The Health Advocate

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The official magazine of the Australian Healthcare & Hospitals Association

Your voice in public healthcare

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Healthcon 2010

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More with the same says Mark Jennings

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Stephen Duckett explores their creation and funding

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- Health and climate change
- 2010 Victorian Healthcare Awards
- Reform must be evaluated

HESTA Australian Nursing Awards 2011

Do you know a remarkable nurse?

Recognise the outstanding efforts of a remarkable nurse by nominating them in one of three categories:

- *Nurse of the Year*
- *Innovation in Nursing*
- *Graduate Nurse of the Year*

$25,000 in prizes to be won!*

NOMINATE NOW!
Nominations close 28 February 2011

2010 Winners

Winners announced at a gala dinner on Thursday 12 May 2011 at Melbourne's Crown Entertainment Complex

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Remarkable nurses keep inspiring

HESTA Australian Nursing Awards 2011

Re-mark-ab-le (adjective): extraordinary; worthy of notice or attention.

Now in its fifth year the HESTA Australian Nursing Awards are once again accepting nominations in the Nurse of the Year, Innovation in Nursing and Graduate Nurse of the Year categories.

As one of Australia's most prestigious nursing events, the annual awards attract hundreds of nominations, from throughout Australia.

"The stories shared through these nominations are inspiring," says HESTA CEO, Anne-Marie Corboy.

"They are the remarkable accounts of nurses who work in trying circumstances, the nurses who work with patients with challenging needs and nurses who always put their patients first."

Ms Corboy said the awards provided a great opportunity for HESTA to thank nurses, midwives, personal care attendants and assistants in nursing.

"The HESTA Australian Nursing Awards recognise the skills, commitment, achievements and enormous contribution that those in the nursing sector make to Australia's wellbeing."

Nominations now open

"In the Nurse of the Year category nominations can be made by nurses, colleagues, patients and patients' families. It's a great way for patients to show their gratitude or for peers to acknowledge a nurse who makes an extraordinary effort," says Ms Corboy.

"Innovation in Nursing nominees can be teams or individuals, and they usually nominate themselves. The prize money is directed towards expanding or extending their innovative product, service or program."

Only Graduate Nurse Coordinators can nominate in the Graduate Nurse of the Year category.

"If you know a remarkable nurse, I urge you to take the time to nominate them for an award. Whether they work in midwifery, palliative care, aged care, community nursing or emergency care, we want to hear about them," says Ms Corboy.

"Our judging panel of trained nurses, academics and industry representatives looks forward to learning about another group of amazing nurses in 2011."

Nominations close on **Monday 28 February 2011**. The finalists will be announced in April. They will be flown to Melbourne for a gala awards ceremony, at Crown Entertainment Complex, on Thursday 12 May 2011.

To make a nomination, simply visit **hestanursingawards.com** and complete the online form.

Prizes

Major sponsor ME Bank, a supporter of the awards since 2008, proudly provides the prize pool.

- Nurse of the Year: $5,000 travel voucher and $5,000 education grant
- Innovation in Nursing: $10,000 development grant
- Graduate Nurse of the Year: $2,500 travel voucher and $2,500 education grant

Winners

A cool autumn evening was no deterrent for the formally-attired guests who filled the Palladium Room at the Crown Entertainment Complex, for the HESTA Australian Nursing Awards 2010. And within the crowd were the nurses of tomorrow, watching and listening.

As Tory Koch, a student nurse from Flinders University, said, "The fabulous evening highlighted that I have chosen correctly for my career – nurses are inspiring people!"

In 2010 the winners were:

Nurse of the Year
CHARLOTTE COLLINS (WA)

Charlotte, a mental health nurse, who manages a team of professionals and looks after a personal caseload of complex patients, was recognised for her advanced negotiation skills in crisis situations and her advocacy for vulnerable patients.

Finalists: Adele Mollo (VIC), Brendan Roche (WA), Ian Nethery (TAS), Petria McCallum (SA)

Innovation in Nursing
JACINTA VANDERPUUE (NSW)

Jacinta, a clinical nurse educator, and her team developed a diagnostic colour chart to help prostate surgery patients, accurately describe their symptoms to medical staff.

Finalists: Christine Lancaster (NSW), Suanne Robertson (QLD)

Graduate Nurse of the Year
JAMES BONELLO (SA)

James, an emergency nurse, who is also a Lance Corporal in the Army Reserve and a St John Ambulance volunteer, was selected for his community commitment, dedication to further education and integration of holistic care in his nursing practice.

Finalists: Debra Young (VIC), Jess Trubiano (VIC)

About us

HESTA has more than 690,000 members, 89,000 employers and $16 billion in funds – invested for the retirement of our members. We are the Fund more people in health and community services choose.

For more information and to purchase tickets visit: hestanursingawards.com

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AHHA Council and supporters

The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation, the protection of its assets and the quality of its services. The 2010-2011 Board is:
Dr David Panter (SA)
National President
Dr Patrick Bolton (NSW)
National Vice President
Dr Paul Scown (VIC)
National Vice President
Mr Felix Pintado (VIC)
National Treasurer
Ms Siobhan Harpur (TAS)
Director
Dr Yvonne Luxford (Associate Member Representative)
Director

The AHHA National Council oversees our policy development program. It includes the AHHA Board above and the following members for 2010-2011:
Mr Grant Carey Ide (ACT)
Ms Helen Chalmers (SA)
Dr Stephen Christley (SA)
Ms Rosio Cordova (NSW)
Dr Martin Dooland (SA)
Ms Jan Evans (NT)
Dr Mary Foley (NSW)
Ms Jane Holden (TAS)
Mr Graem Kelly (VIC)
Dr David Mountain (WA)
Ms Shaune Noble (NSW)
Mr Patrick O'Brien (QLD)
Dr Tony O'Connell (QLD)
Associate Professor Alan O'Connor (QLD)
Mr Ross O'Donoghue (ACT)
Adjunct Professor Annette Schmiede (NSW)
Ms Joan Scott (ACT)
Mr John Smith (VIC)
Mr Mark Sullivan (VIC)
Ms Sandy Thomson (WA)
Dr Annette Turley (QLD)
Ms Anna Fletcher (Personal Member representative)
Dr Owen Curteis (Asian Hospital Federation)
Professor Helen Lapsley (International Hospital Federation)

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Other organisations support the AHHA with Institutional, Corporate and Associate membership. To find out about joining the AHHA and having your organisation listed contact Terrie Paul.

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DR DAVID PANTER
President of the Australian Healthcare and Hospitals Association

President's view

The number of councillors on the AHHA's National Council has been increased to ensure equity between states and territories. I would like to welcome all the new and renewing members of the AHHA's Council and Board for 2010-2011

I AM HONOURED to be representing the Association as president for another year following the annual elections at the 2010 Annual General Meeting, held in conjunction with the Congress on 23 September in Adelaide.

In preparing for the AGM, I noted that the Association's policy work undertaken during the last twelve months had impacted very positively on the national reform agenda.

It is significant to note that the AHHA has been operating since 1946 as the independent national body representing the public healthcare sector. Over the years since then we have built a strong reputation in all jurisdictions for supporting and representing our members across the breadth of health sectors and services. Our major strength is our capacity to bring members together in communities of interest and policy think tanks to discuss the topical issues affecting us all.

Consequently, our policies and statements are not only focused on achieving a better public healthcare sector but, more importantly, on reflecting the views of members, as you are responsible for managing health services and caring for patients. It is this vital perspective that gives the AHHA its leading voice in influencing government reforms and programs.

AHHA Council and Board for 2010-2011

Under the AHHA's Constitution, all national councillors are required to renominate each year and ratification occurs at the AGM. As a result of this process, we have a very vibrant and experienced National Council and I am very pleased to welcome all new and renewing national councillors. I know they will represent your interests with enthusiasm and expertise. I wish to acknowledge the long-standing commitment of national councillor, Peter Le-Gallou from SA, who has stood down.

The AHHA's AGM incorporated a Special General Meeting to consider proposed amendments to the Association's Constitution. The revisions were aimed at giving more equity between states and territories on National Council (increasing the numbers to a potential for 33 councillors) and to increase the size of the Board from four to six directors. The AGM duly passed the amendments and the resulting National Council for the forthcoming 12 months is listed on page 5. Board directors, elected by and from the National Council members, are indicated. If you would like to know more about our councillors, please visit the gallery page of our website, **www.aushealthcare.com.au**.

AHHA staff

On behalf of all members, I thank the AHHA staff for their fantastic work in managing the wide range of products and activities with limited resources. In doing so, I wish to formally acknowledge the loyalty and commitment of our financial consultant, David Sly, whose sudden and unexpected death during the year was a tragic loss to his family, the AHHA and all who knew him.

AHHA members

Lastly, and as this is our final edition of *The Health Advocate* for 2010, I thank all members for helping us to continue our valuable work over the past year and wish you a safe and relaxing festive season. ha

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The statistics are staggering. Every year, thousands of healthcare employees in Australia suffer the trauma of needlestick or sharps-related injuries at work.[1] It can happen in an instant. Even the smallest skin puncture can expose the employee to more than 30 potentially life-threatening bloodborne pathogens.[2] And yet, the majority of these injuries can be prevented by implementing safety-engineered medical devices combined with education and training.[3-5]

For nearly two decades, BD has led the global effort to protect healthcare employees from the significant risk of occupational exposure to bloodborne pathogens. The passion that BD associates have for improving safety in the healthcare workplace is seen through innovations in technology, product development, manufacturing and education, as well as collaborations with organisations that share our purpose for *helping all people live healthy lives.*

[1] Murphy C. Improved surveillance and mandated use of sharps with engineered sharp injury protections: a national call to action. *Healthcare Infection 2008;* 13:33-37.

[2] Tarantola A, Abiteboul D, Rachline A. Infection risks following accidental exposure to blood or body fluids in health care workers: A review of pathogens transmitted in published cases. *Am J Infect Control, 2006;* 34:367-75.

[3] Sohn S, Eagan J, Depkowitz K *et al.* Effect of Implementing Safety Engineered Devices on Percutaneous Injury Epidemiology. *Infect Control Hosp Epidemiol 2004;* 25:536-542.

[4] Lamontagne, F, Abiteboul D, Lolom I *et al.* Role of Safety-Engineered Devices in Preventing Needlestick Injuries in 32 French Hospitals. *Infect Control Hosp Epidemiol 2007;* 28:18-23.

[5] Jagger, J. Caring for Healthcare Workers: A Global Perspective. *Infect Control Hosp Epidemiol 2007;* 28:1-4.

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Congress report: HEALTHCON 2010

THE ONGOING PARTNERSHIP between the AHHA and the Australian Institute of Health Policy Studies produced another memorable Congress with three days of vibrant presentations, panel discussions and networking events. The event focussed on the future of healthcare in Australia and left delegates with an expanded understanding of the national health reform process.

