his care required initial joint visits with the key worker until John was able to accept HSS staff. Joint visits were gradually weaned, John's anxiety eased, he was

responsible in taking his own medications, and as a result, John's anxiety and potential manic episode were controlled. He did not need to present to ED, and he was able to remain safely managed in the community. John was able to continue with regular visits from his mental health key worker following the Home Support Services episode of care.

In the case of both Edith and John, the medical model alone could not have adequately addressed the environmental or psychosocial impacts on their ability to self-care and sustain ongoing independence. These examples demonstrate that providing a holistic care model not only identifies proactive measures to prevent further loss of function but

addresses the root cause of issues that hinder ongoing independence.

Home Support Services' holistic model has broken away from the perceptions of a system-generated medical blueprint of disease and illness management, towards the concept that all aspects of psychological, physical and social needs are essential to address in order to prevent unnecessary GP and hospital presentations and to effectively care for the person in context of their situation and environment.

For more information and to contact Home Support Services, visit the HSS website at www.homesupportservices.com.au. This article was prepared with the assistance of Joanne Besanko and Emma Kentish at HSS.

By truly listening to our patients and implementing a care plan based on a holistic assessment, we reintroduce the concept of patient-centred care.



ha



GED KEARNEY

Federal Secretary of
the Australian Nursing
Federation

Because We Care

Improving the lot of nurses in aged care facilities

IT'S ALMOST 12 months since the Australian Nursing Federation launched our national aged care campaign 'Because We Care'.

Our aim is simple: to ensure aged care nurses and staff have the resources necessary to deliver the best possible care and that vulnerable older Australians have access to quality care, whenever and wherever they need it.

The 'Because We Care' campaign strategy has been to involve members, residents, the community and key stakeholders in aged care to support the campaign, and let the Federal Government know that substantial funding and operational changes to aged care are imperative if we are going to provide quality care for older Australians.

The campaign has four main objectives:

- The right balance of skills and nursing hours so that nursing and care staff can provide quality care for every resident;
- Fair pay for aged care nurses and care staff who are paid up to \$300 per week less than nurses in other sectors;
- Recognition of the professional skill of Assistants in Nursing and care staff through a national licensing system; and
- A guarantee that taxpayer funding is used for nursing care for each resident.

2010 is going to be a big year for Because We Care

On 3 February 2010, a delegation of 20 aged care nurses and residents went to Parliament House in Canberra to visit with Senator Claire Moore and over 25 Members of Parliament and Senators from all over Australia.

This was an opportunity for MPs to hear directly on why aged care matters and what needs to be done. MPs and Senators spoke to residents about the importance of nurses and care staff to their lives, about the relationships they build, and the workplace conditions experienced by dedicated aged care nurses.

Their stories were a sobering reminder that this issue will not go away, but will only get worse if something is not done in the 2010 budget and in this year's federal election.

Because We Care in the 2010 Federal Election

We all know that there will be a federal election this year, and the ANF will be campaigning in key electorates on aged care policy and changes which must be made to wages, staffing levels and funding accountability.

In March, branches held hundreds of activities in key federal electorates around Australia: in shopping centres, at train stations and, of course, in nursing homes.

April will be a month of community activities, with meetings taking place in each state and territory. These will be an opportunity for all to have their say about aged care in Australia.

TV and radio ads

The ANF launched national TV and radio ads focusing on aged care in March and will continue this campaign in April. We will be asking for the Australian community to support the 'Because We Care' campaign and go to the website to send a message to Prime Minister Rudd that aged care is important to them.

The 2010 Intergenerational Report

In his speech to the National Press Club on 1 February 2010, Treasurer Wayne Swan launched *Australian to 2050: The 2010 Intergenerational Report*. During this speech, the Treasurer stated that Australia faces massive challenges now and into the future with the ageing of the population. Treasurer Swan said that this generation, our generation, "can't sit on our hands".

We agree. The challenges facing aged care nurses, care staff, residents and the Australian community are challenges that we must address in Budget 2010. If we don't, future generations will pay for our policy failures.

See the details at www.becausewecare.org.au. 



The value of opportunity

History of the Peter MacCallum Cancer Institute



EMMA RUSSELL
Principal Historian at
History @ Work

'tHE WAY we think socially is so much about choice: "I have a right to ... go here, go there, study, not study", but when this disease comes ...'

'This disease' is cancer and 60 years ago surgery and radiation were the only treatment choices available. Both were radical, potentially dangerous and painful. At the time, infectious diseases were reducing in virulence and frequency, and people were becoming healthier so living longer. This provided an opportunity for cell-based diseases like cancer to materialise more frequently. Cancer was becoming the new scourge and the medical and scientific world had no choice but to tackle full-on 'the big C', as it was fearfully known.



James Farrell is the longest standing patient at Peter Mac, first presenting with lip and neck cancer in the 1950s. He is reading the 60th anniversary history with the Peter Mac's youngest patient.

