The Health Advocate
The official magazine of the Australian Healthcare & Hospitals Association

National Health Reform tested
The results of AHHA’s Simulation and Master Class

Reconciling opposing views on assisted dying
Can they be accommodated under legislation?

Recognition and response to clinical deterioration
A look at the introduction of an observation and response chart in a major hospital

Activity based funding

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DR DAVID PANTER
President of the
Australian Healthcare and Hospitals Association

Under the national health reforms, funding regimes for the health system are set to change. In this issue we take a closer look at activity based funding.

Dear Editor

The recent National Health Reform Simulation conducted by AHHA provided an excellent opportunity for participants to investigate the implementation challenges from the NHR Agreement and also to participate in a process that may provide a future path for engagement on government policies and programs.

There were many lessons from the simulation in the areas of governance, funding models, nationally consistent performance standards, Commonwealth-state relations and the need for a consumer focus. It is clear that the Medicare Locals (MLs) and Local Hospital Networks (LHNs) will be central to the reform implementation. They will need to work together across boundaries and engage with other services. To be fully effective they will need to quickly establish appropriate governance and an organisational structures, form leadership teams, develop external relationships, set in place management practices and operational procedures and ensure that there are reporting and monitoring procedures in place. It's a lot to ask in a short period of time.

More broadly the process of the simulation could provide some ideas for engagement in government policy and program development and implementation. The government is already considering the concept of co-design through the Human Services Department. They are investigating participation in service design and delivery by engaging with stakeholders and members of the community as a basis for developing co-design techniques to improve service delivery.

The AHHA simulation, which drew on the experience and knowledge of politicians, senior government officials, clinicians, managers, policy shapers, consumers and journalists, might well be one element in the co-design process.

Dr Hugh Watson
Visiting Fellow, College of Business and Economics, ANU

From 1 July 2014, the Commonwealth's contribution to hospital funding will be based on funding levels set by the Intergovernmental Agreement on Federal Financial Relations and the National Healthcare Agreement (2008) plus 45 percent of the growth in activity (admitted and non-admitted) at the agreed efficient prices, rising to 50 percent from 1 July 2017, supplemented by incentive and other payments included in the Agreement.

To date, the ‘efficient price’ has not been defined and the yet to be established Independent Hospital Pricing Authority will have the task of defining the concept and setting the value. The Simulation was designed to test the IHPA’s role in this respect and highlighted the lack of clarity about how the value of the efficient price would be set.

The Simulation observed that the Heads of Agreement does not specify the range of hospital services to come under the remit of the IHPA.

Unless the Commonwealth and states take a visionary approach to broadening this definition, the IHPA will have no capacity to price services that substitute for in-patient care and no capacity to price innovative models of care created by the need to integrate services across LHN-ML boundaries, particularly for the chronically ill and the aged. This could skew the incentives inappropriately and run counter to the intent of the reforms.

As always, I am interested in your views on any issue raised in The Health Advocate. Please write to our editor and let us know what you and your colleagues are thinking.

NTWO COLD winter days in Canberra (21-22 June 2011) the AHHA convened the National Health Reform Simulation. This ground-breaking event brought together senior people with current or recent experience in the healthcare system, including consumers and media, to participate in a ‘road-test’ of the new environment that will be created by the NHR Agreement and its enabling legislation and to identify some of the challenges around its implementation. The Simulation was followed by a Master Class (24 June 2011), which presented an opportunity to further consider the issues discussed at the Simulation.

These events provided a unique occasion to bring together a large group of expert participants to share their knowledge and judgement in considering how the reform agenda will work ‘on the ground’. You will can find out more about the Simulation on pages 8-11.

Also in this edition of The Health Advocate, we focus on the funding regimes to be implemented under the reforms. Funding and financial incentives drive the operation of the health system, so the Simulation discussed these issues in detail.

By way of background, the COAG Heads of Agreement (February 2011) committed all governments to “a national approach to activity based funding (ABF)” and that public hospital services will be funded, wherever possible, on the basis of a national efficient price for each public hospital service provided to public patients”.

The Health Advocate
August 2011

The recent National Health Reform Simulation conducted by AHHA provided an excellent opportunity for participants to investigate the implementation challenges from the NHR Agreement and also to participate in a process in the healthcare system, including consumers and media, to participate in a ‘road-test’ of the new environment that will be created by the NHR Agreement and its enabling legislation and to identify some of the challenges around its implementation. The Simulation was followed by a Master Class (24 June 2011), which presented an opportunity to further consider the issues discussed at the Simulation.

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The health sector wants to see the COAG health system reforms implemented successfully and is looking for government leadership and support to achieve this according to an innovative policy Simulation and Master Class convened by the Australian Healthcare and Hospitals Association.

The health policy simulation was a two-day exercise led by Chris Spry, an expert from the UK, which simulated the implementation of the healthcare reforms. It involved a diverse group of health experts and stakeholders, including ex-Health Ministers, clinicians, consumers, health service managers and people with experience leading government agencies and peak bodies in the health sector.

This was the first time that the implementation of these complex reforms has been modelled using a simulation method involving stakeholders from all sectors of the health system. It provided a unique and valuable insight into how the health system reforms might unfold and a number of lessons that we hope will inform the ‘real life’ implementation process.

The events offered a valuable and thought-provoking contribution to the effective implementation of Australia’s health reform agenda. Their outcomes will complement other approaches to implementation planning such as reliance on historical experience and use of quantitative data.

The take-home message from both events was that people working in the health sector are very committed to the reform agenda and, in particular, the aims of delivering more coordinated and integrated health care.

During the simulation, clinicians and managers working within the new Medicare Locals and Local Hospital Networks quickly identified...
the need to focus on developing productive working relationships and cooperating on building new and improved models of care. Simulation players in Commonwealth and state government roles recognised that strong leadership by all jurisdictions will be required to support these local organisations during the implementation process, including clarification of the aims of the reforms and ongoing resources to build capacity.

Without adequate support and direction from governments, hospitals and community healthcare organisations may not be able to meet the challenges of implementation and instead fall back into their entrenched practices and cultures. This would be a missed opportunity to achieve lasting improvements to our health system.

The simulation exercise also provided some important warnings of the potential for some proposed financing changes to result in perverse incentives, which could undermine the delivery of high quality and efficient care. This highlights the need to base performance measures and funding mechanisms on comprehensive and rigorous data and to involve practitioners and consumers in their ongoing review.

Participants at both events identified a number of critical issues as requiring early and purposeful attention in the implementation of the National Health Reforms.
control, meet service level targets and ‘stay out of the newspapers’ was at odds with the aspirations of progressive clinicians. It is evident therefore, that there is an urgent need for governments to clarify the roles of MLs and LHNs and the processes for joint activities while they are in the process of being established. They will also require immediate support to build leadership capabilities and provide organisational improvement and governance support to assist cultural change.

Population health planning will be a very important component of the work of the LHNs and MLs and governments will need to facilitate the development of more effective skills for undertaking joint evidence-based population health planning. This function must be supported by the provision of clinically relevant datasets at the local level. Planning could be facilitated by the creation of joint population health planning groups with direct reporting accountability to the governing Boards / Councils and ultimately to governments. Coming up with mechanisms to promote integration and coordination of care focused the minds of people at both events. They detailed a range of innovative strategies and called on governments to:

- Introduce performance indicators that are shared by LHNs and MLs to avoid performance reporting echoing the silos of the health system and to facilitate joint service planning and integration of services;
- Establish jointly funded and operated clinical governance arrangements, involving Lead Clinician Groups, to manage and coordinate the care of patients needing integrated services across boundaries;
- Establish and expedite nationally consistent clinical practice guidelines which are designed to foster integrated care across LHN-ML boundaries;
- Establish a strong case management capacity within MLs, particularly for the most complex patients with multiple co-morbidities, including the appointment of case managers to coordinate care;
- Promote widespread use of the patient controlled electronic health record (PCEHR) and encourage multi-provider access, including GPs and specialists;
- Harness the existence of several different ‘single point of access’ portals for patients where one phone call (or maybe one attendance) triggers an integrated service response based upon well-designed decision-support systems; and
- Introduce funding regimes to incentivise cost effective integrated care across the primary, community and secondary care services.

I thought this was a really useful exercise, well brought together and conceptualised. It highlighted many of the entrenched views and positions which challenge health reform and the need to take both a broader system view and patient perspective.

**Funding models - incentives for appropriate care**

The new Commonwealth-state financing arrangements are a central innovation of the reforms and pivotal to their success. However, to date, the ‘efficient price’ has never been defined and the yet to be established Independent Hospital Pricing Authority (IHPA) will have the task of defining the concept and setting the value. The Simulation was designed to test IHPA’s role in this respect and highlighted the lack of clarity about how the value of the efficient price would be set. While not being deterred by the emphasis on increasing productivity, participants agreed that financial instruments need to be finely-tuned in order to drive incentives towards delivery of cost-effective care in the most appropriate settings and not at the expense of quality and safety. Effective integrated care will require a team effort across multiple services. Traditional funding mechanisms, such as fee-for-service, are unlikely to provide adequate incentives for multi-professional team arrangements.

Participants urged Commonwealth and state governments to take a visionary approach to broadening the definition of hospital services. This will give the IHPA capacity to price services that substitute for in-patient care and to price innovative models of care created by the need to integrate services across LHN-ML boundaries. They also recommended that initiatives for new and innovative funding models from service deliverers and consumers should be submitted to the IPHA for costing. Other recommendation designed to encourage and fund new models of care called on the Commonwealth and states to:

- Establish joint LHN-ML ‘innovation funding pools’ targeted at incentivising new integrated models of care thus encouraging collaborative decision making and a partnership. The Multi-Purpose-Service model is an excellent example of a multi-governmental pooled funding
arrangement and should continue to be utilised as a resource;
• introduce new blended payments (fee-for-service and block funding) for integrated episodes of care (such as bundled care / packages of care) provided by a range of providers across sectors and boundaries;
• ensure innovative use of Activity Based Funding (ABF) to facilitate care delivery in the setting most appropriate to the patient needs.