Health Ministers Nicola Roxon (Commonwealth) and John Hill (South Australia), together with an excellent team of keynote and sessional speakers stimulated delegates. Special guests, Graham Phillips (dinner speaker) and Bernie Hobbs from ABC TV (panel facilitator) entertained us with their wit and knowledge.

AHHA-AIHPS Congress 2010

Multiple Dimensions of Healthcare
22-24 September in Adelaide

Congress Policy Think Tank

Day one of the Congress was a debate and workshop chaired by Professor John McCallum who beamed us up into National Health and Hospitals Network Reforms. We discussed the lack of an evaluative framework in the reform agreement and debated how we will measure and know the outcomes and impacts. We also identified key issues for health facilities when implementing the reform agenda.

After establishing the principles for the national health reform, John stayed with the futuristic theme by inviting delegates on board the Enterprise. He told us that our first passengers should be today's researchers, practitioners and policy makers because, on our journey into the new century, we must forge stronger collaborations between these groups. In this way, we will build the necessary platforms from which to translate evidence-based research into practice.

An expert panel consisting of Mr Peter Broadhead, Professor Kathy Eagar, Professor Philip Darbyshire, Mr Alec Djoneff, Dr Mary Foley, Professor Sandra Leggat, Dr Emma Parkinson-Lawrence, Professor Vivian Lin, Professor Adrian Nowitzke and Professor Brian Oldenburg also shared their views on the health reform process and identified key issues for implementing the Australian reform agenda.

A number of presenters emphasised the need for good research to underpin implementation of the reforms, supporting John McCallum's earlier remarks that collaborations are needed to build a sustainable research environment.

Break-out groups discussed issues flowing from the morning's stimulating presentations, including key priorities for evaluation and applied research, critical collaborations between researchers and practitioners and the advocacy agenda for the AHHA and AIHPS.

Participants concluded that without a coordinated research agenda linked to the national reforms, it will be impossible to assess their impact. They agreed to mount a campaign calling on the Council of Australian Governments (COAG) to establish a National Evaluation and Monitoring Framework with dedicated funding. This will ensure that research can generate the necessary evidence >

> The congress panel was excellent – very skilled facilitation by Bernie Hobbs and a lovely interaction with panel members.

to assess the outcomes of the reforms at a local and regional level and where necessary, make changes to improve the implementation process.

Research under this framework should be linked directly to the Local Hospital Networks and Medicare Locals so that health services

> Mark Jennings was a highlight – the whole conference was excellent.

can collaborate with researchers in their local area and be supported to undertake research that can lead to local improvements. This evaluation also needs to be supported by a National Health Research Innovation Fund to ensure research findings are translated into improvements in the delivery of health care.

AHHA awards

The second day began with two important presentations. In recognition of their outstanding contribution to the Association and to healthcare in Australia, AHHA President Dr David Panter awarded Professor Kathy Eagar with Life Membership while the Sidney Sax Medal, the AHHA's highest award, was presented to Gillian Biscoe. Both were thrilled with their awards. You will find more details and photos on pages 11 and 42. Gillian Biscoe was a fabulous MC once again for our Congress.

Ministerial speeches

Australia's longest serving Health Minister, South Australia's John Hill, opened the Congress on day two. In his usual well-informed style, he discussed the national health reform agenda and the complementary and ongoing activities in South Australia.

The Commonwealth Minister for Health, Nicola Roxon, opened the third day of the Congress. This was her first major speech after being re-appointed as Minister for Health and Ageing following the federal election. Her speech certainly gave us a valuable opportunity to hear first-hand how she envisages implementing the reforms during her second term.

> Exceptional speakers!

Nicola remembered back to her address and discussion at last year's Congress in Hobart and has kept her word when she told us that change was on its way. Much has happened since then. She referred to the "landmark agreement" with the states and territories (except Western Australia) at the April COAG meeting, complemented by the major budget announcements in May, which focussed on primary care, e-health and aged care investments. She generously made herself available to join delegates for morning tea after her speech.

Keynote speeches

Reaching for the stars – a vision for the future was the session title for two high profile international experts from the US and UK, invited to the Congress because of their focus on linking practice and research in healthcare. Mark Jennings, Director of Health Care Improvement from the Kings Fund in the UK talked about turning policy into practice while Dr Eric Silfen, Chief Medical Officer of Philips

> The plenary sessions were fantastic – excellent speakers who acknowledged each other's views and ideas.

Healthcare in the USA, discussed innovations and challenges in biomedicine.

Other keynote speakers on day two included Professor Tony McMichael of the Australian National University, who discussed the importance of climate change challenges to health and healthcare, and Professor Niki Ellis of the Institute for Safety Compensation and Recovery Research, who took the delegates on a journey in building future thinking and methods in research agenda planning.

Professor Kathy Eagar of the University of Wollongong motivated delegates with her passion for healthcare. She looked to the 'brave new world' of the future with some enlightening thoughts and took the opportunity to make us aware of multiple issues within the health reform process with her presentation *Your integration is my fragmentation: design flaws and ways forward for the Australian health system*. Kathy's colleague Professor Judith Dwyer from Flinders University took a policy perspective in her presentation, *Your control is my paralysis: how high policy goals in the capital work out in the suburbs and what can be done about it* and demonstrated clearly that there are several issues across the multiple dimensions of healthcare and the national health reforms.

Other sessions

Delegates found it hard to choose between the great speakers in the concurrent, breakfast and lunchtime sessions. In the final session, Bernie Hobbs, a judge on ABC TV's 'The New Inventors' expertly, and with a lot of humour, facilitated the Congress panel.

Next year's Congress

Looking to the future, the 2011 Congress will be presented by the AHHA and AIHPS together with a brand new healthcare collaboration. We are partnering with the Australasian Association for Quality in Health Care, the Australian Council on Healthcare Standards and the Royal Australasian College of Medical Administrators to put on a block-buster conference to be held in Melbourne at the Hotel Sofitel from 12-14 October.

> Gillian Biscoe was excellent as MC and a very worthy recipient of the Sidney Sax Medal. Her humour, warmth and honesty set the stage for a wonderful congress.

Entertainment

On Thursday evening our cocktails were sponsored by the HESTA Super Fund and the Congress dinner was sponsored by Philips Healthcare. The guest presenter Dr Graham Phillips from the ABC TV science program Catalyst, entertained delegates with interesting stories and ideas. Over to the side, a local body painting artist, Emma Hack, created a futuristic painting on her model.

The theme of the 2011 Congress is *The great healthcare challenge! - achieving patient-centred outcomes*.

More information

Visit the AHHA website, **www.aushealthcare.com.au**, for more information including many of the presentations which are available to download.

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Wilkie deal a plus for hospitals

IN SEPTEMBER, THE AHHA welcomed the agreement between Federal Labor and independent MP-elect Andrew Wilkie for additional funding for Royal Hobart and other hospitals.

This agreement reflected AHHA's insistent calls over many years for funding to address ageing public hospital infrastructure around Australia. The $340 million for Hobart hospital and the $1.8 billion for other hospitals will greatly assist in upgrading equipment and buildings to world-class standards.

To ensure that this funding delivers the best possible gains to the community, the AHHA believes it is essential that extensive consultation take place with our members to assess the types and level of services required in each region.

The AHHA is the only independent body representing public hospital, community and aged care facilities at a national level. We have the knowledge and experience to advise on how these funds can be distributed to achieve maximum health gains.

Means-testing health rebate will help rural Australia

HEALTH MINISTER NICOLA Roxon has called on the independents in both Houses of Parliament to support the government's plans to reintroduce legislation to means-test the private health insurance (PHI) rebate.

The AHHA welcomed this announcement and supported the government's initiative. The AHHA believes that the PHI rebate is an inequitable use of taxpayer dollars and could be better spent directly on health services. Means testing the rebate will free up resources for health services in places of need, such as rural and regional Australia, and help ensure our public health system can provide care for our ageing population into the future.

Evidence demonstrates that the PHI rebate is an inefficient mechanism for increasing PHI fund membership and does not take pressure off the public hospital system [Dr John Deeble, The Chalmers Oration 2009; available as an AHHA Occasional Paper].

Events & meetings

Community and Primary Healthcare Policy Think Tank

REGIONAL COMMUNITY AND primary healthcare organisations should be established, resourced by a single Commonwealth Government funder, according to a policy think tank held on 1 September by the Australian Healthcare and Hospitals Association (AHHA) and supported by the Australian General Practice Network (AGPN).

The think tank involved over 60 people from primary and community health services across Australia and developed recommendations for the incoming federal government on progressing reforms in primary and community care.

A key recommendation was the establishment of local primary care organisations that would be funded according to the needs of their populations, with additional loadings for any special needs. These organisations would coordinate the health services of patients across the health sector. They would also play an important role in public health and prevention, thereby working to reduce health inequalities in their communities.

AHHA is concerned that coordination of patient care has not been adequately addressed in the current reforms. Recommendations arising from the think-tank to address this issue include:

- sharing of patient information supported by an electronic health record;
- establishing a single point of access to services; and
- developing and implementing guidelines for care pathways to foster multidisciplinary care.

The think tank recommended that the boundaries of these community and primary healthcare organisations would align with those of hospital networks to facilitate seamless patient care between primary/community and hospital care. The organisations would also work with other sectors such as aged care and mental health to coordinate the care of patients. Clearly, it would be essential to involve the community in planning the services to ensure they reflect the needs of the population.

In relation to rural health, the think tank called for a commitment from all governments to a rural health plan, including implementation of the fast broadband internet system and allocation of a fair share of infrastructure funding. Participants also called for bipartisan support to ensure the gross inequities in Indigenous health are rectified.

Funding hospital-type patients in the community in preference to increasing the number of hospitals beds was recommended to reflect the emerging trend to care for more acutely ill patients in their homes as an alternative to hospital care.

The AHHA will be following up the outcomes of the think tank in an advocacy campaign.

Ministerial Meetings

THE AHHA, AS part of its advocacy program, is conducting a series of meetings with Commonwealth and state/territory health ministers.

An AHHA delegation has already met with the Commonwealth Health Minister Nicola Roxon while she was attending our Congress on 24 September and four state/territory Health Ministers: Katy Gallagher in the ACT (10 September), Carmel Tebbutt in New South Wales (16 September), John Hill in South Australia (23 September) and Daniel Andrews in Victoria (30 September).

The main topic of conversation with all ministers has been the implementation of the National Health and Hospital Network reforms. The AHHA has been sharply focused on the national reform agenda during the last 12 months and applauded the NHHN reforms put forward by the Commonwealth Government, believing that they have the potential to deliver important funding and structural changes for public hospitals and primary/community healthcare services. Despite our support for the reforms, however, we have identified a number of deficiencies and gaps that we are working to alleviate. In the medium term, the manner in which any reforms are implemented will be critical in harnessing provider and community support.