In Australia, there was the Government's Cancer Advisory Committee of 1928; 10 annual Cancer Conferences during the 1930s; cancer research was underway in Victoria at the Baker Institute, Walter and Eliza Hall Institute and The University of Melbourne; and the establishment of the Anti-Cancer Council of Victoria in 1935. This was a solid cancer campaign, but was it durable and was it making inroads?

In 1943, visiting UK doctors Edith and Ralston Paterson, the doyens of cancer research and medicine, were invited by the Victorian Government to study the way cancer was managed in that State. They advocated 'a single central institute' for as much radiotherapy and surgery as possible, with a department dedicated to research. Victoria accepted these expert recommendations gratefully and six years later in 1949, Dr Peter MacCallum, a leading Victorian pathologist with a keen interest in cancer, opened Australia's first dedicated cancer institute in central Melbourne. His ethos was: 'Nothing but the best is good enough for cancer.' He knew there was no choice if cancer was to be beaten. A dedicated specialist hospital with a substantial concentration of cancer patients would provide medical, surgical and nursing staff opportunities to develop untold expertise, while the opportunities for scientists with large patient cohorts, samples and data would ensure the most comprehensive and significant research.

'It was the first time I realised that physical space was not so important as the intellectual capital that was inside the physical space.'

Medical physics, the application of radioactive substances, was soon joined by the biological sciences with the opening at Peter Mac of the first Radiobiological Research Unit in Australia. The advent of chemotherapeutic drugs in the late 1950s and the blossoming of the Peter

Mac biological research laboratories during the 1960s and 1970s led scientists and doctors to believe 'tissue was the issue', not whole tumours. Eventually the very heart and soul of cancerous cells became the focus as cancer genomics and genetics programs evolved to understand and then to predict and control the origins, mechanisms and behaviours of maverick cells.

Treatment opportunities at the Peter Mac still include radiotherapy and surgery, but nowadays with 3D images showing real-time metabolic activity, and in Australia's finest 21st century laparoscopic theatre. Targeted therapeutic drugs, with or without radiation, will eventually enable genetic and metabolic manipulation. The goal is opportunistic drugs that accommodate an individual patient's biological and genetic make-up.

Maybe it was inevitable that a missionary zeal would permeate the Peter Mac when there was only cancer and its manifestations to focus on. The opportunities to be found in a dedicated specialist hospital have been pursued with wide-ranging creativity, far-reaching collaborations and through an 'osmosis of ideas' between researchers and medical staff, providing the 'best' that Dr Peter MacCallum wanted 60 years ago.

Today there are opportunities for treatment and care that we couldn't have dreamt about not so long ago, but those working at the Peter Mac don't want any choice at all – 'part of our job is to make ourselves obsolete and no one would be more delighted than us if that could happen.'

Our History, published in April 2009, provides a snapshot of Melbourne's Peter MacCallum Cancer Institute's first 60 years based on oral history interviews and an extensive photographic archive. For a copy of *Our History* or more information, contact Anne Rahilly at anne.rahilly@petermac.org. 

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FOR MORE than 60 years, the AHHA has upheld the voice of public healthcare.

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As a member, you have access to regular professional development activities and to networking opportunities with colleagues across Australia through our stimulating and innovative events. You also receive the *Australian Health Review*, Australia's foremost journal for health policy, systems and management

(paper copy or online), up-to-the-minute news bulletins and other professional information.

AHHA values your knowledge and experience

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

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

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

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

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

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\$25	\$100	\$7,890.00
\$100	\$250	\$16,900.00
\$250	\$400	\$22,500.00
\$400	\$550	\$27,900.00
\$550	\$700	\$34,600.00
\$700	\$850	\$39,500.00
\$850	\$1000	\$45,100.00
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*Fee includes GST - valid from July 1, 2010 to June 30, 2011

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(See 2010/11 fee scale)

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

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New Board for HESTA Super Fund

HESTA, Australia's biggest industry super fund for health and community services, has announced the appointment of three new board members.

The new appointees are Maree O'Halloran, a lawyer and Director of NSW's Welfare Rights Centre; Tim Lyons, Assistant Secretary of the ACTU and the AHHA's very own Executive Director, Prue Power.

The fund's new Chair is Angela Emslie, who has served on the HESTA board since 1994. Ged Kearney, Federal Secretary of the Australian Nurse's Federation steps into the role of Deputy Chair.

HESTA CEO Anne-Marie Corboy said, "With the new appointees, we now have a very broad representation from across health and community services nationally, and their skills and experience will benefit our 680,000-strong membership base."

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Hospital Beds for Humanity kicks off

Medicraft Hill-Rom has completed its first Hospital Beds for Humanity Project, by delivering 43 beds and 88 mattresses to Port Moresby General Hospital, Papua New Guinea, on 17 February.

Medicraft volunteers refurbished the beds, donated by Brisbane Private Hospital, Queensland and St George Hospital, New South Wales as part of their own bed

upgrade programs, before being delivered and installed by Medicraft team members. Dunlop Foams provided materials and support for the program.