Participants raised concerns about the future resourcing of Community Health Services and suggested two options: i) enable MLs to commission services from the Community Health Services and/or; ii) the Independent Hospital Pricing Authority to cost non-hospital services as part of an efficient price approach to integrated care.

Development and impact of nationally consistent performance standards

There is an urgent need to clarify and rationalise the roles of the national agencies to reduce the reporting burden for health services across the continuum of care, to stop duplication of effort and to avoid confusion among practitioners and the community arising from differing analysis, interpretation and reporting.

The Simulation and Master Class focused on the National Health Performance Agency (NHPA), Australian Institute of Health and Welfare (AIHW), Australian Commission on Safety and Quality in Australia (ACSQHC), COAG Reform Council (CRC) and National E-Health Transition Authority (NeHTA).

A range of recommendations were put forward which focused on ensuring that the national performance agencies add value to health services, rather than generating extra red tape and an additional reporting burden. It is clear that these bodies must work together to set standards, performance indicators and other incentives to drive a continuous cycle of service improvement together with an innovative approach to promoting integrated care.

National performance agencies were urged to foster health improvement within a learning environment by allowing provider access to clinically meaningful data and feedback about their patient care practices. This is the key to improving quality as practitioners who are collecting the data can also recognise the overall purpose for its collection. In this context, the agencies must use data to encourage best practice and innovation (the ‘carrot-approach’) in preference to the ‘stick-approach’ of measuring and assessing, applying sanctions or, even worse, ‘naming and shaming’.

Participants would like to see a broader approach to performance agencies that gives equal weight to the measurement of consumer experience as is given to more easily quantifiable measures. They also should develop, as matter of urgency, reliable and sensitive health outcome measures to avoid a reporting focus on cost only.

The National E-Health Transition Authority has a critical role in facilitating sharing of patient data between local healthcare providers.

Commonwealth-state leadership – providing a role model

Governments – both Commonwealth and state – have a responsibility to consistently sustain the essential mission of the NHR both in its wider health improvement sense and in delivering an integrated approach to high quality care. Governments will demonstrate this commitment through the quality of leadership they give, the way they task the various bodies at Commonwealth, COAG and state levels, and the tone and behaviours demonstrated by their own bureaucracies.

They will develop overarching processes to developing a Policy, Implementation and Evaluation cycle to underpin delivery of cost effective and excellent patient-centred health care.

Participants believe that Commonwealth and state governments should cooperate in accepting responsibility for whole-of-system management, providing clear leadership, guidance and information about the reforms. This means creating a partnership (as distinct from competitive) approach with clearly articulated areas of responsibility and accountability (contributions), thus sharing the outcomes (risks and benefits) of the reformed system.

A better deal for patients - re-stating the consumer focus

For the community generally, the essential mission of the healthcare system is often viewed as providing prompt, safe, effective and responsive healthcare that is integrated across the continuum of care so that it is experienced as a well-coordinated package. The challenge for any healthcare system is to genuinely place the consumer at the ‘centre’ with all of the system players seeing that as their unifying purpose. It was encouraging that clinicians in the Simulation were inclined to pursue this mission – potentially positive ‘default’ behaviour.

Participants recommended that all governments accept a shared responsibility to sustain the essential mission of the NHR to improve population health outcomes and enrich the consumer experience and to communicate this clearly so there is no misunderstanding within the system or the community.
How can we make best use of Performance Reporting?

The AHHA Health Reform Simulation examined some of the challenges surrounding the ‘alphabet soup’ of performance reporting agencies and the possibility of a culture that values open debate and innovation.

The Australian Healthcare and Hospitals Association held a National Health Reform Simulation in Canberra in June. This groundbreaking event brought together the cream of Australia’s health sector to simulate health reform plans and identify some of the challenges around implementation.

One of the major elements of national health reform being put to the test at the AHHA’s simulation workshop was the role of the myriad of existing and planned national performance reporting agencies. Joining the veteran Australian Institute of Health and Welfare (AIHW) and the teenage Australian Commission on Safety and Quality in Health Care (ACSQHC) are the toddler COAG Reform Council (CRC) (established in 2007) and the embryonic National Health Performance Authority (NHPA) (with enabling legislation still to be passed).

Some of the challenges – and potential lessons – for these performance agencies identified at the AHHA simulation workshop are outlined below.

Assisting, not only assessing, performance

The logic driving the establishment of the NHPA is that improved transparency and public reporting will automatically drive better performance. But, workshop participants argued the need to ‘close the loop’, drawing on the well-known continuous improvement cycle of ‘plan, do, study, act’.

One obvious gap is that none of the agencies (with the possible exception of ACSQHC) have any remit beyond identifying ‘good’ and ‘poor’ performing health services. The workshop identified the value of a ‘national service improvement’ function, so that poor performing health services were assisted in learning about best practice initiatives that had been effective in other health services.

Avoiding a blame-focused performance culture

In a similar vein, there was strong consumer and clinician support for the view that health services should not be blamed for poor performance, but helped to improve.

Consumers were particularly concerned that ‘naming and shaming’ of Local Hospital Networks and Medicare Locals that did not meet performance targets might result in withdrawal of funding, causing these health services to fall even further behind. Instead, there should be capacity-building for less well-performing health services, providing them with tools and resources to encourage improvement.

Managing performance across the entire performance cycle

Many of the new performance agencies focus squarely on health outcome indicators relating to access and quality issues (such as the new four-hour emergency target). But, workshop participants urged the performance agencies to adopt a broad approach that gave equal weight to measurement of consumer experience.

There was also recognition that with the establishment of new agencies such as Medicare Locals, the initial focus of performance management should include ‘process’ measures, not only health outcome measures. Citing Steve Leeder in his absence (‘the target matters, but so does the archery’), workshop participants suggested that building collaborative relationships between Local Health Networks (LHNs), Medicare Locals and other health, community and aged care services was an essential first step in the long journey of health system reform.
Including the private sector

Historically, most health performance reporting has been at the level of states and territories (such as the annual Report on Government Services) and has focused mainly on public hospitals. The new NHPA will produce Hospital Performance Reports (with information on each Local Hospital Network and individual public and private hospitals) and Healthy Community Reports (with information on the performance of Medicare Locals and measurement of the health of local communities).

Workshop participants suggested that, to date, there had been only limited engagement with the private sector (private hospitals, private specialists, GPs) by the performance agencies. Consumers and clinicians want access to performance data about all parts of the health system, not just public hospitals.

Encouraging integration and avoiding perverse incentives

Another potential trap for the national performance agencies is to focus tightly on performance measures for each type of health service, while neglecting continuity of care issues. Workshop participants offered several proposals to avoid performance reporting echoing the silos of the health system.

First, performance measures could focus on improving the outcomes for people with chronic diseases such as diabetes, where good outcomes depend on effective working relationships across many health providers.

Second, the national agencies could explicitly measure how well health services are performing in providing integrated care and whether they are collaborating with other health services.

Finally, there was a heartfelt plea not to ignore the need to improve the performance of sometimes-neglected areas including mental health services.

Participants warned against the obvious risk of performance measures resulting in perverse incentives – all the effort and resources being diverted to public hospital waiting time measures, with inadequate attention on other health services or population groups.

Promoting intelligent use of performance data

There was strong interest in ensuring that the national performance agencies added value to health services, rather than generating extra red tape and reporting burden. At the front-end, this included adherence to the ‘collect data once, use it multiple times’ approach.

Workshop participants also highlighted the benefits of effectively managed data linkage, the potential of the personally controlled electronic health record and the need for national performance agencies to provide data back to health services that was clinically meaningful and could help generate a picture of population health needs for local planning.

Building a learning culture

The final set of issues and lessons relates to ensuring that health services (and governments) can learn and improve from the heightened focus on performance reporting.

One barrier is that the national performance agencies are generally prohibited from providing ‘policy advice’ on performance improvement: they can report poor performance, but are not allowed to offer advice to governments about systemic changes that might improve health service performance.

Creating a culture that encourages debate and promotes innovation is likely to be a continuing challenge for a health system, when the default position is to take a risk-averse approach and keep health system issues out of the media.
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National Healthcare Agreement: Performance report for 2009-10

THE AUSTRALIAN HEALTHCARE and Hospitals Association welcomed the release of the National Healthcare Agreement Performance Report for 2009-10 by the COAG Reform Council. This valuable document will help Australia’s public hospitals continue to improve the care they provide to the community and provide governments, the hospital sector and consumers with important data on hospital activity over the reporting period.

The report reveals a number of areas in which hospitals have improved their performance. In particular AHHA was pleased to note the reduction in waiting times for Emergency Department treatment across the country. This supports AHHA’s focus on demand management through a number of strategies, including improving the prevention and management of chronic conditions in the community.

In relation to elective surgery AHHA is concerned that the indicators being used do not accurately reflect the complexities involved in this area of hospital care. For example, some jurisdictions have been focussing on ‘removing’ long-wait patients from elective surgery lists by ensuring priority for their care at the same time as treating patients with the most urgent surgical needs. This may represent a more clinically appropriate and equitable use of hospital resources but the effect this has in the short-term is to increase median waiting times because of the focus on ‘outliers’ rather than on people more recently added to the waiting list.

To address this issue, AHHA recommends using different measures over the first few years of activity so that it is better understood that health services are focussing their effort in the most effective areas such as significantly reducing the number of long-wait patients at the same time as achieving the highest percentage of Category 1 and 2 surgeries possible within recommended times.

AHHA would also like to see a greater focus on the patient experience in hospitals through the systematic collection of nationally consistent data from patients. For example, there needs to be national agreement on the content of key data sources such as patient discharge summaries. The consumer experience needs to be placed at the centre of all hospital and health policies and this can only be achieved if we have robust and comparable data from all jurisdictions.