Health Minister Roxon said that, now that the election period is over, progress on implementing the reforms will proceed quickly and according to the original timeframe. Plans are still on track for the establishment of LHNs and MLs from July 2011. The Independent Hospital Pricing Authority will be also established from this date. The government will also be focusing on rural and regional health with the provision of rural incentives, cancer centres, hospital funding (HHF) and GP Super Clinics.

All the state and territory ministers we spoke to are implementing the agreed reforms and acknowledge this presents both significant challenges as well as opportunities. While they are moving to introduce LHNs, they believe the reforms in the primary/community health sector require further planning and discussion including how the Medicare Locals will function and interact with the Local Hospital Networks. There is a common view that the definition of primary health care needs clarifying. It was also argued in the structures for provision of community care services do not need to be uniform across Australia and that varied opportunities will be fostered under bilateral agreements.

L to R: Shaune Noble, Patrick Bolton, The Hon Carmel Tebbutt, Prue Power, Terrie Paul, Ig Oostermeyer.

Branch meetings

AHHA BRANCH MEETINGS are designed to strengthen the AHHA's local structures by bringing members together in each jurisdiction. They also provide an opportunity for our members and stakeholders to hear from interesting guest presenters.

In 2010, Dr Chris Baggoley, Chief Executive of the Australian Commission on Safety and Quality in Health Care, toured a number of cities for the AHHA. He discussed the role of the Commission in developing national healthcare standards and clinical guidelines in Sydney (16 August), Melbourne (2 September) and Perth (6 September). Further meetings have taken place in Queensland and South Australia. The new CEO of ACT Health, Dr Peggy Brown, addressed the ACT branch meeting (18 November) and Tasmanian members had the opportunity to meet during their annual Combined Health Colleges Conference (21-22 July 2010).

The AHHA, in partnership with the Australasian College of Health Service Management (NSW) and law firm DLA Phillips Fox, convened a second Health Law Seminar for the year on the topic *What is the National Health and Hospitals Network?* (11 November).

Improving health care productivity

MARK JENNINGS
Director of Healthcare Improvement at The King's Fund, London

More with the same, not more of the same, says Mark Jennings

ON THE EVE of the formation of the UK National Health Service in 1948 the then Minister for Health, Aneurin Bevan, said "expectation will exceed capacity, we shall never have all we need; this service will always appear inadequate"[1]. Over the last 60 years or so this has been more or less true with health services never quite keeping up with expectations. But for all of those years there had been an average year on year real term increase in resources of 4% and the Labour government's NHS investment boosted this to 7% over the last decade[2].

The health system now faces a very different financial landscape and will need to operate in an environment with, at best, no significant growth in real terms for the foreseeable future. In responding to these impending constraints on public expenditure, what options does the NHS have? An analysis of the relationship between quality and efficiency in the NHS helps identify the broad options.

Chart 1 describes the four possible quadrants of operation. The NHS has operated for the last decade in quadrant 1; increasing quality funded by investment resulting in declining productivity and efficiency[3]. This is no longer an option as the era of growth and investment has come to an end (as noted above) so the best we can expect is funding keeping pace with general inflation.

Quadrant 2 is where the NHS has operated in past periods of financial constraint; cutting services to be apparently more efficient but effectively reducing quality of care, typically by restricting capacity and access. Again this is not now an option as public commitments have been made guaranteeing care standards and access.

The worst of all options is quadrant 3, reducing quality and efficiency as a result of organisations looking after their own interests rather than that of the system and the public.

The remaining quadrant is the only place the NHS can now successfully operate. The challenge is to simultaneously provide the highest quality of care and the highest levels of efficiency.

But how can this be achieved, and how can it be done quickly given that growth money dries up at the end of this financial year, leaving the NHS to find £15 to £20 billion in productivity improvements while continuing to provide quality care. Some of the solutions being promulgated are[4]:

- Major reconfiguration of clinical services;
- Moving care outside hospital;
- Rationalisation of the primary and secondary care estate;
- Health and social care integration; and
- Organisational restructuring (removing tiers of management etc).

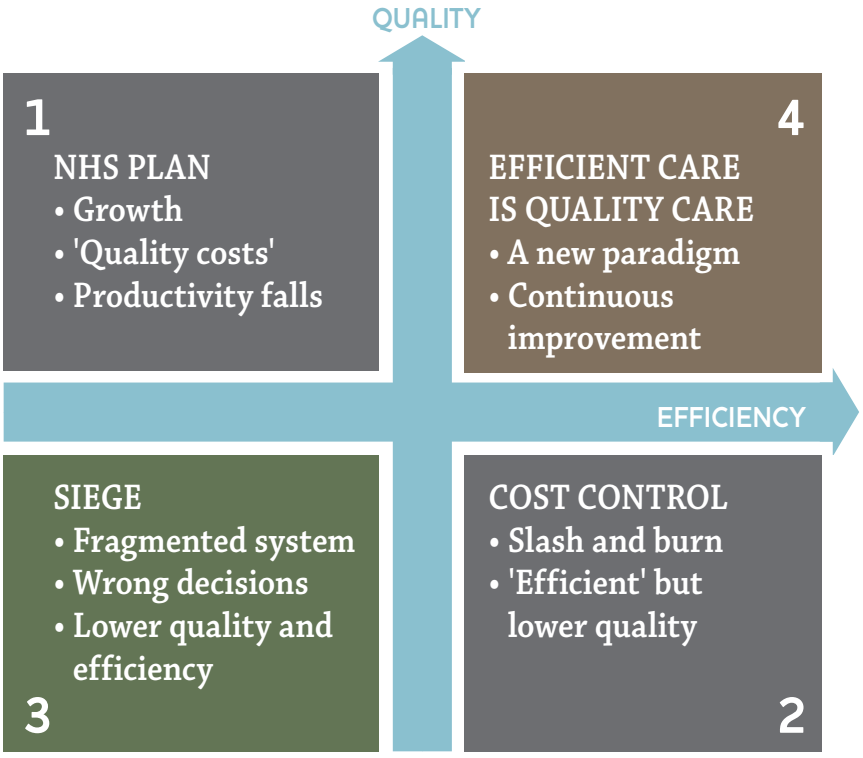
These solutions share common characteristics. They are all large scale, ambitious, have been talked about for a long time, have relatively weak evidence in terms of delivering productivity improvements or savings and, at best, they will only deliver in the longer term. In short these solutions, if they can be achieved at all, are unlikely to deliver the quality and cost improvement needed as fiscal tightening grips the NHS over the next five years or so.

The alternatives

So what are the alternatives? The key messages that emerged from the recent King's Fund's Improving NHS Productivity: More with the same not more of the same publication are[5]:

1. How the challenge is seen is critical. Even with zero real terms growth the NHS is receiving the same amount of money as previous years, so overall the response should not be to commission the same care for less money but to commission more care (to satisfy increasing demands) for the same money. In other words, the challenge is to fill a potential *care gap*, rather than focusing on finding savings to meet a *financial gap*.
2. In the years of plenty the focus was on growth - what could be bought with the extra money available each year. The vast majority of NHS expenditure was subject to relatively little scrutiny. All parts of the system must now work together to ensure there is value added for total health expenditure.
3. To effectively respond to the scale of this challenge the NHS will need to examine *what* it does as well as *how efficiently* it does it. When the NHS has needed to tighten its belt in the past it has concentrated productivity improvement efforts on achieving technical efficiencies in its current outputs. The central levers such as tariff and pay settlements will help drive technical efficiency from providers so the key for the commissioners of care (the payers) is to focus on allocative efficiency decisions, decommissioning those services that do not add sufficient value.
4. The real key to achieving improved quality and efficiency is to influence the practice of frontline clinicians as they take decisions on a daily basis about patient care with the aim of reducing the variations in care. We do this by improving standards. Variation is an inevitable characteristic of any healthcare system. However, it is easy for the natural variation in patients and demography to mask artificial variation, which is induced by the way care is delivered and the system is managed. Jack Wennberg said of the US health system: "Variations in care are often idiosyncratic and unscientific with local medical opinion and local supply of resources appearing more important than science in determining how medical care is delivered"[6]. This is equally true of the NHS today.

CHART 1 - NHS QUALITY AND EFFICIENCY



Standardise best practice

Large amounts of public money are wasted and care sub-optimally provided due to unjustified variations in care and care delivery. The NHS Institute has highlighted the extent of the variation and identified an opportunity to improve care and reduce costs by a minimum of £3.3 billion - simply by adopting what we already know how to do[7]. Examples include more than a two-fold variation between hospitals in length of stay for the same procedure, day case procedures being carried out routinely as inpatient cases and a four-fold variation in the likelihood of having a tonsillectomy between areas.

In almost all cases, adopting the practice of higher performers will deliver improved care for patients and a more efficient service for the taxpayer. These variations are caused by the practices of clinicians and managers at a clinical micro-system level taking thousands of decisions on a daily basis to refer, prescribe, admit and discharge based on personal and local practices - which differ from the best practice elsewhere in the system.

In combination these approaches can help move the NHS from the 'quality costs' paradigm of the last decade to a new way of seeing the world where health care can only be considered high quality if it is also efficient and effective. ha

References

1. Rivett, G - From Cradle to Grave: fifty years of the NHS, London, Kings Fund 1998.
2. Appleby, Crawford, Emmerson. How cold will it be? 2009 The King's Fund.
3. Office for National Statistics, Public Service Productivity: Health Care, (2008) ONS.
4. Nicholson D. The Year: NHS Chief Executive's Annual Report 2008/09. Department of Health 2009.
5. Appleby, Ham, Imerson and Jennings. Improving NHS Productivity: More with the same not more of the same, London, The King's Fund.
6. Wennberg J - Unwarranted variations in healthcare delivery BMJ 2002;325:961-964 (26 October).
7. NHS Better Care Better Value Indicators, NHS Institute for Innovation and improvement. **www.productivity.nhs.uk**.

Reform must be evaluated

PATRICK BOLTON
Vice President of the Australian Healthcare and Hospitals Association

Patrick Bolton believes effective evaluation is required for **effective reform**

BACK IN THE eighties, a book called *Godel, Escher, Bach: An Eternal Golden Braid* by Douglas Hofstadter became popular. It explained Godel's incompleteness theorems, among other things. My loose interpretation of Godel's first theorem is that there are unprovable truths and conversely, falsehoods that cannot be disproved.

The leading Australian health services researcher Kathy Eagar has been advocating her own version of Godel's theorem in respect of the current round of healthcare reform under the title *your integration is my fragmentation*. She provides evidence in support of a position that says structures that improve integration for some health service users inevitably result in fragmentation for others. Eagar makes a good argument, but either my thinking is too linear or I am too much of an optimist, because I still believe that it should be possible to create a system which provides integrated care for all those who need it, albeit that some will receive better integrated care than others.

