ISSUE 22 December 2013

The Health Advocate

The official magazine of the Australian Healthcare & Hospitals Association

Your voice in healthcare

A glimpse of gold
A look inside the new Gold Coast Hospital

Lean Thinking
Lowering costs without lowering the quality of care

Closing the gap
Better health for Aboriginal and Torres Strait Islander people

Innovation in healthcare

How the sector is responding to future challenges

Plus!

- Diverting hospital waste from landfill
- Mobile apps that can be medical devices
- Physical health and mental illness

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HESTA Australian Nursing Awards

2013 winners, left to right: Kathy Kirby representing Understanding Dementia, Sara Lohmeyer and Annabel Pike.

Know someone in nursing who deserves an award?

Recognise their outstanding leadership and innovation by nominating them in one of three categories:

- **Nurse of the Year**
- **Team Innovation**
- **Outstanding Graduate**

NOMINATE NOW!
Nominations close 28 February 2014

$30,000 in prizes to be won!*

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HESTA Australian Nursing Awards

It's time to thank Australia's *best nurses and midwives*

If you know someone who goes above and beyond for the benefit of patients and colleagues or showcases innovation in nursing, nominate them now for the 2014 HESTA Australian Nursing Awards.

Individuals and teams can be nominated in three categories — Outstanding Graduate, Team Innovation and Nurse of the Year.

Nominations for the awards will remain open at **hestaawards.com.au** until Friday, 28 February 2014.

HESTA CEO Anne-Marie Corboy said nurses were not only the backbone of the health system, but also its heart and soul.

"Our community owes nurses a great debt and one way we can thank them is by nominating an outstanding individual or team of nurses for these awards."

HESTA CEO, Anne-Marie Corboy

Long-time awards supporter, ME Bank, has generously provided a prize pool of $30,000 to be shared among the winners in each category.

ME Bank CEO, Jamie McPhee, said, "We are proud to continue our support of the HESTA Awards program, recognising the tireless contribution of individuals and organisations in the health and community services sector."

Finalists will be announced in April 2014 and interstate finalists will be flown to Sydney for the awards dinner on Thursday, 8 May 2014.

HESTA is the leading super fund for health and community services, with more than 760,000 members and $24 billion in assets. More people in health and community services choose HESTA for their super.

To make a nomination — by 28 February 2014 — or to find out more about the awards, visit **hestaawards.com.au**

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Left to right, HESTA CEO Anne-Marie Corboy, 2013 winners: Kathy Kirby representing Understanding Dementia, Sara Lohmeyer and Annabel Pike, ME Bank CEO Jamie McPhee and MC Tracey Curro.

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ConnectCare IP Nurse Call

In 2010 Questek's first Australian true IP point-to-point Wi-Fi Nurse Call system was released and is now installed in sites all over the country, providing full Nurse Call functionality for facilities which are difficult to cable or for those operators who want to maximise the value of their investment in Wi-Fi IP infrastructure. Questek also recognises the growing call for IP functionality using Cat5e, Cat6 and Cat6a structured cabling for hard-wired Nurse Call systems – and have responded with ConnectCare, a unique system that offers full flexibility of IP hard wired or IP over Wi-Fi or a combination of both!

Questek's Hard Wired IP Design

Questek engineers understand the need to future proof your facilities and have developed a "full IP to the device" Nurse Call system. The system has been in development for over 2 years with thorough testing and ultimate flexibility. The system is currently being installed in Queensland Children's Hospital, a 450 bed paediatric Hospital in the heart of Brisbane.

Each room has an IP master at either the bed head or the over-door light, connected via structured cabling using standard IP protocol and connected to managed PoE switches (eg Cisco, HP, Linksys, etc).

Each IP master has up to sixteen local inputs operated by a Controller Area Network (CAN) bus – commonly used in aerospace, automotive, industrial and medical equipment. This allows for communication and messaging without having a host Nurse Call controller or computer.

By using the CAN bus, Questek can save significantly on PoE infrastructure, whilst supporting bi-directional and continuous monitoring of call point communication. The system is capable of having every device IP based or a mix of IP and CAN bus which significantly reduces the cost of installation.

The Questek system uses internationally recognised protocols and is **Plug & Play compatible** with any PoE switch. This simple point ensures that network administrators can feel comfortable knowing that they have standard switching for all IP devices across their network, without proprietary "switches" that may be difficult to support. The system can be run off a physically separate LAN, but with the world of convergence a VLAN for segregation from the global network allows this separation, which will still provide redundancy for mission critical devices.

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The Health Advocate

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From the AHHA desk

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

Encouraging new ideas

A welcome message for the new government, and a celebration of innovations in health

Following strong interest in positions on the AHHA Board for 2013/14, I was delighted to be re-appointed to the Chair for a third term in 2013-14, with Siobhan Harpur continuing as Deputy Chair. My thanks go to outgoing Treasurer, Felix Pintado, having held the position for the maximum three years, and we welcome Deb Cole as our new Treasurer. Board Members Felix Pintado and Kathy Eagar were reappointed, with new members Paul Dugdale and Elizabeth Koff completing the Board. In addition, I extend my sincere thanks for the contributions of to the two Board Members not continuing, Annette Schmiede and Kathy Byrne, and outgoing council representatives Yvonne Luxford and Anna Fletcher. We welcome Martin Dooland and Greg Mundy to their new roles on Council. The Board and Council look forward to continuing the important work of the AHHA and to continue to foster closer relationships between clinicians, academics, policy-makers, administrators and politicians.

Since the last issue of *The Health Advocate*, Australia has ushered in a new Prime Minister, and consequently, a new Health Minister. That Peter Dutton has been allocated the portfolios of both Health and Sport is in some ways encouraging, as it implies that health is seen as a holistic concept that takes broader social factors like physical activity and lifestyle choices into account. However, it is also slightly disappointing that the Aged Care portfolio has been removed from Health and allocated to Social Services. Given that by 2056, one in four people will be aged 65 or over, if we don't reconfigure our social structures to adapt to an ageing society with increased longevity, we risk an irretrievable loss in our quality of life.

The appointment of Assistant Minister for Health, Senator Fiona Nash, and Assistant Minister for Social Services, Senator Mitch Fifield should ameliorate some of these anxieties.

The AHHA welcomes the opportunities that a new government brings and hopes that health reform becomes more of a priority into the future, at least more than it was in the election campaign of the two major parties. Australia still has a long way to go in striving to achieve a higher quality, safer, and more streamlined healthcare system, but that's not to say that there aren't already things happening to improve health services across the nation.

This December issue of *The Health Advocate*, the last for 2013, caps off the year by highlighting some innovative thoughts and activities currently going on in health around our nation. From 'Lean Thinking' management processes to state-of-the-art hospital designs and recycling programs, this magazine addresses some important initiatives and ideas that will no doubt have much broader implications within and between healthcare sectors.

Not only do these involve innovations in technology, but also in ideas and cultural understanding. Such innovation is vital for effective health reform at all levels, be it at the front-line, in management, or in policy.

It is important to remember the need to be open-minded about the possibilities for change, and to encourage new ideas that can benefit health services staff and patients alike. Just as easily as new ideas can be generated, they can also be squashed if there isn't a nourishing environment in which they can flourish and reach their full potential. Sadly, the latter is too often the likely outcome. Let this magazine, then, stand as a celebration of new ideas about how we can approach provider roles, patient care, infrastructure, management and processes, and the sorts of changes that need to be made to ensure that we achieve a more integrated and coordinated healthcare system for the future; one that benefits not only the service providers but also, most importantly, the broader community we serve. 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**

Medicare turns 30: the party's not over yet

The AHHA and its research arm, the Deeble Institute, wish to join in the celebration of Medicare's 30th birthday. At the time of its creation, Medicare was built on the founding principles of equity, efficiency and universality. These are now the bedrock of the Australian healthcare system, one that is open to any individual regardless of social standing. However, Medicare is starting to show signs of strain as the health needs and expectations of Australians continue to change, and it is now time to make some reforms.

Preparation essential ahead of rising temperatures

With longer, hotter summers projected for the future, the AHHA has welcomed a new study by Judith McInnes and Joseph Ibrahim of Monash University's Department of Epidemiology and Preventative Medicine. "This study highlights the importance for all aged care facilities to have an actionable plan to minimise the impact of rising temperatures during the warmer months," said Alison Verhoeven, Chief Executive of the AHHA. According to the study, published in the AHHA's *Australian Health Review,* having a documented heatwave plan, good air conditioning, a back-up power generator and a regular maintenance program were reported to facilitate preparedness.

PHOTO BY AVERY BROWN

Health appointments welcomed

The AHHA welcomed the appointment of Peter Dutton as Federal Minister for Health, and Senator Fiona Nash as Assistant Minister for Health. The AHHA shares their commitment to promoting and maintaining a strong health system for Australia.

Peter Dutton

Healthcare not immune to climate change

Speaking at the Greening the Health Sector think tank hosted by the AHHA and the Climate and Health Alliance in Melbourne on August 30, members of the Australian healthcare and hospitals sector described the ways in which they plan to reduce waste and increase sustainability.

Alison Verhoeven, AHHA CEO, and Joe Aherne, LEI Group Australia CEO, at the signing ceremony.

AHHA launches Lean training partnership

A partnership agreement between the AHHA and the LEI Group Australia was formalised at a signing ceremony in Ireland in October. LEI Group Australia, a leading provider of Lean education and consultancy, will partner with the AHHA to deliver training programs to organisations affiliated with the AHHA network.

Research needed into care for melanoma patients

With Australia having the world's highest incidence of cutaneous melanoma, and survival rates increasing due to improvements in diagnosis and primary treatment, the AHHA supports greater scrutiny of melanoma follow-up practices, as outlined in a recent study published in the *Australian Health Review*. The study showed that follow-up practices in Australia currently vary widely across the country. "This may have major implications for both patients and the health budget," said AHHA's Chief Executive, Alison Verhoeven. The AHHA therefore welcomes the proposal put forward by the authors of the study: that existing melanoma follow-up practices should be classified into a small number of alternate models of care. This would help identify which models work best, with a view to overcoming the lack of uniformity currently seen in the treatment of the disease.

Deeble Institute's inaugural symposium

The AHHA and its research arm, the Deeble Institute for Health Policy Research, co-hosted the Deeble Institute's inaugural symposium on the future of universal healthcare in Australia. Entitled 'Universal healthcare and its challenges for the future', the symposium challenged delegates to consider a renewal of Medicare, Australia's universal health system, and health funding that supports the goals of universal access to high quality, safe healthcare.

BY ALISON VERHOEVEN
Chief Executive, AHHA

After the poll

Campaigning for health reform in a post-election climate

The AHHA is pleased to welcome Minister for Health, Peter Dutton, and Assistant Minister for Health, Senator Fiona Nash, to their important roles in the Abbott government. The AHHA shares their commitment to promoting and maintaining a strong health system for Australia.

Our interests across the healthcare sector are broad and cut across a number of portfolios in the Abbott government. We are looking forward also to working with Senator Mitch Fifield as Assistant Minister for Social Services responsible for the National Disability Insurance Scheme and aged care, both important areas of policy reform; and with Senator Nigel Scullion, Minister for Indigenous Affairs, and Senator Michael Ronaldson, Minister for Veterans' Affairs. National health reform must be an important priority for the government and we encourage all responsible ministers to revisit the key principles that underpinned the reforms of the past few years, as they develop and implement health policy.

