The Health Advocate

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The official magazine of the Australian Healthcare & Hospitals Association

Your voice in public healthcare

Creating a greener future

Fiona Armstrong proposes a Green Health Alliance

What exactly is *primary health care?*

Gordon Gregory clarifies some semantic confusion

Dementia misses out

Glenn Rees wonders why it is absent from reform

Sink your teeth into it!

AHHA leads oral health policy solutions – get involved

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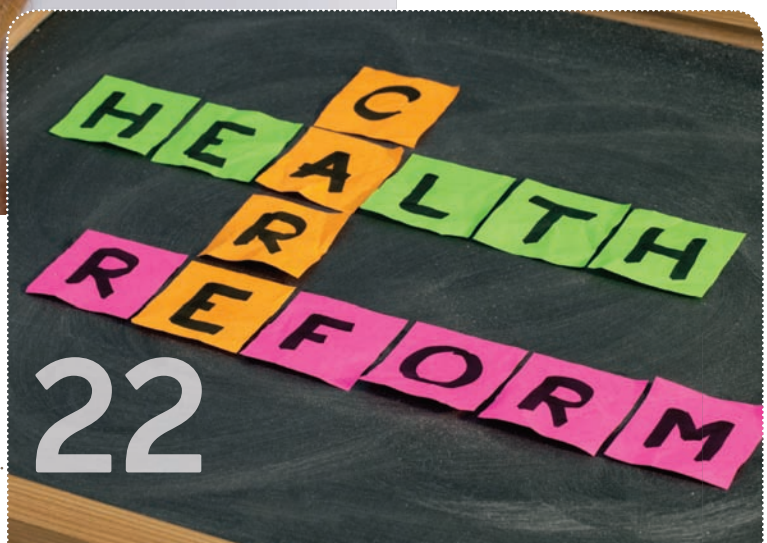

Every issue

In depth

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Briefing

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DR DAVID PANTER
President of the Australian Healthcare and Hospitals Association

President's view

On 23 June, as you all know, Julia Gillard replaced Kevin Rudd as Prime Minister of Australia. Then, as we went to print with this issue of The Health Advocate, she announced the Federal Election for Saturday 21 August.

Health and hospitals have formed a critical plank of the ALP's election platform. Given all the effort taken to reach agreement at COAG, we doubt that we will see significant change in direction under a re-elected Labor Government. At the time of writing, the Coalition's health policy is still unclear.

Of course, in this environment the AHHA has prepared its election campaign principles and policies, focusing on the reforms.

Prior to the COAG agreement, the AHHA outlined four core principles necessary to underpin sustainable reform:

a) Preservation of the universality and scope of the national Medicare system;
b) A transparent and binding funding agreement between Commonwealth and states/territories incorporating clear accountability for expenditure and service delivery;
c) A reformed governance structure incorporating:
   i. national standards to ensure high quality care and efficient delivery of services which meet the needs of the community and provide timely information from which to report outcomes to the public;
   ii. regional entities with influence over the allocation of funding locally and the authority to develop, monitor and improve delivery of services; and
d) Implementation of mechanisms to ensure improved coordination of the patient journey between hospitals, primary/community care and private specialty facilities.

The National Health and Hospitals Network agreement reflects, in part, these core principles as well as AHHA's detailed policy on health system governance. For example, it:

- Rationalises Commonwealth-state roles (Commonwealth: price and standards – State: service agreements) and minimises funding sources as well as provides greater transparency of, and accountability for, funding; and
- Strikes a balance between national oversight and regional influence and control over health delivery programs via the establishment of local entities (Local Hospital Networks and Medicare Locals).

There are a number of significant 'missing pieces' in the reform proposals and we are campaigning on all sides of politics for those that will have the most impact on the health system.

Oral and Dental Health: The NHHN does not recognise oral and dental health services as a component of primary health care to be transferred to the Commonwealth government and does nothing to advance oral/dental health within the broader health agenda. Read about the AHHA's proposals for dental health in our feature story (pp 8-11).

Mental health: The NHHN does not address mental health holistically. Firstly it is difficult to understand the proposed changes and their impacts across primary, community and inpatient mental health services. Secondly it is also unclear how responsibility for policy, funding and governance will play out.

Out-of-hospital specialist care: There is no doubt that problems are emerging around the definitions of 'primary' care and specialist care outside hospitals, which is not recognised in the NHHN. In addition, the illogical way in which these services have been carved up will cause confusion for providers and consumers.

Hospital demand management strategy: There is no coherent hospital demand management strategy in the NHHN, an issue of increasing importance with the ever burgeoning number of people finding themselves in hospital.

We strongly encourage you to get involved in the debate, so please send us your thoughts, letters or an article to include in the next issue!

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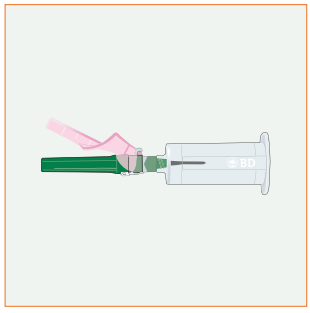

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Sink your teeth into it!

The AHHA's ongoing efforts to get oral health on the **policy agenda**

Felix Pintado and panel

BELOW: Think Tank facilitator, Andrew McAuliffe and Dr Mike Warburton.
RIGHT: L-R Dr Martin Dooland, Professor Mike Morgan and Felix Pintado.

Over 3-4 June 2010 in Melbourne, the Australian Healthcare and Hospitals Association in collaboration with Change Champions held a seminar and Policy Think Tank called *Chomping into reform: Improving the delivery of oral and dental health*. The event was dedicated to linking on-the-ground practice and innovations in oral health with the national policy agenda. The AHHA has built a consensus position to take forward to all political parties for the Federal Election in the context of broader health system reforms.

Background

The AHHA established a Community of Interest in August 2007 to develop oral health policy for the Association. As the only national organisation representing the public healthcare sector, the AHHA required a clear position on public dental services and policy to take forward at a national level. This group is led by Dr Martin Dooland from the South Australian Dental Service (now Executive Director of Statewide Services in Adelaide incorporating the SADS).

In November 2007 the Rudd Labor government was elected. One of the party's election platforms was the reintroduction of a Commonwealth Dental Health Program (CDHP) resembling an initiative axed by the previous Coalition government when it came to power in 1996. It was a long time between drinks.

The same Coalition government made a last-ditched effort in its dying days to sweeten the electorate by introducing a limited program under Medicare called the Chronic Disease Dental Program (CDDP). This program was designed to provide necessary oral health care for people with underlying chronic diseases. In practice, many people who do not strictly qualify under the criteria have been able to access this program.

Since the 2007 election the Medicare program has been fraught with problems of scope, massive over-expenditure and, in some cases, actual rorting by medical and dental professionals (a small number of people, a large amount of public money).

Unfortunately for the community, the Government was adamant that the CDHP would only go ahead if the Senate (ie. the Opposition and minor parties) allowed closure of the Medicare program. To date this has not happened, in spite of the significant pressure applied by the AHHA and other organisations on all sides of politics.

At the first Senate stalemate in 2008 the AHHA developed an alternative position which entails implementation of both the CDHP and CDDP in parallel with very specific scope respectively. Ultimately it results in a coordinated oral health program covering care for people most in need: pensioners, low income earners, the working poor, Indigenous people and rural and remote communities. The combined program with revisions would cost less than the existing Medicare CDDP and would provide considerably more services.

Overarching principles for oral health

At *Chomping into reform* the delegates agreed on establishing the main principles for oral health, and emphasised that the basics are already there:

ABOVE: Professor Mike Morgan (top) and Dr Clive Wright

- National Oral Health Plan 2004-2013 (NOHP) – re-establish the NOHP as the basis for action;
- The AHHA recommends an immediate review of the Plan to highlight progress and identify the key gaps and areas for action;
- National Health and Hospitals Reform Commission (NHHRC) – align principles with issues identified and (where possible) recommendations of the NHHRC;
- Push for the mainstreaming of oral health across professions; and
- Protect the gains! Australia has some of the best child oral health in the world but then we lose it in adulthood – this is a major problem for low income families and pensioners, and reflects access to services more than underlying disease levels.

While we have missed the boat on universal dental care in the near future, this remains a longer term objective and governments must still focus on achieving equality in access to oral health services and improved health outcomes. To this end we must examine the disparities in the system and aim to have dental health insurance as part of the national health insurance program.

Campaign strategy

Delegates at *Chomping into reform* raised a number of key issues that must all be addressed in the short term. They emphasised that these strategies are not to be 'cherry picked' and form components of the overall approach recommended by the AHHA.

Strategy 1: CHIEF DENTAL OFFICER/ ADVISORY BODY

Australia is the only country in the region that does not have a Chief Dental Officer or equivalent advisory body with a Chair. It is critical for Government to receive ongoing advice on the best mechanisms to systemically include oral health in the National Health and Hospitals Network reforms. Action in oral and dental health requires national leadership and coordination. An alternative might be to establish an Office for Oral Health in the Commonwealth Department of Health and Ageing that includes an oral health professional with significant public dental health expertise.

Two of the key terms of reference for this position or Office would be to monitor and review progress against the National Oral Health Plan and oversee national planning and performance (workforce, achievement of targets, service delivery gaps).

Strategy 2: EVALUATION and EVIDENCE

The Commonwealth Government must ensure that any programs in oral/dental health, such as the Medicare Teen Dental Program, the Medicare Chronic Disease Dental Program, and (if ever implemented) the Commonwealth Dental Health Plan must have built-in funding for full evaluation during and after implementation. Participants in the Policy Think Tank highlighted the lack of data available to assess the outcomes and overall impact of existing programs.

The AHHA recommended in 2008 that the Commonwealth must commit funding to evaluate the programs to measure what impact they have. We are now in a position that the actual outcomes of the two Medicare programs

IF YOU are interested in signing up to be a part of the AHHA's Election 2010 Campaign for Accessible Oral and Dental Health, contact us on 02 6162 0780 or by email at admin@aushealthcare.com.au.

> The combined dental program would cost less than the existing Medicare CDDP and would provide considerably more services

are very difficult to assess due to the dearth of evidence.

This must also occur at the local level to ensure any programs funded and implemented are fully evaluated for their effectiveness in terms of outcomes, cost and generalisability.

Strategy 3: NATIONAL STANDARDS and TARGETS

Thus far in the discussion about oral health policy there has been little consideration given to the structure and role that national standards can have in oral health. Standards and reporting are being established for all other parts of the health system, so why not for oral and dental health?

Strategy for standards:

- Establish and state the intent of the standard;
- Back up with evidence to indicate its importance; and
- Estimate the likely costs involved to achieve the standard (this will vary by jurisdiction dependent on the level of progress made – eg. variable use of co-payments, different scope of practice limitation, extent to which child and adult populations are covered by state-funded services).

The National Oral Health Plan contains a set of indicators that could be updated and used across the oral health sector (starting, at least, with all public sector dental services). Lessons from target setting in the UK indicate that it is better to have higher level targets and goals that allow for services to work in a range of flexible ways to achieve them (outcome-focussed rather than input or process measures).

The AHHA recommends agreeing on indicators and targets for general and emergency oral health care in the first instance.

Strategy 4: WORKFORCE

While planning, coordination and accreditation is underway, there are a number of outstanding issues that remain for the oral health workforce, and implications for the broader health workforce.

Due to the CDHP not going ahead, a number of professionals including dentists and Aboriginal Health Workers have not been employed. In the current funding environment for public dental services there is no capacity for marginal growth, which means increased service capacity is unattainable. The AHHA continues to push for significant increases of dedicated funding to the State and Territory public dental services in order to expand their capacity to provide much-needed oral health care to those most in need.

