ISSUE 18 April 2013

The Health Advocate

The official magazine of the Australian Healthcare & Hospitals Association

Your voice in heathcare

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How the National Health Reforms are working in reality, at the local and state level

Baby steps for the NDIS
There's been a lot of talk, but up until now we haven't known what the NDIS will look like

AHHA Networks:
A brief overview

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BY DR PAUL SCOWN
Chair of the Australian Healthcare and Hospitals Association

Welcome to 2013

Being an election year, 2013 will see the AHHA undertake careful and rigorous scrutiny of the health policies of all major political parties in the months to come, continuing our strong stance as Australia's only independent voice for Australian public healthcare.

With this in mind, the AHHA intends to convene a high profile Election Health Forum on Tuesday 20 August. This Forum will be preceded, on Monday 19 August, by the inaugural Deeble Institute Symposium which will debate 'Federalism and Universal Healthcare'. These two events will be held in Canberra and will take the place of our Congress this year, so please keep these dates free and we will keep you informed of the programs. Remember, 2013 is Canberra's centenary and there will be heaps of exciting things to do in the city.

The implementation of the National Health Reforms, including the establishment of the Local Hospital Network structures and Medicare Locals across Australia, provides yet another excellent opportunity for AHHA to represent your interests as service providers. A clear demonstration of the AHHA's advocacy work on behalf of hospital members has been our loud criticism of the Commonwealth Government's hospital funding cuts, announced without consultation last October, and the pressure we were able to exert, which saw a reversal of a portion of these cuts to health services in Victoria. Of course, we now continue the fight to extend this decision across all states and territories.

To support us in this cause and to have your voices heard, we encourage Health Services around the nation to join AHHA now. We have a special offer for all membership applications received before 30 April 2013. These applicants will enjoy all the benefits of membership until 30 June 2013 for free and membership in 2013/14 at the current 2012/13 membership rates.

While it is important to look ahead, it is just as important to reflect on what has already come to pass. With this in mind, and to celebrate AHHA's legacy as a vibrant healthcare organisation, this issue of *The Health Advocate* is dedicated to the activities of the Association and its members. Here, we see contributions from staff and members (State, LHN, Medicare Local and Personal), providing readers with great insight into what the AHHA and our various members are doing and thinking around topical healthcare issues. Our goal is to facilitate sharing the knowledge, views and experience across the AHHA membership and encourage continued contributions from you all. We value your opinions and commend your achievements. The year has only just begun, and we're already off with a bang. The AHHA's much-respected policy agenda is in full swing. I look forward to representing you all during this busy and exciting year. ha

AHHA in the news

HAVE YOUR SAY...
We'd like to hear your opinion on these or any other healthcare issues. Write to us at **admin@ahha.asn.au** or **PO Box 78, Deakin West, ACT, 2600**

The AHHA Federal Budget Submission

In response to the Treasurer's invitation to submit ideas and priorities for the 2013-14 Budget, the AHHA Submission outlines central issues of concern to our members: The Social Determinants of Health; National Health Reform; Aboriginal and Torres Strait Islander Health and Cardiovascular Care; Oral and Dental health; Refugee Employment in the Health Services Program; Ambulance Access; Greening the Health Sector; National Postgraduate Nurse Program and Nurse Graduate Support Teams; A National Arts in Health Program; and a Sustainable Future for Multi-Purpose Services. We believe additional funding in these areas will ensure greater viability and sustainability.

Emergency Department targets could backfire

The AHHA warned that patients could suffer if hospitals were pushed to achieve unrealistic targets, such as limits on emergency department waiting times. The AHHA was responding to the NHPA report on emergency department performance but cautioned against knee-jerk reactions to its findings. We believe no patient should have to wait any longer than necessary for treatment, but imposing time targets in isolation risks pushing hospitals to focus on meeting arbitrary targets, rather than delivering high quality, patient-focused care.

Better dental care in the States' hands

The AHHA, along with five other peak organisations, wrote to Premiers and Chief Ministers in November, urging them to sign the National Partnership Agreement with the Commonwealth to allow significant additional Federal funds to be allocated to public dental health services. Hopes for a much better dental care system are being severely threatened by States' refusing to accept the Federal Government's offer of very large increases in funding. Access to public dental health services, especially for children and people on low income, can be dramatically improved if the States and Territories agree to simply maintain their financial effort on oral health at 2010-11 levels and accept the significant Commonwealth funds to augment this.

Oral and dental health is one of the priorities outlined in the AHHA submission to Treasury.

A major milestone towards better oral health

The AHHA welcomed the passage of the Dental Benefits Amendment Bill 2012 through Federal Parliament saying it represents a major step forward for dental services in Australia. This investment in Medicare funded dental care will have a lasting impact on the oral and general health of Australian children. As poor dental health can cause a range of health and social problems, including chronic illnesses, social difficulties and barriers to entering employment, there will be ongoing benefits as children grow into adulthood.

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Government and industry are both to blame for delays in PBS listing.

PBS delays need industry and government action

A new study reported in the *Australian Health Review* revealed that Australians are waiting longer for approved medicines but industry tactics may be as much to blame for the delays as changes to government policy. In February 2011, the Australian Government announced that it would defer the listing of seven medicines on the Pharmaceutical Benefits Scheme and further, all future listings would now be considered by Cabinet, which could slow the review process. The study showed that, while it has delayed access to new treatments, there are other delays earlier in the approval process that also have a significant impact on the overall timeliness of listing. These will all need to be addressed to ensure Australians have timely access to medicines on the PBS.

There are alternative ways of measuring hospital efficiency, says a new study.

AHHA mourns the loss of Gavin Mooney

The AHHA expressed its shock and deep sadness at the death of Professor Gavin Mooney and his partner Delys Weston. Gavin was one of Australia's leading health economists who used his knowledge and skills to improve the lives of the disadvantaged in Australia and around the world. He saw beyond the dollars and cents to the real life impact of illness and disability on both individuals and our society as a whole.

Hospital death rates not the answer

Hospital death rates are not always a good measure of hospital performance, according to a study in the *Australian Health Review*. Study leader Dr. Anna Barker said: 'Our research has looked at the use of mortality rates for conditions with overall low mortality as an indicator of hospital performance. We found that there are a number of statistical limitations, challenges and biases inherent in these indicators and argue that they should be used with extreme caution. When this data falsely identifies a hospital as under-performing, time spent by hospital staff responding to this is time that is unavailable for other valuable work that may have a more direct impact on the quality of patient care. This process can also cause considerable inefficiency and damage to morale.'

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1. Australian Commission on Safety and Quality in Healthcare, National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines, August 2010. http://www.safetyandquality.gov.au Accessed February 10 2012.
2. New South Wales Government. NSW Health Policy Directive Document Number PD2012_007. http://www.health.nsw.gov.au Accessed March 20, 2012.
3. Government of South Australia. SA Health Objective File Number: eA507858. http://www.sahealth.sa.gov.au Accessed March 20, 2012.
4. Government of Western Australia Department of Health Operational Directive OD 0350/11. http://www.health.wa.gov.au Accessed February 10, 2012.

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BY DR TONY O'CONNELL
Queensland Health
director-general

Will the health system operate more efficiently under new arrangements? Not unless traditional models of care and work roles are addressed.

State public health systems in a new world order

Will the State public health systems work more efficiently under the new system? **Dr Tony O'Connell** says there's more work to do.

National Health Reform has been embraced by federal, state and territory governments. It promises a more efficient, better integrated, affordable and sustainable system, with less cost-shifting and blame-gaming. It also promises a system better able to manage increased demand arising from growing/ageing populations and burgeoning chronic disease, especially obesity and diabetes.

But what is different (structurally or functionally) in the new arrangements, and are the mal-aligned financial drivers plaguing the previous system now lined up? More importantly, will the new structures and processes be sufficient to deliver this promise of a more smoothly functioning system?

The clear and worrying answer is NO. The system can be further improved, but it would be naïve to assume that the recent reforms can be eased into like a comfy pair of slippers; we're going to need heavy working boots for the daunting challenges ahead!

Historically, staff of public hospitals, ordinary citizens, and even health departments, have responded to the pressures on our acute system with calls for more hospital beds and more staff. But it is clear that using augmentation of supply as the sole solution to these pressures in an industry in which demand is often supply-driven is unaffordable in the current tight fiscal environment. It is also unachievable in the face of looming labour shortages, especially if we continue to work in the

ways we always have. The strong focus in the national reform agreement on performance against challenging access targets in Emergency Departments and Elective Surgery has also meant that the attractiveness of the public system has increased. This has contributed to rising Emergency Department attendances, well out-stripping raw population rises.

The structural reforms, whereby new Medicare Locals are given more responsibility for co-ordinating primary care and local hospital networks (often now as autonomous statutory bodies), provide more flexible and responsive approaches to local demands. While critical, on their own, these reforms are not enough. They must be supplemented by major changes to how our public hospitals actually work.

What is required is significant redesign of our models of care and work roles, finding alternative locations in which we deliver care (e.g. Hospital in the Home, Hospital in the Nursing Home). We also need to see extensive business process reengineering of those activities which underpin daily clinical care. This will require new behaviours by hospital managers as well as frontline clinicians and, ideally, by ordinary citizens; taking more responsibility for lifestyle choices and management of their chronic diseases.