Some rationalisation of activity and investment is needed to ensure the health reforms initiated by the previous government achieve the original goals and objectives of a high quality, safe, effective and efficient healthcare system for Australia. In its election campaign, the Coalition promised to increase local management of hospitals, and pledged to divert funding from administration to frontline services. It is important that changes are appropriately targeted to reduce duplication while ensuring optimal services.

As we move into 2014, the AHHA will continue to advocate for, and monitor the progress of, national health reform. The Australian health system is built on a solid foundation, with Medicare and a strong public healthcare and hospitals sector providing the basis for universal access to quality healthcare services. However, the system is under pressure due to increasing costs, workforce issues, uneven distribution of services, and demand pressures, particularly in emergency departments and for elective surgery.

Some rationalisation of activity and investment is needed to ensure the health reforms initiated by the previous government achieve the original goals and objectives of a high-quality healthcare system.

Key components of a coordinated, equitable and sustainable health system include:

- Transparency and accountability to ensure effective and efficient resource use and service delivery by a high-performing public health sector;
- National governance and consistent reporting (however, duplication of agency functions and service provider reporting needs to be addressed);
- Funding arrangements that are patient-centred, supporting the right care in the most appropriate environment;
- Bundled payments options for patients with chronic or complex conditions which should be implemented as soon as possible;
- A balance between the roles of the public and private systems, including a broad review of the relationship between private health insurance and Medicare as there are strong arguments that the private health insurance rebate is not an efficient use of resources;
- Formal and vigorous evaluation of health policy and funding approaches to support continuous improvement of the system; and
- Health promotion and disease prevention programs that are evidence based and resourced and evaluated more effectively.

Aside from our active advocacy program, the AHHA has been busy with a number of major projects in the latter portion of 2013. Our research arm, the Deeble Institute, has been working on a project commissioned by

The Australian health system is built on a solid foundation but pressures from demand, costs and workforce issues are being felt.

the Secretariat of the National Lead Clinicians Group. The project, a horizon scanning exercise, seeks feedback from clinicians about the important emerging issues that are likely to affect the clinical delivery of care in the near future. A number of Evidence Briefs have been commissioned on emerging clinical issues. These will be used to inform the ongoing work of the National Lead Clinicians Group.

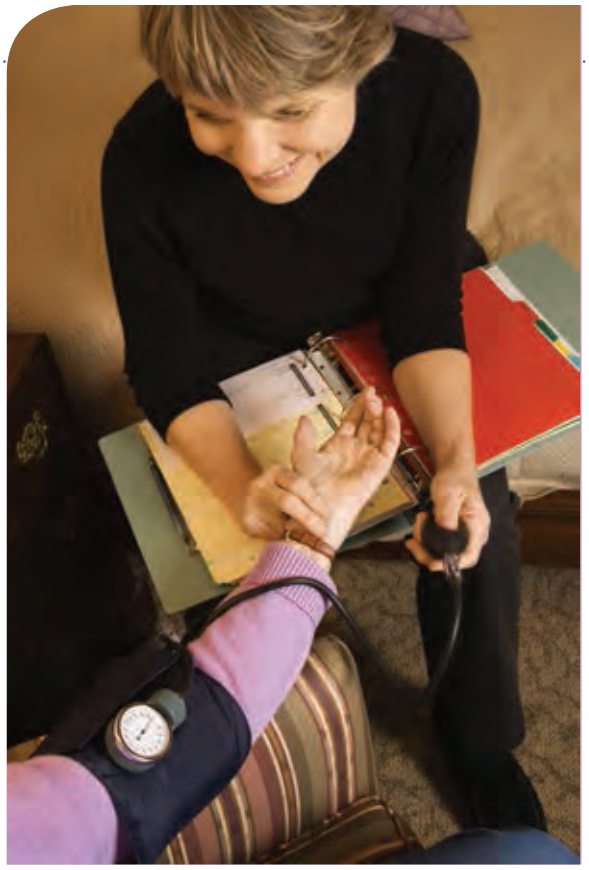
The AHHA's peer-reviewed journal, the *Australian Health Review*, publishes significant research on health and health services policy. An example is a recent article by Kara Burns and Suzanne Belton on the moral and ethical dilemmas faced by the medical profession in regard to the taking and distribution of medical images on personal devices. In addition to this, two recently published articles provided insight into two emerging issues: Drew Carter led a team of researchers from the University of Adelaide who reported on the need for further study and uniformity in the follow-up treatment for melanoma patients in Australia; Judith McInnes and Joseph Ibrahim from Monash University reported on the need for adequate preparation and planning in aged-care facilities to meet the challenge of rising temperatures during the warmer months.

The *Australian Health Review* is available by subscription at: www.publish.csiro.au/nid/270.htm. A number of articles are also made available in open access format.

Our business arm, Just Health Consultants, continues to have success with its Palliative Care training program. Around 5000 people have now undertaken this course to gain a better understanding of caring for a dying person. A series of face-to-face workshops will be held in Tasmania, beginning in 2014. With the majority of Australians expressing a desire to die at home, palliative care is an important area of work for the AHHA.

A new dimension to our online training offerings are courses focused on Lean management, provided in collaboration with the LEI Group Australia, part of the international Leading Edge Group. Already widely used in the UK and Canada by healthcare professionals, the Leading Edge Group's program of white, yellow, green and black belt training in Lean management is designed to promote continuous quality improvement in hospitals and other healthcare settings. More information is available at: http://ahha.asn.au/content/lean-healthcare-training and on page 16.

We at the AHHA wish everyone a happy and safe holiday season and look forward to an exciting year ahead in 2014. Keep an eye on our web page and our publications for more about our work and our upcoming events. ha



Innovation, engagement and cross-sector collaboration

Working together for a patient-centred health system. By Sean Rooney, Acting CEO of Australian Medicare Local Alliance

One of the easiest ways to explain the failure of the health system is to refer to the patients who fall through the gaps. They're out there and, as you read this article, another patient has just been let down by a system that's not working *systematically*.

A seamless, well-coordinated and integrated health system should not be taken for granted. Fundamental to the creation of such a system are the communication channels between sectors, entities and agencies and, importantly, the timely sharing of data. This is about keeping people well and out of hospital by plugging the holes between the primary and the acute sectors, breaking down these rigid silos so that the patient journey minimises and at best eliminates any opportunity for patients to fall through the gaps in health service delivery. In essence, the aim is to achieve better communication, seamless transfers and a reduction in the duplication of services.

To do this, the Department of Health has funded the Australian Medicare Local Alliance (AML Alliance) to identify where the complexities lie for consumers navigating the system between the primary and acute sectors. This project, which is part of the Commonwealth's National Lead Clinicians Group Initiative, has five key objectives: to improve the clinical literacy and communication channels between the primary and acute and aged care sectors; to trial models of multi-disciplinary care that can be scaled up or down to suit the circumstances; to build up the capacity of clinical leadership in Medicare Locals; to share information about integrated care through the National Clinicians Network; and more broadly, to create a solid collaborative network that can gain mutual benefit from the gathered intelligence.

Through its Medicare Local members, the AML Alliance has already been able to identify some factors that will make a difference to getting the primary and acute sectors working together. These include: having shared strategic goals; being transparent with consumers between sectors; co-locating services where possible; establishing joint strategic planning between Medicare Locals and Local Hospital Networks/Districts; and applying good governance arrangements, including reciprocal board representation across sectors.

To further develop this work, next year the AML Alliance will be hosting a series of workshops to bring Medicare Locals and Local Hospital Networks/Districts together to examine models of care. The workshops will examine clinical engagement at the local level. They will also look at just what that means in terms of practicalities and governance at the multiple system levels, and among agencies and services that are fundamental to the patient journey. HealthPathways is one such workshop program which is already making a difference in these areas.

Such issues need to be thought through, evaluated and assessed in terms of impact and, importantly, through a sustainability lens. The health system cannot continue as is, but any changes that are made must be changes that can rejig the system to work for the longer term, rather than to bring about short-term gains.

While it's not rocket science, it's fair to say that a fundamental overhaul to the way the healthcare system operates is an extraordinarily complex challenge. It needs intellectual and strategic commitment from all players – Medicare Locals, Local Hospital Networks/Districts, the bureaucracy and, of course, the patients.

By now, another patient has probably fallen through the gaps in the health system. So, as we work towards reducing and eliminating this flaw, we will at some point look back on this ambition to integrate two high functioning health sectors and ask ourselves: should it really have taken this long to realise the need? ha

BY IAN CRETTENDEN
Acting CEO of Health Workforce Australia

Health LEADS Australia

The first national capability framework for leadership across the health system is helping deal with a rapidly changing industry

Health systems are increasingly complex and beset with rapidly changing environments and issues. In response to these changing circumstances comes Health LEADS Australia, the first national capability framework for leadership across the health system.

Health LEADS Australia sets the foundations to build leadership capacity across all areas, professions and levels of healthcare, resulting in leadership for a people-centred health system that is equitable, effective and sustainable. It has five key areas of focus: leads self; engages others; achieves outcomes; drives innovation; and shapes systems. These recognise that leadership is required from everyone with the capacity and desire to work towards improving the health system; it is not constrained to particular positions, professions or sectors.

In an effort to drive reform and lead others, Health LEADS Australia was created through widespread consultation, research and close engagement with stakeholders and health industry partners after 'leadership for the sustainability of the health system' was identified as one of five priorities for health workforce innovation and reform.

As the national body dedicated to building a sustainable health workforce, Health Workforce Australia (HWA) has led the development of this work.

HWA aims to ensure Australia can continue to provide high quality care to all its people when they need it, regardless of where they live. Along with building the evidence to support workforce planning, HWA has explored the impact of effective leadership on large scale and sustainable change. Evidence shows quality leadership in the health system directly and indirectly affects the quality of patient care and makes a critical difference to the success of innovations and reform. As such, the Australian health system needs strong leadership at all organisational levels if it is to achieve excellence and be sustainable and responsive to the health needs of Australians now and into the future. This need exists in other comparable countries such as Canada and the UK, which have recently identified the qualities of effective leaders for health and developed strategies to strengthen them.

Having a nationally agreed health leadership framework provides a common language about leadership and identifies both key focus areas and capabilities for development. This in turn will enable health leadership to be embedded in both early career education and training and in continuing and professional development. As the first step in building such a national leadership framework for a people-centred health system, over time, Health LEADS Australia will be supported with tools, stories, networks and programs. It will connect people with similar interests, support communities of practices and coordinate development of measurable behaviours and appropriate tools.

In July 2013, HWA offered a free, non-exclusive licence to individuals and organisations to use Health LEADS Australia for non-commercial purposes. Since then, HWA has received more than 100 requests with 50 successfully negotiated to date. The range of organisations taking up these licences include state health departments, aged care providers, hospitals, clinical and health service management colleges, universities and consumer groups. HWA is also negotiating with a range of organisations interested in a licence to use Health LEADS Australia for commercial purposes.

In July 2013, HWA offered a free, non-exclusive licence to individuals and organisations to use Health LEADS Australia for non-commercial purposes. Since then HWA has received more than 100 requests with 50 successfully negotiated to date.

Through the licences and the support of HWA, organisations identify areas of interest and can be linked with others expressing similar interests. In this way, the development of resources is iterative, practical, reflects user needs and supports shared and common use.

For more information or to request a free licence to use Health LEADS Australia, contact HWA at hwaleadership@hwa.gov.au

A glimpse of gold

A look inside the new Gold Coast University Hospital. By Kaylene Sutherland, the Hospital's Director of Business Transition

On September 28, the new Gold Coast University Hospital (GCUH) opened its doors to the general public, signalling the closure of the old Gold Coast Hospital and the relocation of its patients. These are exciting times for health services in the region, with the GCUH incorporating some of the most effective contemporary models of care and health service delivery in the country.