The intern year must have clearly established objectives prior to implementation, particularly around building the skills of the students in a range of practice settings. There is the risk that this may not have the anticipated positive impact on public dental services unless there are clear guidelines for the outcomes expected for both the interns themselves and the services. The costs to both public and private services must also be factored in (eg. for infrastructure) and funding for ongoing placement upon graduation must be incorporated into recurrent financing.

The AHHA has undertaken to work with the Dean of Dental Schools across the country to help establish improved strategies for workforce development (linking education/ training to areas of service need).

The AHHA has undertaken to explore further options for improving the capacity of all health professionals in recognising, treating or referring oral health problems.

Strategy 5: PUBLIC-PRIVATE MODEL

There are issues around how to make both the public and private dental systems accountable, especially in the context of increasing use of the private sector using public dollars (eg. buying in services where and when the public service does not have capacity).

The AHHA will work with professional and other non-profit associations with interests in oral health to further explore a fully developed public-private model for oral health care covering the Australian population.

Strategy 6: PREVENTION and PROMOTION

Oral and dental health must be incorporated in the overall preventive health agenda with a key role in the National Preventive Health Agency.

Delegates representing all the State/ Territory public dental services, as well as others from across the system, backed up the World Health Organisation's definition of health promotion and stressed it must continue to form the basis of all public health activity in oral health (including as part of overall health – link to health promoting services such as hospitals). ha

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Hospitals still under pressure

THE RELEASE of *Australian Hospital Statistics 2008-09* revealed the increased stress being placed on public hospitals by the rising demand for emergency care and the need for long-term planning around improving the patient journey and providing more coordination and care options in the community.

A significant proportion of people presenting to emergency departments (EDs) do not require emergency treatment but end up at a public hospital because they cannot access more appropriate forms of care in the community. This is not the best solution for consumers and is a poor use of our health care resources. The ED should be the final when someone needs to access health care, except in true emergency situations.

The report also demonstrates that overall 8.5% of all hospital admissions are potentially preventable, if timely and effective non-hospital care had been provided. This reflects a lack of focus on prevention and chronic disease management in primary care which hopefully will be addressed through the COAG reform process.

AHHA and Heart Foundation present Warren Snowdon with Indigenous heart health actions

A REPORT prepared by the Heart Foundation and the Australian Healthcare and Hospitals Association on disparities faced by Indigenous heart patients when in hospital was officially handed to the Minister for Indigenous Health, Warren Snowdon, on 2 June.

Better hospital care for Aboriginal and Torres Strait Islander people experiencing heart attack is the result of a collaboration between the two organisations over the past 18 months, bringing together an expert steering committee and involving two major forums in Sydney and Canberra.

Executive Director of the AHHA, Ms Prue Power, said the Close the Gap agenda has a strong focus on prevention and primary care. "While much needed and much welcomed, we also should be looking closely at systemic changes that address disparities in acute care for Indigenous Australians and we are, therefore, pleased that the Australian Government has been closely engaged with the development of this report."

The AHHA and Heart Foundation are now working with other partners to take the recommendations forward. You can download the report from the AHHA website (www.aushealthcare.com.au) or obtain a hard copy by contacting us on 02 6162 0780.

L-R: Traven Lea (AGPN), Prue Power (AHHA), Hon Warren Snowdon, Dr Lyn Roberts (Heart Foundation)

Primary care reform must focus on chronic disease management

IN WHAT appears to be a statement of the obvious, Hal Swerissen from La Trobe University led a team looking at the best way to focus reform of primary health care. The results are reported in the May 2010 issue of Australian Health Review, the AHHA's leading peer-reviewed journal.

"Chronic disease management programs in primary care, particularly those offered under Medicare, will play an increasingly important role in helping our health system meet this challenge. Therefore it is vital that they are closely examined, particularly in the context of the current health system reform efforts to improve governance and funding of the health system and strengthen primary healthcare," said Professor Swerissen.

Problems identified with the current system include seemingly arbitrary caps on services and the potential for overlap between some programs. Overall, the system appears to be designed to manage costs rather than chronic disease and is unlikely to result in the best health outcomes for patients.

"This could be addressed with a better MBS design, particularly around allied health access and a more sophisticated approach to service caps is needed that provides 'service packages' in line with assessed patient need, rather than the current one-size-fits-all approach," concluded Professor Swerissen.

There is also a need to provide support to GPs to deliver chronic disease management and to assist the patient to navigate the system. Future reform efforts must not only address questions of optimal item structure and allied health access, but also provide an adequate support structure to improve routine monitoring and coordination of services for patients with chronic disease.

To subscribe to the Australian Health Review and access this and many other articles, contact the AHHA on 02 6162 0780.

Dietitians starved by Medicare program

MANY AUSTRALIANS with chronic diseases are not receiving optimum care from dietitians under Medicare due to problems associated with the Chronic Disease Management program. These are reported in a new study in the May 2010 issue of Australian Health Review.

"Australian dietitians are the third most utilised allied health providers under the Strengthening Medicare: Chronic Disease Management program. However, despite the fact that dietitians provided 124,111 individual services to Medicare patients in 2007-08, little research has been undertaken to date on their role within Medicare," said study author Dr Robyn Cant from Monash University.

The main problems identified were associated with the limitations on the number of consultations available under the program and the associated remuneration. Dietitians universally regarded an initial half-hour patient consultation as inadequate to assess, educate and develop dietary goals with a patient. Further, dietitians judged the current Medicare rebate of $50.05 per consultation as limiting their sessions to 20–30 minutes because of expectations of remuneration in accord with their professional fees.

"Nutrition is a key factor affecting the health of Australians over the next 20 years and should be a focus of all efforts to prevent and manage chronic disease. The Medicare CDM program can improve access to accredited dietitians for people with chronic diseases. However, this study identified a number of barriers which still exist within this program which need to be overcome to ensure that people with chronic conditions can receive best practice care," Dr Cant said.

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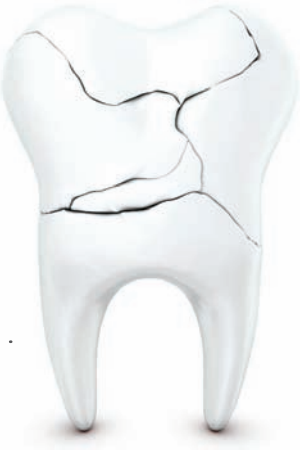
More problems for oral health programs

REPORTS OF rorting of the Medicare chronic disease dental scheme came as no surprise to the AHHA. The potential for these sorts of problems was identified by AHHA 18 months ago in our analysis of the scheme. Unfortunately, unless the scheme is significantly altered, we are likely to uncover more cases of the misuse of scarce health funding via this badly designed program.

As we have previously argued, the potential for rorting is only one of the many flaws in the design of this scheme. Research by AHHA and others has demonstrated that it is extremely poorly targeted with services being provided disproportionately to people in affluent areas and very little being delivered to disadvantaged communities where this kind of support is most needed. There is also evidence that the funding has been used to provide some expensive and cosmetic services – such as crowns – rather than less costly but equally effective treatment and preventive care.

The AHHA will continue to push publicly for resolution of these problems in parallel with the implementation of the promised Commonwealth Dental Health Program. The people most in need are not getting the care – this cannot go on any longer.



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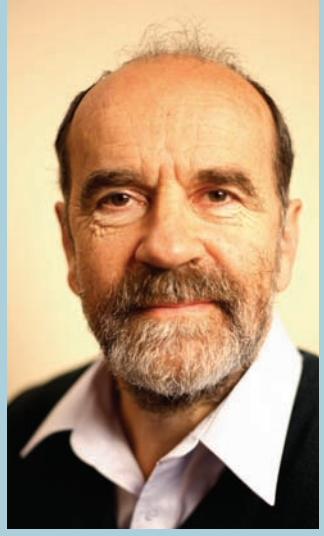
What exactly is primary health care?



GORDON GREGORY
Executive Director
of the National Rural
Health Alliance

croakey

Gordon Gregory reminds us of
the foundations of primary care
in the health sector

FOR PEOPLE in the health sector, the most common reference point for drawing a distinction between 'primary care' and 'primary health care' is the Declaration from the International Conference on Primary Health Care held in September 1978 in Alma-Ata.

Reading that Declaration now, and as a relative newcomer to the health sector, it seems that the main purpose of that Declaration was to state and promote some of the key principles for national and international efforts to make good health and health services available to all the world's citizens. The clearest and strongest messages in the Declaration are that health is a human right to which international commitments should be made, and that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care".

It is only in the margins of the Declaration, as it were, that the point is made that health status is determined to a significant extent by such things as access to education and fresh water, rather than by access to health services per se.

Defining primary health care

Part I of the Declaration states that "the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector" (emphasis added).

The part of the Declaration (VI) which explicitly defines primary health care does not include any reference to those individuals or professions providing health services, nor to what (these days) would be regarded as the social and economic determinants of health. Rather, it refers to the methods and technology by which health care is made available, and to the participatory, affordability and locality aspects of such care.

Part VII defines that primary health care "includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and

child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

The section continues: "in addition to the health sector [primary health care includes] all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors."

Much has been made of this marginal matter, and a whole generation of health professionals seems to have a favourable if somewhat imprecise view of what the Alma-Ata Declaration says about the breadth of the determinants of health.

Perhaps one of the reasons for this 'positive press' is that the Declaration spells out very clearly that health services are delivered by a wide range of health professionals: "[primary health care] relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community."

Clear distinctions

Historians of the health professions might be able to say what the status was in 1978 of the balance between medicine, on the one hand, and all other health professions on the other. It seems likely that one of the reasons why nurses, allied health professionals and others adhere strongly to the Declaration is that it was a critical and high-status affirmation of the proper place of non-medical health professionals in providing health services.

The Alma-Ata Declaration provides only an imprecise distinction between primary care and primary health care – and does not go very far in defining the range of policy matter which impacts on health status. However there is considerable value in clinging to the distinction and making it more rather than less clear.

That value resides in the utility of us continually reminding ourselves – as a nation, as health professionals, as citizens and health consumers – that we cannot and should not rely on the health system for long life and wellbeing.

We should recognise that those who are born poor or with a disability will need our help as individuals and as a society to give them a fair chance at equivalent health. As individuals we must recognise that our own actions play a large part in determining our lifetime health trajectory. As taxpayers we should recognise that investments in health-promoting infrastructure, in food distribution and quality, and in employment programs and regional development can be viewed as investments in the nation's health, just as much as the money spent on hospitals and health professionals.

The term 'primary health care', if properly nurtured, can act as a useful rallying-cry or lightning rod for such positions and attitudes. It can remind us of the need not to medicalise health conditions; to focus on wellness rather than illness; and to support investment in universal education, an income safety net, equal employment opportunity and so much more.

And with a little care in language and communication, the distinctions can be easily maintained.

The term 'primary health care' is the larger phrase (it has three words, not two) and stands for the bigger picture. 'Primary care' is provided when a health professional interacts in a planned and scheduled way with a patient.

Defining the terms

A 2002 World Health Organisation meeting on Primary Care, Family Medicine and General Practice in Barcelona defined primary care as "a span or an assembly of first-contact health care services directly accessible to the public". Helen Keleher, in the Australian Journal of Primary Health in 2001, wrote that: "primary care more often than not involves a single service or intermittent management of a person's specific illness or disease condition in a service that is typically contained to a time-limited appointment".

One of the reasons for the confusion between the terms is that primary care professionals are proud of the primary health care work they do – for instance, through providing broad advice on health and fitness when dealing with a patient's specific illness or disease. Beware the commentator who dares suggest that a doctor or a nurse does not do or is not capable of doing primary health care!