Of the 43 beds, three electric models were donated to the hospital's ICU. They are the first beds of their kind to be used in PNG. The remaining beds will be put to use in the labour and maternity wards.



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BD AutoShield™ Safety Pen Needle

BD is excited to launch the first safety-engineered pen needle available in Australia.

The BD AutoShield™ Pen Needle is a new safety-engineered pen needle designed to help minimise the risk of accidental needlesticks among healthcare workers.

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BD is committed to providing innovative solutions and pursuing a better injection experience. [ha](#)





PRUE POWER

Executive Director of the
Australian Healthcare &
Hospitals Association

The AHHA's take on health system reform

A new model of health governance for **Australia**

aT THE time of writing, the Prime Minister has just announced the first of the Government's major health reform proposals, focusing on public hospitals. The AHHA, along with many other leaders in the industry, has welcomed the overall direction proposed but there are many details to be worked through.

Our vision for Australian health system governance involves effective national oversight coupled with significant regional influence and control over health delivery programs. It is based on the fact that real improvement in health care occurs at the interface between providers and patients in health facilities. But this interface is compromised because multiple programs and funding sources impede good clinical decision making and make coordinating care very difficult.

Underpinning the AHHA vision is the concept that providers will ensure best practice care if they are recognised (and paid) for creating innovative mechanisms to coordinate care among the various hospital, medical and community services. To this end, we implore the Government to ensure its local networks cover all forms of health and community care, including public and private providers. Presently, the prospect of continuing silos of primary and acute health care means we're only likely to shift the boundaries without addressing the problems of integration.

This is where real gains in efficiency and enhanced safety and quality are to be won. The National Health and Hospitals Reform Commission estimated gross savings of 20% could be achieved if waste, duplication and inefficiency could be addressed. The Government has used this figure to justify its proposals, but our members are understandably concerned that 20% savings means the decade-long shortfall in funding will not be breached.

National consistency with more local input

The AHHA has been working for some time on developing a governance model – and for years we have advocated for a single national funder.

The ultimate goal for health reform is to achieve improved national consistency of hospital funding along with greater transparency and accountability as the key to driving better service quality and planning – and the best outcomes for patients. The AHHA supports the Government's plan to shift clinical input and financial decision-making closer to the community. Flexibility to use funds to meet local needs is essential, and would be a great step forward to have a national framework that guides this for all health services across the country.

What's missing?

There are some critical issues that are largely missing from the proposals that AHHA hopes will be addressed in further announcements. How will Local Hospital (Health) Networks be supported to govern and fund appropriately? Can we sustain the number of Networks indicated by the

Government, given that good governance is such a critical prerequisite for improved healthcare and there will be a major requirement for leadership development? What plan is there for evolving the Networks to cover all health funding and provision? How will the new system motivate development of innovative care models?

The AHHA is also keen to know how the Government will be dealing with dental and oral health, mental health and e-health, given that all of these and other issues cross acute and primary care boundaries.

The AHHA wants to see more detail on the mechanisms for consumer engagement in the proposed reforms and, in particular, more information about how key consumer health issues, such as a person-controlled health record, will be addressed. Finally, we need more evidence for how the proposals will actually change service delivery and provision, particularly to ensure equity of access and quality health care for consumers.

By the time you read this, the Commonwealth directions for the future may be clearer again. Whichever way the wind blows, the AHHA will continue to influence the debate along the frontier of change. [ha](#)



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Diary



The AHHA hosts a variety of engaging events. Here's what's on throughout 2010.

April – August

Date	Event	Location	Registration
Throughout May	State/Territory Branch Seminars	All states	Open registration
3-4 June	AHHA-Change Champions Oral Health Think Tank and Seminar	Melbourne	Open registration
9-25 June	AHHA-ODPN Reform Workshops	Various	Open registration
13 August	AHHA Think Tank	Melbourne (TBC)	All members

September – December

Date	Event	Location	Registration
22 September	AHHA Pre-Congress Workshops	Adelaide	Open registration
23 September	AHHA Annual General Meeting	Adelaide	All members
23-24 September	AHHA-AIHPS National Congress	Adelaide	Open registration
29 October	AHHA Think Tank	Sydney	All members

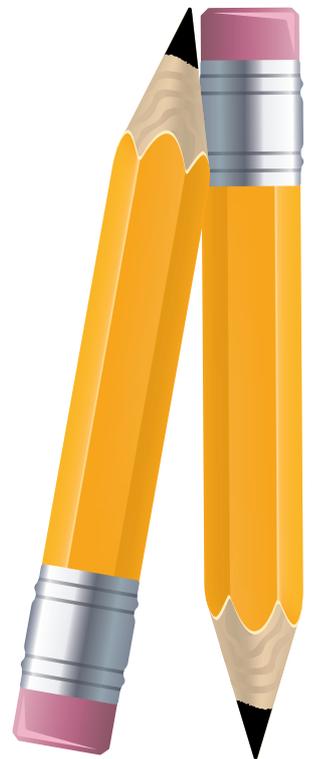


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