The most significant application in GCUH is the high percentage of single patient bedrooms (over 70%), compared to a national average of about 25%. This aspect provides significant improvements in patient safety through infection control, transport, drug management and risk. From a social perspective, the single bedrooms significantly increase patient privacy, family interaction and reduce noise. That each room also has a window for both sunlight and vista to assist in healing is also highly beneficial to patients, visitors and staff alike.

In addition, most wards within the facility are generic. This provides flexibility in patient location as well as reduced future costs for refurbishment for changed models of care and disease profiles. All wards include built-in lifting and movement equipment for the care of bariatric patients; recognition of the changing patient demographic and the requirements of a safe work environment for staff.

The facility has state-of-the-art diagnostic capabilities installed, including an intra-operative MRI in the operating theatre complex, PET scanners, linear accelerators, angiography, cardiac catheter laboratories, clinical measurement and nuclear medicine consistent with the hospital's tertiary and quaternary role. From a technology perspective, there is a networking of these digitalised equipment items.

The functional relationships of areas within the hospital also reflect contemporary care models. These include a medical assessment unit collocated with the emergency department and satellite medical imaging; and birthing suites located adjacent to emergency theatres. These functional adjacencies have been designed to increase both efficiency in throughput and minimise the patient transport for care.

Other aspects of the GCUH design vision include: clear signage outside and inside the hospital to enable easy navigation of the area; maximised therapeutic benefits of a parklands setting, with gardens, courtyards, walkways, bike paths and artwork; emphasis on environmental sustainability to minimise the carbon footprint of the facility; and the promotion of connections with the surrounding precinct by creating accessible and shared amenities. In taking on board all of the design considerations, mock patient rooms were built and showed to both consumers and staff, enabling targeted feedback on comfort and equipment considerations during the design phase. Room reviews were also undertaken in the early stages of construction as part of an eight-stage quality process to ensure that what was being built was a fit-for-purpose facility.

Building a new hospital from scratch meant that the GCUH could incorporate technology on a much larger scale than has been done previously. In fact, the GCUH project now includes the highest level of information and communication technology (ICT) infrastructure and connectivity of any hospital currently under construction or operating in Australia.

The ICT program at the GCUH will add to the existing foundation of telecommunications infrastructure, computer systems and software, and will ensure connectivity to biomedical equipment and external partners like universities. New capabilities will also be provided, including systems to support new services like radiation oncology, expanded

Clockwise, from top left: Panoramic view of the main foyer within GCUH at ground level. A single patient bedroom within the children's ward in Block B. Children's courtyard which is accessible from the children's ward and children's outpatient areas.

medical imaging, food services, neonatal intensive care, and others.

To familiarise with the new facilities, a 'super user' model of training delivery has commenced. Over 60 super users have been identified from the existing Health Service team. They will become experts in new equipment and new technologies and systems to be able to 'on train' other Health Service staff.

An online training tool has also been developed specifically to aid the delivery of the training to all staff and complement other face-to-face training and on-site inductions.

Combined, these features and the opportunity of building a brand new facility have enabled a thoughtful hospital design not only for patients and their loved ones, but also a modern workplace for staff.

BY JOE AHERNE FCPA,
CEO, Leading Edge Group

Lean Thinking in healthcare

Lowering costs without lowering quality

Current pressures to reduce healthcare expenditure have caused much consternation, with many believing cost difficulties facing the system will not be resolved without impairing the quality of service. Fortunately, there are measures that can significantly help reduce and stabilise healthcare expenditure without affecting quality of care.

Originating with the Japanese car manufacturer Toyota, but since applied more widely with considerable success, 'Lean Thinking' is a strategy for delivering efficiencies by identifying and eliminating wasteful steps in core processes (in healthcare, these are typically around both patient pathways and administrative processes). The term 'Lean' is used because the new processes use less human effort, space, capital investment, materials and, perhaps most importantly, time between patient appointment and discharge.

The key to Lean Thinking is process management. Good hospitals get brilliant results from people managing brilliant processes. Other hospital systems get average or worse results from brilliant people managing broken processes, a problem that is evident in many healthcare systems throughout the world.

Typical examples of waste in healthcare facilities include: redundant capture of information on patient admission; multiple recording of patient information; excess supplies stored in multiple locations; time spent looking for charts; long waiting queues; continuous back-tracking of movement among medical staff; time spent waiting for equipment, lab results and X-rays and time spent dealing with complaints about services that are stretched, partly because of failures in the systems themselves.

Implementing a number of high-impact changes using the principles of Lean Thinking in healthcare can produce dramatic cost and efficiency improvements. They can also generate wider acceptance of new methodologies. Examples include:

- Applying a systematic approach to care for people with long-term conditions would prevent numbers of emergency admissions to hospitals;
- Managing variation in the patient admission process would cut the number of operations postponed each year;
- Managing the variations in patient discharge – thereby reducing length of stay – would release bed days;
- Increasing access to key diagnostic tests would improve patient flow across the healthcare system and could save thousands of weeks of unnecessary patient waiting times; and
- Treating day surgery as the norm for elective procedures would free up bed capacity, which would also reduce waiting times.

In the UK and Canada, hospitals such as Royal Bolton Hospital, Jewish General Hospital, Montreal and Vancouver Coastal Health are already reaping the benefits that Lean Thinking can bring in terms of cost efficiencies and improved patient care.

In Australia, Flinders Medical Centre (FMC) has been a pioneer of Lean Thinking in healthcare since November 2003. The philosophy has since spread to local government, including the City of Melbourne. To date, the FMC has involved hundreds of staff from all areas of the hospital in a wide variety of process redesign activities. The initial focus of the program was on improving the flow of patients through the emergency department, but the program quickly spread to

"Part of the success is that people return to work with tangible skills they can apply and see immediate results. Because it's healthcare focused, the examples used are applicable and real."

Todd Hutchings, Director of Distance Learning, Ontario Hospitals Association

involve the redesign of managing medical and surgical patients throughout the hospital, and to improving major support services. Results to date have shown that the Redesigning Care program has enabled the hospital to provide safer and more accessible care during a period of increased demand.

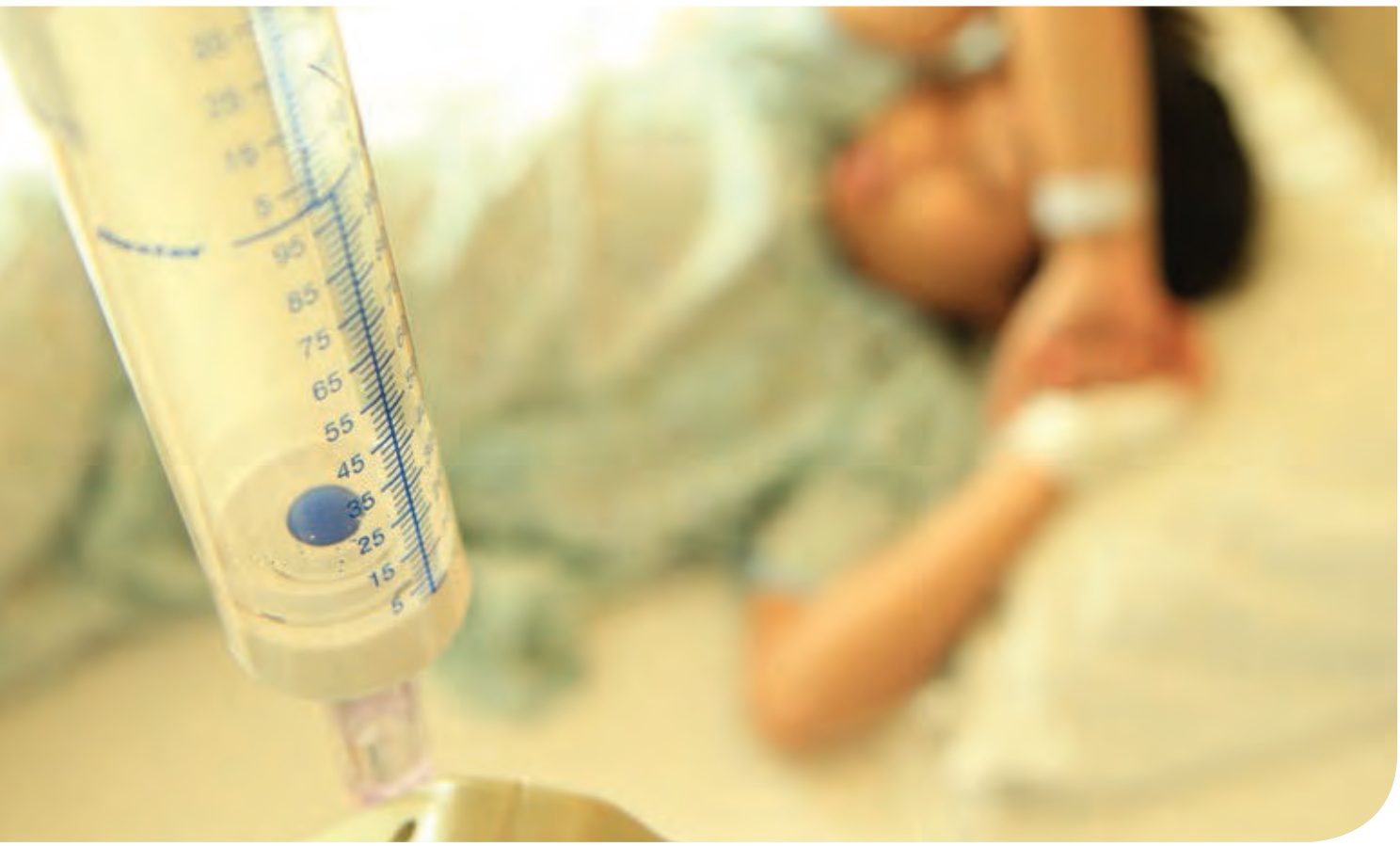
Over the past decade, in real terms, Australian governments have spent an additional $43 billion on health. At this rate, government spending on health will rise by around 2% of GDP over the next decade. Consequently, as we look to the future, we need to ensure that greater value is achieved for the ever scarcer tax revenues invested in health services.

Crucially, this needs to be done without impacting on patients, who must remain central to all our thinking. Indeed, even as the economy improves, it will remain important to achieve maximum returns for all public spending on healthcare as resources saved through efficiencies can be better spent elsewhere, such as health promotion.

The AHHA is uniquely positioned to actively support such change processes and to facilitate further collaboration between clinicians, academics, policymakers, administrators and politicians in this area. As such, the LEI Group Australia has joined with the AHHA to launch a series of Lean Healthcare Certification programs. These training programs, both online and instructor-led, will include entry level (two days duration) and more advanced modules in Lean Thinking (which can be completed over a six-month period).

The right steps taken now and applied consistently throughout the Australian healthcare system will bring savings. Importantly, they will also help reduce some of the frustrations that leave dedicated professionals questioning the lofty rhetoric they hear about how smarter thinking can allow them to 'do more with less'.

The LEI Group Australia is part of the Leading Edge Group, an international consulting and training company with other locations in the UK, Ireland and Canada. For further information on their Lean Healthcare certification programs, delivered in partnership with the AHHA, please contact admin@ahha.asn.au



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The Australian Healthcare and Hospitals Association (AHHA), formerly Australian Healthcare Association (AHA), is the independent membership body and advocate for the Australian healthcare system and a national voice for high quality healthcare in Australia.