It appears that Australia is in a good position to test this because we are about to embark on a natural experiment around health system models. It appears that Western Australia will remain as a control for the healthcare reforms initiated by former Prime Minister Rudd. But the emerging responses of the states appear to vary widely to these proposals, so it is likely we will see significantly different structures in each of the jurisdictions. In addition, the lack of specification around primary and secondary care means we are likely to see lots of alternative models in those sectors too.

I take the variance in implementation of health reform between the jurisdictions as evidence of lack of clarity about what works and also a failure by the parties to set clear objectives for the reform. It is impossible to get somewhere unless one has a clear idea about where one is going. It appears to me that no-one has much idea about where the current set of health reforms is intended to lead.

Regular readers of this column will be aware that I am cynical about the value of the proposed reforms. This is not particular to the current reforms. There is little evidence to show healthcare reforms lead to improved patient outcomes. No recent model of healthcare reform has effectively capped the growth in healthcare costs. There is also limited systematic evidence about the outcomes delivered by different models of health service provision and so no robust basis on which to found any comparisons of efficiency.

Of course the more extensive the reform is, the more the reform itself will cost. One would expect it to take some time before the benefits from any reform were realised. Unfortunately, few attempts at reform are allowed to bed down before policy makers begin making new changes. So it can be argued that any benefits that do arise from reform are offset by the cost of the disruption caused by continuing reform. This is particularly likely with the current round of Australian reforms. The only outcome measure anyone has proposed for these reforms is that "things will improve". This is sufficiently broad that one can paint success or failure against it depending on one's mood. Since I think improvement is unlikely, the reform could be labelled a failure, which will need to be addressed by more reform.

One of the points I understand Eagar and others to have made is that improvements in healthcare – both efficiency and outcomes – are realised at the coalface. Health system reform of the kind that Australia is undergoing can only modify the drivers of care and this does not automatically translate into changes to patient care. A corollary of this is that it might be more effective to leave the major structural elements alone and implement strategies that work directly at the coalface. Of course the benefit of such an approach cannot be assessed unless it is evaluated. Indeed (and somewhat obviously) the benefit of any intervention cannot be assessed unless it is evaluated.

The natural experiment that is emerging as the different jurisdictions apply different interpretations to the requirement to reform may or may not improve matters. But we can't know this and nor can we know which approaches are most beneficial or harmful unless we evaluate them. It has been said that those who do not study history are doomed to repeat it, but you can't even study history unless there are records of what happened.

Keeping the Canadian health system healthy

PAMELA C. FRALICK
President and CEO
of the Canadian
Healthcare Association

The Canadian Healthcare Association's **plan for the future**

AS WITH MOST countries, Canada is ever on the search for ways to add efficiency and effectiveness to its health system. Escalating costs, political unpredictability and the entrenched value system of a citizenry that cherishes its universal care compete to make significant change challenging at best, stalemated at worst. This clash of rival issues and ideology currently at play provides an opening for meaningful dialogue. And action. Within the current context, the Canadian Healthcare Association (CHA) has developed a six-point vision to help guide and strengthen the future of Canada's health system(s)[1].

The current context

After severe cuts in the 1990s and a fragmented approach to address pieces of the greater need in the early years of the new millennium, a 10-year, CAD$41 billion agreement was reached in 2004 by federal, provincial and territorial governments. *A 10-year Plan to Strengthen Health Care* (the 10-year Plan) identified areas for priority action including wait times, health human resources, home care, primary care, northern access, a national pharmaceuticals strategy and prevention/promotion/public health. The formulation of the 10-year Plan, combined with the 2003 Accord – which addressed catastrophic drug coverage, diagnostic/medical equipment, IT/EHR and Aboriginal health – meant most Canadians felt encouraged that the reinvestment in their health system would pay needed dividends.

Today, only a few short years from the conclusion of the 10-year Plan, the debate is being rekindled. Layered on this predictable and escalating dialogue is the recent global recession. While not affecting Canada as seriously as many other countries, we were not spared and the 's' word – sustainability – is on everyone's lips.

Canadians take great pride in their universal health system and consistently express high levels of satisfaction with their interface with health services. A Health Canada report entitled *Healthy Canadians – A Federal Report on Comparable Health Indicators 2008* found that 85.2% of Canadians were "very satisfied" or "somewhat satisfied" with health care services overall. That level was unchanged from 2005, the last time the survey was conducted. However there are clearly areas that can be improved.

While lauded for its universality and quality by objective international bodies, Canada's health system has been assessed as expensive. According to the Canadian Institute of Health Information (CIHI), in 2009, we spent CAD$183 billion on healthcare, or almost half a billion dollars a day and more than CAD$5,400 per person. As a proportion of GDP, that will equate to 11.9%, up from 10.8% a year ago, placing us in 6th position of 31 OECD member countries. There are projections suggesting this trend will continue unabated and squeeze out many other government services in coming years.

However, it is important to consider the context, specifically the reality of recessionary times, which traditionally have created these sorts of spikes. As CIHI points out, "after adjusting for inflation and population growth, spending on healthcare this year (2008) is expected to grow by 2.5%. This is lower than the estimated growth rate for 2008 (4.2%)."

Our investments can buy progress. Our life expectancy is 80.7 years, more than 1.5 years higher than the OECD average (79.0 years) and 2.5 years greater than in the United States (78.1 years). Our infant mortality rate is 5.0 per 1,000 live births, almost equal to the OECD average of 4.9. Deaths by heart attack decreased by 30% between 1998 and 2004 and waiting times for five identified conditions have decreased due to priority setting in these areas.

But in terms of financial sustainability, the jury is still out. There are many experts and pundits alike who believe costs are unsustainable and will rise, whether due to the increased costs of new pharmaceuticals and diagnostics, the aging population, a lowered tax base or many other contributing factors. Contrarily, there are many who provide compelling data to support the view that such a sustainability crisis does not exist[2].

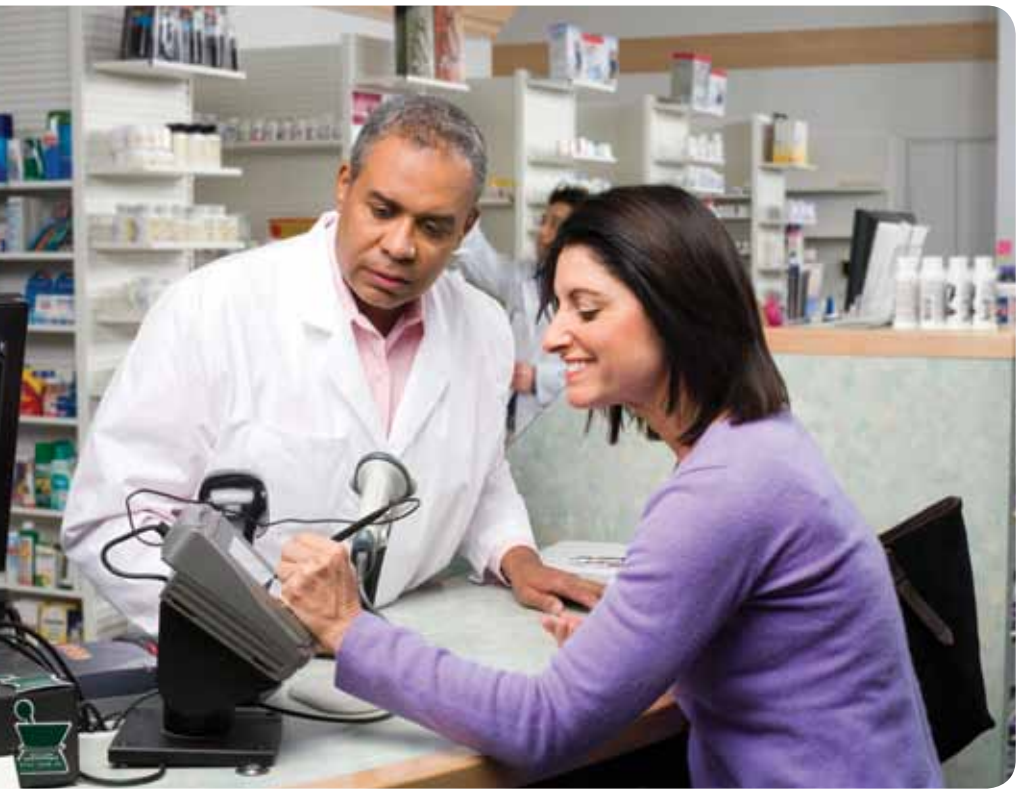
From an international perspective

In September, the OECD report *Economic Survey: Canada 2010* was released. This non-partisan organisation noted that Canada offers high quality services to residents, albeit at high cost. The report takes Canada to task on several fronts, citing our lack of drug, dental and community therapies, the lack of price signals (e.g. patient co-payments/deductibles) and the general prohibition against private financing[3]. It expressed concern over our lack of cost-saving incentives, gaps in information and our decentralised systems. The OECD concludes Canada's health spending trends are not sustainable and recommends a course of action – several, in fact, from the imposition of co-payments through physician payment capitation to equal contracting to private and public hospitals.

In a country which values its universal health system as much as it does its hockey, these are sensitive and controversial suggestions that will require national and political will if they are to be fully explored and addressed. While CHA supports the notion of national dialogue on these and others of the recommendations, we also feel there are immediate issues that can be addressed.

CHA's recommendations

As Canada moves towards the end of the 10-year Plan, the Canadian Healthcare Association has undertaken a focussed review of its own advocacy and policy directions this past year. Drawing upon the expertise of its members as well as notable external stakeholders and sources, in June the Board of Directors approved a six-point plan to guide our activities (summarised below). The Board is committed to action on these fronts, with the sustainability of the health system as an overarching goal and an unwavering commitment to access to comparable services for all Canadians, based on need not ability to pay.



Six-point plan

Funding - Adequate and predictable funding of the health system, ensuring all Canadians have access to comparable services. One focus will be how the system will be funded, from decisions on how federal transfers are made to provinces and territories, to recommendations on the way each jurisdiction funds its health services (see box over page for recently approved CHA Guiding Principles).

Health Human Resources (HHR) – Additional data is required, particularly minimum data sets for all health professions. Pan-Canadian coordination of HHR data is essential. Healthy workplaces are a cornerstone of recruitment and retention and will be pursued through CHA's ongoing support of the Quality Worklife - Quality Healthcare Collaborative (Learn more at **www.qwqhc.ca**).

