ahha
australian healthcare &
hospitals association

THE AUSTRALIAN HEALTHCARE AND HOSPITALS ASSOCIATION

60 YEARS ON

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Preface

The Australian Healthcare and Hospitals Association (formerly the Australian Hospital Association) has a unique and significant position in Australia's health care industry, being the only organisation representing the public health care sector. AHHA's primary role is to uphold and improve Australia's public health care sector for the benefit of members and the whole community, through high-level advocacy and representation.

This year marks the organisation's 60th birthday. Over the past 60 years, we have experienced many challenges that have required determination and commitment from members and staff in order to accomplish, on the most part, highly satisfactory outcomes.

AHHA's strength is its capacity to be the 'collective voice' of public health care in Australia. This is achieved by connecting our natural networks of policy shapers, clinicians, managers and academics from across the nation and harnessing their expertise in the creation of innovative national policy solutions.

To this end, our vision is:

> *That all Australians will have access to effective health services of high quality, appropriate and responsive to their needs and coordinated across all settings (home, residential facility or hospital). Health services will be efficiently delivered by capable personnel and adequately resourced to ensure sustainability and safety. AHA views its mission as representing and supporting all people who work in Australia's public health system to provide high quality, safe care to their clients and patients.*

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> *To represent and support all people who work in Australia's public health system to provide high quality, safe care to their clients and patients.*

The story of the Association's first forty years was admirably covered by Mary Dickenson and Catherine Mason in their book, published by the Australian Hospital Association in 1987, titled: *Hospitals and Politics: The Australian Hospital Association 1946–1986*. Their story is encapsulated in the Appendix to the book, a *Chronicle of Significant Events in the History of the AHA*. For those who may not have had an opportunity to read the full text of this book an amplified version appears as Appendix A of this paper.

This booklet takes the history of the Association beyond 1986 and up to the present.

I wish to thank Selby Steele, a dedicated supporter of the AHHA and President from 1978 – 1980, for taking the time to update our story in this valuable history. Selby Steele is credited with making a tremendous contribution to the growth of the Association as well as to the health care sector generally.

Selby was skilfully assisted in this endeavour by Royce Kronborg, another long-serving supporter of the AHHA. Royce Kronborg is an Honorary Life Member after holding several important positions with the AHHA over a period spanning 20 years including Honorary Federal Secretary/Treasurer, National President from 1974 - 1976 and IHF President.

I would also like to thank all those who read the document
and provided input.

Stephen Christley
National President

Selby Steele
President 1978–1980

Royce Kronborg
Honorary Life Member

Introduction

The Australian Hospital Association was formally established at its first Annual General Meeting in February 1947. Initially, the large teaching hospitals in Melbourne and Sydney formed the membership.

Over the years the Association has broadened its membership base to become the national industry body for all services in the public health sector, including state health departments, regional health services, hospitals, community health centres and aged care facilities. These services are eligible for Institutional Membership, which forms the core membership category. AHHA also offers Personal Membership and Associate Membership (open to companies that provide services to the healthcare sector). Honorary Life Membership is bestowed on people who have made an outstanding contribution to the Association.

In addition to its dominant policy development and advocacy roles, the AHHA provides members with a wide range of high quality services and products designed to assist and enhance their working life, including:

- Australian Health Review (AHR) – our well-regarded quarterly peer-reviewed journal;
- Healthcare Brief – our informative quarterly newsletter;
- E-Healthcare Brief – our popular weekly news summary;
- Professional information via the website and regular eBulletins providing readers with up-to-date news, details of industry events and new jobs posted on our Just Health Jobs site;
- Conferences, Seminars, Think Tanks.

To better reflect the growing diversity in the membership base and the emergent policies at Federal and state levels focusing on out-of-hospital services, AHA changed its name to the Australian Healthcare Association in 1996. Ten years later, in 2006, the name was again changed to become the Australian Healthcare and Hospitals Association. This time, the aim of the change was to regain its original identity while still reflecting its comprehensive membership base.

The Beginnings

On 18 November 1946, Dr Herbert Schlink (later Sir Herbert), a gynaecologist and Chairman of the board of Sydney's Royal Prince Alfred Hospital, convened a meeting of the Provisional Federal Council of the Australian Hospital Association (now the Australian Healthcare and Hospitals Association) at The Royal Melbourne Hospital.