LEI Group Australia is proud to partner with the Australian Healthcare and Hospitals Association to prepare healthcare professionals and organizations to increase efficiencies and improve organisational performance through the delivery of a series of Lean Healthcare educational programmess at Yellow, Green and Black Belt levels.

For more information on pricing and registration please contact: Andrew McAuliffe at 02 6162 0780
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HTTP://AHHA.ASN.AU/CONTENT/LEAN-HEALTHCARE-TRAINING

BY SIOBHAN HARPUR
Director of Population Health Operations Tasmanian Dept. of Health & Human Services

Calculated success at work in Tasmania

If employees are fit, healthy and safe, it's not only good for them and their families, it's also very good for business

Evidence shows physically active workers with good nutrition, and who don't smoke, take less sick leave and work more effective hours than others.

In fact, in the 2005 Medibank Private report titled *The Health of Australia's Workforce*, the self-rated performance of 'healthy' workers was 8.5 out of 10 compared to 3.7 out of 10 for 'unhealthy' employees.

It's one thing knowing this and quite another calculating the return on investment for a particular business in a particular place and time. This is often a real barrier to making changes.

Naturally, many employers are hesitant to introduce a health and wellbeing program for staff without a measurable link to better business outcomes in the future.

So, to encourage more organisations to implement health and wellbeing programs, Population Health and the Menzies Research Institute – through the partnering Healthy@Work initiative – set out to develop a Workplace Health Savings Calculator to identify and calculate potential savings.

A literature review identified potential savings through lower absenteeism and staff turnover from using a successful program. This information was then translated into a user-friendly calculator.

Because most people spend a lot of time at work, the World Health Organization has identified the workplace as one of the most important settings for health promotion.

PHOTO COURTESY JUICY ISLE

The calculator allows employers to enter variables about their organisation, like average wage and number of full-time employees, and then produce potential dollar savings to help justify their investment in a health and wellbeing program. Such a program will make healthy choices easy choices, which means:

- Encouraging and facilitating use of stairs, and providing showers and bicycle racks;
- Providing facilities to encourage staff to bring home-prepared food to work by providing a means to refrigerate and reheat food;
- Making policy changes like introducing healthy catering arrangements;
- Supporting cultural change such as contributing to the cost of meals rather than providing free alcohol at work dinners or functions;
- Encouraging staff to access lifestyle support programs such as the Get Healthy Information & Coaching Service (www.gethealthy.tas.gov.au) and resources available through the Australian government's Swap It, Don't Stop It! campaign; and
- Helping individuals with smoking cessation programs and easy access to employee assistance schemes for mental and social wellbeing.

The Workplace Health Savings Calculator was adopted by the former Federal Government and adapted into a web version, released on the national Health Workers Portal, www.healthyworkers.gov.au, in June 2013.

If the calculator is used as designed, it should encourage many more Tasmanian businesses to adopt health and wellbeing programs so they and their staff can reap the real benefits. ha

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BY ANDREW MCAULIFFE
Senior Director,
AHHA Policy & Networks

Don't worry – be 'appy

The rise of medical mobile apps and the need for proper regulation

An article in the most recent *Australian Health Review* highlighted the increasing use of mobile devices for clinical photography and the need for a new approach to obtaining consent and managing the storage and use of such images in the digital age.

However, it is not just photography apps that have been embraced in the health sector. *Business Insider Australia* reports there are already roughly 100,000 health applications available in major app stores, and the top 10 mobile health applications generate up to 4 million free and 300,000 paid daily downloads.[1] But how reliable are these apps? Are they worth the investment or do they present more risks to clinicians and consumers when misused?

The Therapeutic Goods Administration (TGA) released a guidance notice in September 2013 to clarify the distinction between medical software products and medical devices. Many apps could be considered medical devices under the definition in the Therapeutic Goods Act 1989, as they can be used for the '...diagnosis, prevention, monitoring, treatment or alleviation of disease...injury or disability...'

Whether considered to be medical devices or not, the TGA suggests that, under its risk-based approach, the regulatory focus is on apps that present the greatest risk to users.

With the number of medical apps likely to rise alongside the increasing worldwide availability of apps generally, the TGA – as a founding member of the International Medical Device Regulators Forum (IMDRF) – is working to develop consistent approaches to the regulation of medical apps.

The US Food and Drug Administration also adopts a risk-based strategy, as highlighted by the release of the Mobile Medical Applications Guidance for Industry and Food and Drug Administration Staff in September. In the guide, the FDA uses three categories for assessing medical apps:

1. Apps that are not medical devices

These provide information to clinicians and consumers but do not provide any diagnostic or related process:

Electronic reference books		**MIMS: prescribing and drug reference guide**	
Educational tools		**Radiology 2.0: Teaching tool to introduce the CT appearance of ED presentations.**	
Patient education / Directories		**Hawaii Medical Service: Association Provider directory & questions to ask list**	

2. Apps that may be medical devices

These may meet the definition of a medical device but where some enforcement discretion will be applied:

Guidance-Encouragement tools		**Quit Buddy – ANPHA: Customisable support to quit smoking**	
Exercise management		**PT Timer – Stretch & Exercise: Rehab programs and exercise tracker**	
Signs and Symptoms		**iTriage: Symptom catalogue and self-triage tool**	

3. Apps that are or will be regulated

These involve the use of the smart device to undertake or assist diagnostics or treatment procedures:

Imaging tools		**MobiUS SP1: Ultrasound head for iPhone and iPad**	
CPR feedback		**CPR Pro: Real-time feedback and prompting during resuscitation**	
Hearing tests		**Siemens Hearing Test: Hearing impairment analysis**	

It is clear that the availability and scope of medical apps will continue to increase rapidly. Consequently, regulatory authorities face a major challenge to apply appropriate and timely controls to protect consumers and clinicians. Until a clear system of 'certification' of medical apps is established, users will need to continue to apply their own assessment of the quality, reliability and appropriate of app tools and the information they contain. ha

Note: The apps listed above are provided as examples only and are not endorsed or recommended by the AHHA.

1. Workman, B. (2013, 14 September). The Explosion In Health Apps, And How They're Disrupting The Gigantic, Lethargic Health Care Industry, Business Insider Australia. Retrieved 8 October 2013 from www.businessinsider.com.au/mobile-will-disrupt-health-care-2013-9

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Patients and environment

Sustainability at the centre of Canberra Hospital developments. By Daniel Holloway, Communications Officer, AHHA

With the opening of stage two of Canberra's Centenary Hospital for Women and Children just around the corner, Canberra residents can look forward to a hospital that will be a leader in sustainable, energy-efficient healthcare delivery.

As the opening of stage one in August 2012 indicated, the overall design of the hospital shows a dramatic shift in how healthcare is perceived in Australia today. Gone are the clinical fixtures and ominous trolleys and medical equipment; in their place are wide, open corridors, full of natural light.

Every room, including corridors and staircases, is equipped with windows to illuminate the building with natural light in favour of artificial. This is to help 'bring the outdoors in', according to Canberra Hospital Executive Director, Business and Infrastructure, Rosemary Kennedy.

By exposing the rooms to the exterior environment in this way, some of the isolation and unrest patients may feel when they are restricted to their beds is removed, particularly in the case of children.

To further combat this feeling of isolation, the hospital also has a number of playgrounds and outdoor areas that not only facilitate the physical therapy that some patients may require during their stay, but also allow children to spend some time out of their beds and outdoors. One playground that is already generating excitement is the George Gregan playground, which features life-sized animal fixtures and a range of physically beneficial equipment. This playground is sure to be one of the most popular aspects of the new building.

Aesthetic value is also a feature in the design of the new rooms, as virtually all medical equipment is purposely shielded from view. For example, the apparatus used to deliver oxygen and other necessary medications is now built into the wall behind the beds. This removes the clinical feel and creates a peaceful and comfortable atmosphere; one that is both family friendly and inviting.

Beyond the aesthetic appeal, the building is also pioneering many environmentally sustainable features, from the light fixtures to the water being used in the toilets.

Due to the abundance of natural light throughout the building, the need for artificial light has substantially diminished. As a result, the lighting installed throughout the building is dimmed during the day, only requiring full power at night. This low-energy lighting has helped reduce power usage.

In addition to this low-energy lighting, many of the semi-occupied spaces have been equipped with motion-sensing lights that only come on when an individual is present.

Each room within the building is also equipped with specially glazed windows that help regulate temperature, thereby reducing the burden placed on heating and air-conditioning systems. Moreover, the rooms are fitted with individual climate controls that cut out when the windows are opened, thereby eliminating unnecessary power usage even further.

The water used for toilet flushing and irrigation is sourced directly from a 50,000 litre rain water tank. Sourcing water in this way eliminates the need for unnecessary consumption of the water supply, and having a fixed amount of water at any one time eliminates water waste.

Thoughtful design and a focus on environmentally friendly healthcare has placed Canberra's Centenary Hospital for Women and Children at the forefront of sustainable healthcare. For patients, particularly children, this means that a hospital stay might also be a little less overwhelming.

For more information on Canberra's Centenary Hospital for Women and Children, see: http://health.act.gov.au/health-services/canberra-hospital/our-services/women-youth-and-children/centenary-hospital-for-women-and-children.

For more information on the AHHA Greening Health & Hospitals Network, see: https://ahha.asn.au/forums/greening-health-hospitals-network ha

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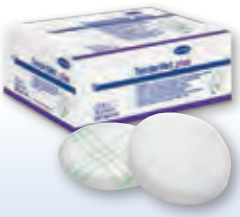

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BY LYN BRODIE
CEO, The Lowitja Institute

On the journey to better health

Working with Aboriginal and Torres Strait Islander peoples to close the gap

In 2010, when Dr Lowitja O'Donoghue AC launched the Institute that bears her name, she spoke of 'tossing out old methods of working, in favour of a radically different approach'. Dr O'Donoghue was referring to the philosophy that drove the establishment of the Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH), the predecessor organisation of the Lowitja Institute.

Innovation continues to drive our work, as we aim to achieve our vision of 'equity in health outcomes for Aboriginal and Torres Strait Islander peoples'. The methodologies we have developed and continue to refine are innovative in the health research sector. At the core of such methodologies is a powerful and simple idea: Aboriginal people have a strong and leading voice in everything we do, from agenda setting, determining the research question to conducting or participating in the research. Importantly, Aboriginal people are involved in ensuring the findings of the research actually make a difference. End-users having a determining voice in the research is considered innovative, and only more recently has there been a spotlight on this in the broader health research sector.

We work collaboratively, bringing researchers, policymakers and end-users (Aboriginal communities and Aboriginal Medical Services) to the table, to facilitate collaborative, evidence-based research. While mainstream research has begun to have a greater focus on research translation and implementation, our focus is now on Knowledge Exchange. Our model has all the stakeholders exchanging know-how at all stages of the research: design before the research begins, while the research is being conducted, and then implementing and translating the findings into practice and/or policy. We recognised many years ago that simply trying to translate research findings at the end of the process would never reach the level of success that can be achieved by bringing everyone along on the entire journey.

The diversity of knowledge and perspectives ensures robust discussion and spurns new and exciting concepts. It challenges mainstream norms and, importantly, captures valuable knowledge from Aboriginal and Torres Strait Islander peoples; knowledge that has ensured our nation's First Peoples thrived for tens of thousands of years.