Another reason is that – uttered in a dark room as the opening gambit in a conversation with the listener having no clue as to context – the term 'primary care' could mean many different things. In this context the practice should be to use the term 'primary care in the health sector' or 'primary care in health'.

In a context which is clearly already about health, like a health textbook or a paper in a health journal or about health issues, there is no need to add the word 'health' to 'primary care' and so confuse the issue. With greater care and clarity, when the government of the day establishes a task force to plan for better and fairer access to health professionals, one can be confident it will be a primary care strategy.

> The Alma-Ata Declaration provides only an imprecise distinction between primary care and primary health care

And wouldn't it be a great step forward to aspire to a national primary health care strategy: a national approach to whole-of-government action to improve health and wellbeing. Terms like 'whole of government' slip off the tongue so easily but describe approaches to public policy which are inherently difficult to put into operation.

A broader approach

The current round of health reform relates almost exclusively to primary care. Yet reform of primary care in health may be a relatively ineffective way to improve health outcomes. More important are housing in the community for the homeless and those with mental illness, a national food distribution and affordability program, taxation policies to reduce the disparities in income and asset levels, innovative programs to improve school retention rates where they are low, community development programs to support sustainability of smaller communities, canny ways to implement research findings into public health policies – and so the list goes on.

No one likes to be put into a box, particularly if it is too small. People who are good at primary care should not be thought of as narrow in their capacities or practices. And it is those primary care professionals who should lead from the inside towards a clearer understanding of what primary health care really means.

This article first appeared on Croakey, the Crikey health blog (blogs.crikey.com.au/croakey). Croakey is funded by a consortium of health organisations: Public Health Association of Australia, VicHealth, Epidemiology Unit of the Victorian Infectious Diseases Reference Laboratory, Brain and Mind Research Institute at the University of Sydney, Australian Health Promotion Association, UNSW Research Centre for Primary Health Care & Equity, and the Australian Health Care Reform Alliance.

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

Be careful not to catch reform fatigue

Patrick Bolton warns health managers about the **cycle of reform**

EARLIER THIS YEAR the British Health Service Journal ran a lead article on reform fatigue. This is not surprising in the UK, which has now had several decades of continuous reform. The same is true of New Zealand, where there has also been a couple of decades of healthcare reform. Both of these countries have identified that one of the issues that arises from healthcare reform is how to stop reform once it has started.

This seems to me to be a real risk for Australia. The Rudd reforms were not well thought through, are patchy, poorly integrated, and do not represent real change. We still have two funders, it is not clear that the changes have reduced or streamlined the health bureaucracy, there are significant gaps such as those in dental and mental health, and the system is not obviously higher quality, more equitable or efficient than the old. The "reform" seems increasingly likely to change the boundaries, but not the structures or players. This will create all the costs of change with no benefit, all to satisfy the appearance of reform.

I remember an article in the British Medical Journal at around the time of the last set of reforms in NSW which said that major restructures in commercial organisations cost two or three years' profits, and drew an analogy with healthcare. In NSW the current set of reforms will see the pendulum swing back to an earlier size of health service. The current model has only been in existence for around five years. It may not have been around long enough to have made a reasonable assessment of whether the new structure was more or less efficient than the old, particularly if any benefits from the first few years were consumed by the cost of change. This is unfortunate because the range of models across Australia offer the potential for comparison which would allow some conclusions about the strengths and weaknesses of different sizes of health service in different settings. We may have evidence on which to base some of our decisions if we are prepared to look for and use it.

A significant problem with the current reform is lack of clarity about the objectives of the change, and therefore lack of planned measurement about how well it is achieved. This is a disappointing failure of public accountability by Government. If Government is to be criticised for not thinking their policies through then the Opposition must also be criticised for not calling them to task or providing an alternative.

If one is not clear about where one wants to go, one is unlikely to end up somewhere that one wants to be. Unintended consequences of reform are likely. These provide a reason for further tinkering. It is interesting that in response to criticisms the Rudd Government has started to portray its reform package as the first step in a journey. A cynic might suggest that this is a convenient excuse from a bunch of people who should know where they are going but are in fact lost. However, it does lead to an expectation of further change.

Change is a significant risk to efficient care. Many health service managers are apprehensive about what the changes will mean for them. These are not circumstances in which people perform at their best. One of the things that strikes me about periods of turmoil in health is that patients keep getting seen whatever else is going on. This may be testament to the robustness of Australian healthcare workers. However, it isn't clear whether the quality of care is affected.

> The Rudd reforms were not well thought through, are patchy, poorly integrated, and do not represent real change

There is a real risk that we face a period of substantial upheaval and cost for little appreciable gain, and that successive policy makers will add fuel to the fire with continued tinkering. Reform fatigue? I think I've caught it!

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Solving the health reform puzzle

Help is here thanks to the **Parliamentary Library**!

Amongst the deluge of reports and opinions on health reform that are released almost daily, here is one that is well worth a read. The Commonwealth Parliamentary Library produced its annual Budget Review back in May, and it gives a very useful analysis of health and aged care reforms and federal budget announcements.

My short and rather brutal summary is that a lot of money is being spent on health reform for most uncertain outcomes, while so-called reforms in medicines and pharmacy policy look to have benefited the pharmaceutical and pharmacy industries more than the public purse or public policy. Meanwhile, the government has wimped out on significant health workforce reform, while taking only baby steps towards achieving the promise of e-health.

Here are some relevant snippets from the paper to help navigate the budget announcements for reform. To download the health section of the Budget Review 2010-11 visit the website: *http://www.aph.gov.au/library/pubs/RP/BudgetReview2010-11/index.htm*.

General overview

Pages 140-142

"questions could be raised as to whether or not the Government has exercised sufficient fiscal responsibility in relation to the establishment of a National Health and Hospitals Network. Has the Government spent too much in gaining the support of the Premiers for this reform, especially given that there is some debate as to whether or not the reform will achieve its stated objectives? In relation to savings measures, it could be asked whether or not more significant savings might have been made by the Government in what it pays for medicines…the costs and benefits of the Government's approach (in health and hospitals reform) will most likely be the subject of much debate for decades to come."

Pages 156-157

"While the health funding and reform commitments in the Budget are significant, some argue that aged care, mental health, Indigenous health and dental health have not received adequate attention. The calls for greater investment in these sectors are likely to continue into the future. Mental health in particular remains an area of significant stakeholder concern. Reforming the health workforce to meet the challenges of current and future health needs continues to be a challenge for policy makers and, while alternative workforce options are being investigated, this Budget appears to have favoured more traditional solutions. Nevertheless innovative approaches, such as the budget proposals to manage patients with diabetes (and veterans with chronic diseases) through fund-holding arrangements, signal a preparedness to explore new models. However, changes are usually associated with uncertainty and questions remain over whether such approaches will deliver better care or create perverse incentives.

How the proposed independent Local Hospital Networks and Medicare Locals will improve integration and coordination at the local level is yet to be determined. Governance arrangements need to be established, performance standards set, information and data systems established, reporting protocols agreed and, not least, goodwill established between stakeholders and vested interests overcome. Furthermore, although Western Australia will continue to be funded through the existing National Healthcare Specific Purpose Payment arrangements, it will continue to remain outside these arrangements as long as it is not a signatory to the COAG agreement. A truly national reform program therefore remains an elusive goal."

A noteworthy reform in aged care

Page 161

"One of the more notable initiatives in the aged

care budget was the introduction of consumer-directed aged care packages. These were a recommendation of the National Health and Hospitals Reform Commission (NHHRC) and will give older Australians and their carers greater flexibility and choice about the type of care they access. Under this initiative, consumers will be able to tailor their care to their needs and make decisions about the design and delivery of the care provided to them. This represents a shift from the current model where care is largely linked to the package, not the consumer. Implementation will be phased, with 500 consumer directed packages to be released in 2010–11. The Government has not detailed what support (if any) will be provided to consumers about making decisions in relation to their care or when negotiating with service providers to ensure value for money."

Only baby steps in e-health

Page 166

"The idea of an efficient, secure national electronic personal health record system was arguably one of the most substantial reforms advanced by the NHHRC – an important systematic opportunity 'to improve the safety and quality of health care, reduce waste and inefficiency, and improve continuity and health outcomes for patients'. The commitment in this Budget to such an e-health future is considerably less than some expected. It is short of recent estimates by the consulting firm Booz and Company which concluded that Australia would need to spend between $4 and $8.5 billion to implement an e-health strategy. As a number of commentators have pointed out, in effect, the commitment in this Budget is but 'a small investment'. It appears the general consensus is that considerably more funding will need to be invested to ensure viable e-health outcomes."

Pharmaceutical industry and pharmacy owners have done well

Page 172

"The Government has signed a Memorandum of Understanding (MOU) with Medicines Australia which is designed to ensure 'a stable environment for business and continued access to new medicines for all Australians'.

Although measures announced in this Budget are predicted to garner the Government $1.9 billion of savings over five years, the MOU with Medicines Australia also includes a guarantee that the Government will not seek to impose any further price savings on the pharmaceutical industry before 30 June 2014 or introduce any measure which favours the dispensing of generic medicines, thereby possibly precluding further measures which could deliver additional savings to the Government."

Page 177

"The 5th Community Pharmacy Agreement (5CPA) was finalised on 3 May 2010 and the full details have been released with this Budget. The total value of the 5CPA is now $15.4 billon, around $300 million higher than originally announced. The projected savings are unchanged, highlighting the strong negotiating skills of the [Pharmacy] Guild.

Three features of the 5CPA which benefit pharmacy remain relatively unchanged from previous agreements and each of these is not without controversy – the location rules, the continuation of the wholesaler Community Service Obligations payment in full (with a pause on indexation until 2011), and a dispensing fee for each PBS prescription dispensed. A new fee has also been added. This provides for $0.15 per transaction to be paid to pharmacists dispensing scripts under the Repatriation Pharmaceutical Benefits Scheme (RPBS) and under co-payment prescriptions that are generated electronically. This is expected to cost around $75.5 million during the life of the 5CPA.

MELISSA SWEET
Freelance health journalist and moderator of *Croakey*, the health blog for *Crikey*

not for a decade or so, as a result of government initiatives. Because this initiative focuses on supporting the traditional, medico- oriented perspective of health teams, it could be seen as a backwards step to realising a more cooperative and collaborative health workforce in the future.

In essence, the Government's enthusiasm for reform in other areas of the health portfolio is perhaps not matched in the workforce area. While previous budgets hinted there might be underlying enthusiasm to explore multiple options for workforce change, this Budget appears to have embraced a more traditional solution."

> My short and rather brutal summary is that a lot of money is being spent on health reform for most uncertain outcomes

Questions about workforce reforms

Pages 192-93

The paper says there are questions about whether the investment in expanding a general practice nurse initiative will "deliver where it is most needed".

"There appears, for example, to be no guarantee that solo practices, which could gain great benefits from the services of a practice nurse, will be eligible for funding under the measure. Similarly, it could be asked if it would be more appropriate to encourage nurses into aged care, rather than general practice. This is particularly so given the increases in medical practitioner numbers that will be realised, albeit

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Image: iStockphoto

FIONA ARMSTRONG
Public policy analyst and commentator in climate and health policy

croakey

"There is a great need to add the health lobby to the mitigation debate. [Climate change] is the great issue of our age. We have to take more action; we need to be saying: "this is a very serious threat". This will help focus minds on the importance of getting greenhouse gas emissions down and doing more about biosequestration. We have to add our voice to that debate."
Professor Anthony Costello, lead author of the report *Managing the Health Effects of Climate Change* published by the Lancet in May 2009.

Background

Climate change poses serious immediate and long term threats to the health and wellbeing of the Australian and global population. Climate change is occurring extremely rapidly with the Earth's climate now changing faster than at any time in the last 10,000 years – during which human civilisation has flourished. Projections regarding its effects are now well beyond the predictions of the 2007 Intergovernmental Panel on Climate Change (IPCC) report and its worst case scenarios.