Activity-based funding will be an important driver of increased efficiency in the public system, but it does require a heightened awareness by clinicians of the cost generated by their daily service delivery decisions.

Better alignment of intentions and drivers in busy complex institutions like hospitals is essential to achieving excellent performance – we can't afford to have managers delivering mixed messages. Hospital managers working with lead clinicians will need to drive improved performance across the board (access, flow, high quality care safely delivered, satisfied staff providing excellent patient experiences and services delivered within available resources).

I've been inspired by the hundreds of examples of improved efficiency achieved through clinical service redesign in dozens of large and medium-size public hospitals across Australia. I see these redesign efforts as fundamental for the continuous improvement in the functioning of our hospitals. The returns on investment are staggering, at a minimum five-fold. The generated savings and efficiencies occur both in 'dark green dollars' (reduced recurrent expenditure) and 'light green dollars' (freed-up capacity to enable more services to be delivered).

What is required is significant redesign of our models of care and work roles, finding alternative locations in which we deliver care (e.g. Hospital in the Home, Hospital in the Nursing Home)

Asking our staff to just work harder is not an option. True sustainability comes from making their work environment more efficient and satisfying by removing the daily frustrations they encounter. To do that we need to use a redesign methodology that taps into their unique understanding of what doesn't work and what could work in their local environment.

National Health Reform gave us some fundamental building blocks for a significantly more efficient public health system. Clinical service redesign methodologies are the missing variable in the formula.

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BY WALTER KMET
CEO, WentWest

Local care for local needs

Walter Kmet offers an insider's view of Medicare Locals

As we enter a new year, it is becoming apparent that many Medicare Locals are making significant progress towards establishing themselves as locally based primary health care organisations. Clearly there is a long way to go, and we are seeing bumps along the way. That said, the evidence of the benefits of a strong primary healthcare system, supported by the structural reforms at this level, continues to mount.

In 2011, the UK's King's Fund noted that 'there is a need for general practice to adapt rapidly so it operates at a scale that can provide a platform for integrated care.' This does not speak to the size of individual GP practices, but rather the opportunity for GP practices to be a hub, or a home, for a wider system of care.

Many Australian GPs and their practices are already very much in this space. However, more effective integration of patient care, and a rebalancing of the health system towards primary care, is urgently needed. This is the only way we will be able to address the inequities and gaps that currently exist.

Many Medicare Locals, such as Hunter, Barwon, Central Coast and Western Sydney, are now developing Health Pathways to improve their systems of care. Such Health Pathways are a proven method of increasing capability of general practice and allied health. They are also shown to increase capacity to better coordinate care around patient needs.

I recall my own beginning in the private hospital sector some 20 plus years ago, when clinical pathways began making an impact on length of stay. Health Pathways are, in my view, the contemporary primary care equivalent.

Making the most of limited and unequally distributed resources remains a daily challenge for most health professionals and managers. One of the great untapped opportunities remains system change that better connects the coterie of health and human service providers.

Mental health, an area in which the burden of disease is growing, is one such opportunity. Many Medicare Locals are now taking a system approach to mental health, building on program funding by forming lasting and value-adding partnerships and service delivery consortia. This is a way of bringing the public, private and not for profit sectors together around patient needs and, in some cases, redesigning systems as a means to do this.

System redesign that ensures health systems are fit for purpose in a changing world will take some time to complete and, amongst other things, will require an investment in change management. We can't deal with new challenges by doing things as we have always done. At the same time, we will need to ensure that, wherever possible, we build on what is already working. Renovating is not as easy as building from scratch, but it is something that we need to become good at. We will also have to move quickly to implement service innovations and best practice in a way that considers local needs and operating environments.

> Much of the practical steps towards system redesign will be seen in the strengthening of relationships between Medicare Locals and Local Hospital/Health Districts, many of whom have already signed formal agreements

Medicare Locals must continue to mature as a system capable of doing this. A promising sign is my inbox, which sees an almost daily conversation amongst Medicare Local CEOs

as to how best practice can be shared. Clearly, learning is continuing across the system.

Some of this conversation is about how Medicare Locals are immersing themselves in local health systems and communities to lead and influence better health outcomes. This in itself is a positive investment in change management; one that is critical to the system as a whole. It is also a system investment that the National Primary Health Care Strategic Framework outlines as a priority.

Much of the practical steps towards system redesign will be seen in the strengthening of relationships between Medicare Locals and Local Hospital/Health Districts, many of whom have already signed formal agreements.

Such developments will be greatly assisted with support at the state and territory level. A recent example of this was a NSW Health sponsored Planning Workshop attended by NSW Ministry of Health Directors, including the Director General and ML/LHD Chairs and CEOs. This was followed by meeting of RACGP (NSW), AMA and NSW MLs.

From these meetings one thing is very clear: we have much more in common than not in our efforts to promote primary care and general practice as the home of patient care. ha

BY GRAEME HOUGHTON
Chair, Tasmanian Health Organisations;
Adjunct Associate Professor, School of Public Health, La Trobe University

Local Hospital Networks

What should we expect from our new Local Hospital Networks (LHNs) and the governing bodies appointed to lead them?

Usually, a governing body's role is to appoint a CEO and approve statements of vision, mission, values, some policies, as well as strategic and financial plans. It is also responsible for managing the relationship with the CEO, accounting information to stakeholders and monitoring performance.

Where there is no tradition of decentralised governance, or indeed a culture of centralisation, the amount of work involved in getting networked organisations (like LHNs) operational should not be underestimated.

This is why members of governing bodies must be oriented; they must work through the internal dynamics that most newly formed work groups experience. They must also establish the systems to support their work (secretariat, meeting processes, committee structure, style and content of agendas and minutes etc.). In doing so, they may need to recruit their CEO. Some members may also need to undergo training in corporate governance. Only after they have been oriented to the organisations within their network, and developed an understanding of the characteristics of the external environment, can they govern effectively. Since members of governing bodies serve only part time, and getting established takes a lot of time, these are issues that need to be considered early on.

One style of governance that I have observed in the three Tasmanian LHNs is the Tasmanian Health Organisations (THOs) approach. Perhaps because their Governing Councils comprise only four people, plus a chair common to all three LHNs, the 'forming, storming, norming' has been barely an issue. This was greatly aided by the fact that almost all Council members have governance experience or have undergone governance training. That being said, after six months, most of the 'performing' still lies ahead of us.

In most jurisdictions, the immediate priority is to maintain high levels of patient throughput.

The authority of THOs is limited by compliance with the Act that establishes them, a Ministerial Charter for each THO (which specifies, *inter alia*, that they must comply with any Ministerial Policies and provisions of the State Services Act 2000 and the Industrial Relations Act 1984). They also need to comply with an annual Corporate Plan (approved by the Minister); a Business Plan and a Service Agreement (negotiated annually with the Department of Health and Human Services); and regulations and directions (issued by authorities including the Treasurer and the Auditor General).

The Corporate Plan, Service Agreement and Business Plan must be presented to Parliament and are, along with the work of the THOs, potentially exposed to intense political and media scrutiny. Like in some other jurisdictions, these documents are intended to clarify the roles of funders, owners, purchasers and providers. In this case, the THOs are the providers. While they, as providers, are accountable for all aspects of their performance, it is debatable whether they have adequate authority for this purpose.

Nevertheless, the THOs' commitment to the devolution of authority and accountability requires a change to the established working culture among staff. This includes staff within the THO and DHHS and other instrumentalities, e.g. Treasury and Finance, Premier and Cabinet.

Work culture in all jurisdictions needs to respond, in part, to the National Health Reforms. These Reforms include a raft of measures for improving Indigenous health, safety, performance, health workforce, e-health, preventive medicine and Medicare Locals.

While LHNs may not be explicitly expected to contribute to reforms on the broad national front, it is reasonable to expect them to do what they can to make local health care more effective, more equitable, more efficient and safer.

In most jurisdictions, the immediate priority is to maintain high levels of patient throughput. This is to ensure that communities have timely access to emergency and planned care, and that LHNs are capable of limiting financial resources while managing clinical and other risks.

In addition to this, one should expect LHNs to produce plans that are more aligned with community needs and expectations, and vice versa. LHNs should also ensure that clinicians are more engaged in partnerships to manage finances, quality and productive partnerships, especially with Medicare Locals.

While governance and management are different activities, and the governing body must not meddle, it is reasonable to expect governing bodies to add value to the tasks of financial and clinical management, as well as the development of a productive internal working culture. Governing bodies of LHNs should be thinking about these issues from the get go.

Time will tell as to how successful new governance models adopted by LHNs actually are. ha

BY ANDREW MCAULIFFE
Senior Director, AHHA
Policy & Networks

Behind the rhetoric – Funding cut facts

The flow-on effect of the funding adjustments has impacted on patient services

There has been considerable media coverage of the impact of the hospital funding reductions arising from the Mid-Year Economic and Fiscal Outlook (MYEFO) released by the Federal Treasurer in October 2012. The flow-on effect of the funding adjustments has been felt at the hospital level and has impacted directly on patient services. While the agreements covering the allocation of funding allow for adjustments, there are considerable issues with the methodology that has been adopted by the Australian Government.