Aboriginal Medical Services, known as the community controlled sector, started more than 40 years ago. Aboriginal people knew that their own cultural model of care, which looks beyond the disease or illness and has a focus on the whole person, including family, would achieve far greater health outcomes for their communities. This consumer-centric model is one that mainstream health providers might very well aspire to adopt. The complexity of this model, together with the complexity of health issues faced by Aboriginal people, means that evidence-based research is vital and widely embraced in the sector, provided it is collaborative, driven by Aboriginal people, and answering the questions asked by the community. The Institute continues to drive the expansion of a professional Aboriginal and Torres Strait Islander health and health research workforce to enhance this process and ultimately the impact of the work.

Prior to the establishment of the CRCATH, research was done on, not with, Aboriginal people. Perhaps our greatest innovation has been to change the face of how research is now done in this sector. We know there is a long way to go, however, this innovation has already contributed to gains in health outcomes, and will ensure that we will be a major contributor to ultimately closing the health gap for Aboriginal and Torres Strait Islander peoples. Dr O'Donoghue spoke of a 'radically different approach' and that approach is ensuring Aboriginal and Torres Strait Islander peoples have a strong and leading voice in the research designed to benefit their communities. ha

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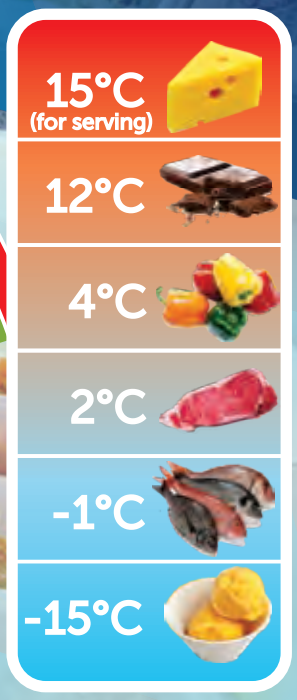

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JOE GALLAGHER
CEO, First Nations Health Authority

Community-Driven, Nation-Based

Canadian insights into autonomous indigenous healthcare management

On October 1, 2013, First Nations in the area now known as British Columbia (BC) became the first original peoples in the country to take over federal space in health service delivery. The transfer of First Nations health services from Health Canada to the newly formed First Nations Health Authority (FNHA) was over a decade in the making. The lessons learned from the establishment of FNHA may provide important insight for other countries, such as Australia, in how to create greater autonomy and specificity in indigenous healthcare management.

Unlike the rest of Canada, there are few treaties in British Columbia. An absence of treaties has created a landscape where the relationships between the federal, provincial and First Nations governments are still being defined. A lack of progress at treaty negotiations tables had First Nations leadership looking for collective solutions to social issues common to all 203 communities. Health and wellness emerged as common ground upon which BC First Nations communities could unite to work towards change.

As First Nations people, we knew that the first step in our journey was to create agreement amongst ourselves. Significant investments were made to develop engagement and consensus building processes in order to establish the fundamental standards and instructions for the new health governance relationship. Seven Directives were set, each of which continue to define our approach to investment and health service transformation.

There is widespread recognition that First Nations Health is not something that we can improve on our own. Willing and able government partners were key to our success. From legal agreements where precision was needed, to blue sky political accords where a common vision was the goal – BC First Nations have focused on using the right instruments to do the right job. Continually redefining the relationship between government and First Nations has enabled the evolution of a living and breathing health partnership.

Over time, the partners have become more accountable, accommodating, and responsive to one another for the successful implementation of their shared commitments. Each partner has done significant internal work to be a better participant at the table which, in turn, has led to evolving and more responsive working relationships.

7 Directives

Directive #1: Community-Driven, Nation-Based
Directive #2: Increase First Nations Decision-Making and Control
Directive #3: Improve Services
Directive #4: Foster Meaningful Collaboration and Partnership
Directive #5: Develop Human and Economic Capacity
Directive #6: Be Without Prejudice to First Nations Interests
Directive #7: Function at a High Operational Standard

With a united voice from our community leaders and through meaningful participation, willing partnerships, and a vision for better health outcomes, communities are mapping out the creation of a more effective, and innovative health system that will bring to life the vision of healthy, self-determining and vibrant BC First Nations children, families and communities.

About the FNHA

The First Nations Health Authority plans, designs, manages, and funds the delivery of First Nations health programs and services in BC. These community-based services are largely focused on health promotion and disease prevention – such as:

- Primary Care Services
- Children, Youth and Maternal Health
- Mental Health and Addictions Programming
- Health and Wellness Planning
- Health Infrastructure and Human Resources
- Environmental Health and Research
- Traditional Medicines, Foods and Healing
- First Nations Health Benefits
- eHealth Technology

Our work does not replace or duplicate the role or services of the BC Ministry of Health and Regional Health Authorities. The First Nations Health Authority collaborates, coordinates, and integrates our respective health programs and services to achieve better health outcomes for BC First Nations. The First Nations Health Authority has over 300 staff members located throughout the province of BC.

Connect with us online: www.fnha.ca

BY SOPHI MACMILLAN
Chief Executive, Vinyl Council of Australia

Fantastic plastic

Australian PVC Recovery in Hospitals initiative diverting hospital waste from landfill

In Australian healthcare each year, over 50 million IV fluid bags as well as significant quantities of tubing and oxygen masks, made from polyvinyl chloride (PVC), are disposed of by hospitals and end up in landfill. Although it represents only a fraction of all the plastics consumed in single-use, disposable products in hospitals, these alone are equivalent to over 2,500 tonnes of PVC a year.

Plastics account for about one third of a hospital's general waste, and of that, a quarter is estimated to be PVC.

When you think about the resources that have gone into making these products for their valuable but short use-life, recycling should be considered a better option than landfill. What's more, medical-grade PVC produces a high quality recyclate for which there is good local demand from manufacturers who want to produce new products, such as hosing and slip-resistant matting.

> **"Sustainability, just like patient care, is a core business for hospitals, from the wards to the executive team"**
> **Associate Professor Anthony M. Schembri, General Manager, Liverpool Hospital**

In 2008, I was approached by Dr Forbes McGain, an Anaesthetist and ICU Physician at Western Health, about the feasibility of recycling hospital plastic waste. This idea was borne from his frustration at the lack of resource recovery within his workplace and his passion for sustainability in healthcare. From that first conversation, and with the commitment of a number of Western Health staff, the foundations of the PVC Recovery in Hospitals program grew.

A successful pilot program, launched in 2009, demonstrated that PVC medical products can be separated relatively easily by hospital staff and recovered for recycling. The trials showed that with clear guidance to help recognise recyclable waste streams, change current behaviours, and set up appropriate systems, we can recover tonnes of PVC medical product waste from hospitals and divert it from landfill.

This year, we launched the PVC Recovery in Hospitals program nationally. This is ensuring that hospitals have access to education resources for how to implement recycling strategies for commonly used PVC medical products within their own facilities.

For hospitals, some of the key challenges in implementing waste recovery include changing behaviour, finding storage space for waste and bins, and the logistics of moving waste. Good planning, ongoing education, and liaison with the hospital's waste management team and contractors go a long way to overcoming these issues. Depending on the set-up and partners involved, PVC Recovery can help reduce waste disposal costs for the hospital or be a cost-neutral waste management solution.

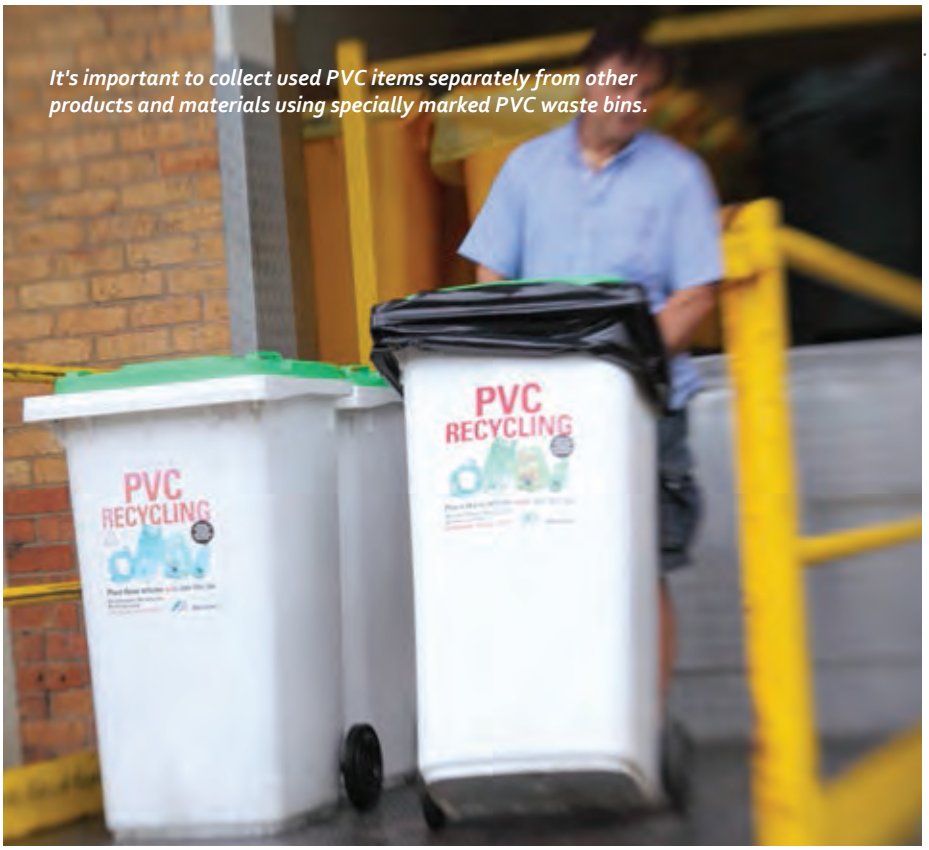
To be successful and improve recyclability, it is essential to collect used PVC items separately from other products and materials using specially

marked PVC waste bins, and to minimise contamination by other materials in the PVC bins. Implementing a recycling program at any place of work – like at home – requires ongoing education to change behaviours. People have been used to doing things in a certain way for a long time and it will take a while for people to adjust to a new system. Therefore, a process of continually engaging staff in how to implement the PVC Recovery program will be required.

The educational resources now available enable interested hospitals to join the PVC Recovery in Hospitals program.

Since the launch of the PVC Recovery initiative, over 350,000 IV bags – 15 tonnes of recyclable plastic – have been recycled and the volume is growing by the week as more hospitals join. Several hospitals and dialysis units now operate PVC Recovery programs and many more are planning theirs. Are you?

Educational resources for the PVC Recovery in Healthcare program can be found at www.vinyl.org.au/pvcrecovery ha



It's important to collect used PVC items separately from other products and materials using specially marked PVC waste bins.

"We recycle so much at home – let's do it in the hospital. It's so easy with the bins provided."

Jessica Andrews, ANUM Recovery, Western Hospital

BY BRENDA HAPPELL
Professor, Institute for Health and Social Science Research, and Centre for Mental Health Nursing Innovation (pictured) and
ROBERT STANTON
Researcher Officer, Institute for Health and Social Science Research, and Centre for Mental Health Nursing Innovation

Physical health and mental illness

Centre for Mental Health Nursing Innovation leads specialist nursing role to address poor physical health in people with mental illness

A person diagnosed with a serious mental illness such as schizophrenia or bipolar affective disorder is likely to live 25 years less than other members of the general population. Rather than implementing strategies to actively reduce this unacceptable gap, it is worsening.

Reducing this gap is a major research priority of Central Queensland University's Centre for Mental Health Nursing Innovation (CMHNI). Our research recognises nurses in mental health as a hitherto under-utilised resource in addressing physical health needs. Nurses are well placed because of their numbers, the relationships they enjoy with consumers, and their knowledge of both physical and mental health – and the factors that influence both.