This was followed, in February 1947, by the first Annual General Meeting, held in Sydney, at which membership of the Council was confirmed and a set of rules adopted. Sir Herbert became the Foundation President of the Association and remained in this position until 1958. In his foundational address Dr Schlink presented a theme that the AHA maintains today:

> *'The Australian Hospital Association wishes to serve the welfare of the nation by developing methods and programmes for making better hospital care available to all.'*

The Prime Minister of the time, Ben Chifley, had posited that the Government intended to introduce a full-time salaried medical service in Australia. Undoubtedly, one of the motivations for forming the AHA was the concern of the medical profession that a nationalised health scheme, similar to that being implemented in the United Kingdom, might be introduced in Australia.

Dr Schlink recruited teaching hospitals in Sydney and Melbourne as inaugural members of the Association as their boards were regarded as having considerable influence on Government

Dr Herbert Schlink

decision making. Throughout his time as President, Dr Schlink restricted Federal Council membership to representatives of teaching hospitals.

An editorial in The Australian Modern Hospital, the journal published by the Association from 1949 - 1955 stated:

> *'Due to rising costs and neglect in forward planning, the financial position of Australian hospitals has never been worse. An additional reason for their present difficult situation is the political difference of policy between the various Governments - Federal and State.'*

Echoes of this early comment have resounded over the subsequent sixty years and still determine the Association's policy positions today.

The story of the Association's first forty years was admirably covered by Mary Dickenson and Catherine Mason in their book, published by the Australian Hospital Association in 1987, titled: *Hospitals and Politics: The Australian Hospital Association 1946–1986*. This story is encapsulated in the Appendix to their book, a *Chronicle of Significant Events in the History of the AHA*. For those who may not have had an opportunity to read the full text of this book, an amplified version appears as Appendix A of this paper.

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The Second Half Of The 1980s

1983

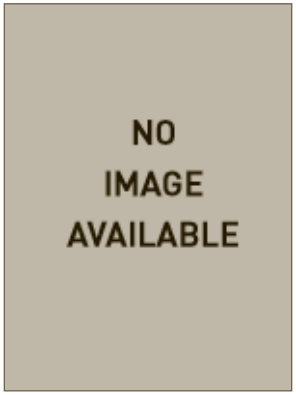
After an unusually controversial internal debate, the Association finally moved to Canberra in 1983. This historic decision gave the Association much greater access to Government Ministers, their counterparts on Opposition and Federal Departmental officers. The move also facilitated involvement with, or representation on, numerous bodies such as the Australian Institute of Health, the National Health Technology Advisory Council, the Standards Council of Australia, the Australian Council on Hospital Standards and the National Health and Medical Research Council.

1986 - 1987

At the 1986 Annual General Meeting, Keith Bagley, a solicitor from New South Wales, was elected National President. Honorary Life Membership was conferred on Royce Kronborg, at the completion of his term as a councillor and President of the International Hospital Federation. Royce's outstanding commitment to the AHA had spanned nearly 20 years, commencing in 1967 when he was appointed Honorary Federal Secretary and Treasurer. Dr Donald Child was nominated, and subsequently elected, to the Council of the IHF to fill the vacancy created by Royce Kronborg's retirement.

At this meeting, the Association also made the first award of the Sidney Sax Medal, awarded to and individual 'active in the health services field, who has made an outstanding contribution in the field of health services policy, organisation, delivery and non-clinical research'. The inaugural recipient was Dr James Lawson (who became Professor of Health Administration at the University of New South Wales).

Keith Bagley



Errol Pickering

Dr John Morris

In February 1987, Errol Pickering resigned after nearly seven years as National Director to assume the position of Executive Director of the International Hospital Federation in London. His successor, Dr John Morris, commenced in the following month.

Two notable publications were launched during the year, namely Hospitals and Politics: The Australian Hospital Association 1946 - 86, by Mary Dickenson and Catherine Mason and The Governance of Hospital Services, also by Mary Dickenson.

1988 - 1989

In 1988, John Blandford, Administrator of the Flinders Medical Centre in Adelaide, was elected National President.