Increasing emissions from the use of coal, oil and gas and burning of wood and charcoal has led to an accumulation of greenhouse gases being trapped in the Earth's atmosphere. Global atmospheric concentrations of carbon dioxide, methane and nitrous oxide are now higher than at any time in last 800,000 years.

Ice core data spanning many thousands of years shows atmospheric carbon dioxide now far exceeds pre-industrial times, when it was around 280 parts per million (ppm). Since the industrial revolution atmospheric CO_2 has risen rapidly to its current level of 387ppm; beyond the level considered safe by climate scientists (between 300-350 ppm). The current rate of increase (about 2ppm each year) is much faster than at any time over the last million years, during which an increase of 30ppm has always taken more than 1000 years to occur.

Global warming directly correlates to the increasing concentration of greenhouse gases in the atmosphere, and average global temperature has increased almost 1°C over the last century. Irreversible climate change has already occurred with the current global average level (0.8°C) of warming.

An important and previously underestimated contributor to global warming is the positive feedback loop associated with melting of the ice on the Earth's surface. Reduced ice cover is leading to a loss of 'albedo' – the capacity of ice to reflect solar radiation back into space.

This leads to an increase in warming and risks leakage from the massive stores of carbon and methane (a much more powerful greenhouse gas than carbon dioxide) in permafrost beneath melting sea ice. The volume of gases in the permafrost exceeds by many times those already in the atmosphere. Release of carbon from under the Arctic Sea ice and the loss of the Greenland ice sheet are considered the most significant tipping points for a sudden transition from the Earth's previously stable climate to one in which catastrophic and irreversible change occurs. Current temperatures and atmospheric CO_2 levels are now too high to maintain the climate to which humans are currently adapted, and unless prompt action is taken, are expected to lead to such dramatic alterations in the earth's climate that human intervention will be futile.

Leading international climate scientists such as Professor James Hansen from the NASA Goddard Institute for Space Studies says to avoid catastrophic irreversible climate change temperature increases must peak as far below 2°C as possible. Two degrees is considered to be the global warming "guardrail" beyond which warming must not occur to "avoid dangerous anthropogenic interference with the climate system". However even a warming of 2°C poses "unacceptable risks to key natural and human systems, including significant loss of species, major reductions in food-production capacity in developing countries, severe water stress for hundreds of millions of people, and significant sea-level rise and coastal flooding".

Australia is considered particularly vulnerable to climate change, and a failure to mitigate further increases in temperature is expected to lead to a severe decline in food production, increased water insecurity and an unprecedented wave of extinctions. The recent Garnaut report warns unmitigated

A Green Health Alliance

Fiona Armstrong builds the case for a **coordinated effort in green healthcare**

Images: iStockphoto

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climate change could lead to a fall in agricultural production in Australia by over 90% by 2100. The distribution of negative impacts where the majority of people and species are adversely affected by climate change becomes a severe risk beyond 2°C warming. A high risk of "large scale discontinuities" accompanies a scenario of more than 3°C warming.

The interdependence of all the different parts of the Earth's climate system means these changes are non-linear. Once a particular threshold is reached, it could lead to a cascading of abrupt and irreversible change to the Earth's climate. Of the nine identified planetary boundaries identified by Earth System scientists as the limits beyond which humanity cannot safely exist, three have already been transgressed. These are: climate change (the boundary for which is described as atmospheric CO_2 above 350ppm); biodiversity loss; and changes to the global nitrogen cycle.

Given the pace of global warming, the targets for industrialised countries outlined in the IPCC report to reduce greenhouse gas emissions by 25-40% by 2020 (80% by 2050) are no longer considered adequate. Strong emissions cuts must commence immediately, with emissions peaking prior to 2020 before they begin to decline to carbon negative levels by 2050 is now considered necessary to avoid abrupt or irreversible climate change.

To have even a 50:50 chance of constraining temperature rises to 2.4°C, global emissions should be reduced by 60-80% immediately. Current proposals to reduce emissions however fall well short of what is required. Modelling suggests that current proposals will lead to a 4°C increase in global temperature and atmospheric CO_2 levels of 730 ppm by 2100. If emissions continue at a "business-as-usual" level, it is predicted atmospheric CO_2 will reach 1000ppm by the end of the century.

There is no time to waste. It is now two years since James Hansen's seminal paper, *Target Atmospheric CO_2: Where should humanity aim?*, was published in which he and his colleagues warned that: "Continued growth of greenhouse gas emissions, for just another decade, practically eliminates the possibility of near-term return of atmospheric composition beneath the tipping level for catastrophic effects."

A healthy proposal

The proposal to establish a Green Health Alliance acknowledges that climate change poses a serious and increasing threat to human health and that health care stakeholders have an important contribution to make in advocating for policy action on climate change and environmental issues.

It is envisaged that the membership of the Alliance would be a broad cross section of the sector as possible, and include health care professionals, health care service providers, institutions, academics, researchers, and health care consumers. The Alliance would be composed of and represent stakeholders in the health care sector who wish to see the issue of the environmental impact of the health care sector and the health implications of climate change addressed through prompt policy action. This would be based around a collective understanding that there are significant environmental consequences associated with the delivery of health care and profound human health and ecological impacts associated with unmitigated climate change.

Process for developing a Green Health Alliance

Develop proposal that outlines the purpose and likely benefits of an Alliance

↓

Canvas interest in and potential membership of an Alliance

↓

Develop an issues paper outlining what the alliance might do (i.e. potential positions/underlying principles; potential members; and options for governance and operation)

↓

Conduct a Workshop/Roundtable meeting to discuss: membership; objectives; priorities; governance and funding

↓

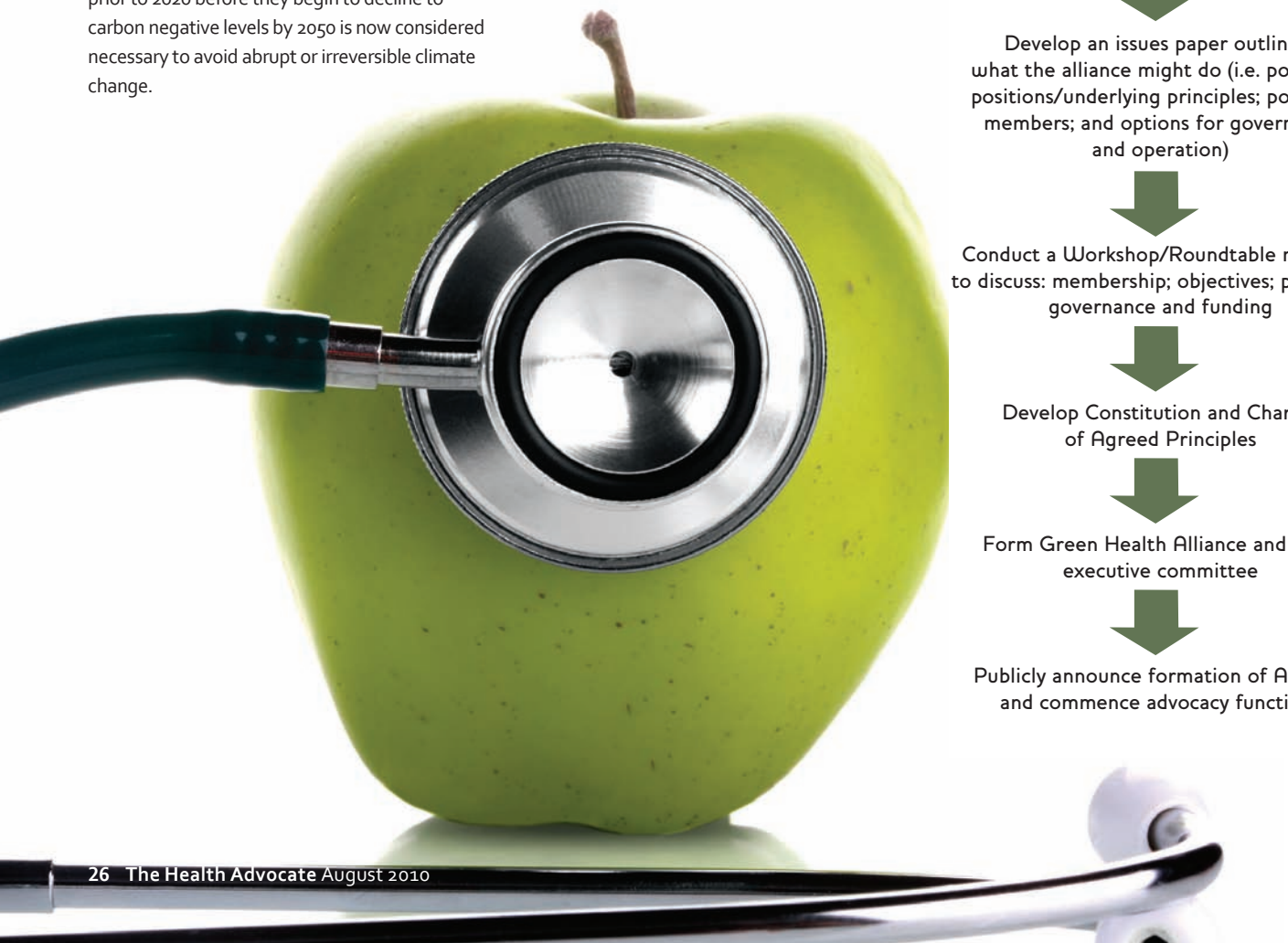
Develop Constitution and Charter of Agreed Principles

↓

Form Green Health Alliance and elect executive committee

↓

Publicly announce formation of Alliance and commence advocacy functions



Purpose

The purpose of such an alliance would be to raise awareness of the health implications of climate change and the associated challenges of peak oil, increasing population and food and water insecurity. The establishment of the Alliance would demonstrate the public interest concern of health care sector and its members' commitment to contribute to the development of sound evidence-based public policy that protects the community from the adverse consequences of environmental damage and climate change.

Suggested objectives for the Alliance

The Alliance may advocate for strong emissions policies to reduce the current and future health impacts and risks associated with increasing global temperature, sea level rise, and food and water insecurity. It may also start from the premise that the health sector itself should be making an effort to reduce its effect on the environment. In this regard the Alliance may advocate for a commitment from the health sector to reduce environmental harm through, for example, pushing for the inclusion of mandatory criteria in the accreditation of healthcare facilities for the use of energy and water; production of waste; standards for energy efficiency; and establishment of environment committees in all health care institutions. It may also advocate for policy development in the areas of drawdown of excess CO_2, healthy power generation, healthy transport and urban planning, sustainable healthy agricultural systems, improvements to land use, and protecting and conserving water supply.

Expected outcomes

The anticipated outcomes from the establishment of the Green Health Alliance would be:

- Improved climate literacy within the health care sector;
- Increased awareness of, and engagement with, the importance of climate change mitigation within the health sector;
- Increased understanding in the community of the health risks associated with failing to prevent further climate change;
- The development and implementation of policy initiatives to significantly reduce greenhouse gas emissions in Australia;
- The development and implementation of policy initiatives to reduce atmospheric CO_2 through drawdown of carbon dioxide; and
- The establishment of national initiatives to improve the environmental performance (and reduce the environmental impact) of health care institutions.

> The proposal to establish a Green Health Alliance acknowledges that climate change poses a serious and increasing threat to human health

Process to establish the Alliance

Interested parties are invited to join a core group of individuals and organisations with a workshop/roundtable meeting to be held in August involving health care stakeholders interested in forming a Green Health Alliance. The AHHA has already nominated Mark Sullivan, CEO of Dianella Community Health in Victoria.