Wellness – Whether from a cost-savings or quality of life perspective, the arguments for reallocating resources to health promotion and illness prevention are increasingly incontestable and must be acted upon despite the long-term nature of outcomes versus the typically short-term political tenure of funders. CHA is currently building its detailed policy paper and we are cautiously excited by the September meeting of all federal, provincial and territorial Ministers of Health, during which a Declaration on Prevention and Promotion was endorsed, committing all jurisdictions to promote healthy living and address critical issues such as obesity and sodium intake. This inoculation of "Ottawa Charter"-type thinking and action bodes well for the future of the population. But ongoing, dedicated political will is required.

Continuing Care - Home, Long-Term, Respite, Palliative. Advocacy is required on the appropriate use and funding of home care and


Hospital for Sick Children, Toronto.

facility-based long-term care. This is necessary for both the fiscal sustainability of the health system and the pressing need to address the health requirements of the aging population. The dissemination of CHA's recent policy briefs on home care and facility-based long-term care as well as several presentations to politicians, senior officials and stakeholders have heightened awareness of both the strengths and weaknesses in the system. CHA will continue to take advantage of opportunities to advance our research and recommendations.

Leadership - Political leadership, the role of the federal government in health and social issues. Board leadership, the role of good governance in contributing to a sound, accountable health system. Executive leadership, the role of senior staff in ensuring the health system is sustainable and provides best quality. These are all keys to the health of the system and will be addressed.

Pharmacare – One of the 'hottest' topics in Canada today. This must be addressed quickly, whether a plan for all or catastrophic coverage.

Concluding thoughts

There are still many systems issues that give rise to concern and questions:

- Have we developed into a risk-averse culture – satisfied with the status quo?
- Are we truly patient-centred? Two recent reports from Alberta and Saskatchewan suggest not.
- Are we capable of living up to our expectations for collaborative, team-based work?
- Can we produce the outcome data needed to drive appropriate change?

The debates that will unfold for the next three years and beyond will provide challenges, yes, but also opportunities to come to terms with our collective needs, determine how we evolve into a more sustainable and modernized health system and how we ensure Canadians' needs are the driving force behind all that we do. The Canadian Healthcare Association is prepared to do its part, and hopes that its vision will contribute to a redefining of Canada's future health systems. ha

References

1. Canada's provinces and territories are responsible for delivery of health services, the federal government is responsible for particular populations. Thus Canada has 14 health systems, rather than one national health system.

2. See "The Sustainability of Medicare", by Hugh Mackenzie and Michael Rachlis, 2010.

3. Interestingly, the public share of health spending in Canada is 70%, below the OECD average, as it has been since 1997.

Canadian Institute for Health Information. (2010). Wait times tables: A Comparison by Province 2010. [Electronic version.] Available online at **https://secure.cihi.ca/estore/productSeries.htm?pc=PCC395**.

Canadian Institute for Health Information. (2009). Health Care in Canada 2009: A Decade in Review. Ottawa, ON: Author.

Dagnone, T. (2009). For Patient's sake: Patient First Review Commissioner's Report to the Saskatchewan Minister of Health. [Electronic edition]. Available at **http://www.gov.sk.ca/news?newsId=920e5560-eaac-4f26-a9f6-a7010a45a5ab1**.

Health Canada (2004). A 10-year Plan to Strengthen Health Care. [Electronic version]. Available at **http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php**.

Health Canada. (2003). 2003 Health Ministers' Accord on Health Renewal. [Electroinic version]. Available at **http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index-eng.php**.

Horne, F. (2010). Alberta Health Act Consultation Report. September 15, 2010. [Electronic version.] Available at **http://www.health.alberta.ca/initiatives/your-health-act-whats-new.html**.

Organisation for Economic Co-operation and Development. (2010). OECD Economic Surveys: Canada 2010. ISSN: 1995-302X.

Guiding principles

Prior to initiating a change in the funding mechanisms for health services, the following conditions must be considered. The funding model should:

- Support the mission of the organisation.
- Promote equitable and accessible delivery of services across the population served.
- Encourage appropriate/evidence-based care in the most appropriate setting from the most appropriate health provider.
- Reflect the complexity of services delivered and the population served.
- Have as a goal to improve quality, patient safety, accessibility, transparency and accountability.
- Have the necessary infrastructure in place – including computer systems and electronic records.
- Be phased in with close monitoring of its impact, based on specific criteria including efficiency, outcomes and quality of service.
- Be based on accurate data including appropriate baseline data as well as historical data.
- Have regular review of both the framework and indicators.

Health and climate change

Tony McMichael outlines the **challenges to health and healthcare** posed by climate change

OVERALL THE health sector has been rather slow to see the great, and increasing, implications of climate change for population health and for the healthcare system. Meanwhile, the public discussion has focused primarily on risks to economic processes, vulnerable industries, physical property, environmental amenity and iconic national ecosystems. These are precious assets, but not as precious as the health and survival of this and (more worryingly) future generations.

Within Australia, as in other modern western nations, a narrow, essentially individualised and frankly misleading model of 'health' and its determinants prevails. Individuals are viewed as free agents, responsible for their own actions (including consumer choices) and hence the primary arbiters of their own health.

This view of health served our society fairly well during the prosperous and relatively stable final third of the 20th century. During that time, universal health insurance policies in Australia limited the differentials in health security and status. Meanwhile, we have become less attuned to asking what it is about how a population lives that leads to epidemics of measles, smallpox, diphtheria and dysentery. Or that leads to a rise in levels of obesity. Or that can influence the functioning of the natural world (including the climate system) and its life-supporting processes.

Should we be worried?

There is no space here to review the core science on the determinants of climate change and the evidence of recent human-induced global warming. The Earth's climate undergoes continual change in response to various regular, irregular and chaotic natural 'forcings'. Against that background, most of the unusually rapid global warming over the past half-century is attributable to human actions.

So, how worried should we be about a possible average global

> The health risks from climate change are diverse and will impinge differently over time and place.

TONY MCMICHAEL
National Centre for Epidemiology and Population Health, The Australian National University

increase of 2-5ºC within the coming century – a range now widely regarded as possible, given current trends and plausible future human behaviours?

Recent survey research showed many Australian politicians see no difficulties in coping with a world 4-6ºC warmer than today. This reflects a serious lack of understanding of how such increases would disrupt many basic biophysical and ecological relationships and processes.

The health risks from climate change are diverse and will impinge differently over time and place. The obvious risks are from extreme events, especially heatwaves, bushfires and floods in Australia. The experience of January 2009 in Melbourne and Adelaide underscored the vulnerability of older-aged persons, many with underlying chronic disease processes, to the sustained physiological stress posed by urban-environmental thermal extremes with little relief at night.

Climate change entails both trends in average conditions, such as temperature, annual rainfall and humidity, and increases in weather variability. Bureau of Meteorology data clearly shows an increase in the (decadally-averaged) annual number of very hot days during 1960-2009.

In the longer term, the health consequences of climate change will also encompass shifts in patterns of various climate-sensitive infectious diseases; changes in regional food yields and nutritional quality; impacts on morale and mental health from environmental disruptions and threats, especially in those parts of rural Australia now facing long-term drying because of climate change; and adverse consequences for remote communities, including many Indigenous communities, because of environmental changes and increased exposure to extreme weather conditions and events.

Risks to health in Australia

The main current and future risks to health in Australia can be summarised thus:

Already apparent
(events that are amplified by climate change):

- An increase in the annual number of very hot days, resulting in hospitalisations and deaths; and
- An increase in the number and severity of bushfires, resulting in injury, death, respiratory hazards and mental health concerns.

Likely current impacts
(not easy to identify and attribute)

- Contribution to a rise in microbial food-poisoning, resulting in gastroenteritis and diarrhoeal diseases; and
- Increased mental health concerns in the warmer, drier parts of rural Australia.

Predicted health impacts
(almost certain to occur in the future)

- Extreme weather events, resulting in injuries, deaths, infectious disease outbreaks and mental health concerns;
- Water shortages, impacting local food yields, rural wellbeing and hygiene;
- An increase in mosquito-borne infectious diseases, including Ross River fever, dengue fever and encephalitis;
- Heat-stressed livestock, resulting in a possible increase in risks of zoonotic agents;
- Increased stresses on outdoor workers, impacting physiological threshold, behaviour, productivity and earnings; and
- Stressed/displaced groups, resulting in tensions, conflicts and mental health concerns. ha

Leading-edge roles for the health sector

1. **Explain the extent and significance of risks to health. More and better research is needed to help our society understand the full spectrum of the risks posed by climate change. Risks to health are of fundamental importance.**
2. **Reduce the sector's climate footprint. The health sector is very energy and water-intensive. For example, in NSW the health system accounts for just over half of total governmental within-building energy use.**
3. **Emphasise the localised benefits to health that will result from greenhouse gas emissions reduction actions. These include cleaner urban air, more physical activity in our daily lives and improved urban design and housing standards.**

Care until the end

Australia's **palliative care** system needs a boost says Yvonne Luxford

THE MOST IMPORTANT message to come out of this year's AHHA Congress was that while the health reform agenda is very welcome, we must ensure that we make the most of this historic opportunity. This will involve a lot of effort.

As Professor Ken Hillman said in his paper *Caring at the end of life in acute hospitals*, significant work needs to be done to ensure that every Australian has access to quality care at the end of their life. Such care should be delivered in a culturally appropriate manner, in the location of their choice and accompanied by whom they choose. The need for mechanisms to ensure this is embedded in the health reform process was echoed by Professor Kathy Eagar's keynote address, *Your integration is my fragmentation*.

Dedication is not enough

Many speakers at Congress reminded us that Australia has a good health system – it isn't that the current system is broken. But it could definitely do with improvements in the face of the increasing pressure it will be placed under with an ageing population and the burden of chronic disease.

Palliative care is no different. Australia currently ranks second in the world in *The Economist's Quality of Death Index* – surely evidence that we are doing well in this field. This ranking was gained largely due to the dedication of health professionals, carers and volunteers working in the field and through the commitment of all governments to the provision of palliative care.

But dedication is not enough. Governments need to boost their financial support of palliative care services as they grow to meet the inevitable increase in demand. In addition, we need a systematic educational program for all health professionals as well as the public.

There are a number of barriers to achieving these objectives, but they are by no means insurmountable.

Let's talk about dying

One of the first things we need to do is get people talking more openly about dying. There are numerous reasons why we have evolved into a 'death denying' society, including cultural issues, high expectations from ongoing improvements in medical treatments and constant media presentations implying that every life can be saved. Many also believe that there is a direct relationship between our refusal to accept death and our lack of interest in, or awareness of, palliative care.

You might expect a greater focus on palliative care in the aged care industry at least, particularly with the increasing acuity of people entering residential facilities. In fact, Australia was the leader in developing the clear, evidence-based *Guidelines for a Palliative Approach in Residential Aged Care*, which promoted appropriate end of life care in the sector. These guidelines were approved by the National Health and Medical Research Council in 2005 and have been broadly accepted. However, inadequate levels of training and funding create significant barriers to their incorporation into everyday care.