At that meeting it was resolved that the Memorandum and Articles of Association be altered to increase the effectiveness of the Association at state level. This was achieved by restructuring to establish a new category of State Association membership. It provided for incorporated state associations to join AHA in their own right and to take on the responsibilities previously held by an AHA state branch. Where no state association existed, or where the members of that state did not wish to utilise the option, a state branch would continue to function and to represent the interests of members at state level.

Following this decision, the New South Wales Branch Council resolved that it should amalgamate with the Hospitals and Health Services Association of New South Wales to form a new association. The South Australian Branch and the South Australian Hospitals Association also merged to become the Hospitals and Health Services Association of South Australia. In Victoria, the Victorian Hospitals Association was appointed the State Association member for Victoria, following the winding up of the Victorian State Branch and the transfer of its assets to the VHA.

These changes proved to be very effective, bringing extra members via the new category of State Association membership. As a result, membership of the Association increased by 30 per cent in 1988-89 and by a further 27 per cent in 1989 - 90.

The 1988 amendments to the Memorandum and Articles also gave legal effect to the existence of a National Executive and provided for the election of this Executive from among members of the National Council.

1988 was the year of the Australian Bicentenary celebrations and in this year the AHA collaborated with the Australian College of Health Service Executives and the Australian Association of Nurse Administrators to hold a joint Congress at Broadbeach in Queensland, attended by over 800 delegates.

AHA maintained a high level of industry information for members. As well as a revamped Hospital Brief, a twice yearly publication called Bulletin Board commenced. In addition, the Association's video library had expanded to one hundred and forty titles.

In September 1989, John Morris resigned as Executive Director and was succeeded by Peter Read, who held the position until he was appointed Executive Director of Policy and Planning of Queensland Health in 1991.

John Blandford

Peter Read

Johnathon Tribe

Peter Baukderstone & Mark Liveris

The 1990s

1990 - 1991

At the 1990 Annual Meeting, Jonathan Tribe, Executive Director of The Royal Melbourne Hospital, was elected National President and Peter Baulderstone was appointed National Director in June 1991.

1992 - 93

Professor Mark Liveris, Deputy Vice-Chancellor (Health Sciences), Curtin University and President of the Board of Royal Perth Hospital followed Mr Tribe into the Presidential position for 1992-93. Dr Diana Horvath, Chief Executive Officer of the Central Sydney Area Health Service, then held the position for the succeeding two years. In 1992, Allan Hughes was elected to the Council of the International Hospital Federation, following the completion of the term of Dr Child.

At 30 June 1993, the membership had grown to 638 institutional members, 162 personal members, 53 associate members (health industry organisations not directly involved in health service provision) and six honorary life members. This growth in membership prompted the Association, in 1993-94, to reduce its membership fees by 12.5 per cent for all institutional members, fulfilling a pledge to return financial gains to members.

1995 - 1996

Ron Tindale, Deputy Chief Executive Officer of the Western Sydney Area Health Service, was elected National President in 1995. In his 1996 Presidential Address he alluded to the implications of the changes taking place in health service structures.

'Virtually all States are reorganising the scale of their management and governance units. The increasing political

significance of the health portfolio means that any government looks for board members who endorse their objectives and priorities. The same holds true for managers and anyone who is a senior government employee or appointee. The most knowledgeable, dedicated managers have the most responsible positions in their own organisations - with all the associated work pressures. Government needs their insights into health management, financing and delivery problems – either through bodies like AHA or as direct members of committees and working parties. These people have the breadth of knowledge; the grasp of detail; and the personal credibility to make a real contribution to improving the organisation of our health system. [I suggest that] Government, and bodies like the AHA, must rethink how they build their input into decision making processes.'

He also recommended that AHA give greater consideration to collaborating with other representative bodies (including co-location) to achieve economies in sharing overhead costs, increasing utilisation of external consultants for specified research or policy development and concentrating on those issues which were deemed to be of the most significance to public hospitals and health services.

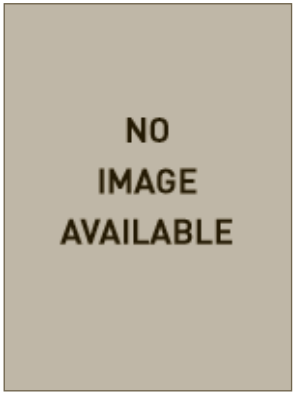
On 9 December 1996, the Association's name was changed to the Australian Healthcare Association. The move recognised that the nature of health service had changed, with the restructuring of hospitals and other entities as components of area health services, networks and regional services. This new aggregation of services aimed to provide integration and co-ordination across a wide spectrum of health services for a designated population.