The total amount of funding payable to the states and territories under the National Partnership and National Health Reform Agreements is determined by a combination of escalation in the health price index, population share and growth, and an index of technology cost growth.

The health price index used by Treasury was markedly lower than in recent years and no clear explanation of the methodology for calculation of the index has been provided by Treasury.

The population growth figures used by Treasury were also significantly lower than earlier estimates used in the 2011-12 and 2012-13 Budget papers. This was due to changes in the Australian Bureau of Statistics (ABS) methodology. It is the usual practice for historical population estimates to be adjusted following determination of the variation in population estimates between censuses (the intercensal error). This adjustment is usually applied to the five year period between censuses. Following the 2011 Census, the ABS determined, as a result of improved data capture and matching processes, that the previous methodology for the estimation of 'undercount' had resulted in the undercount in previous censuses being overestimated and the estimated population was also overestimated.

Due to the resulting larger than normal 2006-2011 intercensal error, the ABS decided to revise historical population estimates over a 20 year period (1991-2011). This approach was selected following extensive consultation and to ensure that the credibility of the data was maintained and that the population growth for 2006-2011 reflected the components of growth.

Despite this approach by the ABS, the Australian Government Treasury has chosen to apply the adjustment to a single year (2011) which produces a population growth figure for 2011 of 0.03% which is in stark contrast to the ABS figure of 1.6%. As a result of the changed population estimates, Treasury reduced the 2011-12 allocations by $150M and the 2012-13 allocations by $254M.

The health price index used by Treasury was markedly lower than in recent years and no clear explanation of the methodology for calculation of the index has been provided.

The approach taken by Treasury raises two key issues.

1. The decision to apply the population adjustment to a single year ignores the recommendations of the ABS.
2. There is no evidence of consultation with state and territory health departments prior to the release of the MYEFO regarding the health price index and population estimate methodologies, or the impact of reduced funding allocations.

This is in contrast to the stated intentions of the National Health Reform Agreement for the 'Commonwealth, State and Territory (the States) governments to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system'. It also contradicts the stated joint responsibility to collect and provide 'data to support the objectives of comparability and transparency…'.

Understandably, the lack of consultation and transparency has significantly impacted on the confidence of the states and territories in the pooled funding arrangements as the unilateral manipulation of the funding formula components by Treasury significantly shifts the burden of risk to the states and territories and local service providers.

While the retrospective adjustment and reconciliation of funding allocations is a normal process, the impact of retrospective reductions could previously be 'buffered' by State and Territory Treasuries. The capacity for this has been reduced through the pooling of funds in the NHFP and the devolution of budgets to local areas. While the funding allocations have reduced as a result of the population adjustments, the Federal Minister for Health can continue to state correctly that funding to the states and territories has increased. The states and territories can correctly state that, compared to original allocations in the 2011-12 and 2012-13 budgets, Commonwealth contributions have decreased. The challenge is for local service providers to accommodate the repayment of the 2011-12 allocations, the reductions in 2012-13 allocations and the reduced allocation in subsequent years. Furthermore, the remainder of the existing budgeted financial year and the investment and expenditure planned for future years will also need to be taken into account.

This is an edited version of an AHHA Acute Network Update. The full version is available at http://ahha.asn.au/policy-advocacy/policy-issues

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BY DR STEPHEN WILSON
Head of Department of Rehabilitation Medicine, Royal North Shore and Ryde Health Service

First steps for the NDIS

We're only now starting to get an idea of what the NDIS will look like in reality. **Dr Stephen Wilson** explains.

The National Disability Insurance Scheme (NDIS) has been heralded as the 'most significant reform in disability services seen in Australian history'. In terms of sheer scale, the scheme ranks in the same league as the introduction of Medicare. Every Australian will contribute through tax to the tune of 1 billion dollars for the first stage in this year's budget.

As critical as such funding is, perhaps an even more important anticipated outcome from the NDIS is a change in the way Australians value the rights of all residents to a reasonable quality of life, regardless of their different abilities. Such a cultural shift would deliver on the objectives of the National Disability Agreement and the UN Convention on the Rights of Persons with Disabilities, which Australia ratified in 2008.

In July 2011, the report of the Productivity Commission Inquiry into Disability Care and Support set a template and a timetable for roll out of the NDIS up to 2018. Since then, there has been bipartisan support for the scheme, with the introduction of the Prime Minister's National Disability Insurance Scheme Bill 2012 to Parliament last November.

Though the Bill was tabled in November, progress has been made since the COAG meeting held in July. Here, the Commonwealth reached in-principle agreements with South Australia, Tasmania and the Australian Capital Territory to implement and fund pilot NDIS projects, commencing from July 2013. NSW has also committed to funding a pilot in the Hunter region and Victoria in the Barwon region.

At this stage, we can only speculate on what the scheme will look like after these pilots have been evaluated. The final scheme will no doubt be influenced by the outcome of the 73 consumer and provider projects recently sponsored by the NDIS Practical Design Fund.

Governance

At the federal level, the responsibility for the NDIS will be with the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). State and territory governments will need to consider the responsibilities within the portfolios of disability and health for service delivery in their own jurisdiction.

There will need to be an increase in the provision of permanent group housing and intermittent respite care for those with special needs. Delivery of services will most likely be through enhancements to existing non-government and not-for-profit DSOs.

In addition, there will need to be an increase in the provision of permanent group housing and intermittent respite care for those with special needs. The actual delivery of services will most likely be through enhancements to existing non-government and not-for-profit disability support organisations (DSOs). Increased investment in these services will be welcomed by the multiple organisations involved, with greater than 200 DSOs operating in New South Wales alone.

Actual delivery of services under the new NDIS will most likely be through enhancements to existing disability support organisations.

The first tier of activity for the NDIS sets a goal to minimise the impacts of disability—but thresholds for entry and inclusion have yet to be determined.

Assessment

The 2011 Productivity Commission Inquiry report has suggested three tiers of activity for the NDIS. Tier one applies to the whole Australian population of 22.5 million people, in which the goal is to build community capacity to minimise the impacts of disability. Tier two targets the 4 million people with a disability and their 800,000 primary carers through the provision of information and referral services. Tier three includes the group with significant disability requiring funded support. This group has been estimated at 410,000 people and will consume most of the funds. A 'Rules' consultation paper has been released and the process of assessment for 'Participants' is still unclear. The threshold for entry and inclusion is likely to be a contentious issue and subject to available funding.

A framework for assessment has been suggested that is broadly based on the International Classification of Functioning (ICF), with an emphasis on participation in society for the person with a lifelong disability. The range of disabilities qualifying for support will require a toolbox of assessments which may include physical, cognitive, psychological, sensory and behavioural measures. One parallel system that has been implemented and operating for over 20 years is the age-related disability assessments carried out by aged care assessment teams. A similar multi-disciplinary approach involving specialists in assessing Ability and Disability could achieve a similar standardised system, coordinating a multitude of assessment tools to determine eligibility for Tier 3 interventions and resources.

One parallel system that has been implemented and operating for over 20 years is the age-related disability assessments carried out by aged care assessment teams.

Models of care

The 'no fault' model for funding services to people suffering disability following motor accident may influence the pilot programs; particularly since Mr David Bowen was appointed CEO of the NDIS Launch Transition Agency, following a previous role as inaugural CEO of NSW Lifetime Care.

The challenge for the pilots will be to maintain a consumer focus. Individual choice must be exercised for services by the person with a disability, with inclusion of the needs of families and carers within their chosen environment.

Summary

The first year has demonstrated progress with a number of the building blocks for this scheme. A key feature is the separation of those people eligible for insurance under a National Injury Insurance Scheme (NIIS) and those currently falling through the gap who will get adequate services under the NDIS.

There are great expectations from the whole community for the pilot projects. While still in their early days, the progress made so far is revealing tangible evidence of achieving the NDIS vision for long-term care and support for all Australians with significant disability.

Further information:

- National Disability Insurance Scheme (www.ndis.gov.au)
- World Health Organisation, International Classification of Functioning Disability and Health (ICF) (www.who.int/classifications/icf/en/) .

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Overview of AHHA Networks

The AHHA's networks are designed to support knowledge development and knowledge sharing for members.

The AHHA establishes Member Networks to:

- ensure expert input to our health policies, research and advocacy programs; and
- create stimulating forums for learning through knowledge sharing, analysis and review.

It is through these Networks that the AHHA ensures our policies reflect our members' views. At the same time, members benefit from the opportunity to learn from each other and to develop both professionally and personally.

Network collaboration involves email communication, phone hookups and face-to-face Policy Think Tanks. In 2013, there will be an increasing focus on the use of online collaboration and social media to support policy development and knowledge sharing.

There will also be links with the Deeble Institute to identify and inform health policy research opportunities.