Unfortunately, the lack of training in dealing with death and dying applies to many professionals across the health system. How can we criticise doctors for insisting upon trying every last heroic treatment if we don't adequately educate them to recognise when a patient would be better served by a palliative approach? In recent years, the federal government has funded an undergraduate program to ensure that health professionals do receive this vital training and we expect to see an impact as more new graduates take up positions in the system.

A powerful mechanism to drive faster change is to encourage a cultural transformation in our society. We would like to see community members talking openly with their loved ones about what they want at the end of their lives, completing advance care plans and appointing substitute decision makers.

In this context, the Australian Health Ministers' Advisory Council

YVONNE LUXFORD
Chief Executive Officer of Palliative Care Australia

has sought consultation regarding a national framework on Advance Care Directives in order to establish some level of uniformity of expectations, requirements and outcomes across the country. While differing legal requirements do create yet another complexity, they are not considered to be insurmountable.

One of the stated aims of the health reforms is to create a system that is patient-centred. Well-coordinated, person focused care requires a range of health professionals working together as a team and is recognised as a key strategy to improving the quality and effectiveness of care in chronic and more complex cases.

Palliative care, by definition, presupposes the operation of a team approach. Using the 13 Standards for providing quality palliative care for all Australians as its foundation, the National Standards Assessment Program (NSAP) assists services to attain best practice through self-assessment, peer mentoring and workshopping. The work of NSAP is complemented by two other quality enhancing projects – Palliative Care Outcomes Collaboration, which is developing national quality and outcomes benchmarks, and CareSearch which provides online evidence based palliative care information and research.

The development of strong partnerships between local and regional primary care services, aged care services and specialist services is fundamental to achieving sustainable and responsive palliative care services focused on population needs. The health reforms are expected to provide the foundation for such integration to flourish.

Sustainability of the provision of good end of life care for our population is dependent upon the success of this integration and the ongoing education of all health professionals in the importance of a palliative approach. Ultimately we need everybody, including health professionals, to have conversations about dying. ha

Creating and funding local hospital networks

THE COMMONWEALTH LABOR Government started the health system transformation process in 2007 by appointing a National Health and Hospitals Reform Commission. The Commission's June 2009 final report made recommendations across the full health spectrum[1].

For hospitals, it recommended activity-based funding, with 60% of funding for the 'efficient price' of hospital activity to come from the state or territory government (hereafter state) and 40% from the Commonwealth Government. The Commission did not make any recommendation about changes in local governance.

In contrast, the Commonwealth Government's response changed the balance of funding to 40:60 and mandated new local boards to govern 'local hospital networks'.

Creating local hospital networks

There is little evidence of the relative efficacy of local vs centralised governance. There are sound arguments for the benefits of decentralised management (local responsiveness, innovation) as well as for centralisation (economies of scale) and recognised weaknesses of both (inequity vs remoteness of decision makers). It should be no surprise that in the absence of an unequivocal best approach, different people can legitimately argue for different solutions and policy might involve swings over time from one preferred solution to its polar opposite. Johnston[2] recognised the importance of managing issues that have no right answer, maximising the positives of the contemporarily preferred solution while minimising its negatives.

Unfortunately, there is no recognition in the public policies released to date that there are any positives in the centralised structures in those states that have adopted them, nor recognition of the negatives of a decentralised, local governance solution.

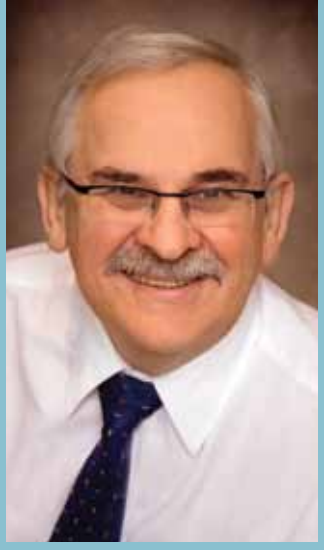
States as 'owners' of public hospitals and under whose legislation the new boards will be created will presumably have some autonomy. This gives states an opportunity, and an obligation, to reflect on what aspects of their existing centralised structures should be maintained. Should all local networks use a common payroll system to ensure consistency of data and achieve economies of scale? Should there be common clinical information systems and a consistent process for managing, reporting and disseminating lessons from adverse events? What about industrial relations and award negotiations?

The issue in the new system design is deciding what will be national, state and local. And what autonomy will the new local networks have? Will they be another layer or part of a streamlined/devolved system? What strengths of the current structures should be ported to the new, or do we start with a clean slate and assume there is no merit in current approaches?

Funding local hospital networks

The Commission's recommendation of a 60:40 State/Commonwealth split in funding responsibilities for the 'efficient price' recognised current funding realities and policy responsibilities. Public hospitals are, and will be, creatures of state legislation. The states will regulate capital and bear political accountability (e.g. for ambulance by-pass) and any residual risks of cost escalation or service inadequacy.

The average marginal cost of additional activity in hospitals is probably less than 50% so under the Commission's proposals, the Commonwealth contribution would be at, or below, marginal cost. This would mitigate any incentive for excess hospital activity growth that might squeeze out funding for expansion of primary care and lower



STEPHEN DUCKETT
Adjunct Professor,
University of Queensland

Questions still surround **local hospital networks** says Stephen Duckett

intensity substitute activity such as sub-acute services. States (with responsibility for capital planning) would also be responsible for determining (capping) hospital activity. This would mean that states would continue to bear all the residual risks and political accountability for service dysfunction.

The Commonwealth proposal doesn't have the same conceptual clarity and logic. Under the Commonwealth's proposal, the states as owners will be the minority funders. Assignment of risk for adequacy of funded activity will be unclear, with Commonwealth payments in many cases above marginal costs but with states still managing overall capital provision.

Public pronouncements to date have not made clear how an 'efficient price' will be calculated – whether hospitals will be funded by the Commonwealth at 60% of the average national price for patients within each Diagnosis Related Group (DRG) or whether the payment rate for each DRG will vary (20% for some, 80% for others) but the average payment across all DRGs will be 60%.

The different choices here have quite different incentive effects. If payment in any given DRG is below marginal cost, hospitals will not have an incentive to increase volume in that DRG, which may hamper Commonwealth goals of reduction in surgical waiting times.

As the new payments to hospitals will be cast as direct payments to hospitals, they will presumably not be subject to equalisation by the Commonwealth Grants Commission. In the past this body has taken into account factors such as the greater costs of treating Indigenous people, providing services in rural and remote Australia and economies of scale, to determine a state's share of GST reimbursement. Volume effects, such as Indigenous people having higher hospital utilisation, will be addressed by the very nature of activity-based funding but relative costs, such as Indigenous people having a longer length of stay, will need to be addressed and incorporated in the funding design. This is a very complex task and to a large extent is uncharted territory.

At this stage the states appear to have independent choices to make about the level and structure of their funding design. Theory suggests a mixed fixed and variable design for funding[3] and following this approach, states may chose to structure their funding as fixed over the medium term with incremental (operating) funding being related to new capital works coming on stream. States might also structure funding to ensure appropriate marginal incentives, depending on whether the Commonwealth structures funding according to the marginal cost in each DRG or the average DRG.

> Creating and funding the new local hospital networks involves critical policy choices.

So the message here is that there are important choices yet to be made in designing the new funding arrangements.

Conclusion

Creating and funding the new local hospital networks involves critical policy choices. Decisions about these choices should be based on the articulated policy aims. Unfortunately, the Commonwealth has not been clear about the relative priority of its espoused aims. In the absence of clarity of policy intent, choice of policy instruments and design of incentives may be confused. The possibilities of the potential transformation of the system may then not be realised.

A number of commentators have already critiqued the new hospital arrangements and the Commission's proposals from which they evolved. But in the absence of clarity about precisely how the new scheme will work it is difficult to be either critical or laudatory. That said, despite its potential weaknesses, at least the Commonwealth proposal now exposes the Commonwealth to the growth pressures of public hospitals and so is an advance. ha

References

1. National Health and Hospitals Reform Commission (2009) A healthier future for all Australians - Final Report (http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/nhhrc-report accessed 2 August 2010).
2. Johnson, B (1996) Polarity management: identifying and managing unsolvable problems HRD Press.
3. Laffont, J.-J. and J. Tirole (1993). A theory of incentives in procurement and regulation. Cambridge, Mass., The MIT Press.

JUDITH DWYER
Professor of Health Care Management at Flinders University

Recognition of Indigenous Australia

Judith Dwyer believes the **recognition of Indigenous Australia** is health system business

NEW PARADIGM IS probably an overstatement of the current shift in Australian parliamentary workings. But nevertheless, a few new paradigm things might be able to happen for the country. One of them, I hope, will be proper recognition of Aboriginal and Torres Strait Islander people in our Constitution.

Somehow we've ended up without any kind of treaty or formal settlement of relationships between the newcomers and the original inhabitants of Australia. There were battles and negotiations and agreements, but unlike in comparable countries (Canada, New Zealand and the USA) no settlement was translated into the nation's legal framework.

Now, an agreement between Labor and the Greens to hold a referendum at the next federal election gives us an opportunity to fix this gap. The Coalition supports the idea of recognition (at least in the Preamble), so it may be possible for the referendum to have bipartisan support, which is important because we don't pass many referenda – eight out of 44 so far.

This truly is health system business, because recognition matters for the health of Aboriginal Australians and for their healthcare. There is no way to run a randomised trial on it, but there is good policy logic to argue that the large longevity gap for Indigenous people in Australia is partly related to the absence of any formal settlement of the terms on which our modern country is established.

This is supported by several authors, including Ring and Firman (MJA 1998) who suggest that lack of recognition, among other factors, may be involved. Citing evidence that a sense of control over one's life helps with longevity, they concluded that:

"A greater sense of control may only come from a wider acceptance and recognition of a valued role for Australian Indigenous people in Australian society."

Recognition would also provide a more solid basis for the efforts of the health system to provide better care for Aboriginal patients. It's not so long ago that Aboriginal people were excluded from our public hospitals or were placed in special 'back wards'. But since the transfer of responsibility for health from ATSIC to the Commonwealth's health portfolio in 1995, things have significantly improved. More funding goes to the Aboriginal community-controlled health sector, with good evidence of impact on health outcomes, and the mainstream health system has been responding (however slowly or in patches) to its responsibilities. We should feel good about that, and keep working on it.

But there is a problem at the heart of this endeavour. Hospitals and health services staff are often doing creative, energetic interventions to respond to the needs of Aboriginal patients, including finding ways to establish trust and rapport in an intercultural relationship. At the same time, there is a strange kind of denial. The system operates on an underlying premise that 'we treat everyone the same, no-one is special, nothing special is happening here'.