In preparation for the workshop background discussion paper will be developed and circulated to stakeholders prior to the event to assist in moving to some core areas of agreement.

The membership, objectives, priorities and governance, as well as discussion regarding the core areas of consensus for the alliance would be best discussed at the face to face meeting.

Governance

There are a range of governance structures that might be appropriate for this Alliance and this should be determined by the Alliance members. One possible structure for the Alliance could be a similar approach to that of the Australian Health Care Reform Alliance with an elected executive committee established from the membership, and its advocacy to centre on the core areas of consensus that are able to be articulated within the group. For example, the membership may choose to elect a ten person executive committee to carry out the functions of the Alliance. This committee may then appoint a Chair and/or spokesperson to represent the Alliance.

Get involved

If you are interested in joining the Green Health Alliance or want more information, please contact Fiona Armstrong at fiona-armstrong@bigpond.com or through the AHHA on 02 6162 0780 or by email at admin@aushealthcare.com.au.

*This article first appeared on Croakey, the Crikey health blog (*blogs.crikey.com.au/croakey*). Croakey is funded by a consortium of health organisations: Public Health Association of Australia, VicHealth, Epidemiology Unit of the Victorian Infectious Diseases Reference Laboratory, Brain and Mind Research Institute at the University of Sydney, Australian Health Promotion Association, UNSW Research Centre for Primary Health Care & Equity, and the Australian Health Care Reform Alliance.*

IN THE 2010 Federal Budget, the Australian Government announced significant increases in funding for the health and hospital system.

Although the increased funding for health was timely and welcome, it does not address the challenges that confront the health system in respect to the dementia epidemic and the care of people with dementia. Adequately addressing this challenge requires much more than general increases in the number of doctors, beds and nurses.

The neglect of dementia in the COAG health reform process and the Budget was a great disappointment for the 1 million Australians whose lives are currently touched by dementia.

This neglect also has significant implications for future prevalence rates and treatments for dementia. If we do not invest now in dementia research, care and prevention we will experience increased costs in the future. There is strong evidence that we can reduce the future numbers of individuals with dementia and alleviate future pressures on the health system by properly

Dementia is a health problem too!

Glenn Rees laments the lack of attention to this massive health issue in the community

GLENN REES
Chief Executive Officer
of Alzheimer's Australia

resourcing dementia research and dementia risk reduction now.

What is needed is a revolution and reform; a cultural shift in the way the health system addresses dementia. Dementia needs to be recognised as chronic disease and not an inevitable part of ageing. As part of this recognition, we need a health policy that is aggressive in tackling dementia, through a commitment not only to high quality dementia care, but also to research.

In the 1950s, the response to cancer by those responsible for health policy was "let's beat it". We see no evidence of this attitude in respect of dementia. This is particularly alarming given the projection that as many as 1 million Australians will have dementia by the middle of this century. Even the prospect of dementia being the third largest area of health and residential care costs by 2030 and the largest by 2060 has not been enough to galvanise the political and policy focus of those in charge of the health system.

Aged Care

By contrast, there has been a stronger commitment by successive Federal Governments in providing specialised funding for aged care to directly confront dementia. The Dementia Initiative – Making Dementia a National Health Priority in the 2005 Budget provided additional funding for measures that have assisted better outcomes for people with dementia through the implementation of high care community packages, increased resources for training, funding for research into dementia care and funding for the National Dementia Support Program administered by Alzheimer's Australia.

Even so there was no additional funding provided for the Dementia Initiative in the 2010 Federal Budget despite the ever increasing number of people with dementia.

The Productivity Commission inquiry into aged care holds out the prospect of reform by promoting choice and greater flexibility in service delivery. If the 60-70% of people with dementia who live in the community are to remain there longer there is a need to address the inadequate funding of community services and the level of unmet need. Adequately funding community services is critical as they provide the care and social support necessary for older people with disabilities to remain independent.

National Health Reform

There has been no national action by the Commonwealth in response to the dementia epidemic in the areas of primary care, acute care, preventative health or research into the causes of dementia that is essential for the development of a cure.

The pleas of consumers for a primary care system that fosters timely diagnosis and effective ongoing care management have essentially been ignored.

There has been no systematic response to the problems that arise in the acute care system from the difficulty of recognising people that may have cognitive impairment. Failure to recognise cognitive impairment often results in a variety of additional secondary problems including increased falls, inadequate nutrition and greater confusion and agitation. It is also difficult to provide adequate and effective treatment of other diseases when an individual has unrecognised cognitive impairment.

We know that dementia is one of the most feared chronic conditions. Yet the policy and community response to dementia has largely been to treat dementia as a normal part of ageing and to carry on with business as usual through the aged care system and residential care in particular.

If the decisions of COAG are to amount to reform for people with dementia and their families and carers, the increased funding has to be translated into systemic reform. This reform must seek to achieve timely diagnosis, hospitals able to identify those with cognitive impairment, and preventative health programs that make the long awaited connection between physical health and brain health. Opportunities are lost in encouraging people to look after their physical health without also emphasising that what is good for your physical health is also good for your brain.

The growing numbers of people with dementia will place ever increasing demands on the aged care system. This means that funding for dementia support programs needs to grow in line with the prevalence of dementia over the coming years. It also means that working towards prevention and treatment for dementia now is even more important.

The challenge for Government is not simply to have more doctors, more beds and more nurses, but to provide better health outcomes for people with dementia and other chronic diseases, as well as providing support for research that will address the causes and treatments for this disease.

Private hospitals are part of Local Hospital Networks

IN CASE YOU missed this stunningly radical policy development, the daring announcement that private hospitals are part of Local Hospital Networks was buried in testimony the Commonwealth Department of Health and Ageing gave to a Senate Inquiry in early June.

This shift in thinking would, if implemented, change our hospital system forever.

But you needn't get too excited. This new era of competition is a pipe dream.

The statement 'private hospitals are part of Local Hospital Networks' is what the Department said. It may not have been what the Department actually meant.

One in 10 of all of Australia's hospital beds are operated in Catholic hospitals. Some are in public hospitals that have trained thousands of doctors and nurses. Others are in some of the nation's best private hospitals that are also training tomorrow's health workforce – a community contribution for which they're not widely recognised.

With feet in both public and private hospital camps, Catholic Health Australia is like many who are still unsure how Local Hospital Networks will work. The concept of devolved governance is one we support – it's how our hospitals have worked for decades.

But the confused view of the Department about private hospitals in local networks is just one of dozens of yet to be resolved challenges. The confusion suggests nobody yet has a detailed answer.

Our experience in both public and private hospitals leads us to having a very clear position as to where private hospitals should fit, and how they should relate to Local Hospital Networks.

Importantly, our view is not one driven by commercial need for profit. It's driven by a mission imperative to serve the health care needs of Australians.

Private hospitals will not by default simply become part of Local Hospital Networks. The networks, however, would be unwise not to incorporate into their health service plans the opportunity to utilise current or yet to be created private hospital capacity where it is willingly made available to undertake public patient services.

Many private hospitals, not just those in the Catholic network, will willingly seek to work with newly established networks. Others will want no role.

> This shift in thinking would, if implemented, change our hospital system forever

Yet the remarkably difficult target of treating 95 per cent of all elective surgery patients within clinically recommended times suggests networks have no choice but to partner with private hospitals if this probably unrealistic goal is ever to be achieved.

The success of these partnerships will be determined by the nature of the relationship the new networks establish with private operators. Not wanting to speak for commercial operators, Catholic Health Australia suggests the three essentials for success are:

1. Private hospital organisations within new network boundaries may or may not seek formal positions on governance bodies. Obvious conflicts will in some cases make such governance roles impossible. As a minimum, non-government providers need a place in policy and service planning. They need a figurative seat at the national oversight and local network tables, be that a legal seat or not.

2. Local Hospital Network service plans need to be inclusive of the opportunity for private service provision. The plans should allow for using current available private hospital capacity and for some new private capacity to be created. For many, this will be a new way of operating and some will not want non-government bodies at what has previously been a government only table.

3. Network agreements with

Martin Laverty tells us how **Catholic Health Australia** sees the future

MARTIN LAVERTY
Chief Executive Officer of Catholic Health Australia

private hospital providers need to be both certain and long term. It's not reasonable for private hospitals to be expected to do just occasional ad hoc work in times of peak demand. Agreements for treating public patients in private hospitals also need to be priced in recognition of what it actually costs to deliver the service.

Private patient services must continue in private hospitals as they do today. With the majority of surgery performed in the private part of the hospital system now, any significant disruption to this balance would see even more burden placed on public hospitals.

Most importantly, Local Hospital Networks must be established and operate in full transparency. The promised new methods of cost, performance and patient outcome accountability need to be achieved, and these accountabilities applied across both the private and public sectors.

Of course if real transparency and accountability is put in place, Australia might move a step closer to the future the Department of Health and Ageing envisaged when it implied to the Senate that public and private hospitals would start competing against each other.

If real transparency and accountability is in place, allocative efficiency could follow. Scarce health dollars could be directed to the most cost- and quality-effective parts of the public and private hospital system, leading to a win for both patients and taxpayers.

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

Implementing good ideas? Back the horse that's trying

Judith Dwyer gives some pointers on authority in the new system

Jack Lang, former NSW Premier, gave Paul Keating this famous advice: 'In any horse race, son, always back the one called Self Interest. At least you'll know he's trying.' This is more than a great line about how politics really works; it is also a profound insight into one of the most common reasons why good policies and ambitious social programs come to grief.

Think about the home insulation catastrophe – the only people who can be relied on to care about whether the insulation is needed, and properly and safely installed at reasonable cost, are the ones who live in (or own) the house. But they were side-stepped in the way the scheme worked. The installer sent the bill direct to the government, in some cases for houses that didn't exist, or that already had ceiling insulation. This can be seen as a principal:agent problem – the government effectively appointed itself as the householder's agent, and they didn't do a very good job at looking after their interests. The more general principle here is to align interests (and thus effort) with decision-making.

When it comes to re-designing the structure of the health system under the COAG-approved reforms, there is a lot to be gained from paying attention to this problem. Capital decisions are a good example. Under 'business as usual' rules in the public sector, the incentives for health services are to load up the costs of whatever project the government has decided to fund with everything they have ever wanted, because that's your bite at the cherry and it can be a long time between bites. The government capital managers' incentive is to build the cheapest project possible, regardless of impact on operating costs, because the operating budget is your problem.

A more virtuous alternative was used in Victoria under Kennett. Each Network was told how much money they would get for building projects over the following 5 years. The Networks then had to figure out what projects, at what cost, were most critical. You still had to go back to the government for release of the funds, so building the Taj for administration was not going to happen. But your incentives were firstly to design the thing for efficient operating; and then to find the best value option for each project, so that more of 'your' money was left for the rest of your agenda. This is what I would call correct alignment.

> Jack Lang gave Paul Keating this famous advice: 'In any horse race always back the one called Self Interest. At least you'll know he's trying.'

On any given day, those whose performance will be judged on the success of the local health services are going to be more focused on achieving that success than are those with broader and higher responsibilities. The idea of local health and hospital networks is based on this proposition. Now the challenge is to design the structures, the legislation and the delegations of authority so that the incentives are virtuous, and the horse is really trying. ha

What of the 'dumped' national funding authority?

ANDREW PODGER
President of the Institute of Public Administration Australia

croakey

There are more important concerns according to **Andrew Podger**

AS WE HEARD in June, the Federal Government has dropped plans for a National Funding Authority, which was announced as part of its health reform package, to oversee the distribution of money to state funding authorities for Local Hospital Networks.

Does this matter?