AHHA is also concerned that there are significant data gaps and outdated figures in the report, including information on cancer rates which dates from 2007. The data on quality and safety indicators is also insufficient to drive improvements although AHHA supports progress in these areas on key indicators, such as adverse drug reactions and unplanned readmissions within 28 days.

Unfortunately, while there are a number of positives in the Report the poor quality of the data in some areas reduces the usefulness of this document as a tool to improve hospitals’ performance.
A new study has found that private health insurance practices for subsidising high-cost pharmaceuticals are inconsistent, not transparent to consumers and may undermine the principle of equitable access to healthcare, which underpins our ‘community rating’ system of private health insurance.

For most Australians, access to pharmaceuticals occurs via the tax-funded Pharmaceutical Benefits Scheme (PBS). However, there are two significant non-government funding arrangements for pharmaceuticals; payment by individual consumers and by private health insurance. These two funding sources are becoming increasingly more important as the cost of medicines rises and a smaller proportion of this cost is subsidised by the PBS, according to study leader Senthil Lingaratnam, clinical and research pharmacist from the Peter MacCallum Cancer Centre.

This study investigated the policies of PHI companies towards reimbursement of non-PBS pharmaceuticals. The research found that the maximum limits offered for non-PBS pharmaceuticals, under comprehensive general treatment insurance, varied significantly and typically did not adequately cover high-cost pharmaceuticals. Some companies occasionally offered ex-gratia payments for high-cost pharmaceuticals. However, there was little consistency found across PHI companies in the manner in which they handle requests for high-cost pharmaceuticals in excess of the defined benefit limits. Such information and processes are not transparent to consumers.

“Our findings suggest that if PHI is to offer more equitable access to high-cost non-PBS pharmaceuticals, companies will need to be better informed of the clinical benefit and cost-effectiveness of these pharmaceuticals and must be assured that the risks associated with each application are equitably borne by all stakeholders; health insurers, hospitals, pharmaceutical industry, consumers and government alike,” Mr Lingaratnam said.

This study is reported in the most recent edition of the Australian Health Review, the peer reviewed journal of the AHHA.
Study probes Indigenous cancer deaths

A STUDY HIGHLIGHTS the reasons behind the higher cancer mortality of Indigenous Australians and makes practical recommendations for addressing the current poor access to cancer detection, screening, treatment and support services.

Research leader Dr Shaouli Shahid, Post-Doctoral Research Fellow, Curtin University Cancer, found that a major cause of death among Indigenous Australians who are generally diagnosed later with their disease, have poorer continuity of care and lower uptake and completion of cancer treatment.

One underlying reason for this is that a large proportion of Indigenous Australians live in rural and remote areas, which makes access to cancer treatment services more challenging. Factors, such as transport, accommodation, poor socio-economic status and cultural appropriateness of services also impact negatively on health service access and, in turn, lead to poor cancer outcomes.

A key theme identified in the analysis was the need for instrumental and emotional support in all aspects of the cancer journey. This was particularly the case in relation to the whole-of-treatment infrastructure and to practical logistical issues relating to all aspects of treatment and included problems with transport and accommodation arrangements. The expense of treatment and medication costs was also raised.

One example provided in the paper illustrates how difficult relocating for treatment could be, particularly for women with children. One woman whose child had to attend hospital in Perth for cancer treatment had four other children who had to accompany her. She could not leave them behind in the community because her husband was in jail and there was no one else to look after them.

had to withdraw her children from school and because she could not drive, trips to the hospital to visit her child were not easy. There are no childcare facilities associated with the adult teaching hospitals in Perth.

To improve cancer outcomes for Aboriginal people, logistical, infrastructure and cultural safety issues must be addressed. One way of ensuring this could be by dedicated support to better coordinate cancer diagnostic and treatment services with primary healthcare services. The study also makes specific recommendations in key areas, including transport, accommodation, hospital environment, Aboriginal support and liaison and transfer of care.

This study is reported in the most recent edition of the Australian Health Review, the peer reviewed journal of the AHHA.

Australian Health Review – new impact factor

THE AUSTRALIAN HEALTH and Hospitals Association welcomed the release of the latest international rating for its academic journal, the Australian Health Review. International recognition for academic journals is difficult to achieve and is measured by an Impact Factor. The AHR joined the ranks of an elite group when it received its first rating last year and has now received a rating of 0.803. This is a major boost of 27 percent in only one year.

The Editor in Chief, Professor Andrew Wilson said, “We are delighted that the success of the AHR has been acknowledged in this way. This result will further endorse the AHR as the premier Australian journal for health policy and management, and ensure that we continue to attract high quality authors and reviewers”.

The journal citation report is calculated by Thomson Reuters and is based on the average number of times published papers are cited in academic literature for a period after publication. Impact Factors have a huge influence on the way published scientific research is perceived and evaluated.
A new paper calls for a re-think of how we calculate the risks and benefits of caesarean sections versus vaginal births in healthy populations of women.

Australia is experiencing an increase in unexplained caesarean section births in healthy populations of women. The effect of this increase on health services has been justified by the belief that caesarean section is cost neutral when compared with uncomplicated vaginal birth. However, this research shows that many hidden costs associated with caesarean sections are not being considered when balancing the risks of this procedure with the benefits, according to study leader Meredith McIntyre, Senior Lecturer, School of Nursing and Midwifery, Monash University.

Medical risk in pregnancy is known to affect 15 percent or less of all pregnancies. Risk management involving the remaining 85 percent of women results in risk prevention strategies being applied in the absence of risk. Costs to women and the economic burden to the health system of serious morbidity associated with caesarean section in the absence of medical risk has been omitted from calculations comparing costs of caesarean birth and uncomplicated vaginal birth.

However, unexplained caesarean section is associated with serious morbidity in current and subsequent pregnancies for mother and baby. A large UK study reported that maternal mortality for elective caesarean section was higher by a factor of 2.8 times compared with vaginal delivery. Morbidity affecting babies creates a stressful experience for mothers and interferes with early healthy mother/baby interactions.

Neonatal intensive care unit admissions have been found to delay the maternal bonding and breastfeeding and there is an increased risk of ongoing respiratory problems including wheezing and asthma.

Maternal morbidities associated with surgery increase the probability of re-hospitalisation to twice that of vaginal birth. Readmission is associated with increased suffering, higher costs, disruption to early parenting and increased family burden.

Primary caesarean delivery also is associated with genital tract injury, wound infection, systemic infections and depression. Primary caesarean section is reported as conferring serious risk of complications in the second pregnancy for both mother and baby, including double the risk for unexplained stillbirths, spontaneous abortion, ectopic pregnancy, infertility, uterine scar rupture and caesarean hysterectomies which are associated with life-threatening consequences for women.

However, despite these findings, the rates of unexplained caesarean births are increasing without apparent consideration of the negative, and in severe cases, life-threatening effects to the health and future fertility of those women concerned and to the overall capacity of the healthcare system to absorb the increasing demand for operating theatre resources.

The false understanding that elective caesarean birth is cost neutral when compared with a normal vaginal birth has misled practice and contributed to overuse. It is important to expose costs to women and the healthcare system of morbidities associated with unexplained caesarean section to inform policy development and women’s choices. Hidden costs in terms of serious morbidity affecting women’s future health and fertility associated with caesarean delivery in the absence of medical risk need to be calculated into the overall cost burden.

This study is reported in the most recent edition of the *Australian Health Review*, the peer reviewed journal of the AHHA.
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Navigating the MAZE
Is casemix a neoliberal plot?

When casemix was first introduced in the 1990s, most of us working in the casemix states of Victoria and South Australia were very nervous. We believed that our hospitals were efficient, but we worried about two things. The funding pool was cut before it was turned into a price per admission (‘the efficient price is what you got last year, minus 10 percent, casemix adjusted’); and what would happen to our special services (as you know, every hospital is special)? I was working at the Adelaide Women’s and Children’s at the time and we were rightly fearful about neonatal intensive care units. Psychiatrists meanwhile just went ballistic – admissions for mental illness don’t really meet the two basic rules in the same way that gall bladder operations do: clinically meaningful categories with similar resource use.

The cynical analysis was that the incentives in the system would work too well and treatment profiles would move to the procedures with bigger margins – ‘lock up your children, here come the grommets!’ we said. And we set about putting in place the onerous information gathering machinery needed to produce the data to send to the health department for them to turn it into ‘equieps’ or ‘WIES’ (the volume of clinical activity) and adjust our budgets. More coders, more accountants, now! Victoria went first, and in the neoliberal logic of the system, the government set aside extra money for increases in activity. The annual pool was exhausted in three months and the money for increases in activity. The annual pool was exhausted in three months and the money for increases in activity. The annual pool was exhausted in three months and the money for increases in activity. The annual pool was exhausted in three months and the money for increases in activity.

The neoliberal behind this kind of thing (I still blame Maggie Thatcher) promised rational decision-making based on ‘best buys’ for the community, through the decisions of the government they elected. Government, not hospitals, should decide what is provided, to whom, to what standard, etc. As it happened, hospital casemix has been an impressive success story, but governments never did direct hospitals as to what kind of admissions would be paid for. Yes, there are some marginal exceptions – limiting super-specialties and a forbidden list (which seemed to be largely about sex and drugs and rock’n’roll – no sterilisation reversals, penis enlargements, tattoo removals, etc.). But really, economic rationalism had limited application in allocation decisions at the level of hospital budgets (as opposed to as between clinical specialties).

Where it made a big difference is in hospital efficiency – huge productivity gains were made, with little downside – and the capacity of hospitals to understand their costs and use that information in decision-making was greatly enhanced. Work on developing similar classification and payment systems for ambulatory care has progressed but more slowly and per head payments for apprentice health professionals represent a kind of rough justice there.