1997 - 1998

Peter Baulderstone resigned as National Director in June 1997, having occupied the position for six years. His replacement, Professor Don Hindle, commenced in October of that year. At the 1997 Annual General Meeting, John Smith, Chief

Ron Tindale

Don Hindle



Mark Cormack

Allan Hughes

Executive Officer of the West Wimmera Health Service in Victoria, was elected National President.

From 17-21 November, 1997 Australia hosted, for the second time, an International Hospital Federation Congress. The event was held in Melbourne and included eighty speakers and around 1,300 delegates. The Australian Organising Committee was chaired by Allan Hughes.

In 1998, Ron Tindale replaced Allan Hughes on the IHF Council.

At the 1998 Annual General Meeting, John Smith voiced some concern about the financial implications to the Association of the changing membership base:

'The aggregations of many hospitals and health services have resulted in fewer member entities with consequent pressure on State Associations to reduce membership fees for these aggregated services. In turn, these reductions impact on the AHA at a national level and the services that it can provide. National Council has worked hard to ensure that AHA responds appropriately to these pressures by establishing priorities, developing business and financial plans and working closely with the States to provide effective services and representation for the membership.'

1999 - 2000

Don Hindle, who had been National Director since October 1997, resigned in February 1999, being succeeded in June of that year by Mark Cormack.

In November 1999, Allan Hughes, Chief Executive Officer of Ballarat Health Services, but who had been the Chief Executive Officer of the Victorian Hospitals Association from 1985 - 1995, became National President.

That year it was reported that the Association had reduced its staffing and overhead costs, returning a modest surplus for the year and stressing the importance of finding a balance between affordable membership fees and a value for money range of membership products and services.

1986–2000: National Reviews and Enquiries

Throughout the years from 1986 to the end of the century, the Association participated in, or presented its views to, numerous government reviews or inquiries, and made submissions to authorities on a diverse range of subjects of importance to members. Apart from those related to health service financing, some examples from the 1990s are:

1990 - 1991

Inquiry into the Export of Health Services by the Australian Industries Commission Pharmaceutical Benefits Safety Net Committee

Review of Structure of Australian Council on Hospital Standards

1993 - 1994

Review of Funding of Clinical Training in the Health Professions

Submission on Public Pathology Funding

1994 - 1995

National Review of Nurse Education in the Higher Education Sector

Council of Australian Government (COAG) review of government roles and responsibilities in health

Inquiry into the Supply of Medical Specialist Services

National Strategy for Management Development in the Australian Health Industry

1996 - 1997

Submission of views and lobbying in relation to threats to the public benevolent status of health organisations

1997 -1998

Submission to the Federal Government on Indigenous Health

1999 - 2000

Senate Inquiry into Childbirth Practices

National Electronic Health Records Task Force

House of Representatives Substance Abuse in Australian Communities Inquiry

National Strategy for an Ageing Australia

Review of National Rural Health Policy

The New Millennium

2001 - 2002

Early in 2001 the Hospitals and Healthcare Association of South Australia was incorporated into the AHA as a state branch. This followed a unanimous decision by members at the Association's final meeting in May 2000. AHA maintained a staffed branch that would continue to provide direct service to South Australian members until 2004.

In September 2001, Deborah Green, Chief Executive Officer of the South Eastern Sydney Area Health Service, was elected National President. Dr Owen Curteis became the AHA representative on IHF, following the untimely death of Ron Tindale.

Also in 2001, the AHA began its affiliation with the Asian Hospitals Federation. Dr Curteis has taken on the responsibility for representing AHA on the AHF ever since.

During the succeeding months the medical indemnity scene in Australia reached a crisis point with the imminent collapse of Australia's largest medical indemnity insurer, UMP. The Prime Minister called a national summit in April 2002, at which the AHA was a participant. The AHA's major concerns in this area were the management of clinical risk, improvement of quality management processes, and a more open approach to the management of adverse incidents. This was intended to lead to a national education and training program and its eventual incorporation into accreditation and risk management protocols.