Nicola Roxon is mostly right. Dropping the National Health and Hospitals Network Funding Authority will not change anything substantial in the Government's health reforms. The state-based Funds (with boards including both state and federal representatives) will still be there to introduce activity-based funding of Local Hospital Networks.

But it does highlight the unfortunate compromise made with Premier Brumby that leaves the states with exclusive authority over much of the design and management of the Local Hospital Networks and constrains the ability to achieve a central objective of reform concerning a more flexible and integrated health and aged care system.

Hopefully the Government's move to direct the moneys straight from Treasury to these funds will not mean the continuation of the silliest aspect of the 2008 COAG 'reforms' which has the Federal health portfolio only tangentially involved in public hospitals (via its Outcome 13 for goodness sake) with the bulk of the funds identified only in the Treasury portfolio.

Please let us see the health portfolio having overall responsibility for a single national health system, with all the Commonwealth funds identified there, and all the accountabilities for national standards being brought together there.

Roxon is also right to say there is a large implementation task ahead and inevitably there will be tweaking in the process. I certainly hope so.

It is essential to give more strength to the primary health care organisations and their influence over planning and reporting on the overall health system in their regions, and to ensure they have some authority to shift resources between types of care.

I am sure there is also more work to be done on the structure of the Federal health portfolio to ensure capacity to analyse health and financial risks across the health system and to identify cost effective approaches to manage them, as a true national health insurer must. This might also lead in time to some separation of policy from administration, and a rethinking of the relationship between the Department and Medicare Australia, now unfortunately in another portfolio.

The key now is to maximise the benefits that can be obtained from the Government's initiatives, notwithstanding the disappointment of many of us that they did not go far enough.

There is still real potential for long-term gains not only to patient care but also to cost controls. But this potential will only be realised by careful implementation and some complementary measures over time.

Roxon is also right to say there is a large implementation task ahead and inevitably there will be tweaking

This article first appeared on Croakey, the Crikey health blog (blogs.crikey.com.au/croakey). Croakey is funded by a consortium of health organisations: Public Health Association of Australia, VicHealth, Epidemiology Unit of the Victorian Infectious Diseases Reference Laboratory, Brain and Mind Research Institute at the University of Sydney, Australian Health Promotion Association, UNSW Research Centre for Primary Health Care & Equity, and the Australian Health Care Reform Alliance.

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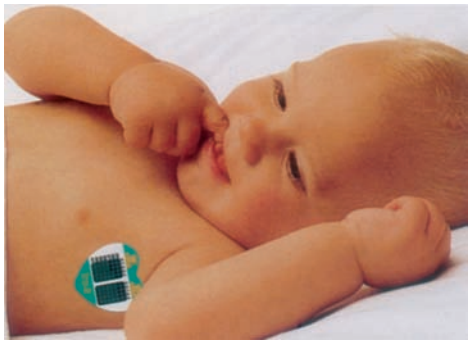

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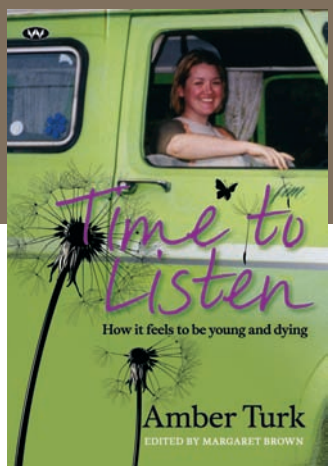
Amber's journey



Lessons for health professionals in dealing with **suffering and the end of life**

I feel that I am truly ready to die... I have had a fantastic life and have been so lucky to have so many wonderful people in my life who I have had the privilege of loving and who have loved me back. So I want you to celebrate all the good times and remember me when I was gorgeous. Because that is truly who I am. Not this sick, icky person who can't do anything... I wasn't perfect, but I know now that I didn't have to be.

Amber Turk, 21 July 2003.

Amber Turk lived with an inoperable brain tumour for 12 months before dying at the age of 27. During her final year she wrote a journal documenting her emotional and physical journey. Margaret Brown, a Research Fellow at the Hawke Research Institute, University of South Australia, brought together Amber's own words with those of her mum and a selection of health professionals who encountered her during the period of her illness.

A professional text

As well as being of general interest, this book is a text for medical professionals to read alongside books that teach about diagnosis, cause, treatment and prognosis.

Cassell's opening words in his book *The Nature of Suffering and the Goals of Medicine* are: 'The test of medicine should be its adequacy in the face of suffering.' His book starts from the premise that modern medicine fails that test. He argues that it is 'as though the scientific entity of disease is more real and more important than the person and the suffering... [it] is one of the strange intellectual paradoxes of our times'.

Cassell states that the four fundamental tasks of doctors are: finding out what is the matter (diagnosis); how it happened (cause); deciding what to do (treatment); and predicting the outcome (prognosis). Thus, he argues, the central assumption on which 20th-century medicine is founded provides no basis for the understanding of suffering.

The four tasks described by Cassell were attended to in Amber's medical care during her last 12 months. This book is not a criticism of the medical treatment or the care she received. The questions to be asked are numerous. Where was her suffering recorded or measured? What was it like to be diagnosed, treated and to be told the prognosis? How was she to deal with and accept the uncertainty that remained with her, from the time that her 'nose felt funny' and the diagnosis of a brain tumour, until her death?

It was completely unbelievable... there is the whole thing of what, what do we know – what is going to happen to me and so on? You just don't know and they don't know. The doctors don't know. Well, they say... we can try this and we can try that, but nothing they give you is enough to hold on to.

Listening as a fundamental moral act

Amber's journal became the witness to her suffering. She did not want to be a burden to her mother. Many of Amber's friends supported her and were important to her. Amber's pain must have been challenging for these young people who did not want to give up hope and believed that Amber would improve after each treatment. But Amber knew that she was going to die and she had to struggle with others not accepting that the treatments had failed. She also had to cope with the uncertainty of when she would die.

> Amber knew that she was going to die and had to struggle with others not accepting that the treatments had failed

Amber's need to be heard became increasingly intense, but who would listen? Arthur Frank, in his book *The Wounded Storyteller*, states:

[O]ne of our most difficult duties as human beings is to listen to the voices of those who suffer. The voices of the ill are easy to ignore... most of us would rather forget our own vulnerability... Listening is hard but it is also a fundamental moral act.

Where in the prescribed texts about caring for a dying patient is the emphasis on listening? Listening is not accountable, nor is it funded. You cannot define it or put a real value on it. But it is critical for people like Amber whose experience of life and death shows just how hard it can be to struggle through the pain.

Time to Listen: How it feels to be young and dying by Amber Turk (edited by Margaret Brown) is available from Wakefield Press: *www.wakefieldpress.com.au*.

Food, Inc.

Why it's so relevant for **Australian audiences**

Food, Inc. is not simply a documentary that exposes America's industrialised food system and its effect on the environment, health, economy and workers' rights. It's a campaign that encourages people to become actively involved in fighting for a healthier, fairer food supply.

Food, Inc. provides a devastating expose of the dysfunctional nature of the modern food system. It is a film that highlights the hypocrisy behind government attempts to encourage individuals to eat a healthy diet, while at the same time pursuing policies and partnerships with large food companies that create unhealthy food environments.

The film explains that in the space of a few generations the food system has been transformed from its ecological basis to a highly efficient commercial entity controlled from seed to supermarket by a small number of large multinational corporations. Revealing footage illustrates how the drive for increased efficiencies, 'innovations' and profit are positioned ahead of public health, social, animal welfare and environmental interests. For example, viewers are shown inside chicken farms that have become highly mechanised factories controlling drug and nutrition inputs that can produce a full weight chicken with enlarged breasts in 49 days that otherwise would take 3 months.

A particularly stark example of the exploitation of the power differential in the food system is illustrated through Monsanto's pursuit of an elderly farmer. The farmer operated a creaky old seed cleaner machine to help a handful of his friends preserve their seed supply. From a public health perspective this might be seen as a public good because it is protecting seed biodiversity albeit with contamination from some of Monsanto's genetically engineered seed. In the commercial world it was defined as a threat to ownership of a seed's genetic material. The film shows Monsanto's team of lawyers challenging this individual. After losing his savings attempting to defend himself, Monsanto then extracted the ultimate indignity – through tears he is shown being forced to reveal the names of his close friends to whom he had supplied cleaned seed.

Food, Inc. does not address food systems in other countries. So, how relevant is its analysis to the Australian context?

When we consider Australian circumstances such as the huge proportion of chicken meat sourced from intensive chicken factories, the duopoly controlling approximately 75% of the food retail sector and the pervasive influence of food industry interests in state and commonwealth food regulation committees, the answer is 'very relevant'.

There is a common lesson. Control of the food system by large corporations supported by government policies driven by an ideology of deregulation and the pursuit of unfettered growth, has resulted in a food system that is a commercial success, but a public health, social and environmental failure.

Clearly, the film's producers are aware that in exposing how large corporations are so entrenched in controlling the US food system they risk further disempowering the citizens they are attempting to inform. Much attention is

> The film explains that in the space of a few generations the food system has been transformed

DR MARK LAWRENCE
Associate Professor in Public Health Nutrition at Deakin University

devoted to actions and reforms to help shift the various power relationships within the food system. For example, linking food producers directly with citizens, making governments more accountable for their decision-making and encouraging citizens to 'vote' through the choices they make each time they purchase food.

The film's closing credits are accompanied by Bruce Springsteen's *This land is your land* – providing a powerful reminder of the film's core message. The film itself is one component of a broader campaign to promote change – there is a Food, Inc. website with valuable complementary information [www.foodincmovie.com].

A must see if you are concerned about where your food comes from and what's in it! ha

This article first appeared on Croakey, the Crikey health blog (blogs.crikey.com.au/croakey). Croakey is funded by a consortium of health organisations: Public Health Association of Australia, VicHealth, Epidemiology Unit of the Victorian Infectious Diseases Reference Laboratory, Brain and Mind Research Institute at the University of Sydney, Australian Health Promotion Association, UNSW Research Centre for Primary Health Care & Equity, and the Australian Health Care Reform Alliance.

E-health delivering real outcomes for the health system

THE SAFETY and quality benefits that e-health can bring to the Australian health sector have been well documented – notably the potential to improve direct patient care due to timely access to and transfer of quality, more accurate clinical information.

As the lead organisation supporting the national vision for e-health in Australia, the National E-Health Transition Authority (NEHTA) has focused on the establishment of a national e-health infrastructure. The use of modern electronic technologies for communication and clinical information transfer within health systems information is low in Australia. The work NEHTA is doing in building this critical infrastructure will allow e-health in Australia to progress even further and these benefits to be realised.

This is a national, consistent, secure standards-based set of components – the 'rail gauge' participation by all jurisdictions and health providers which will require compliance to the national standard, the arbiter of this being Standards Australia.

Key infrastructure includes:

- Health identifiers for all Australians (HI), for each registered health practitioner or Hippy (HPI-I health professional identifier –individual) and the Hippo (HPI-O organisations where they work);
- An authentication system (NASH – National Authentication System for Health);
- Standardising commonly used terminology; and
- Secure messaging enabling encrypted transfer of clinical information.

NEHTA welcomed the Federal Budget announcement on 11 May of a $466.7 million investment over two years as a 'down payment' by government towards the funding of a 'personally controlled' electronic health record for all Australians. There is no doubt that having electronic health records for all Australians is a key goal for the work currently being undertaken: all of which contributes to a better health system. The parameters for this are only now being proposed and the expectation is that consumer and clinical communities will be intrinsic to the development of this, not just consulted.

Some of the work NEHTA is doing now can contribute to outcomes for the greater health system. The Healthcare Identifiers are being developed conjointly with the technical teams working with the Clinical Unit. This Unit has practicing clinicians providing guidance and reality testing of the NEHTA 'products' ensuring that they are fit for purpose and competent in their scope. The Clinical Safety program ensures that these products are safe in the clinical environment. They will then need to be field tested and approved by the clinical community external to NEHTA.