GPs are starting to be paid on a similar system with new chronic care items, although the bread and butter of short or long consultations remains. Much of public health and the non-personal care side of community health are also yet to be casemixed. Perhaps we will draw a line, realising that not everything is fundable in a casemix way. DRGs (Diagnosis Related Groups) work for hospitals because of the more predictable and ‘pigeonholable’ characteristics of in-patient care. Paying for ongoing care for chronic illness in a way that optimises outcomes (and minimises waste) is a mystery still to be cracked. Maybe the neoliberalist approach will crack it. Or maybe the system needs to accept that an underlying base of out-of-hospital care on which to support good chronic care delivery has to be resourced (and held accountable) in a different way.

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Smarter Choices, Better Care

Queensland moves ahead in implementing activity based funding
Queensland Health is moving to a new approach to fund public healthcare services across the state. The implementation of activity-based funding (ABF) is central to the ‘Smarter Choices, Better Care’ approach with its vision of better clinical care and value for money.

Queensland Health is committed to providing high quality, safe and sustainable healthcare services to meet the needs of communities. Like the health departments of other Australian states and territories, Queensland Health is required to manage its health service provision within the fixed annual budget that it receives from State Treasury. It recognises the need to prioritise and distribute allocated funding to healthcare services that improve health outcomes and the quality of patient experience. Within a finite budget, increasing funding in one area requires a funding adjustment elsewhere.

Like its counterparts in other jurisdictions, Queensland public sector health is a system under pressure associated with the substantial growth in demand for health care and the increased cost of health service provision. In Australia, health expenditure as a proportion of gross domestic product (GDP) increased from 6.3 percent in 1981-82 to 9.0 percent of GDP in 2008-09. Increased spending on public hospitals accounted for the largest part, over one quarter, of the overall increase in health spending in the 2008-09 year.

There are other significant challenges facing the Australian health system to which Queensland Health has given organisational priorities. These include addressing the inequities in healthcare outcomes and access to services that are experienced by some sections of our community and the growing safety and quality concerns arising from the changing complex healthcare environment. More than ever, it is important that health managers, clinicians and non-directorate healthcare service providers place greater focus on the value of the health care we deliver for the amount of money spent.

The introduction of ABF will stimulate increased efficiency in the delivery of healthcare services and allow greater financial transparency across and within Queensland public hospitals. It will be implemented through an approach designed to both build on our strengths and address our current healthcare challenges. The approach taken to ABF implementation will support continuous improvement in patient safety and quality through technological and clinical innovations, thus leading to better health outcomes and greater cost effectiveness. The ‘Smarter Choices, Better Care’ approach will take approximately three years to be fully implemented and will be introduced through a phased implementation that commenced on 1 July 2011.

The building blocks to make this happen are:
- Policy directions that aim to meet patient and community needs, taking into account population-based health service planning.
- Purchasing healthcare services to deliver the greatest benefits to patients and populations within available resources.
- Funding District Health Services on this basis and, in particular, funding Queensland Health hospitals based on the cost of health ‘activities’ (healthcare services) delivered.

Over the last fifteen months, Queensland Health has been engaged in a considerable work program resulting in the design of a comprehensive ABF allocation tool. This tool calculates and distributes funding to ABF participating hospitals across emergency department, in-patient (including sub-acute and non-acute) and out-patient services. It addresses cost differences between hospitals and the complexity of the healthcare services by establishing peer groups - hospital groups that offer healthcare services with similar levels of complexity. The Queensland peer group cost weights are based on 2009/10 National Hospital Cost Data Collection and AR-DRG Version 6.0. They represent the complexity of a service and how much it costs to deliver that service.

In 2010, in preparation for implementation, Queensland Health commissioned external audits of public hospitals with regard to the:
- Accuracy of counting and reporting of patient care activities delivered and the adequacy of the counting tools;
- Accuracy of coding patient records against national standards and the capacity and expertise in clinical coding in these facilities; and
- Reliability and adequacy of costing processes including clinical costing data, systems and practices.

Work associated with the recommendations from these three audits is currently being undertaken across relevant corporate divisions and District Health Services within Queensland Health.

To prepare staff for ABF, nominated District representatives within the organisation have received training to provide staff support within their region. To supplement this, a first series of ABF online education modules have been made available to all staff that introduce the basics of ABF, study materials and self-assessments.

Considerable focus is also being placed on the development of a suite of clearly defined organisational processes, policies and procedures to support the implementation of the new funding framework. This work takes account of the developing National Health Reform and ABF agenda.

Central to all the above work is the business and cultural change required to realise the benefits of Queensland Health’s new funding framework, which is ongoing.

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In depth

Living with Activity Based Funding

Graeme Houghton shares some insights from fifteen years of casemix
Activity Based Funding (ABF) is one of several key measures set to be introduced in the National Health Reform Agreement. The implementation is subject to confirmation by the Council of Australian Governments and is currently still under negotiation between the Commonwealth and states and territories.

The objectives are said to be to ‘drive efficiency and reduce waste’ and ABF will apply progressively from 1 July 2012. Initially ABF will be used to fund admitted, acute patients. Later it is likely to be the mechanism for funding emergency care, out-patient care, sub-acute care and hospital-auspiced community health services. It is less certain whether ABF will apply to mental health, community service obligations (eg services provided by small, rural hospitals), teaching, training and research.

Many managers in most jurisdictions have some experience of ABF and the observations that follow reflect my experience of fifteen years of living with ABF in two states.

Management’s view

Managers tend to regard ABF in one or more of the following ways:

1. Reward and incentive - It rewards hospitals for treating patients and provides an incentive to admit them regardless of whether admission is in the best interests of individual patients, funders or the community.

2. Compensation - It compensates hospitals for costs incurred for the volume and diversity of the work that they actually do.

3. Driving efficiency - It drives efficiency by encouraging hospitals to be more aware of costs and revenue, both for DRGs (Diagnosis Related Groups) and individual cases and enabling them to target costs for reduction, eg by minimising length of in-patient stay.

4. Commercialisation - It encourages hospitals to selectively admit the most profitable cases, ie those for which revenue minus cost is greatest.

They are all valid in degrees but, because some of these assessments underpin some of the criticisms of ABF, it is worthwhile examining each of them. But before doing so, there are some preliminary observations, which will be obvious to some but are perhaps worth stating.

Observations of ABF

AR-DRGs (Australian Refined Diagnosis Related Groups) are simply a way of describing the output of hospitals. ABF attaches a price to each AR-DRG. One objective of ABF is said to be ‘strengthened management focus on outputs, outcomes and quality’. It would be nice if ABF achieved this but, in my view, any strengthened management focus on outcomes and quality attributable to ABF is limited to issues that might extend length of stay such as nosocomial infections, drug errors and other adverse events. In my experience, the ethical obligation to reduce adverse events has had a far stronger effect on ‘management focus’ than the need to minimise length of stay for financial reasons.

Under ABF, it is appropriate to think of income as coming in the form of revenue earned for work done rather than in the form of government grants.

In theory, because a ‘national efficient price’ will be applied, initially for acute, admitted cases, less efficient hospitals will struggle financially and more efficient hospitals will prosper. In practice, the states have different costs (most notably remuneration of staff) and a hospital that uses its workforce very efficiently may have higher costs than a hospital in another state that uses its poorly remunerated staff less efficiently. It will be interesting to see how the Independent Hospital Pricing Authority deals with such variations in establishing a national price.

The foregoing two points introduce a commercial element into public hospital funding and I will explore below how this has affected behaviour in practice in Victoria and South Australia.

There will almost certainly be a cap on funding and therefore on patient throughput, although, with the Commonwealth and states sharing the funding, it remains to be seen whether there is an absolute limit on ABF or whether a reduced payment will be available beyond a specified, budgeted level of throughput.

In Australia, ABF is longest established in the Victorian public hospital system where WIES (Weighted Inlier Equivalent Separations),...
derived from AR-DRGs, have been used for 18 years as the unit of throughput for most acute in-patients. For 14 years the unit of throughput for out-patients has been VACS (Victorian Ambulatory Classification System). Emergency services are funded for actual workload associated with non-admitted emergency patients plus the costs of emergency services being available.

Examining the viewpoints

1. Reward and incentive
With most public hospitals having waiting lists for elective surgery and busy emergency departments, they have not generally sought to maximise admissions in order to maximise revenue. There is concern that far too many patients with ‘ambulatory care sensitive conditions’ (those for which admission is thought to be avoidable with the application of public health interventions and early management, usually in ambulatory setting such as primary care) are admitted but that is generally considered to be a problem independent of the funding arrangements and best managed in other ways, eg the Hospital Admission Risk Program (HARP) in Victoria.

If hospital activity falls short of the funded target, there is an incentive to increase admissions, perhaps by identifying and reducing barriers to admission, eg bed shortages.

Funds for the current, state-funded ABF systems are capped in various ways. There is an incentive to maximise admissions and throughput but only up to an activity ceiling determined by the limited availability of funds. It remains to be seen what mechanism will be applied to limit activity and cost in the national scheme – or it could conceivably be uncapped, like Medicare and the PBS.

2. Compensation
Most who have worked under the Victorian ABF system would agree that it provides reasonably appropriate compensation for the in-patient and out-patient work that they do. There are many hospital activities that are not funded by ABF and the total income of a teaching hospital is typically 70 percent from ABF.

The costs of teaching, training and research (TTR) have not been accurately quantified but there are various ways of estimating them and funders have several options for compensating hospitals that do a lot of teaching, training and research. Costs of TTR can be block funded, included in the price of admissions and out-patient episodes or a combination of both.

There must be an opportunity for hospitals to make the case that they are not adequately compensated for particular DRGs, eg if they are highly specialised hospitals that take a higher than usual proportion of complex cases.

3. Driving efficiency
ABF deliberately introduces a degree of competition by encouraging hospitals to compare their costs with others, from which the national efficient price will presumably be derived. To manage effectively under ABF, hospitals need to know the costs of their DRGs, or at least the 20 percent of admissions that generate 80 percent of their revenue. There will be a strong incentive to reduce costs below the national efficient price.
Commercialisation

An objective in the introduction of ABF in some jurisdictions was to increase commercial thinking among management, governing bodies and perhaps even clinicians. There is no evidence that public hospitals have sought to preferentially admit selected DRGs over others because they are more profitable.