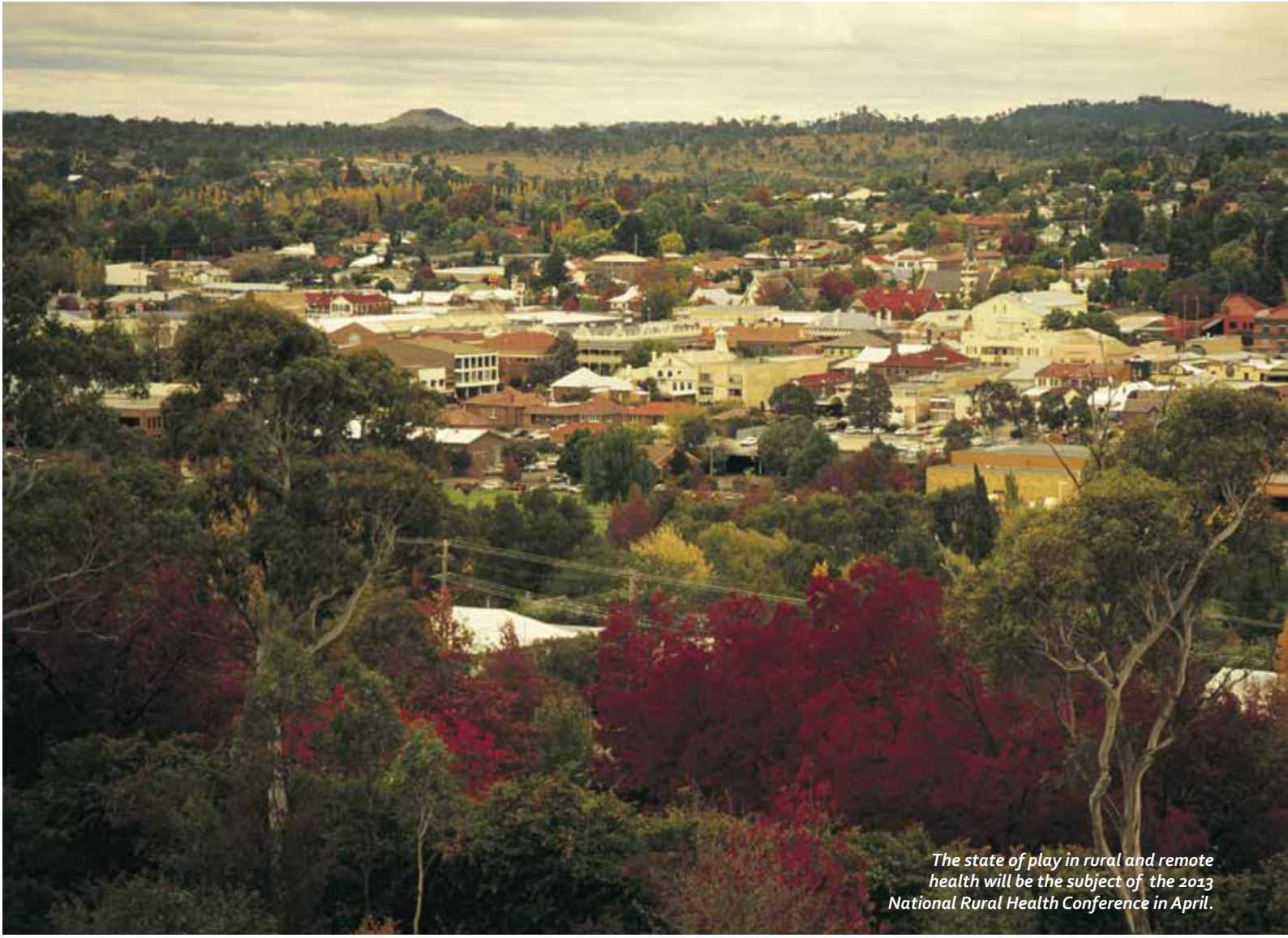
SECTOR NETWORKS

Acute care:

The progress of the National Health Reform agenda is a key focus of the Acute Network. Network activity in recent months has included responding to the IHPA 2013-14 Pricing Framework and meeting with the IHPA CEO to discuss issues raised by members. In June this year the AHHA, in conjunction with the Crawford School of Public Policy at the Australian National University, will conduct a Policy Think Tank addressing *Health Service Performance Measurement: Theory, Practice and Opportunities*. Speakers will include Professor Roland Bal from the Institute of Health Policy and Management, Erasmus University, Netherlands. Professor Bal has undertaken extensive research and published widely on topics including health care policy reform, performance management and safety and quality.

Community and Primary Healthcare:

The ongoing development of the Medicare Local structure and role continues to be a focus of the Community and Primary Healthcare Network. A theme across the sector-based networks is the need for collaboration and integration. The AHHA is supporting this requirement by linking our new Medicare Local members with our existing community health and acute sector members and networks. The Network has been active in informing the funding reforms and the IHPA funding model particularly in areas where the activity-based



The state of play in rural and remote health will be the subject of the 2013 National Rural Health Conference in April.

funding models create barriers to an effective transition of care between the acute and primary care sectors.

Rural and Remote Health:
Registrations are now open for the Rural and Remote Policy Think Tank, to be held in collaboration with the National Rural Health Alliance as part of the 2013 National Rural Health Conference in Adelaide in April. Register at: http://nrha.org.au/12nrhc/pre-conference-events/

The Policy Think Tank, *Service Integration in Rural and Remote Australia – opportunities and challenges to hospital and primary care collaboration*, will focus on models of care and funding structures. It will also consider the state of play, as well as current and future opportunities for improved collaboration and service integration between the acute and primary care sectors.

POLICY NETWORKS

Greening Healthcare and Hospitals Services:

In 2012, the AHHA become a founding member of the Global Green and Healthy Hospitals Network and in line with the GGHH Agenda developed an action plan for the health sector. In 2013, this work will be progressed with a focus on energy and waste management. In collaboration with a range of stakeholders, including the Climate and Health Alliance, the AHHA co-hosted an Energy Policy Roundtable meeting in Canberra in February. This Network is also involved in developing a research proposal with the University of Canberra through the AHHA's Deeble Institute.

It is through these Networks that the AHHA ensures our policies reflect our members' views, and members benefit from the opportunity to learn from each other.

Aboriginal and Torres Strait Islander healthcare:
As a progression of work under collaboration in 2010, the AHHA and the Heart Foundation have been working to ensure better hospital care for Aboriginal and Torres Strait Islander people with Acute Coronary Syndrome. This work has involved identification of successful programs and best-practice approaches to inform the establishment of a Hospital Demonstration Project to foster and disseminate expertise and knowledge and address health disparities.

Oral and Dental Health:

The Oral and Dental Health Network had a big year in 2012, with the Australian Government announcing significant new initiatives and funding. The new programs supported a number of recommendations from the National Advisory Council on Dental Health, of which the AHHA was a member. The AHHA was invited to give evidence to the subsequent Senate Committee Inquiry into the legislative amendments required to implement the new programs. The AHHA will work closely with members to ensure an equitable and structured approach to the implementation and evaluation of the new programs.

Copies of AHHA Network reports, policy papers and submissions can be found on the AHHA website. ha

Special Membership Offer!

Local Hospital Networks, Medicare Locals & Community Health Services

Apply to become an AHHA member before 30 April 2013 and enjoy all the benefits of membership until 30 June 2013 for **FREE** + membership in 2013/14 at the 2012/13 membership rates.

Why join AHHA?

- We directly shape health reform;
- We help protect universal access;
- Our work builds equitable outcomes for vulnerable communities;
- We ensure you have a voice in Commonwealth and State funding matters;
- We will provide discounted governance training for CEs and Board Members.

AHHA work includes:

- Advocating directly with Ministers;
- Providing representational support;
- Coordinating high-level policy development and national advocacy;
- Developing policy options on Activity Based Funding;
- Exerting influence on the Independent Hospital Pricing Authority;
- Providing governance, corporate, clinical advice and training;
- Enhancing national health policymaking through the Deeble Institute;
- Developing policy options in National Benchmarking and Data, Information Management and Service Integration;
- Engaging membership through networks and think tanks;
- Facilitating service integration and improved transfer of care with primary health and hospital sectors;
- Ensuring public health care issues are constantly aired in the media and debated by policymakers at the highest levels;
- Production of the ***Australian Health Review***, ***The Health Advocate*** magazine and twice weekly newsletter ***e-Healthcare Brief***.

For information on AHHA membership, phone +61 2 6162 0780, email admin@ahha.asn.au, or visit the Australian Healthcare and Hospitals Association website at www.ahha.asn.au

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Palliative Care Online Training

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A new online training program has been developed to help health professionals who provide palliative care to aged persons in the community. The modules will help you develop your skills and confidence, so that the next person you care for at the end of their life will benefit.

The four online training modules have been developed to help you to:

- Reflect on the needs of people and their families as they approach the end of life;
- Build your screening and assessment skills;
- Develop confidence in having end of life conversations, especially around Advance Care Planning;
- Invest in your own self-care and build resilience;
- Connect you to a wider network of experts who can support and assist you.

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For more information, contact Terrie Paul, the Director of JustHealth Consultants, by emailing tpaul@ahha.asn.au or by phoning 02 6162 0780.