Take a look at the policies and procedures that guide such improvement efforts in your part of the health system. You will probably find high level policy statements with beautiful wording, but a lack of the serious operational plans, strategies, quality assurance measures and protocols that you would normally expect for any situation that substantially affects good healthcare delivery. I bet, for example, that it is easier for staff to get an interpreter for almost any language on the face of the earth than for local Aboriginal languages (if I'm wrong – please let me know).

Why is this so? I suggest that it is part of the out-workings of a larger denial at the centre of our national life. When I look at health services in those comparator countries I still see lots of problems, but there is a sense that special measures are on a sounder policy footing and the system thus finds it easier to enact and sustain good ideas.

There are many reasons to support recognition, like basic respect, fairness and the politics of reconciliation after any conflict. The need to improve health and healthcare for Aboriginal people means that this is also important health system business.

Judith Dwyer is Professor of Health Care Management at Flinders University and a Research Program Leader for the Lowitja Institute (formerly the CRC for Aboriginal Health).

2010 Victorian Public Healthcare Awards

The 2010 **Victorian Public Healthcare Awards** paid tribute to the state's leading health services and individuals for their dedication and innovation in delivering world-class patient care

Professor Patrick McGorry, winner of the Minister's Award for Individual Achievement in Mental Health and Prue Power, Chair of Judges.

During a celebratory dinner in Melbourne, Premier John Brumby, Health Minister Daniel Andrews and Department of Health Secretary Fran Thorn presented the 2010 Victorian Public Healthcare Awards.

These are Victoria's most prestigious awards. The awards, in 18 categories, honour the doctors, nurses and health professionals at the heart of the health system whose achievements make a difference in the lives many Victorians.

Major winners in 2010 were:

- Peter MacCallum Cancer Centre – Metropolitan health service of the year
- South West Healthcare, Warrnambool – Regional health service of the year
- Robinvale District Health Services – Rural health service of the year
- Inner South Community Health Service – Primary health service of the year.

The health professionals and teams honoured this year are addressing many of our greatest healthcare challenges, such as reducing the burden of chronic disease and cancer on the community. Examples of standout achievements include the historic cure of a rare disease in babies from Southern Health, world-first souvenir films for children undergoing radiotherapy at Peter MacCallum Cancer Centre and individuals such as Australian of the Year and youth mental health advocate Professor Patrick McGorry.

The response this year from health services was remarkable with a record 310 entries. The high calibre of entrants ensured 2010 was the toughest year yet for judges to select winners and was testament to the wonderful and inspiring work happening every day in our public healthcare system.

Prue Power, Executive Director of the Australian Healthcare and Hospitals Association, was the Chair of Judging.

"I enjoyed seeing the collegial spirit displayed by all the judges,' she said. "They diligently undertook their tasks to recognise and celebrate really important values in healthcare: quality, innovation and excellence."

Visit **www.health.vic.gov.au/healthcareawards** for more information on the awards.

2010 VICTORIAN PUBLIC HEALTHCARE AWARDS WINNERS:

DELIVERING SUSTAINABLE AND EFFICIENT HEALTHCARE SERVICES		
Gold	Barwon Health	Increasing information availability in health care
Silver	Peninsula Health	Supply and deliver – supply chain initiatives
Highly Commended	Melbourne Health	Logistics improvements at Melbourne Health
IMPROVING ACCESS PERFORMANCE		
Gold	Southern Health	No wrong door – improving the client journey and referrer experience
Silver	Alfred Health	Ensuring timely access to care for emergency medical patients
Highly Commended	Melbourne Health	Nurse-led non-muscle invasive bladder cancer surveillance service
IMPROVING QUALITY PERFORMANCE		
Gold	Wimmera Health Care Group	Using clinical pathways to improve and sustain quality patient care
Gold	Melbourne Health	Northern Psychiatric Unit clinical risk management initiative
Highly Commended	The Royal Children's Hospital and Murdoch Children's Research Institute	Development and implementation of a paediatric sedation education and credentialing program
REDUCING INEQUALITIES		
Gold	Diabetes Australia – Vic with the Victorian Aboriginal Community Controlled Health Organisation	Feltman: a diabetes education tool
Silver	Eastern Health	Strong n proud – Indigenous youth transition program
Highly Commended	Victorian Deaf Society	Human Services Video Relay Interpreting Service

Left to right: Wayne Ramsey, Minister for Health Daniel Andrews, Shelley Park, Malar Thiagarajan, Alex Veldman.

Left to right: Christine Kilpatrick, Meagan Hunt, Premier of Victoria John Brumby, Felipe Salas, James Williams.

PREVENTION AND PROMOTION		
Gold	Peninsula Health	Cooking up a storm
Silver	The Royal Women's Hospital program for secondary schools	Young people's health and wellbeing – sexual assault prevention
Highly Commended	Barwon Health	Preschool oral health program – smiles 4 miles and partnerships
RESPONDING TO MENTAL HEALTH AND DRUG AND ALCOHOL SERVICE NEEDS		
Gold	Peninsula Health	Breaking the ice – tackling amphetamine related harms
Silver	Austin Health	Improved inpatient management of people with eating disorders
Highly Commended	Prahran Mission UnitingCare	Voices Vic – the establishment of a Victorian hearing voices network
RESPONDING TO AN AGEING POPULATION		
Gold	Western District Health Service	Men's out and about program
Silver	Northern Health	Enhancing practice – a creative response to improving care for older people
Highly Commended	Austin Health	Aged care residential outreach program

DEPARTMENT OF HEALTH SECRETARY'S AWARD: IMPROVING THE PATIENT EXPERIENCE		
Winner	Peter MacCallum Cancer Centre	Personalised souvenir movies for paediatric radiotherapy patients
Highly Commended	Austin Health	Improving the patient experience: health assistants in nursing
Highly Commended	The Royal Women's Hospital	Partners in care – neonatal services model of care

Fran Thorn, Patrick McGorry.

MINISTER'S AWARD: OUTSTANDING ACHIEVEMENT BY AN INDIVIDUAL		
Winner	The Royal Children's Hospital	Alex Auldist
Highly Commended	Austin Health	Bob Jones
Highly Commended	Southern Health	Chris Kimber
MINISTER'S AWARD: OUTSTANDING ACHIEVEMENT BY A TEAM		
Winner	Southern Health	New innovations team
Highly Commended	Austin Health	Intensive care unit team
Highly Commended	The Royal Children's Hospital	The twins' separation team
MINISTER'S AWARD: OUTSTANDING ACHIEVEMENT BY AN INDIVIDUAL IN MENTAL HEALTHCARE		
Winner	Melbourne Health	Patrick McGorry
Highly Commended	Peninsula Health	Priscilla Yardley
Highly Commended	Victorian Mental Illness Awareness Council	Isabell Collins
MINISTER'S AWARD: OUTSTANDING TEAM ACHIEVEMENT IN MENTAL HEALTHCARE		
Winner	Pathways and Barwon Health	Dialectical behaviour therapy team
Highly Commended	Incolink	Apprentice support team
Highly Commended	Southern Health	Butterfly eating disorders day program team

PREMIER'S EXCELLENCE AWARD: TACKLING CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH		
Winner	The Royal Children's Hospital	Chronic illness peer support program
Highly Commended	Western Health	Improving health outcomes in Victorians at risk of low vitamin D
Highly Commended	Diabetes Australia - Vic with the Victorian Aboriginal Community Controlled Health Organisation	Feltman: a diabetes education tool
PREMIER'S EXCELLENCE AWARD: IMPROVING CANCER CARE IN VICTORIA		
Winner	Paediatric Integrated Cancer Service, the Royal Children's Hospital and Peter MacCallum Cancer Centre	GA? No way! Minimising the use of general anaesthesia in radiotherapy mask production for children: an innovative child friendly approach
Highly Commended	Barwon South Western Region Integrated Cancer Service	Changing the culture from corridor conversations to effective multidisciplinary communication
Highly Commended	Alfred Health	Improving quality of life for long term cancer survivors through support services mask production for children: an innovative child friendly approach

Left to right: Fiona Watson, Craig Bennett, Premier of Victoria John Brumby, Wendy Wood, Patricia Faulkner.

PREMIER'S AWARD: PRIMARY HEALTH SERVICE OF THE YEAR	
Winner	Inner South Community Health Service
Highly Commended	EACH Social and Community Health
Highly Commended	Doutta Galla Community Health Service
PREMIER'S AWARD: RURAL HEALTH SERVICE OF THE YEAR	
Winner	Robinvale District Health Services
Highly Commended	Alexandra District Hospital
Highly Commended	West Wimmera Health Service
PREMIER'S AWARD: REGIONAL HEALTH SERVICE OF THE YEAR	
Winner	South West Healthcare
Highly Commended	Western District Health Service
Highly Commended	West Gippsland Healthcare Group
PREMIER'S AWARD: METROPOLITAN HEALTH SERVICE OF THE YEAR	
Winner	Peter MacCallum Cancer Centre
Highly Commended	Austin Health
Highly Commended	Peninsula Health

Stem cell research developments

Embryonic **stem cell research** is in the middle of a legal battle says Alison Choy Flannigan

STEM CELLS ARE seen as the next frontier of medical research as it is hoped their capacity to repair damaged cells may provide clues to the treatment of many currently incurable diseases. Stem cells are categorised as adult, embryonic or induced pluripotent (adult cells that are reprogrammed to act as embryonic stem cells). Embryonic stem cells (ESC), found on the fifth day of a fertilised egg, are able to churn out copies as well as transform into any of the body's cell types. Adult stem cells are found in the body's tissue or umbilical cord blood. While adult stem cells can only develop into one type of cell, ESC are able to become any cell and thus are seen to have wider application. Extraction of ESC involves the destruction of the embryo, which certain people find morally unacceptable.

The view of the Catholic Church

The Catholic Church is strongly against ECS research. It believes an embryo is a human being and its destruction is unjustifiable. However, in 2007 Pope Benedict XVI spoke in support of adult stem cell research as a means of scientific research without endangering a person's life.

In the US

In March 2009, President Obama overturned the ban on the funding of ESC research put in place by his predecessor eight years before. This was eagerly met by the scientific community who could now "make up for lost ground" with access to the funds that would facilitate their research.

In August however, Justice Lamberth in the District of Columbia, ruled that the National Institute of Health's guidelines to provide funding for ESC research were contrary to the Dickey-Wicker amendment (a 1996 law that prohibits the use of federal money for research in which an embryo is destroyed) stating: "Congress has mandated that the public interest is served by preventing taxpayer funding of research that entails the destruction of human embryos."

On 9 September, the Court of Appeal for the District of Columbia made an interim ruling allowing the research to continue pending the current appeal. The decision has the potential to place in jeopardy millions of dollars of grants for stem cell research in the US and has sparked heated debate there.