In my view, ABF has encouraged managers, governing bodies and to some extent clinicians to think more commercially but not to the extent envisaged by some who advocated a market-based, often privatised, approach to delivery of public hospital services.

Details still to be resolved

The ABF systems currently used in Australia do not include any component for capital but there are historically-based and unspecified amounts in the ABF payments for minor expenditure of a capital nature. Depending on how the ‘efficient price’ of services is calculated, this may include payments for leasing of capital items such as information technology, vehicles and diagnostic equipment.

There is a reduced payment for private patients, principally because the cost of medical services is met by Medicare and need not be included in the casemix payment. It is likely that the ABF system adopted nationally will be designed to neither encourage nor discourage admission of private patients to public hospitals.

Conclusions

Hospitals should provide their coders with the training and guidelines to ensure that they code, within the rules, to maximise revenue and they should audit the coding. Funders should audit coding by hospitals to ensure that coding conforms to the rules.

No system of funding is without shortcomings and those who concentrate on the problems associated with ABF sometimes argue that it is more appropriate to fund health services according to the demography of the population that they serve, ie population-based funding. Where, as in some Australian jurisdictions, funds are directed to an aggregation of health services providing comprehensive services for a geographical area, population-based funding may be appropriate. There is still the need to allocate funds to individual health services within the region and ABF is the best way to do this. In my view, ABF and population-based funding are not in competition.

There are many complex matters to be resolved and much to be revealed about the detail of the proposed ABF system before we can be sure that it will be a fair and appropriate system. These issues include treatment of long and short stay outliers, costs of TTR, capping of funds and, especially, the national efficient price.

Nevertheless, I would say of ABF what Churchill said of democracy: it is the worst system “except for all those other forms that have been tried from time to time”.

Finally, there is perhaps a lesson for development of public policy generally in the way in which ABF was introduced in Victoria. There had been a lot of scholarly work by the states and the Commonwealth over several years to develop a DRG-based system for funding public hospitals. While most of the scholars and bureaucrats were of the view that substantial refinement of the system was still required, the Victorian Minister for Health, encouraged by key officers in her department, caught hospitals largely unawares with a system which, while not above criticism, has worked and driven significant improvement in efficiency. The lesson perhaps is that, in a spirit of action research, it is better to try something with the potential to be better than clinging to a system that is obviously faulty.

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Finding a PRICE FOR QUALITY

Improving the measures on which to fund hospital services

In 2005, the primary author of this article was involved with a leading Australian teaching hospital in a study to link patient incident data with patient costing information. In the end, the project proved relatively simple and provided interesting results namely:

- 89 percent of adverse events resulted in an average cost increase of 20 percent;
- The potential annual savings through better management of adverse events in this one hospital alone was between $6 and $17 million dollars; and
- The study offered a realistic and replicable methodology to distribute to other hospitals.

Unfortunately, the study went no further, which should not come as a complete surprise given there is no funding component under the Australian Casemix reimbursement model that rewards quality.

Fast forward to February 2011 and the Council of Australian Governments (COAG) Heads of Agreement: National Health Reform have agreed in principle to the following quality related reforms, namely:

- An expert panel is to be established to advise COAG on the effective implementation of the national standards and the right balance between reward and facilitation payments;
- The Australian Commission on Safety and Quality in Health Care will develop national standards for clinical safety and quality improvement; and
- The National Health Performance Authority (NHPA), which is to be established from 1 July 2011, will monitor performance of Medicare Locals and Local Health and Hospital Networks, and produce public reports on the performance of hospitals and health care services that are uploaded to the MyHospitals website.

In the US, Medicare is introducing Value Based Purchasing whereby a portion of a hospital’s reimbursement will be linked to quality, in the form of Quality Indicators (70 percent) and Patient Satisfaction (30 percent). Value based purchasing in the US is designed to be budget neutral. Medicare will ‘withhold’ 1 percent of its hospital payments in 2013. Hospitals will get greater than 100 percent of their ‘withhold’ back at the end of the year if their combination of Quality Indicators and Patient Satisfaction falls in the top 25 percent of hospitals in the USA.

For those hospitals that fall below the top quartile, they will receive the appropriate percent back based on their percentile position for the year. Therefore some hospitals will stand to lose significant amounts of their ‘withhold’.

While it is difficult at this time to ascertain what Australian hospitals will need to put in place in order to manage quality, it
is clear that a focus on quality will bring positive results, both for the patient and the organisation as a whole. At Community Hospital Anderson in the US for example, where Dr VanNess is CEO, their focus on quality has facilitated an average cost per adjusted discharge of US$1,800 less than their peers. Data provided by the Indiana Hospital Association Databank Program in the US, for the period 1/1/2010 through 31/12/2010, highlights the cost per adjusted discharge as shown in the graph below.

As a physician, who also happens to be a hospital CEO, Dr VanNess has always felt that the focus should always be on quality and patient satisfaction while maintaining cost effectiveness. “We don’t know exactly where healthcare reform will take us but I do believe that if an organisation is to be successful they must have strong performance on established quality and patient indicators accompanied by low costs. To accomplish these goals, accurate ‘real time’ information to make well-informed decisions will be critical.”

Like the US, Australia should link the efficient price in some way with quality. In addition, while the US appears to have their quality payment framework in place, Australia has yet to provide any clear definitions around the model. It is evident that the creation of the National Health Performance Authority (NHPA) should result in the introduction of rigorous performance indicators at a national level, which in principle should drive both health system quality and performance in Australia. However at this time there is very little information regarding the areas for performance measurement and whether Australian public hospitals will be rewarded, through the ‘efficient price’ under activity based funding (ABF) or some other means, for quality. This is important because while US hospitals can put a financial value on the change and therefore have some measure of encouragement to put in place the required processes and systems required to appropriately collect the required data, Australian hospitals remain in the dark.

This introduces a second aspect of quality that is also important to consider, namely data quality. Although the clinical quality indicators remain unknown at this time, what is clear is that the ‘efficient price’ under ABF will be derived from the current costing systems used in Australia. Given the well known issues around the lack of quality and consistency across Australian hospitals’ costing information, it seems clear that rewarding hospitals for the production of robust costing information should also fall under the NHPA’s purview. Therefore, under ABF, Australian hospitals should also be rewarded for submitting quality data. If the past 15 years under casemix funding has taught us anything, it’s that a national approach with a focus on standardising the use of the information nationally to better manage hospitals, rather than on the development of the funding model itself (alongside the concept of ‘central processing/local ownership’ and a ten-year plan for ongoing improvements and refinements in the costing process) is what’s required if ABF is to deliver the anticipated gains for which it is being put in place.

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ASSOCIATION & EVENTS
RECOGNITION AND RESPONSE to clinical deterioration

Case study: The introduction of an observation and response chart in a major hospital
DELAYED RECOGNITION AND response to clinical deterioration is a mandated clinical issue of concern at both state and federal levels. This led to the Australian Commission on Safety and Quality in Health Care (ACSQHC) establishing the Recognising and Responding to Clinical Deterioration Program. As part of this program, the ACSQHC has evolved the concept of an observation and response chart.

It is broadly acknowledged that observation charts are an important tool for recognising the point at which a patient’s condition begins to deteriorate. In spite of the recognised importance of observation charts there has been insufficient research regarding this form of tool, or indeed how such tools can be used to improve the recognition of clinical deterioration.

The Purpose of the Adult Deterioration Detection System (ADDS) Observation Chart is to:

- Support the accurate and timely recognition of clinical deterioration;
- Establish an escalation process for when deterioration is identified; and
- Define the frequency of observations required including the required increase in frequency in instances of clinical deterioration.

Broad local audit of documented vital signs has revealed significant scope for improvement regarding accuracy and completeness, as well as appropriate frequency of observations relative to the individual patient’s clinical condition.

Once accurate, appropriate and complete vital sign observation is achieved there are many variations in the associated escalation of care relative to the early warning signs of clinical deterioration that will need to be addressed.

There is anecdotal evidence at a local level that many patients have exhibited vital signs of concern for 24-48 hours prior to the MET (Medical Emergency Team) call being made; with some instances revealing a precursory clinical deterioration window of up to 72 hours. This anecdotal observation is consistent with findings elicited from audits of the MET process nationally. Local audit of MET calls for one ward did reveal that in up to half of all instances there had been no review of a patient by the home medical team in the period prior to the MET call being initiated.

Division of Medicine, Flinders Medical Centre

There was a clear opportunity to improve on the status quo within the Division of Medicine at Flinders Medical Centre (the Division) with regard to vital sign observation, documentation and appropriate response to the early stages or ‘pre-MET’ phase of clinical deterioration.

Recognition and response to clinical deterioration was identified as a key point of focus within the Division in November 2009. Collaborative links were established with the Centre for Nursing and Midwifery Education and Research (CNMER), which had recently established clinical deterioration nursing education workshops.

Agreed project goals were established. Audits were undertaken and questionnaires distributed to the multidisciplinary team targeting the confidence rating for staff in reference to both the ability to detect deterioration and influence escalation of patient care. Patient/relative questionnaires were also distributed.

The importance of aligning with the federal agenda was crucial in order to ensure that any changes instituted by the Division dovetailed appropriately with any future initiatives that were instituted by the relevant federal bodies.

Further to this, early discussions were initiated with the ACSQHC regarding the ‘observation and response charts’ that were being evolved by the Commission in collaboration with Queensland Health and...
The University of Queensland. A working copy of a multiparameter system, ADDS Observation and Response Chart, which was felt to be most appropriate for the tertiary hospital setting, was subsequently secured from the Commission as a crucial foundation element of the project. Within the prescribed acceptable limits detailed in the associated developers guide, some adjustments have been made to the initial observation chart in order to align with local MET criteria and address issues that have arisen during the pilot phase.