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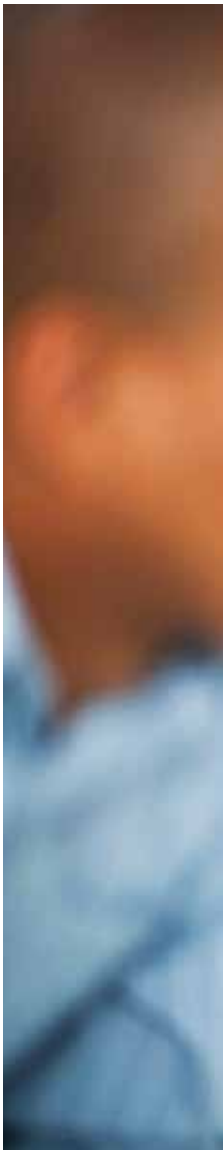

Corporate governance in Queensland hospital and health boards: An explanation of key issues. By **Steven Grant*** and **Penelope Eden†** of MinterEllison.

Introduction

As part of reforms to Queensland health services, regional statutory bodies called 'Hospital and Health Services' (Services) were established from 1 July 2012 under the Hospital and Health Boards Act 2011 (Qld) (Act). These statutory bodies are controlled by 'Hospital and Health Boards' (HH Boards) in accordance with the Act. Like the board of a private sector company, HH Boards face an array of complex corporate governance issues on a day-to-day basis. However, unlike private sector company boards, HH Boards are also subject to a range of legislation as boards of statutory bodies.

Like the board of a private sector company, HH Boards face an array of complex corporate governance issues on a day-to-day basis.

Statutory framework – a statutory body with a corporate sole

Each Service is established under the Act as a body corporate that represents the State of Queensland and has the right to sue and be sued. This means that a Service is a body corporate, like a company, but it is also a statutory body established under legislation. Accordingly, each Service is subject to legislation, including the Financial Accountability Act 2009 (Qld), the Statutory Bodies Financial Arrangements Act 1982 (Qld) and the Crime and Misconduct Act 2001 (Qld), which govern the financial management and accountability of statutory bodies.

In many ways, HH Boards have been established to operate in a manner consistent with that of a private sector company board. For example, there is a schedule to the Act that addresses how an HH Board should operate dealing with matters such as quorum, conduct of meetings, keeping of minutes and disclosure of interests in a similar manner to the constitution of a private sector company. However, in other ways, HH Boards are decidedly different to private sector company boards.

Acting in the public interest and following Ministerial directions

Unlike the board of a company, which is required to act in the best interests of the company and its shareholders, each member of an HH Board is required under the Act to act impartially and in the public interest in performing the member's duties. While the Act does not define what is 'in the public interest', it is likely to involve an analysis of the hospital and health needs of the public in the region where the Service operates. It may also involve consideration of principles such as transparency, accountability, discretion and integrity, which often underpin public sector activities.

The relevant Minister may also issue written directions to the Service if the Minister is satisfied that it is necessary to do so in the public interest. The Service must comply with any such Ministerial direction. Effectively, this means that an HH Board would be compelled to follow any such Ministerial Direction even if the members of an HH Board have a different view of what is required in the public interest to that of the Minister. In practice, this conclusion is supported by the ability of the Governor in Council to appoint and remove members of an HH Board on the advice of the relevant Minister. Nonetheless, it may create some challenging governance issues for members of an HH Board.

Protection from liability

The Act provides that a member of an HH Board is not civilly liable for an act done, or omission

made, honestly and without negligence under the Act. Instead, it attaches that liability to the Service itself. Members of an HH Board should take some comfort in this protection from civil liability. However, they should also be aware that the courts have adopted a fairly narrow view of what actions are considered to be made under a statute and the types of civil liabilities to which this type of protection is afforded when considering similar sections in other legislation. They should also keep in mind that there is no protection for criminal liability that may arise due to their position, or the actions they take, as HH Board members. For example, the Act itself contains an offence in relation to the disclosure of confidential information other than as required or permitted under the Act. There are also Queensland laws which impose personal criminal liability on those concerned in the management of bodies corporate.

Conclusion

The legal framework of a body corporate that is also as statutory body, and the corporate governance issues it creates, can be quite complex – particularly when considering issues of transparency and accountability which often underlie public sector activities. Although HH Board members are afforded some protection from civil liability, they should take steps to properly understand the obligations placed on the Services they control, both as bodies corporate and statutory bodies, as well as their own obligations as board members. This is merely a snapshot of some of the issues which may arise. ha

**** BCom, LLB (Hons) (U.Qld), Senior Associate, Minter Ellison, Brisbane. Steven advises government and non-government entities on corporate governance and mergers and acquisitions.***
† LLB (QUT), Special Counsel, Minter Ellison, Brisbane.

The emotional toll of serious health events

Information is the key in helping patients at risk of depression and anxiety.

Beyondblue and the Australian Healthcare and Hospitals Association have collaborated on a free information resource for hospital patients who have experienced a serious health incident.

Many people experience a strong emotional reaction at the time of, or soon after, a serious unexpected health event – such as a heart attack, stroke, diagnosis of cancer, or other serious illness or injury. Feelings of shock, anger, grief, loss and sadness can be common, and usually pass with time. However, if these feelings and the challenges that follow such an event cause ongoing stress and worry, the person is at greater risk of developing depression or anxiety.

Research shows that 9% of people with depression and up to 16% of those with panic disorder had experienced a serious medical condition or illness prior to the onset of anxiety or depression. The need for patients to receive information about their emotional and mental wellbeing is backed by a beyondblue-funded study by the Heart Research Centre, which found that 81% of people who had experienced a heart attack said they would have benefitted from receiving information about what to expect emotionally when they were discharged from hospital. Only 10% had been provided with this information. The brochure *Have you had a serious health incident? Don't risk depression and anxiety* looks at the emotional impact a person may experience following a serious health incident.

Content includes:

- **What is a serious health event?**
- **What challenges are likely?**
- **The emotional journey**
- **What are 'normal' reactions after a serious health event?**
- **Will the feelings go away?**
- **What is depression?**
- **What is anxiety?**
- **Taking action**
- **Tips for looking after yourself**
- **Tips for family and friends**
- **Where to find more information**

Copies of the full brochure can be downloaded from www.beyondblue.org.au or ordered through the beyondblue info line on 1300 22 4636.

Over the coming year, beyondblue and AHHA will be working closely together to ensure that mental health is adequately addressed and at the forefront of health professionals practice in the acute care setting . ha

Palliative Care Online Training:

JustHealth Consultants launches training package.

Palliative care is a vital component of Australia's health care system, aiming to improve the life of those who have a life-limiting illness, their families and carers.

The Australian Healthcare and Hospitals Association through its business arm, JustHealth Consultants (JHC), has been working on an online training package in Palliative Care which is designed to encourage uptake and use of the *Guidelines for a Palliative Approach for Aged Care in the Community Setting.*

The training has been developed by JHC in partnership with the Silver Chain Group, e3Learning, and several highly qualified experts, including the 2012 International Journal of Palliative Nursing, Educator of the Year Award winner, 'The DeathTalker', Molly Carlile.

The four training modules will assist health professionals who provide palliative care to aged persons in the community to implement the principles of the Guidelines in their practice. The design and content of the four modules are:

Module 1 **A palliative approach to care**
Module 2 **Providing and delivering care to clients and carers**
Module 3 **Delivering a palliative approach for Aged Care in the community setting**
Module 4 **Planning and Assessment.**

To register to complete the training, please visit www.palliativecareonline.com.au or contact Terrie Paul, Director of AHHA JustHealth Consultants at tpaul@ahha.asn.au ha

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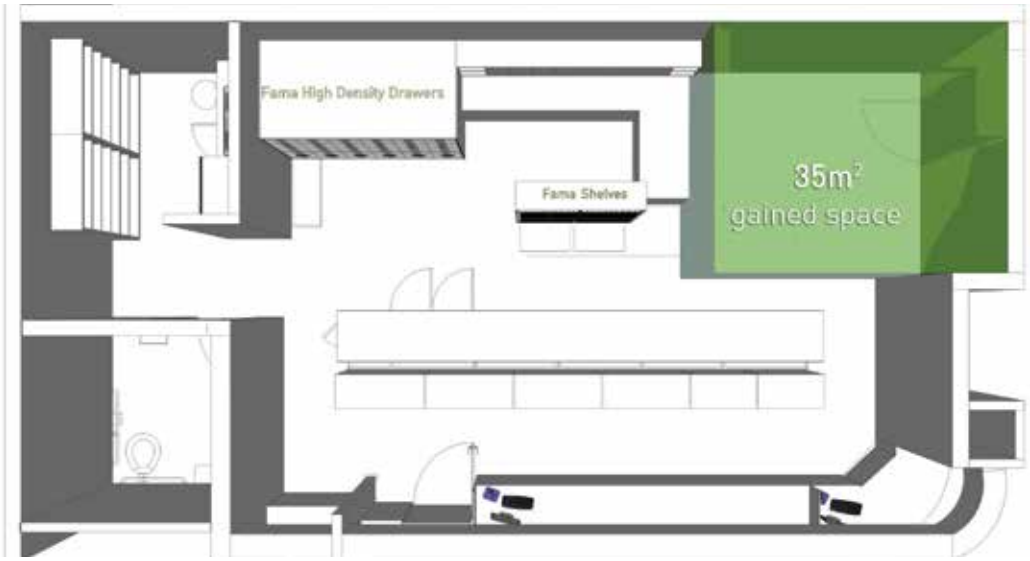