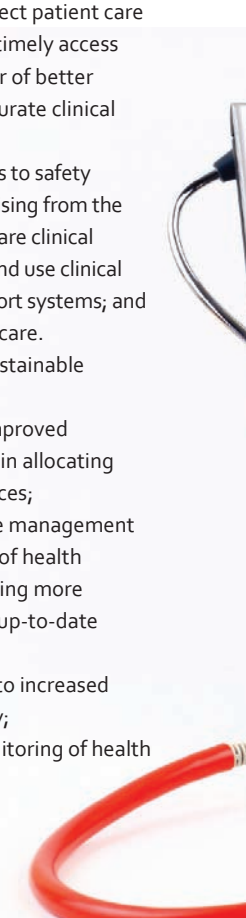
One of the most significant impacts of e-health will be in addressing all aspects of the national health reform agenda but that will require investment in the health system's IT infrastructure and considerable change management. The NEHTA work program ultimately contributes to the sustainability of the health system.

The first wagons on the new e-health railroad relate to the most commonly exchanged health information:

- e-Referrals: a clear, accurate and up-to-date summary mostly generated from the 'health home' – usually the GP to another clinical service in handing over care;
- e-Discharges: immediate, accurate patient records after care aware from the "Health Home" back to the community setting for continuity of care;
- e-Specialist: with some consistent themes for letters from health specialists; and
- e-Medication Management: reducing the risks involved in choice of therapeutic agents/medications, dosing, dispensing and administration of these. Minimising errors, avoiding interactions and allergies.

E-health will deliver:

- Safer healthcare
  - Improving direct patient care as a result of timely access to the transfer of better and more accurate clinical information;
  - Improvements to safety and quality arising from the capacity to share clinical information and use clinical decision support systems; and
  - Continuity of care.
- Efficient and sustainable healthcare
  - Promoting improved effectiveness in allocating health resources;
  - Improving the management and planning of health services by using more accurate and up-to-date information;
  - Contributing to increased accountability;
  - Enabling monitoring of health



DR MUKESH HAIKERWAL
National Clinical Lead with the National E-Health Transition Authority and former National President of the AMA

Mukesh Haikerwal updates us on where we are and where we want to be

reform and performance of the health sector;
- Delivering cost savings as a result of reductions in the duplication of treatment, diagnostic tests and hospital admissions;
- Improving the capacity for disease surveillance and disease management especially with emerging diseases (HIV, Swine 'flu, Bird 'flu, SARS);
- Improving outcomes of public health interventions on the basis of better, more accurate population health data; and
- Improving health research through access to more accurate and timely data, particularly population health data.

• Higher quality healthcare
- Supporting team-based care by improving the capacity to engage all health professionals in an individual's healthcare journey through improved access to shared clinical information;
- Supporting improvements in chronic disease management through access to shared clinical information by an individual's health providers; and
- Increasing the capacity for knowledge sharing among health professionals nationally and internationally.

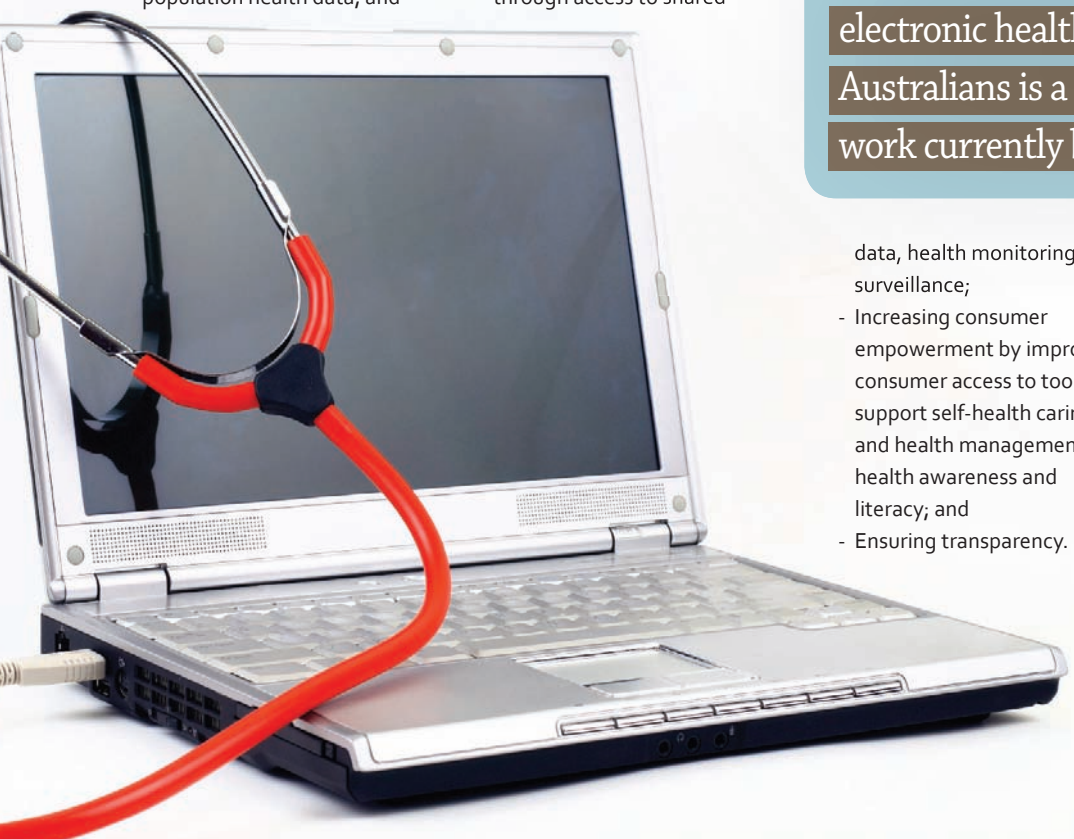
• Equitable healthcare
- Supporting and promoting innovation and responsiveness to local needs and demands arising from improved population health data, health monitoring and surveillance;
- Increasing consumer empowerment by improving consumer access to tools that support self-health caring and health management, health awareness and literacy; and
- Ensuring transparency.

• Accessible healthcare
- Continuing to support choice in our health system; and
- Improving responsiveness in our health system to local needs and demands.

Like any organisation NEHTA needs to be able to clearly demonstrate the benefits of its work. The above is a mere snapshot of how the work NEHTA is doing in e-health can deliver real clinical benefits. The final judge of the system and the benefits it will provide is in the hands of consumers, patients, you and me. We need to be guided through this by the clinicians who we enlist to care for us. We all have a part to play in this and we need to "be the change you want to see in the world" (Mohandas K. (Mahatma) Gandhi).

For more information on NEHTA's work visit the website at *www.nehta.gov.au*.

> There is no doubt that having electronic health records for all Australians is a key goal for the work currently being undertaken



ANNE TRIMMER
Chief Executive Officer of the Medical Technology Association of Australia

Providing the best care where patients need it

Anne Trimmer discusses the push for an **Essential Care List Scheme**

THE MTAA IS CALLING on the Commonwealth Government to establish a national Essential Care List (ECL) scheme. It would cover consumable medical products essential for patient care in a community or home-based setting. With subsidised access to medical products, patients will be more easily able to obtain the items essential for their care. The ECL proposal combines several existing State and Commonwealth schemes as well as a small number of additional products not currently subsidised.

One integrated ECL instead of multiple schemes makes it easier for patients to access products at a time when they are most in need.

Medical technology companies manufacture and supply a wide range of products which contribute to earlier diagnosis and less invasive intervention. They return patients to productive working lives and help them to live independently.

At present many of the medical technology products essential for patient care are either unfunded or, if funded, vary in availability and subsidy depending on the place where the patient lives. Some assistance is available from the Commonwealth Government while other support is from State Governments. Some products are provided for free by healthcare practitioners who understand the benefit to the patient from the use of a particular product.

Access by a patient to products listed on the ECL would follow assessment by a healthcare professional, who may be a specialist nurse for example.

The following criteria are proposed for products to be listed on the ECL:

- Products are essential to the patient's quality of life or survival, in all settings outside hospitals including the community setting and residential care;
- Products should be capable of self-administration or administration with the help of a carer or, if required, by a relevant healthcare professional (which would include home visiting nurses);
- Products must be safe and efficacious and, where regulated, included on the Australian Register of Therapeutic Goods (ARTG);
- Products are appropriate for prescribing in the community setting;
- Products are clinically effective – required levels of clinical evidence will be higher where similar products have not been listed before or where a manufacturer or supplier seeks a higher price than for similar products already listed; and
- The cost of the product is relative to its clinical effectiveness.

The scheme is not intended to be fully-funded and requires a degree of patient co-contribution. MTAA estimates an amount in the range of $200-650 million per annum from government sources, depending on the scope of included items. This sum is a combination of what is currently being spent in the various schemes across Commonwealth and State health budgets, plus additional areas that are currently unfunded. The estimate does not take into account administrative cost savings achieved through the merger of current stand-alone schemes, which we anticipate would be significant.

MTAA believes that through smart administration and increased access to products that enable patients to remain in the community rather than be admitted to hospital, savings for the health system can be achieved.

This will not only be good for the patient, but also deliver cost savings to the Australian economy. Patients will be able to remain productive members of the workforce and stay in their own home, or reduce dependence on a carer.

In general the products contemplated by the scheme can be characterised as aids for daily living that are for the critical care of a patient or that improve the quality of a patient's life. These will often be consumable items that are low technology. In some cases however they may be durable products, and may involve much higher levels of technology sophistication. The product range will also include the hardware that is supported by the consumables. They include:

- oxygen supplies/consumables
- compression hosiery, bandages and garments for lymphoedaema
- continence products
- modern wound care devices (including wound dressings)
- breast prosthetics (non-implantable)
- pumps and consumables for insulin delivery, and continuous flow pumps for drug delivery, together with consumables
- CPAP/sleep apnoea devices
- laryngitic products
- diabetes consumables (pens, strips, pump consumables)
- home dialysis devices, consumables and set-up costs.

More information about the ECL Scheme is available in MTAA's Federal Budget submission at *www.mtaa.org.au/policyissues*.

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Flinders Medical Centre Adelaide chose an Armstrong Infinity flooring solution.

Armstrong's Australian-made, custom-designed and environmentally responsible flooring solutions win out in two major healthcare projects.

Two recent major healthcare installations, Flinders Medical Centre in Adelaide and Royal Children's Hospital in Melbourne, confirm Armstrong Flooring's leadership in this important industry segment.

In both competitive tenders Armstrong's solution provided the flexibility of custom design and environmentally responsible material combined with local manufacture, technical support and comprehensive warranties.

Armstrong Infinity: a custom-designed solution made possible by local manufacture and technical support.

The flooring solutions for both these healthcare projects incorporate Armstrong's custom-design product, Infinity. Based on the proven Armstrong Accolade Plus and slip-resistant Accolade Safe Plus ranges, it provides interior designers, architects and specifiers with the freedom to custom-design a floor that harmonises with the overall vision for the interior.

Armstrong Infinity can be custom-designed online at www.armstronginfinity.com.au

The Infinity palette provides a range of 24 harmonious base colour combinations, to which can be added additional colour chips to create a floor that matches a project's required colour scheme – which can be designed online at www.armstronginfinity.com.au

A particular feature of the Flinders Medical Centre installation was that the project was staged in two parts: after the Birthing Suites were completed in 2009, the client was pleased with the results and decided to specify Infinity for the Critical Care Ward, which was installed in 2010. The consistency of the Infinity production process allowed Armstrong to achieve a perfect colour match for each installation.