Our research recognises nurses in mental health as a hitherto under-utilised resource in addressing physical health needs.

The interest in physical health of people with mental illness and the role of nurses has proliferated in recent years, as demonstrated by numerous publications describing the problem: the need to reconcile these largely segregated areas of healthcare. Unfortunately there's been somewhat less attention to identifying and implementing the solutions – something we hope to change. CMHNI's program of research commenced by conducting in-depth interviews with nurses from the Central Queensland Mental Health Service. The findings indicated support for physical healthcare as an important component of the nursing role by most participants. Lack of time, expertise and broad systemic support were identified as major barriers to providing necessary care. These findings were supported by a national survey of members of the Australian College of Mental Health Nurses.

On the strength of this new information, our previous plans to introduce a tool for nurses to assess physical health needs (trialled in other parts of the world) was abandoned in favour of a nursing role with a specialist focus in cardiometabolic healthcare. The Cardiometabolic Health Nurse (CHN) role provides an expert practitioner to lead the assessment, referral and consumer advocacy in the area of physical health. The role can potentially break down the barriers between mental health and general healthcare, resulting in local health pathways to access timely assessment and treatment in primary care services.

Funding received from the Australian Centre for Health Services Innovation (AusHSI) has enabled a short-term trial of a CHN role at Central Queensland Mental Health Services. Results from our pilot study support the views of nurses locally and Australia-wide regarding the need for a specialist CHN position. Baseline CHN assessments revealed a significant number of consumers with risk factors or health behaviours consistent with the development of poor physical health that were not previously identified.

While we are still analysing the final outcomes from the study, initial indications suggest improved cardiometabolic monitoring and primary care referrals for consumers identified as 'at risk' of poor physical health. CMHNI researchers are currently in discussions with potential collaborators, seeking funding for a multi-site national trial. Generally, though, we are confident this innovative role can contribute to improved physical health outcomes of people with mental illness, which is long overdue. ha

Relevant publications:

Happell, B., Scott, D., Nankivell, J. & Platania-Phung, C. (2013). Screening physical health? Yes! But…: nurses' views on physical health screening in mental health care. Journal of clinical nursing, 22(15-16), 2286-2297.

Happell, B., Scott, D. & Platania-Phung, C. (2013). Nurse views on the cardiometabolic health nurse as an approach to improving the physical health of people with serious mental illness in Australia. International Journal of Mental Health Nursing, 22(5), 418-429.

Happell, B., Stanton, R., Hoey, W. & Scott, D. (2013). Cardiometabolic health nursing to improve health and primary care access in community mental health consumers: Protocol for a randomised controlled trial. International journal of nursing studies.

Trade news

Information from suppliers in the healthcare industry

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When JustHealth Consultants (JHC) was launched in mid-2011 as the consultancy arm of the Australian Healthcare and Hospitals Association, the organisation had no idea how readily the industry would embrace the service. Tired of having no viable option beyond the major commercial consultancy companies, government departments and health organisations were drawn to AHHA's extensive experience and understanding of the health industry.

Since its introduction, JHC has attracted the know-how of Australia's chief health leaders and, through its linkages with the Deeble Institute for Health Policy, has drawn on in-depth research from the cream of Australian health and policy experts. JHC has developed a carefully chosen panel of experts who bring specialised advice, training and mentoring across a wide range of professional areas.

"Because JHC do not have the overheads of larger consultancy firms, we can offer a premium service at very competitive rates," says Terrie Paul, Director of JHC. "Further discounts are available to AHHA member organisations, making our services very affordable indeed."

JustHealth Consultants have successfully been appointed to several health panels, including the Department of Health Management Advisory Panel, and the Independent Hospital Authority Activity Based Funding (ABF) Panel. Other projects delivered in 2013, include:

■ Palliative Care Online Training (www.palliativecareonline.com.au): A free online training program funded by the Department of Health designed to help health professionals who provide palliative care to aged persons in the community. The modules are accredited and enable participants to accrue Continued Professional Development (CPD) points and to gain Recognition of Prior Learning (RPL) from accredited training organisations. The successful training has attracted over 5,000 participants nationally to date and was awarded a Platinum Award at the prestigious LearnX 2013 Awards for Best Online Learning Program.

■ Face-to-face Palliative Care Training Workshops: Funded under the Better Access to Palliative Care in Tasmania Project, face-to-face training will be delivered to 800 Tasmanian participants around the Palliative Approach to Aged Care in the Community Setting Guidelines. These workshops will be conducted over 80 sessions in 2014-15;

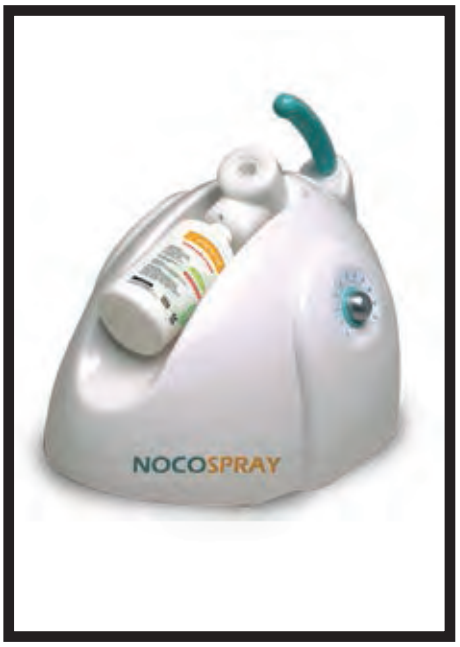
■ Health Needs Assessments & Mental Health Service Mapping Projects to various Medicare Locals Australia-wide;

■ Oral Health Service Review – Queensland Health.

To find out more about AHHA's JustHealth Consultancy Services, email tpaul@ahha.asn.au or telephone (02) 6162 0780. ha

JustHealth Consultants builds on the know-how of industry leaders for advice, training and mentoring across a number of professional areas.

Hospital And Aged Care Product Guide



A guide to the latest products and services pitched at the hospital and aged care sectors

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The unique and patented pan surface is corrosion and scratch-resistant, even sensitive products such as fish and custards are cooked to perfection without sticking or scorching.

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Executive Chef, Mark Taylor recently attended a FRIMA Cooking LIVE event and shared his experience.

"I've just been to a demonstration of this new innovative piece of kitchen equipment, the 'FRIMA VarioCooking Center' and have to say it's a hell of piece of kit!!.

Not only is it a griddle for searing off food, it can be a fryer, boiler, pressure cooker, bratt pan or stockpot. You can set it up to cook super slow overnight on a probe or at the touch of a button it can heat up to 200°C in 90 seconds (our bratt pan can take up to 20 mins to heat up!!) The saving in energy just for that reason is awesome plus not having someone waiting for it to heat up saves on labour too.

I saw it cook chicken and pasta together in a bechamel sauce and it didn't catch one bit on the base, so the cleaning only took about 30 secs, with no chemical either!

I can't wait to replace our old bratt pan and stock pot boilers with this innovative piece of equipment."

To read more about Mark Taylor's experiences at the FRIMA Cooking LIVE event, visit www.foodability.com.au.

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The range of Confoil's DUALPAK® trays is extensive, ranging from a single serve pie right through to large catering trays. That, combined with environmentally friendly & recyclable qualities (containers free of food residue can be placed in some home kerbside recycling bins), make DUALPAK® a versatile option.

Lamanna Direct in Essendon have been benefitting from using DUALPAK® for many years, ever since the business began its own kitchen facilities which manufacture their "Chef in a Box" meals. According to Mick Costanzo of Lamanna Direct, "the fact that (DUALPAK®) can be used in the fridge & freezer, oven & microwave, is very important to our customers". The convenience aspect of DUALPAK® is also reinforced by the availability of either the easy-peel film lidding or clip-on-lids, meaning that DUALPAK® can be used for heating, reheating as well as storage of food including salads. This has been well received by restaurateurs, caterers and cafeteria managers and is growing in popularity in the home delivered meals segment.

Confoil also have the ability to supply DUALPAK® with customised print/logo's as well as manufacture speciality shapes (MOQ's apply). According to Steve Flaherty, Marketing Services Manager at Confoil, the printing capabilities at Confoil have increased dramatically recently, "allowing our customers the opportunity to enhance their product offering to their customers, by including high impact graphics". This capability provides effective product differentiation & reduces the need for further outer packaging. ha

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Worried about Hospital Acquired Infection outbreaks?

How do you cut down on the incidents of hospital acquired infections? Nocospray has been proven to destroy a wide range of harmful bacteria.

Hospital acquired infections (HAIs) are a significant concern for hospitals. In fact, studies have shown that 1 in 9 patients in a hospital will acquire an HAI.[1] Outbreaks can also mean that average patient costs increase by 50% on average.[2] Some infections can even prove deadly, such as Clostridium difficile (C. diff.) with an attributed mortality rate of 10%.[3] C. diff. is resistant to common disinfection solutions, such as alcohol wipes, and can survive on surfaces for at least 5 months.

Outbreaks need no longer be a worry with Nocospray complete disinfection technology. Nocospray has been proven to destroy 99.99% of all harmful bacteria, viruses, funguses, moulds and yeasts. It has been proven in studies to kill C. diff., MRSA, VRE, ESBL, Norovirus, Legionella, Aspergillus niger, H5N1 and H1N1. Nocospray has been developed and tested in both labs and environmental hospital situations.

Nocospray is based on hydrogen peroxide (H_2O_2) and a catalyst. H_2O_2 compounds have had proven success where other disinfection methods, such as bleaching and steaming, have failed.

A laboratory study was recently conducted at The University of Western Australia evaluating the effectiveness of Nocospray in decontaminating rooms infected with Clostridium difficile. The study found that the Nocospray System demonstrated sporocidal activity and there was a consistent reduction in C. difficile spores greater than or equal to 99.99%.[4]

A leading Australian hospital using Nocospray has also reported that "2 months after the addition of Nocospray to our environmental regime, we cut transmission of VRE by 50%".

Nocospray is TGA approved as a hospital grade disinfectant, ideal for use in hospitals, laboratories, aged care facilities and waiting rooms. Nocospray is perfect for daily disinfection of equipment, terminal clean disinfection of rooms, bathrooms, toilets, pan-rooms and for managing and preventing outbreaks. Areas up to 20,000m3 can be successfully treated.

The Nocospray system works by vaporising Nocolyse solution, micro-fined H_2O_2 ions, into the air. These ions cause the salts on the membrane surface of micro-organisms to form new compounds (chlorine), which cause the micro-organisms to self-destruct (on its own chlorine). Because the vapour is having a chemical reaction with compounds on the cell mechanism of viruses and bacteria, it is impossible for these organisms to develop resistance.

Nocolyse vapour is non corrosive and can be safely used in theatres with delicate equipment. It is a dry spray (5 microns) which leaves no wet surface residue. Nocolyse is a non-toxic vapour with no harmful chemicals, so is safer for staff to use. This fits with government requirements to replace harmful disinfection chemicals. The H_2O_2 vapour is biodegradable within minutes, breaking down into microscopic air and water particles. Nocospray is quick and easy to use, disinfecting rooms in half the time of manual wiping protocols. After an initial clean, Nocospray only takes 3 minutes to disinfect a 50m3 space. The room is then ready to use 25 minutes after treatment.