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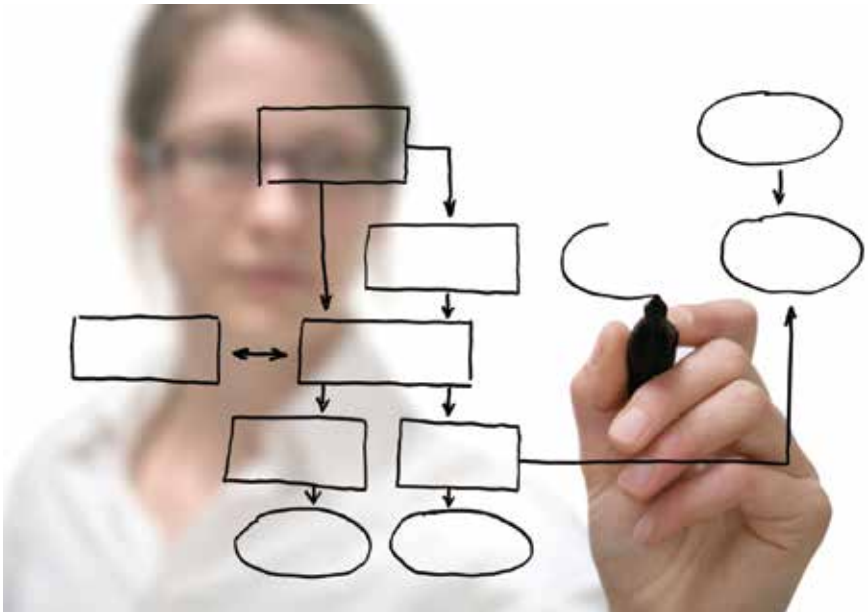
The Deeble Institute

What we do and how you can get involved.



Front-line clinicians often have very good ideas about how to improve patient care. But, convincing others to do things differently is difficult, especially without compelling evidence.

Evidence comes in many forms. Clinical expertise is one valid form of evidence, often used to justify changes in clinical practice. However, sometimes stronger evidence is needed; evidence that can only be generated by doing research. While some clinicians have a lot of experience in research, many others are daunted by the idea, or cannot see how they could possibly fit it into their day and keep on top of their clinical workload.

One of the main goals of the Deeble Institute is to help practitioners get involved in research. We do that by bringing practitioners together with academic researchers from our seven partner universities. Our academics have a good understanding of how to design research that will allow you to generate high quality evidence to help influence 'the powers that be'. There is nothing worse than putting in loads of time and effort into a research project and then, when it is all done, realising that the findings are not scientifically valid and, therefore, will not convince anyone to do things differently.

Our academics also have strong track records in research, which is vital for winning funding from bodies such as the National Health and Medical Research Council or Australian Research Council. The Deeble Institute can help you find academics with expertise in your area of interest that are keen to collaborate and develop proposals for research funding.

Our academics have a good understanding of how to design research that will allow you to generate high quality evidence.

If you are interested in doing some research that changes the way patient care is delivered in your health service, there are several ways the Deeble Institute and AHHA can help. You could, for example, join one of the AHHA's networks. Networks are made up of practitioners, researchers and policymakers and are stimulating forums for learning through knowledge sharing. Once a year, they meet face-to-face at a Policy Think Tank. The rest of the time, they communicate 'virtually'. Currently, the AHHA has networks operating in a range of areas, including:

- acute care
- community and primary health care
- rural and remote health
- oral and dental health.

If you have limited time, you could just come along to a Policy Think Tank on a topic that interests you. The AHHA's Policy Think Tanks are run for one day in various locations around Australia, and are usually very well attended. At each Policy Think Tank held this year, we will have a dedicated break out group for people interested in pursuing research on the topic. We will also invite some of the Deeble Institute's academic experts to come along and meet with interested researchers (or potential researchers) working in health services.

If you have a great idea for research but don't know where to start, just give us a call. We are happy to provide advice, connect you with other like-minded health services, or put you in contact with relevant academic experts.

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Director, Deeble Institute
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BY JUDITH DWYER
Professor of Health Care Management at Flinders University

Do peak bodies have a future?

What is the future for peak bodies, after such a difficult two decades?

It's been a rough 20 or so years for peak bodies. Governments, gripped by enthusiasm for tight contracting and an aversion to paying for criticism, have withdrawn much of the support and recognition that had been more like the norm in the 1970s and '80s. Peak bodies in health and community services faced the test of relevance to their members in a much more pointed way, as they struggled to earn enough from member fees to keep a viable core and offer value to the membership.

The survivors down-sized, reduced their real estate buy and focused on their own version of program budgeting. The other major shift was in the policy role – there was a time when peak bodies were routinely engaged in government policy development, through the kind of consultative working parties that used to be part of the policy engine. It wasn't that governments ever really loved the peaks, it was more about having them in the tent, so that policies were more likely to be workable and acceptable. During the last 20 years, as governments held the making of policy much closer to their chests, peaks have refocused their policy work – more towards developing their own policy packages, with a strong focus on evidence, and greater use of stakeholder think-tanks.

If we assume that the philosophical and ideological tide in public administration is turning, and globally, it is, what will that mean for peaks like AHHA? The buzz among thinkers about public administration has various labels, as authors vie for naming rights on the next era. I like 'public value', a term that suggests we need a much broader frame for thinking about the role of public service than the idea of providing efficient and effective services to citizens as consumers [1]. Public services thus need a new approach, focused more on creating public value – that is, on our broader needs as citizens and communities for non-consumer values like social cohesion, civility and security, and caring for the commons (the air, water and land), as well as good service delivery to individuals and families.

Peak bodies should concentrate on building strong relationships with the public service.

Australia may be lagging in engagement with these ideas – we have had a particularly strong dose of New Public Management thinking (and younger readers could be forgiven for seeing it as part of the natural order of the universe). But we will get there, because the promise of NPM has not been fulfilled, and it is running out of puff.

Public servants will be looking for more engagement with civil society, and the peak bodies, with policy smarts and strong buy-in from the fields they represent

Of course this won't mean going back to where we were. For one thing, there is a lot in the methods of NPM that does work. And the peaks themselves are better for being leaner and more agile.

It will mean that as the tide in public administration shifts public servants will be looking for more engagement with civil society, and the peak bodies, with policy smarts and strong buy-in from the fields they represent, will be there to fill that need.

This is a good time for organisations like AHHA to focus even more on strong relationships with the public service, and being ready to respond vigorously to a friendlier climate. ha

1. O'Flynn, J. (2007) 'From New Public Management to Public Value: Paradigmatic Change and Managerial Implications', Australian Journal of Public Administration, 66(3): 353-366.

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BY PATRICK BOLTON
Director of Clinical Services [Medical] at Prince of Wales Hospital

Quis custodiet ipsos custodes?

Patrick Bolton asks, who watches the watchmen?

Our times demand greater accountability than ever before. There is much that is good about this. It has the potential to identify and thereby reduce misuse of resources, both inadvertent and advertent.

There are, however, at least two problems with this emphasis on accountability. First, it is evidently possible for powerful and well-resourced groups to avoid accountably in a systematic manner. The interview between Oprah Winfrey and Lance Armstrong is going to air as I write. Most of the focus is on Armstrong's behaviour, but it is clear that, as the leading cyclist in the world for many years, he was at the centre of a system that knew about, abetted and provided incentives for his behaviour. This kind of conspiracy of corruption occurs in all areas of human endeavour, albeit that Armstrong is a particularly egregious example.

The second problem is that accountability systems encourage the behaviours they measure, at the expense of those they do not. Perhaps this is simply the first problem restated: The rewards of winning for Armstrong and colleagues were much more material than any risk (or consequence) of being caught doping.

In healthcare, we are rewarded for units of output, with limited regard for the quality of the output, i.e. the outcome – if we are lucky. This is because units of output are easier to measure than outcomes, and measuring throughput is generally easier than thinking about the overall value of the enterprise one is involved in. Auschwitz may have been very efficient at the process it undertook, but this does not make its purpose a good one.

The points I am making are applicable to healthcare. Too often, the health system chews up and spits out its best. In the last six months, general managers of three of NSW's biggest hospitals have been sacked or announced their early retirement in the face of performance pressures on their hospitals. How is this a good thing? Surely when things are at their toughest we want to hang on to our best and most experienced leaders, rather than sacrificing them on a false altar of accountability?

I am not saying there is any conspiracy here, this is far too much business as usual. A conspiracy would be good because then one could deal with the culprits, put in the new order and get on with a better system. This kind of thing is the institutionalised result of the way we run healthcare.

I am a part of this system and accept that I have responsibility for these unintended consequences. But I would also like to see things done differently. The starting points to do this are a clear moral compass and space to think about health which is not conditioned by the need for narrow accountability, as is so much of our working lives.