In line with standard process for a project of this nature, endorsement from the Divisional Executive group was sought in the early stages of project development. Due to the scope and potential application of the project on a broader scale, relevant corporate committees such as the Flinders Medical Centre (FMC) Clinical Practice Committee, FMC Clinical Governance Committee and the Regional Management Executive Committee have been kept informed of the project’s progress to date.

It has been imperative to the success of this project that effective engagement of both medical and nursing clinicians was secured from the outset. Extensive consultation processes have been undertaken with individual wards/units and clinical services prior to initiating the project in each area. Time has been taken to listen and respond to the concerns of clinical staff relative to the individual context of specific areas of clinical focus.

During the initial two weeks of roll out within each clinical area, members of the project team have been embedded in the wards to coach and support front line clinical staff as well as facilitate the resolution of any conflict resulting from the initial introduction of the new chart and associated changes to clinical process. The investment of time in ‘meaningful’ consultation has secured high levels of engagement from both medical and nursing staff while also ensuring ownership of the project at a local level.

Strong collaborative links have been established between the FMC Division of Medicine and the CNMER concerning the project, reflecting the robust educational requirements associated with this endeavour. Multidisciplinary education and information sessions were commenced prior to the launch to cover both the broader project and the essential requirements of the ADDS observation chart. Complete and accurate documentation coupled with appropriate initiation of escalation requirements was a key focus for nursing staff. The ability to interpret the document, establish a sound understanding of the escalation requirements and utilise the scope to specify unique parameter ranges for specific patients have been points of key focus for medical staff.

Advertising and marketing campaigns for the project have also been launched (Patient Safety ADDS Up) to coincide with the commencement of the education and promotional programs.

**The outcomes**

The chart is not only proving useful in documenting observation and response, but also in improving general communication and efficiencies across wards. Apart from seeing an improvement in the frequency, accuracy and completeness of documented patient observations in line with individual patient care plans, we have also observed improved efficiencies in appropriate escalation of care on the wards. A longer term expected outcome of the initiative will be a reduction in the number of MET calls initiated in the future, with the result being a smaller but predictably sicker cohort.

All incidents of escalations are being reviewed to establish both the sensitivity and specificity of the ADDS tool and subsequently mapped against other “track and trigger” systems that are available internationally to establish a comparative benchmark. Case studies will also be evolved for instances of escalation to establish any relationship to improved outcomes for individual patients. Preliminary comparisons between the ADDS observation tool and other track and trigger systems has revealed encouraging levels of sensitivity and specificity when the same clinical case study was mapped against all systems under review.

Audit of compliance with core vital signs within the context of individual patient care plans is an area that will continue to be a key indicator that will be captured and used to establish the impact of the project.

The number of MET calls as well as upstream transfers from medical wards to the Intensive Care Unit will also be monitored to establish the impact of the new observation and response chart as well as the associated process changes.

The goals for the future will be to complete roll out to the Division of Medicine (Cardiac and Critical Care Services) and embed a permanent process for review of all documented clinical escalations within the Division of Medicine. It is hoped that the project will extend beyond the Division of Medicine to engage other clinical divisions within Southern Area Health Service. The evolution and crystallisation of lasting cultural change through the fostering of greater collaboration between disciplines within the processes of patient care is a more diffuse potential outcome of the project.
IANELLA COMMUNITY HEALTH has welcomed an announcement by the Minister for Health and Ageing, Nicola Roxon that a $10.5 million GP Super Clinic will be built in Broadmeadows in the City of Hume. The Commonwealth has committed $7 million to the project with Dianella providing the balance of $3.5 million.

Dianella has committed a significant amount of the funding as it is such an important investment in the health of our community.

Dr Ralph Audehm, Dianella’s GP Clinical Director, said: “This will make a huge difference to our community. This funding will allow Dianella to support clients more effectively in our community as well as our health professionals. It will be an integrated hub for all health needs and support training of our new health professionals.”

Dianella's Board President, Dr John Hodgson, said: “We are keen to advance the service planning and design process with a view to having elements of the Super Clinic functioning later this year in our current premises. We plan to have the Super Clinic fully operational in the new building by late 2013.”

Dr Hodgson, who is also a partner in a local private GP service in Hume, was keen to stress that this service will be a boost for all health providers. “Health services in Hume, public and private, have a long history of working well together. Health staff want to work in areas where they can really make a difference for people by providing fully integrated primary care services. However we have been hampered by a lack of adequate buildings. The Hume GP Super Clinic will strengthen this collaboration enormously.”

The project has a particular focus on the needs of Aboriginal community members. In partnership with Victorian Aboriginal Health Service, Victorian Aboriginal Community Controlled Health Service and local Elders, Dianella will respond in a culturally appropriate way to the health needs of Aboriginal people and will also facilitate and support entry of Aboriginal people to the health workforce.

A major element of the clinic is its education partnerships. Dianella has established a strong working relationship with Kangan Institute, University of Melbourne, La Trobe University, the Victorian Metropolitan Alliance and the Victorian Aboriginal Community Controlled Health Service. These partnerships will provide access to inter-professional learning.

The model is the result of substantial consultation within the city and reflects the collaboration of a range of health, education and community service providers, as well as local government, to address the substantial social, economic and health disadvantages experienced by the community of the City of Hume.

Dianella Community Health has been delivering health and wellbeing programs within the City of Hume for over 30 years. Our existing services (with over 270 staff and 100 volunteers) will continue to operate at their current locations complementing the new, largely Medicare funded, services at the Hume GP Super Clinic.

This is an opportunity to develop new responses in areas such as planned chronic care, after-hours access, preventative health, the promotion of healthy lifestyles and the integration of allied health and medical services across different sectors.

At the centre of this proposal is the commitment Dianella has to the social model of health. The proposed service model is an opportunity to develop new responses in areas such as preventative health, the promotion of healthy lifestyles and the integration of services across different sectors. In particular the model emphasises inter-professional clinical practice for the provision of training opportunities to further enhance the development of a skilled workforce.

The clinic will employ a range of health professionals who will work within an integrated program framework with clinical and shared care protocols that ensure inter-professional practice. The integrated service model is supported by an IM and IT system that facilitates shared clinical information.
practicums for medical, nursing, allied health and ancillary health students; facilitate continuing professional education for health workers in Hume City, provide a platform for collaborative research and contribute to workforce planning and development to meet the future workforce needs of the City. Dianella currently works within the Crescent Program clinical school which coordinates medical and health sciences practicums within the northern suburbs of Melbourne.

The Commonwealth Government is to be unreservedly commended for this initiative. We have also discussed our proposal extensively within the local community including at our most recent Annual General Meeting attended by over 600 local residents. Everyone I have spoken to has been of the unanimous view that this is a great initiative.

I would particularly like to acknowledge the efforts of our local member of parliament Ms Maria Vamvakinou and the City of Hume. They have been advocating vigorously for GP Super Clinic funding for this area since 2007. I have no doubt this was a significant factor in the funding being made available. We feel honoured that the Commonwealth has entrusted us with the responsibility for bringing their vision to reality.

MARK SULLIVAN
CEO of Dianella
Podiatric Surgeons are podiatrists who have completed extensive, post-graduate medical and surgical training, which enables them to perform reconstructive surgery of the foot and ankle.

The Australasian College of Podiatric Surgeons (ACPS) is a nationally based organisation responsible for the development, implementation and monitoring of guidelines for the practice of podiatric surgery within Australia and the training of Registrars. The ACPS and its training program are recognised by the following instruments of Australian Commonwealth legislation:

- National Health Act 1953;
- Health Insurance Act 1973;
- Podiatric Surgery and other matters Act 2004;
- National Health Amendment (Prostheses) Act 2005;
- Private Health Insurance Act 2007;
- Private Health Insurance (Complying Product) Amendment Rules 2008;
- Health Practitioner Regulation National Law Act 2009;
- Health Practitioner Regulation National Law Act 2009;
- The Quality Assurance Requirements for Privately Insured Services PHI Circular 31/07

In April 2009, along with Medical Practitioners and Dentists, Podiatric Surgery was recognised as a specialty by the Australian Health Workforce Ministerial Council with protection of specialist title under the Health Practitioner Regulation National Law Act 2009. Commonwealth Accredited Podiatric Surgeons play a substantial role in the provision of foot and ankle surgical services in Australia.

Podiatric surgeons have worked primarily in the private sector and can make themselves available to practice within the public health system. The ACPS continues to maintain the highest standards of training registrars – highlighting the level of commitment exhibited by both Teaching Fellows and their Registrars.

Before attaining a podiatric surgical Fellowship with the ACPS, one must first complete an extensive training program, including:

- a candidate must demonstrate mastery of knowledge in foot and ankle surgery by passing written, oral and practical examinations administered by the ACPS. The exit exam to obtain Fellowship is comprised of an oral VIVA administered by a panel of medical specialists and podiatric specialists.

Podiatric surgeons have a long history of safe practice in Australia and adhere to the same hospital protocols as other surgical specialties.

Perspective on podiatric surgery

If you would like more information on ACPS or podiatric surgery, visit the College website at www.acps.edu.au
The Great HEALTHCARE Challenge!

‘ACHIEVING PATIENT-CENTRED OUTCOMES’

October 12-14 2011
Sofitel Melbourne on Collins

Presented by the Healthcare Collaboration

This exciting new ‘Healthcare Collaboration’ comprising of: the Australasian Association for Quality in Health Care (AAQHC); The Australian Council of Healthcare Standards (ACHS); the Australian Healthcare & Hospitals Association (AHHA); and The Royal Australasian College of Medical Administrators (RACMA), is working together to bring you an unforgettable conference to be held in Melbourne, from October 12 - 14, 2011.

The conference theme reflects the challenges of delivering integrated healthcare in the current reform environment, including Governance; Information Management and E-Health; Clinical Leadership; Appropriateness of Care; Safety and Quality and the need for Patient-centred Outcomes.