Involving a simple 2-step process, Nocospray is also easy for healthcare workers to use. It features a ready to use disinfection solution, and requires only one person to operate. At 5.8kg, it is easily portable. The disinfection process becomes automated and human error is eliminated.

Nocospray is more cost effective than existing disinfection methods, and a fraction of the cost of competing technologies. Factoring in the savings of avoiding costly outbreaks, Nocospray is an extremely wise investment.

Using Nocospray in your facility will increase compliance, create a healthier environment and help prevent dangerous outbreaks. Protect the health of your patients and staff with Nocospray complete disinfection technology.

For more information about Nocospray and to request the full Dr Niki Foster clinical study, please contact Equipmed on 1300 668 755 or email info@equipmed.com. Or visit the website online at www.equipmed.com ha

References

1. Foster NF and Riley TV, "Decontamination of rooms following Clostridium difficile infection: Evaluation of a hydrogen peroxide dry-mist disinfection system" presented at: Australasian College for Infection Prevention and Control (ACIPC) Conference; Conference; 2012 October 10; Sydney, NSW, Australia.

2. Ibid.

3. Ibid.

4. Ibid.

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" The Nocospray System demonstrated sporocidal activity and there was a consistent reduction in C. difficile spores greater than or equal to 99.99%"[1]

[1]Foster NF and Riley TV, "Decontamination of rooms following Clostridium difficile infection: Evaluation of a hydrogen peroxide dry-mist disinfection system" presented at the Australasian College for Infection Prevention and Control Conference, Sydney, 2012.

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

Getting the sparks without the fizz

Some personal reflections on innovation in health

I have recently had two personal experiences which offer an opportunity to reflect on the role of innovation in the health system. First, I had an aortic valve repair. I had known that I had aortic regurgitation for nearly a decade, and that at some point I would need to have it fixed. While mitral valve repair is a well-established procedure, aortic valve repair is described as 'controversial', and the standard procedure is to have it replaced. I consider that I am in an almost unrivalled position to make an informed decision about what the best procedure is for me, and where best to have it done. I sought to, and ended up having, the valve repaired rather than replaced. The technical reasons for this are too complex to enumerate here, but I consider this outcome to be optimal for my circumstances. The procedure itself was an example of successful innovation, but one dependent on having an informed consumer with a large capacity to get the results he wanted from the system.

Still, my surgeon was nonetheless innovative in his approach to the operation overall. The main incision he made was a hemithoracotomy. This is less invasive than, and so preferable to, a thoracotomy. A thoracotomy is usually required to provide adequate exposure of the heart for a valve repair. This meant that he chose to make part of the vascular access I required for cardiac bypass through my groin. This is a less usual approach, but had the advantage that there was one less piece of tubing going through my chest incision.

I would class my postoperative complications as second order – major inconveniences rather than permanent sources of disability – but they relate to the procedures done in my groin, not those in my chest. I'm very grateful to my surgeon and consider that he has given me a superb primary result, but note that, as far as I can tell, the complications arose as the result of innovation in an area that the surgeon was relatively less expert at. Innovation creates new risks, and while these may be mitigated with experience, initial comparisons may show that the outcomes of innovation are worse than they prove to be in the long term. Thought needs to be given to manage these competing risks.

There is plenty of scope to innovate to improve care for people in this situation. This is likely to achieve efficiencies if care is better coordinated.

My second personal experience with the health system was vicarious. My father-in-law was admitted to a suburban hospital with delirium and pneumonia. His family did not have a good experience of communication with the hospital – particularly important since the patient was confused and so unable to communicate for himself. In the absence of this communication, it is not clear how the objective of care was determined. In fact, it did not seem that there was any clear planning about his care. The focus was on fixing his immediate problem without regard to his health in the overall context of his life.

There is plenty of scope to innovate to improve care for people in this situation. This is likely to achieve efficiencies if care is better coordinated. However, the underlying problem here is that it is not clear what we are trying to achieve with healthcare. Mao's Great Leap Forward was predicated on innovation and a disaster for the Chinese. We can innovate all we want, but if we are not clear about what it is we are trying to achieve, all we will get is a bunch of sparklers – they look good for a little while but fizz out without achieving anything.

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

Professionalism, pretty please?

How has the culture of 'command and control' and the cult of managerialism blighted healthcare?

For brevity's sake, let's just think of the stultifying effects of what I'd call 'permission paralysis'. This is not hard to spot and its characteristic feature is the seeming inability of even supposedly senior and experienced health professionals to make decisions and take actions without an endless recourse to 'gaining permission'.

Recently I spoke with two senior and very experienced nurses. One was a clinician and the other a Nurse Practitioner. The clinician described caring for an old homeless gentleman who, in addition to his medical condition, needed a 'good clean up' to help get him roadworthy again. As the nurse was cleaning and bathing and helping freshen this man up, she noticed that his finger and toenails were very long and dirty. Unsurprisingly, a manicure or pedicure had not been high on his priority list. However, as the nurse was about to attend to his nails, she was told that 'Nurses are not allowed to do that' i.e. cut fingernails or toenails. Where this diktat had come from was unclear. The man was not diabetic and there seemed no reason for such a ban. Whose 'permission' was required for this experienced nurse to undertake some sensible and required patient care was equally unclear. Perhaps there was a Nail Therapist in the wings who may have been allowed to do this, under the 'appropriate supervision' of a Senior Nail Therapist, provided that she didn't specialise only in fingers or toes. It is insulting beyond parody and the tragedy is that so many health professionals acquiesce so quietly.

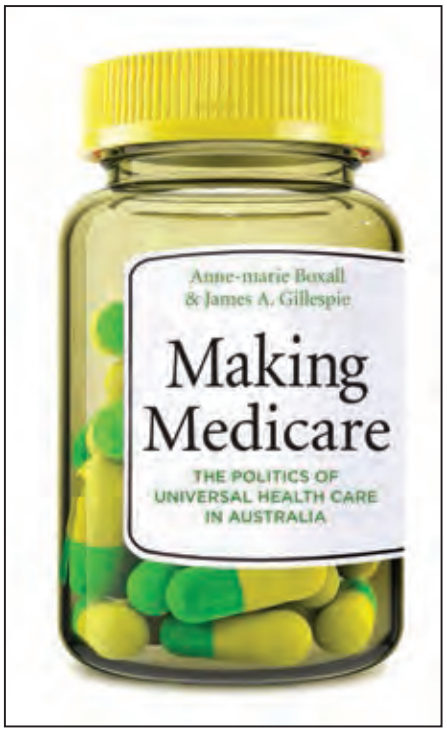
This 'permission paralysis' is corrosive. It chokes initiative and enthusiasm and feeds an organisational culture that celebrates means over ends and professional impotence.

I asked the Nurse Practitioner if she was attending the upcoming National Nurse Practitioner Conference and her response was 'No', because she 'didn't get permission'. So here is a nurse in one of the most senior and supposedly autonomous roles in nursing, who should be at the forefront of developments in her field and who should be driving and modelling active learning and networking for junior nurses, handing over responsibility for all of this and more to 'someone, somewhere' in the organisation who can bless her with their 'permission'. This 'permission paralysis' is corrosive. It chokes initiative and enthusiasm and feeds an organisational culture that celebrates means over ends and professional impotence – the ultimate triumph of bureaucracy. A scathing 2007, report from the UK found that the National Health Service 'has developed a widespread culture more of fear and compliance, than of learning, innovation and enthusiastic participation in improvement'. It also said that 'virtually everyone in the system is looking up (to satisfy an inspector or manager) rather than looking out (to satisfy patients and families)', and that managers 'look up, not out'.

It is salutary to think that the most junior frontline employee in Disney or Ritz will have more decision-making authority when it comes to guest satisfaction than a highly qualified health professional does in our health system.

The last word in 'permission paralysis' came from a nurse who was explaining to me why she hadn't pursued the great practice improvement idea that she'd just shared with me: 'Because in my hospital, I'll meet 10 people with the power to say no to me, before I'll meet one with the authority to say yes.'

And we permit this? We'd better 'look out'.



Making Medicare

Philip Davies reviews *Making Medicare: The Politics of Universal Health Care in Australia* (Written by Anne-marie Boxall & James A. Gillespie)

For many of us, significant birthdays provoke a review of our achievements. Health policies are no different. Medicare turns 30 next February and in *Making Medicare*, Anne-marie Boxall and James A. Gillespie do a thorough job of telling the life story of our national health insurance scheme from its initial conception in the early years of the 20th century; its long and complex gestation; troubled birth; tumultuous early years; and transition into a more settled maturity.

With nearly 200 pages of text, the book's length alone demonstrates how the debate about how best to pay for healthcare (as opposed to organise its delivery) has been almost uniquely protracted in Australia compared to other Western countries. Canada, the UK and New Zealand have, for many years, relied primarily on tax-based funding arrangements. Many mainland European countries have a long and stable history of using social health insurance schemes. In the USA, the intensity of the current debate surrounding 'Obama care' reflects, in part, the relative stability of previous arrangements.

In contrast, Medicare provides fertile ground for historical analysis.

As Boxall and Gillespie point out, Australia has never really reached clear consensus on the goals that its system of health financing should seek to achieve. That is neatly illustrated by a seam of ambiguity that runs through their text concerning the 'universality' of Medicare. At times, the scheme is presented as providing universal access to affordable healthcare (which it does not) while at others it is described, more modestly, as offering universal access to insurance coverage (which it does). To be fair, that ambiguity may stem more from politicians' desire to shape public perceptions to suit their ideological ends rather than any inconsistency in the authors' use of terminology.

The book's detailed description of Medicare's evolution also helps to explain the scheme's iconic status in the Australian national psyche. There are many mutations that didn't survive. In the early 1940s, for example, officials of the Department of Health under Dr John Cumpston advocated, without success, for the establishment of a national health service which favoured "preventive public health ... over merely curative private medical practice". There were also calls for "a salaried medical service" by the National Health and Medical Research Council around this time. Both notions were revived by Dr Moss Cass in the 1960s, but again failed to gain traction. These ideas still resonate with those who today argue for Medicare to place greater emphasis on prevention; do more to address the social determinants of health; and offer alternatives to fee-for-service benefits.

Such a long and complex story could easily degenerate into a tedious and convoluted chronology. To the authors' credit, their book is leavened by insights and anecdotes they have garnered from a series of interviews with key players in Medicare's development. Those accounts, in turn, shed light on the compromises, backroom deals and, in some cases, personal antagonisms, which helped shape the scheme we know today. Anyone seeking to gain a better understanding of how policy is made would be well-advised to read *Making Medicare*. The contrast with the simplistic flowcharts that purport to illustrate the 'policy process' will quickly become all too apparent.

Boxall and Gillespie have succeeded in telling the story of Medicare in a relatively accessible manner. Indeed, some of their descriptions of medico-political power struggles seem almost to be heading into crime fiction territory. However, this is clearly a book that is aimed more at the established or aspiring health policy cognoscente than the casual lay reader. It draws on formal, peer-reviewed literature as well as a wide range of 'grey' literature and other media.

The book has some shortcomings, although none too significant. The authors' lengthy description of the protracted policy turmoil of the Whitlam and Fraser years borders occasionally on the impenetrable. While that might be a fair reflection of the chaos that reigned for much of that period, a better structured narrative might have helped clarify the various protagonists' logic. Scant attention is paid to the role of Medicare in funding diagnostic (laboratory and imaging) services and the particular policy challenges they create. There are also several points where a well-thought-out diagram might have enhanced, or even replaced, some of the more complex descriptive passages.