Research in Australia

In Australia the law is stated in the *Prohibition of Human Cloning for Reproduction Act 2002 (Commonwealth); the Research Involving Human Embryos Act 2002 (Commonwealth) and the Gene Technology Act 2000 (Commonwealth).*

Human embryos must only be created from the process of the fertilisation of a human egg by a human sperm outside the body of a woman with the intention of achieving pregnancy of that woman. ESC research is permitted provided:

- the embryos were created for in-vitro fertilisation;
- they have not been developed for more than 14 days;
- they are no longer needed for such purposes;
- both people whose genetic material is in the embryo give specific proper consent for such use; and
- the research is conducted by a person who is licensed under the *Research Involving Human Embryos Act 2002* and in accordance with the conditions of licence.

Thus any embryos used in ESC research in Australia would otherwise be discarded.

A new Biologicals framework

The *Therapeutic Goods Amendment (2009 Measures No 3) Act 2010 (Commonwealth)* was passed on 13 May 2010 and will introduce into Australia a new framework for the regulation of biologicals. The TGA has a maximum of 12 months to implement the new regulatory framework.

The meaning of biological

Subject to legislative exemptions, a biological is a thing that:

a) either:

- comprises, contains, or is derived from human cells or human tissues; or
- is specified in subsection (2); and

b) is represented in any way to be, or is, whether because of the way in which it is presented, or for any other reason, likely to be taken to be:

- for use in the treatment or prevention of a disease, ailment, defect or injury affecting persons; or
- for use in making a medical diagnosis of the conditions of a person; or
- for use in influencing, inhibiting or modifying a physiological process in persons; or
- for use in testing the susceptibility of persons to a disease or ailment; or
- for use in the replacement or modification of parts of the anatomy in persons.

The biological framework excludes reproductive tissue and solid organs.

Conclusion

These recent developments clearly demonstrate the precarious balance that the law strives to achieve between health and ethics and how the law is required to develop alongside technological advances in the area of stem cell research and biologics. Health providers and life science organisations that operate in this area must constantly keep up to date with legal, ethical and regulatory requirements.

ALISON CHOY FLANNIGAN
Partner in Health, Biosciences and Pharmaceuticals at DLA Phillips Fox

For more information, please contact Alison Choy Flannigan on 02 9286 8629 or by email at alison.choyflannigan@dlaphillipsfox.com

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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.

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

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

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

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

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

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*Companies providing products and services to healthcare providers

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$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

Image: iStockphoto

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

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☐ **E-Healthcare Brief** - The key news and AHHA updates edited by the AHHA team (twice weekly)

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

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Information from suppliers in the **healthcare industry**

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Brisbane Oncology Compounding Centre opening soon

FRESENIUS Kabi Australia Pty Limited has strengthened its presence in Queensland by investing $3.5 million in a new oncology compounding centre located at Geebung in Brisbane. This facility will supply Queensland hospitals and clinics with vital chemotherapy drugs and other specialised intravenous products.

The centre will house leading edge robotic IV automation technology known as Robotic Intravenous Automation (RIVA) which will bring a new level of dose accuracy and patient safety to the compounding process. RIVA will be housed in a special Clean Room and will automate the preparation of IV syringes and bags with patient-specific doses of oncology medication.

The state of the art Brisbane Oncology Compounding Centre is due for completion at the beginning of 2011. It will be licensed by the Therapeutic Goods Administration, and have a capacity to prepare up to 200,000 units of oncology preparations per annum.

Fresenius Kabi is one of Australia's fastest growing and innovative healthcare companies, employing more than 225 people. It specialises in supplying to pharmacies, public and private hospitals and health care professionals in the areas of infusion and transfusion technology, oncology, anaesthesia, blood volume substitution, fluid management, gastroenterology and nutritional support.

FRESENIUS KABI
caring for life

Optima Healthcare Products the new exclusive Australian distibutor for Medi-Plinth

OPTIMA Healthcare Products, a family owned business based in North Shore Victoria, has recently been appointed the exclusive Australasian distributor for Medi-Plinth products.

Throughout the world, healthcare professionals choose Medi-Plinth products to support them and their patients. Medi-Plinth's focus on superior quality and highly competitive products has secured their position as a leading medical equipment manufacturer.

Medi-Plinth's designs have been developed through the experience of decades of manufacturing medical equipment. Medi-Plinth has carried out hundreds of intrinsic improvements to ensure patient positioning products provide optimum security and comfort for both patient and clinician. Medi-Plinth's design team never underestimates the importance of listening to their customers, and they work on the basis that every problem is worth solving. As a result, Medi-Plinth manufactures one of the widest ranges of variable height couches, including unique products such as the Treatment/Plaster Chair.

Medi-Plinth has a reputation for producing high quality examination and treatment couches, that are robustly constructed, offering the level of durability required in environments where patient throughput is very high. They are a stable and comfortable patient platform, and provide excellent comfort and security for patients in a variety of anatomical positions, enabling a wide range of diagnostic and therapeutic medical procedures to be undertaken.

Variable height couches made by Medi-Plinth are ideal for improving the ergonomic and manual handling scenario in all healthcare fields, in organisations as diverse as schools, colleges, universities and sports complexes, as well as in primary care and hospitals.

A wide range of accessories and movement options are available offering flexibility and enhanced patient access.

*Call Optima Healthcare Products on **1800 266 515** for more information on the comprehensive Medi-Plinth equipment range.*

M8 Intensive Care bed wins top award

HOWARD Wright's M8 intensive care medical bed has won its fourth design award by taking out the top award at the Australian International Design Awards.

To date, the M8 has also won the prestigious international iF design award, a Red Dot design award from the Germany-based Red Dot Institute, and an award in the Best Design Awards run by the Designers Institute of New Zealand.

Howard Wright's award-winning M8 critical care bed has been selected as the sole provider in the Western Australian Public Health Unit's contract for critical care beds.

With a design philosophy of "making human care easier", what's innovative about the M8 is that it allows for a wide range of medical procedures to be performed on the bed without the need to transfer the critical care patient.

Unique design features include the ability to convert the bed into a full cardiac chair and the inclusion of a full radiolucent deck enabling X-ray and C-arm imaging capabilities without moving the patient.

Contact:
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11th National Rural Health Conference 13-16 March 2011, Perth, WA

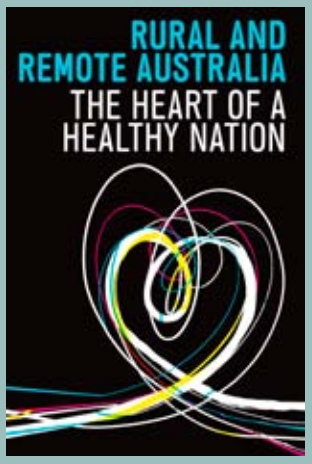
PEOPLE and agencies associated with the AHHA and who are concerned with issues affecting rural and remote areas should consider coming to the 11th National Rural Health Conference at the Perth Convention Centre, 13-16 March 2011. Early Bird registration is now open.

The National Rural Health Alliance, organiser of the Conference, is keen to have good representation at the event from the public healthcare sector and the professionals working in it. The Conference will include plenty to interest rural and remote health clinicians, academics, policy makers and administrators.

Learn about the latest innovations in rural and remote health service delivery from others in the field. Add your voice to the policy debates at the Conference and to the recommendations to governments that emerge.

All participants can provide input to the Conference recommendations as they are developed. The key recommendations are published and promoted widely to organisations, government and the media.

Keynote speakers include Amanda Sheedy, Gavin Mooney, John Menadue, Tom Calma and Christine Jefferies-Stokes. Concurrent sessions will deal with such topics as chronic disease management, depression, farmers' health, Aboriginal health in the Northern Territory, the women's health longitudinal study, e-health and building healthy communities.



The Conference MC is James Fitzpatrick, a medical practitioner with a passion for rural practice. He was 2001 Young Australian of the Year, is a poet and philosopher and is sure to entertain and challenge delegates.

The program is available on the 11th Conference website **www.ruralhealth.org.au**

Snippets

The **last** word

Honorary Life Membership for Professor Kathy Eagar

HONORARY LIFE MEMBERSHIP of the AHHA is precious, awarded rarely and in recognition of a significant, long-term contribution to the Association as well as to healthcare in Australia. This year, the AHHA Board had great pleasure in awarding the Association's 10th Honorary Life Membership to Professor Kathy Eagar.

Kathy has given over 25 years' service to the health and community sectors dividing her time equally between being a clinician, a senior manager and a health academic. She is currently Director of the Centre for Health Service Development where she leads a team of 40 researchers covering 18 disciplines. Her team has a national reputation reflecting a track record of policy-relevant health services research and development focusing on the translation of research findings into policy and practice.

In addition, Kathy manages the Australasian Rehabilitation Outcomes Centre (AROC), the Palliative Care Outcomes Collaboration (PCOC) and the National Casemix and Classification Centre (NCCC).

Kathy has also authored over 250 articles, papers and reports on management, quality, outcomes, information systems and funding of the Australia and New Zealand health and community care systems.

The AHHA appreciates Kathy's expertise and contributions to our policy development and is proud to award her with Honorary Life Membership.

New CEO for the Community Services and Health Industry Skills Council

ROD COOKE HAS been appointed as the CEO of the Community Services and Health Industry Skills Council. CS&HISC is the national body responsible for setting the national vocational and education training standard and qualifications for the two largest industries in Australia, community services and health.

Rod has an extensive background in training and recruitment and in the vocational education sector. He has held senior management and training positions including the positions of CEO with Orana Education & Training Cooperative Ltd, General Manager HR & Administration with Sydney Harbour Foreshore Authority, National Learning & Development Manager with NRMA, and the Australian Army.

Rod has a strong community services and health background as well and is currently on the Board of the Lane Cove Community Aid Service, Rural Financial Counselling Service NSW (Central West) and the United Protestant Association Aged Care Services.

New President and Vice President for the PHAA

THE PUBLIC HEALTH Association of Australia (PHAA) has a new President following the Annual General Meeting (AGM) held in Adelaide.

Professor Helen Keleher was elected President. Professor Keleher is a public health social scientist and Head of the Department of Health Social Science, School of Public Health and Preventive Medicine at Monash University. Her research interests are in primary and community health, the social determinants of health and inequity, building capacity for public health, population health and health promotion in health services/systems and policy and women's health.

The AGM also saw the election of Dr Yvonne Luxford to Vice President. Dr Luxford is currently the Chief Executive Officer of Palliative Care Australia and was previously the Manager of Policy and Advocacy for the Royal Australasian College of Physicians.

The new President and Board Members thanked the outgoing President, Professor Mike Daube, who spear-headed organisational change and development during his two terms.

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