Who Should attend?
This high profile collaborative event will appeal to a wide cross-section of the healthcare industry, across all areas – metropolitan, regional and rural/remote. If you are a manager or a clinician working in Acute Care Hospitals, Aged Care and Primary Care, you will find this conference to be informative and stimulating. Renowned international and Australian speakers will present an exciting and educational program of plenary sessions, invited papers and workshops around the theme “The Great Healthcare Challenge! – achieving patient-centred outcomes”.

Conference Office
Please visit www.healthcollab.org.au to register your interest.
Reconciling opposing WORLD VIEWS ON AID-IN-DYING
Neil Francis discusses how **differing world views on assisted dying** can be accommodated under legalisation

**JUDITH DWYER** is right in saying that the ideology at both ends of the aid-in-dying spectrum must not be allowed to prevail over everyone (The Health Advocate, May 2011). There is a wide range of personal and deeply-held world views and it is inappropriate for those who don’t share a view to be forced to enact it, whether that view is total prohibition or ‘an obligation to pop off’ as Professor Dwyer puts it.

Just as there can be futility of medical treatment, there can be futility of palliative care despite its outstanding quality in Australia. Numerous medical studies show that intolerable suffering sometimes cannot be relieved. This fact is acknowledged by peak body Palliative Care Australia, which neither supports nor opposes voluntary euthanasia or physician-assisted dying. To ever expect perfection is unrealistic.

That leaves a small but significant number of patients suffering in extremis in their final chapter. A proportion of these patients will make a considered and enduring request for assistance to die peacefully. Research shows that most Australian doctors believe such a request can be rational, yet across Australia it is illegal to enact the patient’s request.

National Newspoll surveys in 2007 and 2009 show that 85 percent of Australians believe aid-in-dying for patients in extremis should be legalised. That includes three out of four Catholics, four out of five Anglicans, and nine out of ten with no religion. A Herald-Sun national poll of doctors in 2008 found more doctors believed the law should be reformed than don’t. A majority of nurses believe law reform would be appropriate.

So how may the patient’s persistent and rational request be accommodated? There are three potential broad reform approaches. Firstly, assisting someone to die could be generally decriminalised where it is done only for altruistic reasons and not for personal gain (the Swiss model). Secondly, a doctor could be permitted to administer lethal medication (the Dutch and Belgian model). Thirdly, doctor-administration could be excluded, instead the doctor providing the patient with a prescription to be taken by the patient (the Oregon/Washington model).

All models require transparency (not to be confused with publicity) and oversight of practice, and all three models overseas provide that.

Yet, what happens when a healthcare worker is confronted with such a request but it’s in conflict with their own world view? Law reform must provide all agents with choice. Therefore, any doctor, nurse, ward clerk, pharmacist or other healthcare worker, or institution, must be afforded the opportunity to decline to participate or to have such a request undertaken within its purview.

Equally, any patient whose request is so denied by the healthcare worker or institution is entitled to be advised in a timely manner of that refusal. This is so that other arrangements may be made in accordance with the patient’s wishes.

In this way, those who would seek to use such a law may have their wishes respected (they are not respected by being ignored as they are now) while those opposed for personal or professional reasons may also act in alignment with their own conscience.

Research data from the Netherlands and Belgium show clearly that the rate of non-voluntary euthanasia – hastening of death without an explicit current request from the patient – has not increased since both countries legalised euthanasia in 2002. Rather, it has decreased. Why?

In Oregon, doctors I interviewed in a week-long visit explained that legalisation strongly improves the conversations between doctors and their patients. When patients allude to or explicitly request hastening of death, conversations can be frank, open and honest, and all options can be explored. They no longer need to be held in double-speak and with a nod and a wink, as they are here. That’s the case in the Netherlands and Belgium, too: open conversation improves practice.

In Australia the rate of non-voluntary euthanasia is five times higher than in the Netherlands. Yet we pretend it doesn’t happen for fear of prosecution. Therefore, it happens without professional or ethics standards, peer consultation or oversight and review: in secret.

Legalising aid-in-dying in restricted circumstances, with choice for all, will remove the double-standard and promote improved medical practice, whether that’s of participation or non-participation.

**YourLastRight.com** is the peak body for aid-in-dying law reform in Australia and the national alliance of all state and territory Dying With Dignity and Voluntary Euthanasia societies. For more information contact YourLastRight.com on 03 9877 7677 or visit the website.
More thought required!

Casemix funding in a chronic disease management context

ASEMIX FUNDING IS more good than bad. There is the obvious risk around funding for output rather than outcome and subtler problems, such as systematic variations in complexity and cost structure between health services. These problems can be managed if they are recognised and casemix then provides a basis from which to draw comparisons between peer hospitals, thereby driving efficiency and accountability.

The main risk arising from casemix is the potential that it has to stifle prevention and innovation, particularly in the context of the proposed national health reforms. To illustrate this please consider the notion that general practice is the best place from which to manage chronic disease.

Chronic disease management can be characterised as a set of interventions directed at the secondary and tertiary prevention of disease. While primary prevention is directed at the whole (healthy) population, secondary prevention is directed at those at increased risk of disease, and tertiary prevention at those with the disease. Secondary and tertiary prevention following identification of individuals at risk of, or suffering from, conditions such as diabetes and vascular disease is cost-effective.

The models of prevention are reasonably simple and highly systematic. They do not fit well within a reactive model of care in which services are provided by doctors in response to patients presenting with a current health concern. Most occasions of service in general practice arise like this, in response to the patient coming to see the GP on an ad hoc basis with a current need. This is the basic model by which GP services are funded in Australia on a fee-for-service basis. Chronic disease management relies on regular planned health interactions driven by the provider rather than the consumer. Moreover, the interactions in chronic disease management can generally be provided by non-medical healthcare workers, such as nurses and administrative officers, at lower cost.

Perhaps the best example of chronic disease management in Australia is diabetes centres. These are ubiquitously based in hospitals, albeit that they may engage GPs in the network of care and GPs provide the bulk of care to many lower risk patients. This is because coordinated care of this type requires an infrastructure which to date in Australia has only been funded and available through hospitals. GPs have demonstrated a limited capacity to ensure systematic evidence based care for diabetics, despite incentives to do so. The policy support implemented by the Commonwealth for GPs to provide coordinated care for diabetics may therefore be misplaced.

In a casemix context hospitals get paid for the care that they provide for patients with chronic diseases – amputations and treating acute vascular occlusion in the case of diabetics. Hospital in-patient services tend to see these episodes of care as the entire scope of their role, particularly given that Commonwealth policy places responsibility for secondary and tertiary prevention on general practice. Hospitals have no wish to forego the funding that they receive for these episodes because that would entail change and loss of jobs. Indeed, if casemix funding is uncapped – as it is from the Commonwealth, albeit not from all states – then their incentive is arguably to provide more such services. A higher incidence and less well-controlled diabetes is required for this to occur! This argument applies at a more micro level too. For example, there are models for GPs to screen patients for diabetic retinopathy rather than doing this in hospitals as is generally the case at present. However, a hospital has no motivation to explore such a substitution and the funding model provides a disincentive.

If innovation in pursuit of whole system best practice is to be supported then a big picture view of funding needs to be combined with an operational understanding of service models and innovation for particular diseases. This will be challenging. In particular it will require close liaison between the Independent Hospital Pricing Authority and Medicare Australia. Indeed, funding both organisations separately without compulsion to work collaboratively institutionalises the problem of the hospital-community split.

Footnote

This is to be distinguished from Community and Aboriginal health services, which provide a different and more integrated model of care.
Governance training for the health sector

Ensure the governance of your organisation is best practice

The role of the governance professional is constantly evolving in line with changes in legislation, policy, service delivery, technology and society’s expectations. The Australian Healthcare and Hospitals Association and Chartered Secretaries Australia have combined their expertise and resources to deliver a dedicated program of corporate and clinical governance to the health sector.

It is crucial that directors, senior managers and clinicians understand the common fundamentals of good governance, and then keep abreast of changes. It is their responsibility to ensure that the organisation remains compliant with its legal and regulatory obligations, implements best practice risk management, achieves its strategic objectives and meets public expectations for high quality healthcare.

Our program is designed to give senior decision makers all the tools they need to meet these requirements in today’s complex healthcare environment.

Corporate Governance

Our program focuses on governance essentials and key responsibilities for meeting the compliance and strategic objectives of your organisation. Topics include:

- Values and focus of corporate governance
- Convergence of governance, risk and compliance
- The role of Board and Councils in corporate governance
- Duties and responsibilities of directors, executives and clinicians
- The difference between directing and managing
- Conflicts of interest and how to manage them
- Stakeholder engagement.

Clinical Governance

Our program examines the means by which health facilities and practitioners can ensure high standards of health care, continuously improve the quality of their services, and create and maintain an environment in which clinical excellence can flourish.

Topics include:

- Standards for better healthcare
- Relationship with corporate governance
- Developing a model for sustained improvements in quality
- Embedding clinical governance into an organisational culture
- Aligning clinical governance with vision and strategic effectiveness
- Consumer participation in service planning and evaluation
- Developing a culture of clinical leadership and lifelong learning.

Program delivery

The main module is a six-hour session from 10am to 4pm; however we can adapt the program to suit your needs. Additional modules are also available, which can be adapted to meet detailed requirements of your organisation.

Expert governance practitioners deliver the programs. They focus on the practical implementation of good governance regimes in both corporate and clinical environments.

We are available to come to your organisation in any location to conduct the training or, if you prefer, we can arrange a venue.

To book a course or get more information, contact:
Terrie Paul
Director - Business Services
Email: tpaul@ahha.asn.au
Tel: 02 6162 0780
Fax: 02 6162 0779
Website: www.ahha.asn.au
Address: PO Box 78
Deakin West ACT 2600
Who’s moving?