Armstrong Accolade smoothly transitions from wet to dry areas – a logical and proven choice in healthcare.

Armstrong Accolade is made from inert materials that do not harbour bacteria, making it ideal in healthcare environments. It can be coved up the walls in bathrooms and the melding of standard and slip-resistant sheets allows designers to create a seamless integration between wet and dry areas.

All of which contribute to integrated design, easier cleaning and maintenance and less chance of dirt or organisms building up.

Armstrong Infinity installed in the Birthing Suites at Flinders Medical Centre.

Armstrong is a long-standing Australian manufacturer of commercial vinyl flooring and leads in environmental innovation and practices.

Armstrong is the only Australian manufacturer of broad-based PVC sheet and tile flooring; for 40 years we have invested locally with two flooring plants and nearly 200 people producing durable high-performance products.

We use resources wisely, incorporating post consumer recyclate in our products with no compromise to performance. We have achieved national recognition for our environmental achievements including winning the National Greenhouse Challenge Plus award for reduction in CO_2 emissions, the Keep Australia Beautiful awards for our innovative use of recycled post consumer waste and twice been a finalist in the Savewater Awards®

For more information, call 1800 632 624 or visit www.armstrongflooring.com.au

Become an AHHA member

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

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

Network and learn

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

AHHA values your knowledge and experience

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

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

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

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

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

Image: iStockphoto

Membership Fees 2010/11

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

*Companies providing products and services to healthcare providers

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

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

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

2011 Membership Applications and Renewals

Australian Healthcare & Hospitals Association

Tax Invoice

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

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

Institutional ☐ _____

(See 2010/11 fee scale)

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

Member Details

Name _____

Position _____

Organisation _____

Postal address _____

Suburb _____ State _____ Postcode _____

Email _____

Institutional members may specify an IP address: _____

eSubscriptions (optional)

☐ **Just Health e-Newsletter** - The day's news, events and jobs updates (weekdays)

☐ **E-Healthcare Brief** - The week's news and AHHA updates edited by the AHHA team (weekly)

☐ **AHR Preview** - A reminder to check online for the current quarter's *Australian Health Review*

Payment Details

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

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

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

☐ **Credit Card Payments:**

☐ American Express ☐ Diners

☐ Mastercard ☐ Visa Amount _____

Cardholder Name _____

Card Number _____

Expiry _____ Validation Number _____

Authorised Signature _____

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

Please retain a copy for your records

Trade news

Information from suppliers in the **healthcare industry**

Interest mounts as federal election looms

HEALTH policy is in flux with government takeovers in the wind, obesity and ageing are growing concerns, on the upside innovations in e-health look towards a brighter future. Will the reforms bring the efficiencies that are promised? What further investment in healthcare is needed to ensure that our burgeoning health system is fixed? The Financial Review National Health Conference will debate these issues and many others.
Joining the speaker line-up will be:

- Richard Bowden, Managing Director, Bupa Australia
- Tony Canavan, Director, Partnerships Victoria
- Richard Cooper, Head of Infrastructure, Project Finance, National Australia Bank
- Peter Fleming, Chief Executive Officer, National e-Health Transition Authority (NEHTA)
- Patrick Grier AM, Director, Ramsay Health Care
- Ian Hardy AM, Chief Executive, Helping Hand Aged Care
- Professor Stephen Leeder, Director, Menzies Centre for Health Policy, Public Health, School of Public Health, The University of Sydney
- Mary Ann O'Loughlin, Executive Councillor & Head of Secretariat, COAG Reform Council
- Dr Andrew Pesce, Federal President, The Australian Medical Association
- Dr Lesley Russell, Menzies Foundation fellow at the Menzies Centre for Health Policy, University of Sydney-Australian National University; research associate at the US Studies Centre, University of Sydney; and visiting fellow at the Centre for American Progress, Washington, DC.
- Tim Treby, Project Director, Abigroup

The conference will look at the importance of investing in healthcare and the impact of health reform on the sector.
If you would like to join the discussion and be part of this conference go to *www.afr.com/events*

The future is now

HEALTHCON 2010 is a journey through alternative dimensions and models of quality health care. Our futuristic and action-packed program will address the biggest issues in healthcare policy and management including how to take forward health services in the new reform environment, how to make best use of powerful technologies, how we communicate better and how to avoid getting swept up in future shock.
You can now register for all three days of the AHHA-AIHPS HEALTHCON program at a great price, which includes the workshops on 22 September, the full Congress over 23-24 September and all social events. Be quick, early bird rates close on 9 August!
Visit the website at *www.ahhacongress.com.au* to view the excellent program and register online.

ahha

AUSTRALIAN INSTITUTE OF HEALTH POLICY STUDIES

Why the leading Australian cancer centres are looking to Fresenius Medical Care Seating

ONCOLOGY and Chemotherapy centres across Australia are increasingly finding the need for a high level of patient care and staff safety. They are requiring the most advanced and versatile equipment available, the T600 Treatment chair. The T600 was designed to reduce the Occupational Health and Safety risks prevalent in units where a high level of nurse/patient interaction is required, whilst still providing a high level of patient comfort. The T600 Treatment chair achieves this and so much more...

Visit *www.freseniusmedicalcareseating.com.au* for further information.
Fresenius Medical Care Australia Pty Ltd recently announced a change to the Name of Artistic Healthcare Seating Pty Ltd, which now will become Fresenius Medical Care Seating (Australia) Pty Ltd.
To assist in updating your records, please note the following information:
Fresenius Medical Care Seating (Australia) Pty Ltd
(Formerly Artistic Healthcare Seating Pty Ltd)
786 Stud Road Scoresby VIC 3179 (03) 9780 9500

Fresenius Medical Care

QUT researcher, Dr Adrian Barnett.

Killed by cold: heart and stroke deaths peak in winter

RATES of cardiovascular disease increase dramatically in Australian winters because many people don't know how to rug up against the cold, a Queensland University of Technology (QUT) researcher has found.

Dr Adrian Barnett said the numbers showed that winters in Australia posed a greater risk to health than winters in cold northern European countries such as Finland and Sweden.

"When the temperature goes below 19 degrees in Australia the death rate from heart and circulatory problems goes up.

"We are not very good at protecting ourselves against the cold weather, we don't wear the right sort of clothes in winter and our homes are often not well insulated.

Exposure to the cold raises blood pressure because the veins and arteries constrict, which puts extra stress on the heart and circulatory system.

"We can easily cope with 30 degrees, which people in northern Europe cannot do, but we are very fragile creatures when the temperature drops, even if it is only around 15 degrees," he said.

Dr Barnett said putting on thermals, hats, gloves and slippers was more effective than heaters.

With the support of an expert QUT team you too can address national and global health challenges and help solve highly relevant problems for a better future.

For more information phone 07 3138 8290, email health.research@qut.edu.au, or visit *www.health.qut.edu.au*

Grow your super

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

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

1. Government co-contribution

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

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

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

2. Make a salary sacrifice

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

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

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

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

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

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

Snippets

The **last** word

Queensland Reconciliation Awards for Business

Partnerships Award winners Nhulundu Wooribah Indigenous Health Organisation and Gladstone News Weekly

The Queensland Government's Reconciliation Awards for Business are designed to recognise organisations that are paving the way for reconciliation in Queensland. Now in their eighth year, the Reconciliation Awards for Business provide an opportunity to shine a spotlight on organisations of all sizes working on reconciliation projects and initiatives around the State and allow them to share their achievements with others.

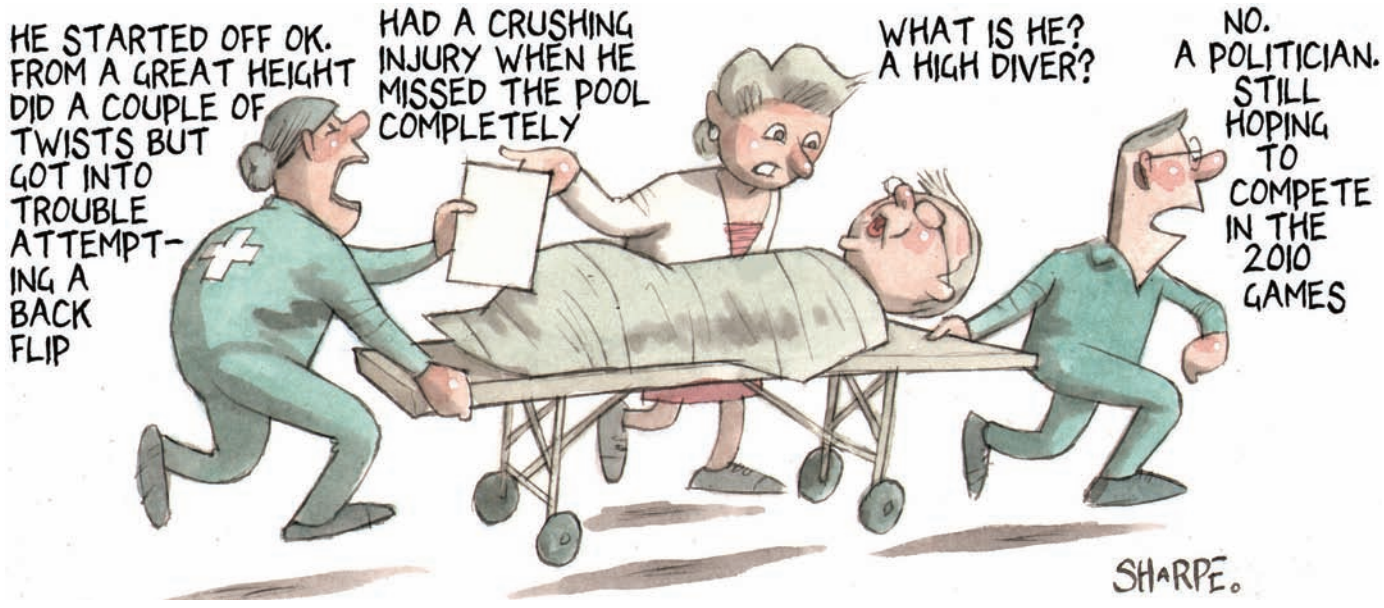
This year two health organisations were among the recipients.

Blue Care (an AHHA member) received the **Community Organisation Award** for non-profit organisations. Blue Care's commitment to encouraging reconciliation is demonstrated through the ongoing program development and employment of Aboriginal and Torres Strait Islander staff, and improving access to aged and health care related services for Indigenous people. Blue Care employs more than 130 trainees every year and has established cross cultural training programs, mentoring, scholarships and career paths for their continued employment in health care. Blue Care also continues to forge strong support to Aboriginal and Torres Strait Islander health providers in South West Queensland, North Queensland, Hervey Bay and the Torres Strait.

Community Organisation Award winner Blue Care

Nhulundu Wooribah Indigenous Health Organisation and Gladstone News Weekly received the **Partnerships Award**. The two organisations joined forces in late 2008 to highlight the positive contribution and achievements of Aboriginal and Torres Strait Islander people to the Gladstone community through reporting positive news stories. The publication and promotion of Indigenous achievements has contributed to forming strong cross-cultural bonds in the community, while also fostering a greater understanding of Indigenous people, their contributions and their cultures. In 2010, the partnership will launch the Gladstone Region Indigenous Community Awards to recognise local Indigenous achievements.

For more information on the awards visit *www.reconciliation.qld.gov.au*.



Reduce the risk of needle-stick injuries

Sandoz have a number of injectable products available with hangers.

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

- **Removing steps in the production process**

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

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

  Reducing the preparation time provides efficient healthcare work practices.

  Cost effective solution by minimising waste and materials.

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hospital.division@sandoz.com or Call 1800 SANDOZ

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