The AHHA provides some of this. It members have the discipline of being engaged with the system and have strong practical experience of its challenges. At the same time, they also seek to share values, reflect and act to make the system work better. ha

Accountability systems encourage the behaviours they measure at the expense of others.

In healthcare, we are rewarded for units of output, with limited regard for the quality of the output, i.e. the outcome – if we are lucky.

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BY PHILIP DARBYSHIRE
Director of Philip Darbyshire Consulting and Professor, Monash University

Judge Dread

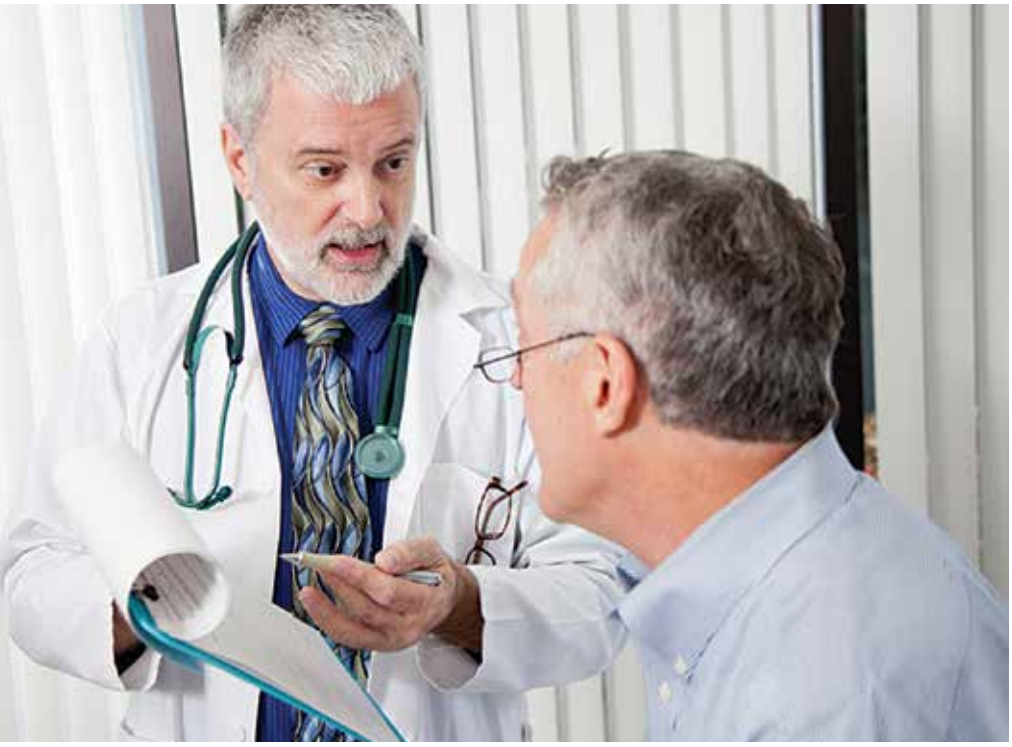
The thought police in health care have some potent weapons in their arsenal. Chief among these are the terms of withering disapproval that are played like trump cards to draw all further discussion to an end.

My particular favourite weapons in the thought police arsenal are the rebuffs that carry such a weight of moral disapproval that the utterer should perhaps be wearing a black cap as they deliver them. The current top ten would surely include such censures as 'inappropriate', 'judgmental', 'victim-blaming' and the all-encompassing and singularly useless; 'unhelpful'. How can anyone fail to occupy the moral high ground with linguistic lieutenants like these at their command?

I recently wrote an opinion piece for a nursing journal where a respondent accused me of being 'judgemental'. Setting aside that the whole point of an opinion piece is to express a judgment, this particular put-down has become almost drained of any force and meaning through constant, thoughtless repetition.

People make judgments every minute of the day. As what Heidegger called 'always and already interpreting beings' we have no choice. It is how we manage to navigate and understand our world. We constantly assess, interpret and indeed 'judge' people, situations and our own thoughts and perceptions.

So why has the idea of 'judgementalism' become such an easy accusation to level in health care and management? Does it mean, at one extreme, that a health professional must never hold or express a view or opinion about patients, clients or colleagues lest in doing so they may express a judgment or an opinion? I would like to think not, but I fear I may be wrong.



I'd be more sympathetic to the term if it focused on the idea that health professionals should not rush to reflex, simplistic, evidentially devoid and ill-considered judgements that may alienate and antagonise either our colleagues or the people that we are here to serve. You know the sort: 'She's a typical....'; 'All X are Y....'; 'Never trust a....'; 'What do you expect from a...'; 'These fat-cat managers are...'

When people say that health professionals 'shouldn't be judgmental', what they are really saying is that health professionals should not hold or express any negative or critical sentiments, especially about patients, clients or certain social groups.

I cannot ever remember a health professional, manager or academic being chided for 'judgmentalism' if the targets of their criticism were racists, homophobes, politicians from whatever wing they disapprove of, 'health bureaucrats', any business that can be prefixed with 'Big', media barons or mining magnates.

Nor is it likely that a health professional will be hauled over the coals for commenting on how wonderful a particular patient or client was. Saying that Mr or Mrs Smith is one of the loveliest, most courageous and inspiring patients you have ever known, or that it is a huge privilege to know such amazing people in the particular client or community group that you work with, remains a perfectly acceptable, if not highly commendable judgment to make.

Perhaps instead of frozen-faced reprimands that you have been 'inappropriate' in your 'judgementalism', and 'the look' that suggests you have just kicked Bambi, all we need remember is what Thumper taught us over 60 years ago: , 'If you can't say something nice, don't say nothing at all'. ha

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Prof. Joy Vickerstaff, former Chief Nursing and Midwifery Officer, ACT

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"Dynamite speaker! Find a way to bring him back to visit each OHSU campus."
"Best speaker ever - most useful info… what a breath of fresh air he was in all this academia!"
- Nurse Education Conference, Oregon, USA

"Absolutely brilliant. Witty, informative, a really inspiring presentation"
"Outstanding look at human spirit - honesty, bravery, essence - an extraordinary human being"
"So good I can't put into words"
"After listening to PD I believe in cloning!"
"Fantastic! Very moving & informative"
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- Ronald MacDonald House Charities, International Conference, Adelaide

"Your overall contribution far exceeded our expectations. We have now collated our participant evaluations and found that their responses echo ours. Your overall feedback score out of a possible total of 5 was a remarkable 4.75! We look forward to any opportunities for working with you in the future."
- Child & Family Health Nurses Conference, Adelaide

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p: PO Box 144, Highbury, SA 5089
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skype: philipdskype
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Bill Runciman

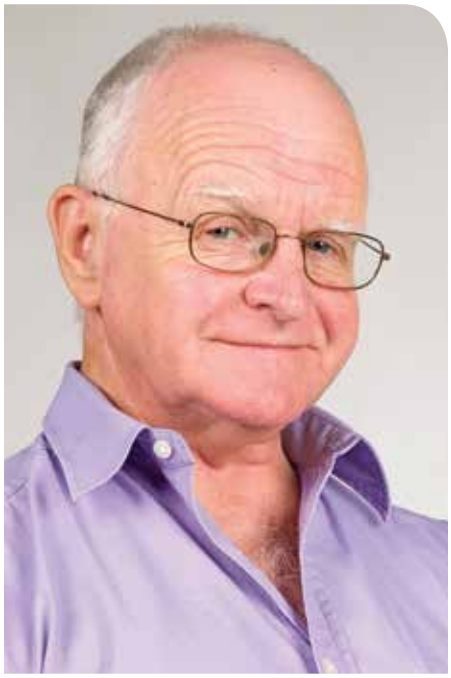
The Professor of Patient Safety and Healthcare Human Factors at the University of South Australia talks to *The Health Advocate*.

AHHA: Tell us a little bit about what you do
BR: I was a practising intensive care consultant for over 30 years, but at the start of 2010 became a full-time patient safety researcher with an appointment as Professor of Patient Safety and Healthcare Human Factors at the University of South Australia. My interest in patient safety started about 30 years ago, before the area became fashionable. I moved to a part-time appointment from the beginning of 2013, in the same capacity.

AHHA: What are some of your most significant recent projects?
BR: I am a Chief Investigator for an NHMRC Project Grant, a Centre for Research Excellence Grant in Patient Safety, an ARC Discovery Grant, and a Grant from HCF Health & Medical Research Foundation. I have a new NHMRC Program Grant for 2014-2019 ($11million) for patient safety research with five other Chief Investigators (see below).

AHHA: What have been the major highlights of these projects so far?
BR: A major output of the current Program Grant was a paper which involved over 35,000 telephone calls and analysis of over 250,000 healthcare encounters from a representative group of Australians. We showed that adult Australians received appropriate healthcare at only 57% of healthcare encounters for 22 common conditions in the years 2009 and 2010. This provides a baseline for planned work.

A companion paper proposed a general way forward for developing clinical standards, indicators and tools for common conditions, using a Wiki based consensus method. These standards, indicators and tools could then be embedded in 'apps' and electronic medical records, so that both healthcare providers and recipients could operate from a common understanding and 'platform' for guiding care as well as for tracking and evaluating care on an on-going basis.