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

Tina Ivanov has moved south from her position as Manager, Clinical Learning and Development at Ambulance Victoria and arrived at Ambulance Tasmania as Director, Clinical Services.

Mick Reid, Director-General, leaves Queensland Health in a much better position than he found it, effective June 2011.

Carol Bryant joins Macquarie University Hospital as CEO. She moves from Westmead Private Hospital where she was also CEO.

Jude Emmer has departed St George Private Hospital where she was the Director of Clinical Services to take up position as the new CEO up at Mt Wilga Hospital.

Andrew Shine leaves Quantum Scientific where he was Marketing Manager and joins Virtus Health as National Director of Diagnostics Business.

Alison Jones, Dean of Medicine at the University of Western Sydney, will be the new Dean of the Graduate School of Medicine at the University of Wollongong.

James Jones has moved on from his role as Director, Primary Care at Schering-Plough to become the new Managing Director at Nycomed.

Phil Tennant changes from his position as Business Unit Head, Neurosciences at AstraZeneca to become the Business Unit Director, Specialty at Bristol-Myers Squibb.

Kim Chant is now Australian Development Manager for Ramsay Healthcare.

Dakshai Patel from Little Company of Mary Healthcare moves to be Finance Manager at North Shore Private Hospital.

Mark Page, former CEO of Ramsay Cairns Hospitals is now CEO of Greenslopes Private Hospital.

Rodney Fox switches from the Ortho Group and to Healthbridge as Chief Financial Officer.

Charlotte Tily, formerly of Bodington Aged Care, joins Anglican Retirement Villages as Facility Manager at Donald Coburn Centre in August 2011.

David Butt resigns as CEO of Australian General Practice Network to take a role as Deputy Secretary at DoHA.

If you know anyone in the hospital and health sector who’s moving, please send details to the Ccentric Group: editor@ccentricgroup.com.
Reach your retirement goals with HESTA

At HESTA, we’re committed to supporting you reach your retirement goals. After all, we have had more than 20 years experience in the health and community services sector.

We deliver our finance education and advice services in easy to understand language, using real life examples. Led by CEO, Anne-Marie Corboy, our role is to inform you about your options – so that you can build a better retirement savings balance, whether you’re 25 or 65.

We now have more than 700,000 members, 98,000 employers and $17 billion in assets. Our size means we can offer many benefits to members and employers. These include: low fees; a fully portable account; easy administration; access to low-cost income protection and death insurance; limited financial advice (at no extra cost); super education sessions and transition to retirement options.

In addition, we provide access to a range of great value products and services such as health insurance, banking and financial planning. HESTA is also at the forefront of super innovation: we are the first major superannuation fund in Australia to introduce a sustainable investment option and to assess fund managers on their after-tax investment returns.

For more information go to hesta.com.au or free call 1800 813 327.

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BD AutoShield™ Safety Pen Needle

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

Compatible with all insulin pens*, the BD AutoShield™ Pen Needle encapsulates the patient end of the needle supporting healthcare worker safety and helping patients feel less intimidated during the injection procedure. After the injection, the plastic shield automatically extends over the needle and locks in place. BD is committed to providing innovative solutions and pursuing a better injection experience.

*as at July 2011

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Flooring for the stars

The GREEN Building Council of Australia’s (GBCA) revised “PVC Credit” permits Armstrong’s best practice PVC products to be used in GBCA Green Star projects. Armstrong’s Accolade Plus, Accolade Safe Plus and Infinity are the only Australian made flooring products to provide this “interim declaration” and therefore comply with the GBCA Best Practice guidelines for PVC in the built environment.

By specifying these Armstrong products you can now earn up to two points towards your new building’s GBCA Green Star rating. *Widely used throughout the health care sector, Accolade Plus, Accolade Safe Plus and Infinity have been installed in recent projects such as the Mater Hospital in Newcastle, the Base Hospital in Orange, the Royal Children’s Hospital in Melbourne, the Robina Hospital on the Gold Coast and the Flinders Medical Centre in Adelaide.

For more information about “Best Practice PVC” visit www.bestpracticepvc.com.au.

*Products are not reviewed or certified under the Green Star rating system. Green Star credit requirements cover the materials in aggregate, not the performance of individual products or brands. For information on Green Star, visit our website.
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 magazine The Health Advocate, up-to-the-minute news bulletins and other professional information.

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

The AHHA reflects your views and gives them a voice. Your ideas will help shape the AHHA’s policy positions and our highly influential advocacy program. Our focus is on improving safety and quality for patients and consumers in all healthcare settings. To do this we are working to achieve better service integration; enhanced information management systems; efficient financing models; targeted performance measures and benchmarking; and a sustainable and flexible workforce.

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

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

Become an AHHA member

Membership Fees 2011-2012

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*Fee includes GST - valid from 1 July 2011 to 30 June 2012

For more information:
W: www.ahha.asn.au
E: admin@ahha.asn.au
T: 02 6162 0780
F: 02 6162 0779
A: PO Box 78
Deakin West, ACT 2600
2011-2012 Membership Applications and Renewals
Australian Healthcare & Hospitals Association

Tax Invoice
PO Box 78 Deakin West ACT 2600  t: +61 2 6162 0780
ABN: 49 008 528 470  f: +61 2 6162 0779
E: admin@ahha.asn.au

Australian  Overseas
Student*  $205  $275
Personal  $275  $378
Associate  $1103  $1502

Institutional  
(See 2011/12 fee scale)
*Documentation required to verify status as a student. All prices for Australian membership include GST and are in Australian dollars.

Member Details
Name ________________________________________________________________
Position ________________________________________________________________
Organisation ____________________________________________________________
Postal address ____________________________________________________________ Suburb __________________________ State __________ Postcode __________
Phone __________________________ Email __________________________
Institutional members may specify an IP address: __________________________

eSubscriptions (optional)
☐ E-Healthcare Brief - The key news and AHHA updates edited by the AHHA team (twice weekly)
☐ AHHA Events Newsletter - Regular notification of upcoming AHHA events including the annual Congress

Payment Details
Amount in AUDs to be paid by credit card, bank transfer or cheque.
☐ Cheques should be made payable to Australian Healthcare & Hospitals Association
☐ Bank Transfer: BSB 062 900 Account 008 00811 AHHA
☐ Credit Card Payments: (Please note – an additional 3% processing fee applies)
☐ American Express  ☐ Diners
☐ Mastercard  ☐ Visa
Amount __________________________

Cardholder Name ______________________________________________________
Card Number __________________________________________________________
Expiry ___________  Validation Number __________________________
Authorised Signature ____________________________________________________

This membership form becomes a tax invoice upon completion and payment. Please contact us on admin@ahha.asn.au if you require further proof of purchase. Please retain a copy for your records.
After hours GP advice is now only a phone call away with the launch of the after hours GP helpline on 1 July. Patients are now able to have Medicare funded consultations with a medical specialist via a video conference for the first time. The Telehealth initiative allows patients in rural, regional and outer metropolitan areas to ‘see’ their specialist close to home without the time and expense of travelling to major cities.

From 1 July, 19 communities around Australia became the nation’s first Medicare Locals. Medicare Locals have the important role of working with GPs, nurses, allied health professionals, Indigenous health organisations and LHNs to identify and respond to gaps in local health services – and help patients and professionals navigate our complex system more easily.

Queenslanders will get better access to more doctors, nurses and allied health workers with the announcement of a $51 million investment into 35 capital projects and additional support projects to improve clinical education and training infrastructure across the state.

Victorians will have better access to elective surgery, emergency treatment and sub-acute hospital beds. $440 million in projects were approved to deliver treatment this year for over 32,000 patients and to start capital works on projects to deliver 106 new hospital beds for critical care, emergency departments and elective surgery.

The federal government continued its anti-smoking campaign that targets hard-to-reach and high-risk groups, with new advertising aimed at pregnant women and their partners and more groups from culturally and linguistically diverse backgrounds.

Patients across Australia will be able to access better health services closer to home under a $3 billion investment in health reform announced in the 2011-12 Budget. Mental health services and regional and rural health infrastructure are the two largest areas of funding.

The federal government’s $2.2 billion mental health package will assist young Australians who suffer from a mental illness. The package includes $420 million over five years to significantly increase youth mental health services including the expansion of two programs pioneered by leading mental health expert Professor Patrick McGorry.

The federal government will fund a $160 million development for the new South Regional Hospital based in Bega, NSW; it will be the majority funding partner for the $220 million major redevelopment and expansion of Tamworth Hospital and it will provide $82 million in new health investments in South Australia, including major redevelopments of the Mt Gambier and Port Lincoln Hospitals.
Flooring for the stars.

You can now earn up to two points towards your new building’s GBCA Green Star® rating.

The Green Building Council of Australia’s (GBCA) new ‘PVC Credit’ now permits Armstrong’s ‘best practice’ PVC flooring products in GBCA Green Star® projects.

Armstrong’s Accolade Plus, Accolade Safe Plus and Infinity are the only Australian made flooring products to comply with the GBCA Best Practice PVC guidelines in the built environment.

In addition, these Armstrong products are currently ecospecifier Verified and are also being assessed by ecospecifier for GreenTag™ LCARate and GreenRate Certification.

For more information call your Armstrong representative, visit www.bestpracticepvc.com.au or email us today at bestpracticepvc@armstrong.com

Products are not reviewed or certified under the Green Star® rating system. Green Star® credit requirements cover the materials in aggregate, not the performance of individual products or brands. For more information on Green Star, visit www.gbc.org.au
Reduce the risk of needle-stick injuries

Sandoz have a number of injectable products available with hangers.

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

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

- Reducing the preparation time & eliminate the need for infusion bags
  - Reducing the preparation time provides efficient healthcare work practices.
  - Cost effective solution by minimising waste and materials.

Find out more about the Sandoz product range and contact your Sandoz Regional Business Manager.

hospital.division@sandoz.com or Call 1800 SANDOZ