Readers looking for proposals to improve Medicare may also be disappointed. Its final chapter, which is tantalisingly titled 'Current Issues, Future Challenges', extends to just 10 pages and offers few new insights. That is disappointing since one might hope that, having conducted such a forensic analysis of the past, the authors would have alighted on some innovative proposals for future change. Perhaps that leaves the door open for this well-credentialed pair to direct their skills towards a more assertive assault on some of the less helpful orthodoxies of Medicare. ha

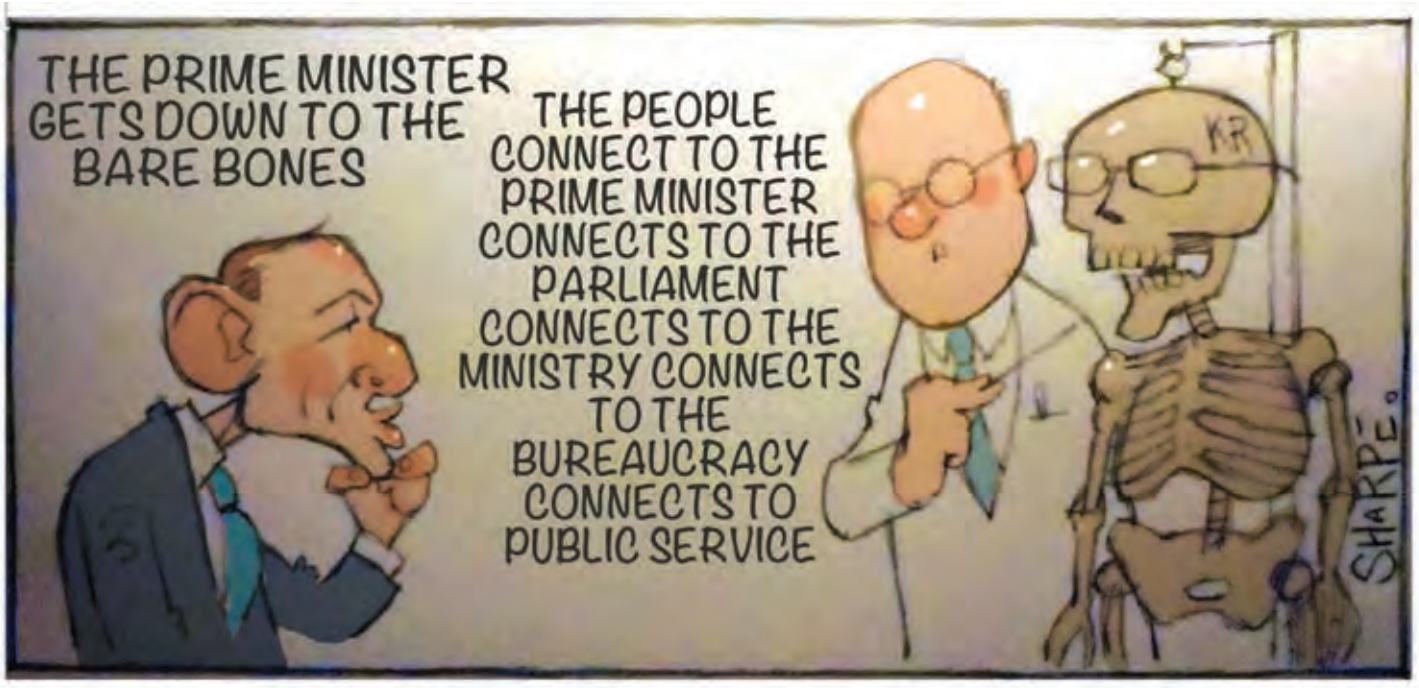
Philip Davies is Deputy Director-General, Queensland Government Department of Health; Adjunct Professor, Faculty of Health, Queensland University of Technology; and Adjunct Professor, School of Business, UTS.

Snippets

The last word

What's been happening since we last met?

- Speaking at the *Greening the Health Sector* Think Tank in Melbourne this September, members of the Australian healthcare and hospitals sector have described the ways in which they plan to reduce waste and increase sustainability. According to Chris Hill of Mater Health Services Queensland, greener healthcare is achieved from the ground up, through individual action.
- As many as one in 10 doctors and medical students have suicidal thoughts, according to a new survey by Beyond Blue. Usually some of the first to recognise these symptoms in others, doctors and medical students have since been urged to seek help when confronted with signs of depression. Unfortunately, even among the medical profession, there is still a perceived stigma about mental health issues.
- In a recent study published in the *Australian Health Review*, researchers have examined the important ethical and legal issues that have arisen with medical photography in the digital age. They say that while medical photography is a necessary part of healthcare, it has fallen into an ethical 'grey area' in recent times.
- An international team of scientists including a strong Australian contingent has made a key discovery in new research to help find the cause and cure of multiple sclerosis.
- Seriously ill skin cancer patients have seen 'spectacular effects' after being given ground-breaking new drugs. Experts have hailed the beginning of a new era as scientists have been able to battle advanced melanoma for the first time. Undergoing current treatment, patients normally die within months of diagnosis.
- A deadlock in the US congress over Barack Obama's healthcare reforms shut down the Federal Government and put hundreds of thousands of public servants out of work for the duration of the shutdown.
- The 2013 Nobel Prize for Medicine has been awarded to three US-based scientists for working out how cells transport hormones, a discovery that gives insight into diseases including diabetes and Alzheimer's. Yale's James Rothman, the University of California Berkeley's Randy Schekman and Stanford's Dr Thomas Sudhof will share the million-dollar prize money.
- In a recent study on the most efficient healthcare systems across the globe by the US media corporation, Bloomberg, Australia has been ranked seventh overall. "Australia's healthcare investment as a percentage of GDP sits at approximately 8.9% per capita. With life expectancy of 81.8 years, Australia is on a par with other high performing countries in this ranking, showing that our investment in a universal healthcare system is a winning model," said Australian Healthcare and Hospitals Association CEO Alison Verhoeven. ha



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

Ms Ngaire Buchanan is moving from Auckland DHB as General Manager of Clinical Operations to join St Vincents & Mater Health Service as the Chief Operating Officer.

Associate Professor Alan O'Connor, previously the Director of Emergency at Royal Brisbane and Women's Hospital in Queensland, is moving to South Australia to take up the post of Network Clinical Director Emergency for the Southern Adelaide Local Health Network.

Mr Philip Balmer is set to start as Director of Hospital Services for Counties Manukau District Health Board. Mr Balmer is leaving his position with Bay of Plenty Health Board as Chief Operating Officer.

Ms Lynne Bickerstaff is leaving Victoria and Monash Health, where she was Director of Operations and Nursing at Monash Medical Centre, to take up the position of General Manager at Camden and Campbelltown Hospitals in the South Western Sydney Local Health District.

Ms Katherine Preston is moving to Tasmania to take up the position of Nurse Unit Manager of Obstetrics at Hobart Private Hospital. Ms Preston was previously the Nurse Unit Manager Maternity at Gympie Hospital.

In a change of industry, **Ms Karen Mills** is moving from Westfield as a Centre Manager of North Rocks to take up the position of Operations Improvement Manager with Primary Health Care.

Taking on the position of Manager of Care and Lifestyle at Sugarloaf Gardens Aged Care is **Ms Kathleen Morilla,** who was previously the Deputy Director of Nursing at Principal Hillside.

Mr Joel George is moving from New Zealand, where he was General Manager/CEO at various Health Services, to take up the job of General Manager at Shoalhaven District Memorial Hospital.

Over in Western Australia, we see **Dr Margaret Sturdy** moving from Hollywood Private Hospital to take up the position of Chief Executive Officer and Director of Medical Services at Peel Health Campus. Dr Sturdy is being replaced by the previous Deputy Director of Medical Services at Hollywood Private, Dr Daniel Heredia.

Mr Ian Power is moving from Griffith Base Hospital to take up the position as General Manager at Shellharbour Hospital.

Ms Susi Tegan is taking up the position of CEO at the Medical Technology Association of Australia (MTAA) having previously been CEO at the Royal Australian and New Zealand College of Ophthamologists. The appointment comes as Ms Anne Trimmer moves on from MTAA after being appointed as Secretary General of the Australian Medical Association. ha

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

Ccentric Executive Search

Become an AHHA member

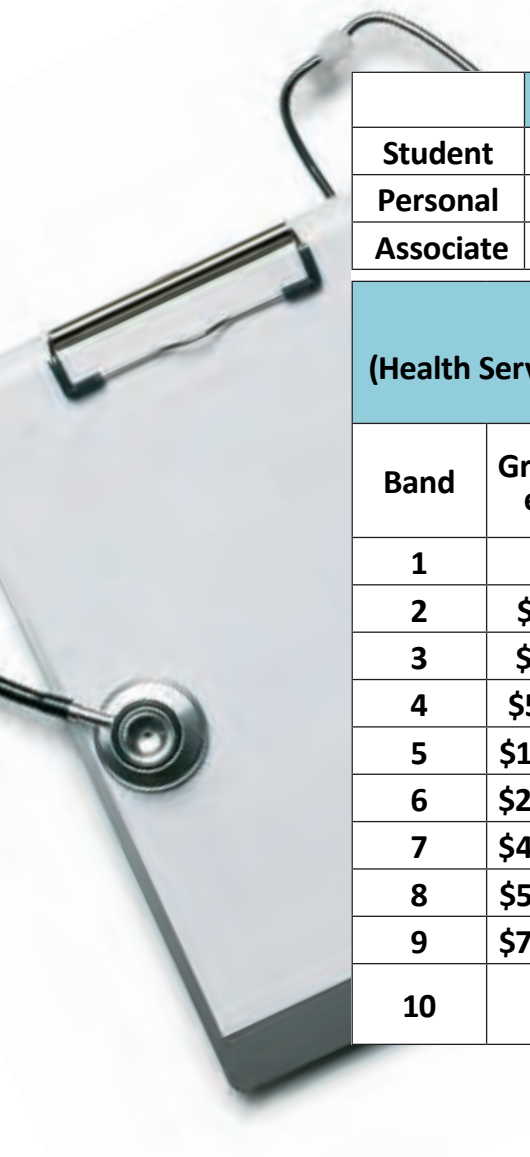
Help make a difference to health policy, share innovative ideas and get support on issues that matter to you – **join the AHHA**

The AHHA 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 will have access to the association's regular professional development activities and to networking opportunities with colleagues across Australia through our stimulating networks and innovative events.

You will also receive the *Australian Health Review*, Australia's foremost journal for health policy, management and delivery systems (print and online), as well as our magazine *The Health Advocate*, up-to-the-minute email news bulletins and other professional information.



Membership Fees 2013 – 2014

	Australian	Overseas
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Personal	$ 303	$ 417
Associate	$ 1,216	$ 1,656

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Band	Gross operating expenditure	Membership fee
1	$0 - $10M	$ 1,957
2	$11M - $25M	$ 3,913
3	$26M - $50M	$ 9,134
4	$51M - $100M	$ 15,295
5	$101M - $250M	$ 18,632
6	$251M - $400M	$ 24,806
7	$401M - $550M	$ 30,760
8	$551M - $700M	$ 38,147
9	$701M - $850M	$43,549
10	$851M and over	$49,723

*Fee includes GST - valid from 3 June 2013 to 30 June 2014

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

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

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

Your knowledge and expertise in these areas are valuable and you can have direct input to our policy development. Join our think tanks or participate in our national seminars or conferences. Our voice is authoritative and influential. It is heard via our high-level advocacy program and extensive media exposure.

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The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation, the protection of its assets and the quality of its services. The 2012-2013 Board is:

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