Bill Runciman

AHHA: What challenges have you encountered with these projects?
BR: A recent challenge was to counter (anticipated) criticisms of our methodology. About a dozen objections were raised, all of which we dealt with in a 'letter to the editor' responding to the various commentators. The main one, that the overall poor rate of compliance was because we had not used indicators supported by Level 1 evidence or NHMRC recommendations graded A or B, was comprehensively dealt with by showing that compliance was, in fact, worse for evidence-based indicators than for consensus-based recommendations.

I am interested in doing work which underpins the foundations of the safety and quality of healthcare, and provides baseline information which has not been available in the past.

AHHA: How does your work fit within the broader Australian Healthcare system?
BR: I believe that we need national clinical standards. These need to be clear, simple and available to both healthcare providers and recipients. The massive waste involved by various States, Territories and private organisations all busily inventing 'wheels' (many of which are not round, and are better at staying in the same place than revolving) cannot be sustained. Developing a method for a national approach is therefore our focus. An example of adopting a national standard was when oximetry and capnography became mandatory for anaesthesia in 1990 rather than being introduced piecemeal over the next decade.

AHHA: What do you have in store for the next few years?
BR: As President of the Australian Patient Safety Foundation and Chief Investigator on the various projects for which we have been funded, I am interested, with my collaborators (Professors Jeffrey Braithwaite, Enrico Coeira, Johanna Westbrook, Ric Day, Ken Hillman), in doing work which underpins the foundations of the safety and quality of healthcare, and provides baseline information which has not been available in the past.

To this end, I have recently published papers on the ontology of patient safety and on the epistemology of patient safety research, as well as on the framework and set of definitions for the International Classification for Patient Safety, together with colleagues from the World Health Organisation. The plan is to continue this work; the emphasis in our new program grant is on understanding what works and what doesn't in translating research into practice. ha

Snippets

The last word

What's been happening since we last met?

- Just before Christmas, the Australian Government launched the first ever National LGBTI Ageing and Aged Care Strategy to support the implementation of *Living Longer Living Better* – the Government's $3.7 billion aged care reform package. The Minister for Ageing, Mark Butler, said the Strategy commits the Government to high quality, culturally appropriate aged care for LGBTI people.
- The Minister for Health, Tanya Plibersek, announced $128 million for 151 grants for ground-breaking health and medical research across Australia. She said that as a result of this investment, medicines were our biggest research-intense goods export; helping to build a stronger, more competitive and more productive economy.
- In early December, NSW became the first state to strike a deal with the Federal Government on funding the National Disability Insurance Scheme (NDIS), with the Commonwealth agreeing to cover 51% of the cost of trialling the scheme in the Hunter Valley.
- The NT Minister for Health, David Tollner, announced reform of the Northern Territory's health system in November, which will see decision making powers returned to the regions and hospitals. Two separate Health and Hospital Services, one in the Top End and the other in Central Australia to oversee service delivery, would be established.
- Almost one million Australians are currently suffering from an eating disorder, according to the *Paying the Price: economic and social impact of eating disorders* report. The socio-economic impact report estimates the total social and economic cost of their eating disorder at $70 billion.
- *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention* is the independent National Mental Health Commission's inaugural annual report card and is a world first of its kind. 'The report uncovers some difficult truths that it will be very difficult to walk away from.'
- The ABS report Deaths, Australia, 2011 shows that life expectancy figures continued to increase over the ten year period ending 2011. Under current estimates, a boy born today could expect to live to be 80 years while a girl could expect to live to 84.
- In the world of medical science, totally blind mice have had their sight restored by injections of light-sensing cells into the eye. The research team in Oxford said their studies closely resemble the treatments that would be needed in people with degenerative eye disease.
- A paralysed woman is now able to feed herself and move everyday items using a robotic arm controlled by her mind. She is paralysed from the neck down but her robotic arm can pick up and move objects with a speed comparable to able-bodied people. Experts are calling it a large step forward for prosthetics controlled directly by the brain. ha

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Who's moving

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

Kate Needham, former Executive Director at the Agency for Clinical Innovation NSW, has been appointed Director Health Strategy at WorkCover NSW.

Andrew Bond, former National Manager of Hospital & Healthcare Facilities at Healthscope, is now Director of Corporate Services and Development at St John of God's new Midland health campus in Perth.

Kate Goodwin, former Director of Clinical Services at St Andrews Hospital Brisbane, is now Director of Clinical Services at Lake Macquarie Private Hospital.

Ailsa Claire, former CEO of NHS Barnsley UK, has returned home to New Zealand and been appointed CEO of Auckland District Health Board.

Also headed back across the Tasman is **Sue Waters,** most recently Professional Lead for Allied Health Professionals, Healthcare Scientists and Pharmacists at Guy's and St Thomas' NHS Foundation Trust. Sue returns as Executive Director of Allied Health, Scientific and Technical at the Auckland District Health Board.

Following this back-to-the-Shaky Isles trend, **Karin Drummond,** former Operations and Nursing Director of Emergency and Medical Services at Townsville Health District Service, is also back in NZ and has been appointed General Manager of Women's Health at Auckland District Health Board.

Not moving so far is **Marcia Fogarty,** who was previously the Clinical Director of Mental Health at Western Sydney Local Health District. Marcia is now the Clinical Director of the Hunter Valley Community Mental Health Service with the Hunter New England Local Health District.

Darren Rogers, former CEO at Mitcham Private Hospital is now CEO of St John of God, Bendigo.

Allan Pelkowitz, former Director of Medical Services at Calvary Health Care ACT, is bravely travelling across the Nullarbor (which is almost four times the distance to New Zealand) to become Director of Medical Services at St John of God Midlands Hospital.

From our international desk: **Mr Mariano Gonzalez,** former Group COO of Al Noor Hospital in Abu Dhabi, has now been appointed as Managing Director of Moorfields Eye Hospital in Dubai.

In the world of Pharma, **Christine Smith,** former Medical Director, Respiratory of AstraZeneca has been appointed as Medical Director at Mundipharma (which incidentally means 'the world of pharma').

Sean Hubbard, who was previously the Deputy CEO of Joondalup Health Campus, is the new Executive Director of the Adult, Women's and Children's Health Service with Mater Health Services.

We all welcome **Alistair Burt,** who has travelled far across the oceans (not just the Tasman!) from his previous role as Clinical Dean of Medicine with the University of Newcastle in the UK. Alistair is to be the new Head of School of Medicine with The University of Adelaide.

Greg Pullen is the new CEO for Catholic Homes Victoria. He was previously the CEO of Northern Health.

Tony Hickmott, formerly Director of Finance at Southern NSW LHD, has joined the Western Sydney Local Health District as Executive Director of Finance.

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

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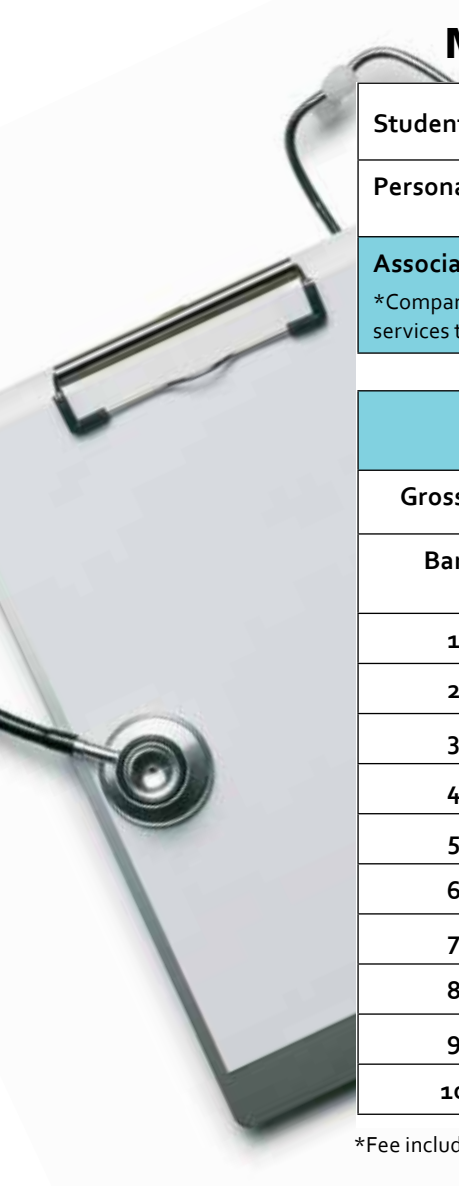

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AHHA Office
Unit 2, 1 Napier Close
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Postal address
PO Box 78
Deakin West ACT 2600
T: 02 6162 0780
F: 02 6162 0779
E: admin@ahha.asn.au
W: www.ahha.asn.au

Editorial and general enquiries
Prue Power or Emily Longstaff
T: 02 6162 0780
E: admin@ahha.asn.au

Subscription enquiries
T: 02 6162 0780
E: admin@ahha.asn.au

Membership enquiries
Amy Kilpatrick
T: 02 6162 0780
E: akilpatrick@ahha.asn.au

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