These years also saw a major focus on workforce issues, with two concurrent national enquiries into the shortage of nurses. These were the Senate Community Affairs Inquiry into Nursing and the National Review of Nursing Education. The AHA provided input to both emphasising, among other things, underlying demand issues, the need for nationally consistent workforce planning and training approaches and the importance of sound partnerships between the industry and the tertiary education sector.

AHA's on-line services to members had increased with the expansion of new technologies. Following a major upgrade of the web-site in 2002, a fuller range of information and services was made available, such as up-to-date information on AHA activities and policies, breaking news, AHA publications on-line, including *Australian Health Review*, a comprehensive listing of industry events and conferences as well as specialised services such as:

- Just Health Consultants, a consultancy network;
- Just Health Jobs, the health sector's own jobs vacancies site; and

- Just Health Tenders - Australia's largest site for health tenders (no longer provided).

2003 - 2005

2003 was a year of radical change in the modus operandi of the Association. The apprehension concerning membership raised by Ron Tindale in 1996 now assumed the status of reality. All states were moving to amalgamate hospital and health services into larger regional governing bodies, resulting in a smaller number of members or potential members. With these amalgamations, boards were abolished in most states in favour of governance by CEOs, responsible directly to the state health department. Faced with ever tightening budgets and policy restrictions imposed by centralised bureaucracy, the capacity of CEOs to be active members of their industry association was threatened.

Furthermore, the level of membership fees previously received from individual hospitals and health services could not be sustained when aggregated into one fee from all services in the region. The necessity to discount created a revenue challenge for the Association, which was further exacerbated by growing competition from other representative bodies in niche areas of the Association's market.

To adjust to this situation, the National Council decided to implement a major restructure in order to reduce costs and consolidate assets, including sale of the buildings in the Australian Capital Territory and South Australia. This was facilitated through reducing staff and outsourcing membership, administration and corporate support functions to state associations in New South Wales and Victoria.

On 30 June, 2003 settlement occurred for sale of the building at 42 Thesiger Court, Deakin and the National Office took a sub-lease in the premises of a Canberra-based firm, Client Solutions, at the same time engaging that firm in a consulting capacity for support in areas such as strategic

AHA 42 Thesiger Court, Deakin

AHA 42 Thesiger Court, Deakin

Prue Power

campaign management, high level representation, specialist policy advice and media communications.

The underlying rational behind the restructure was to consolidate operations by better coordinating all parts of the AHA family, harnessing the skills within the Association and creating greater capability to focus on policy development and high level lobbying. The aim, as always, was to influence the policy agenda of governments and bureaucracies in the interests of members.

During the year, Prue Power was appointed National Director (now titled Executive Director) following the resignation of Mark Cormack.

By the end of 2003, the Victorian Healthcare Association had received the AHA's library material and the Health Services Association of New South Wales was working with AHA to set up a cooperative relationship on matters relating to Council, Congress and management of the Australian Healthcare Review. A number of smaller savings strategies were also implemented, such as reducing the number of face-to-face Council meetings.

Over the next year or so, AHA was able to rebuild its resources and the out-sourced functions were restored to the National Office. Consequently, additional staff members were gradually appointed necessitating a move to the Association's current office at 99 Northbourne Avenue, Canberra.

2004 - 2005

In July 2004, the AHA gathered together a group of highly esteemed professionals in the health system and related areas, this being the inaugural meeting of what has come to be known as the AHHA Think Tank. The group's purpose is to discuss, analyse and recommend innovative policy solutions relating to the health system, with a view to these proposals being presented to government. The group meets at four monthly intervals and is

becoming nationally recognised and respected as an influential voice in the making of Australian health policy.

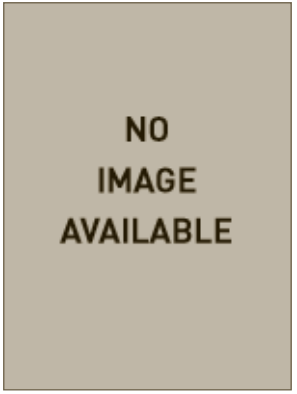
Several changes to the AHR saw a new Editorial Board established and a 'new-look' AHR published (30 September 2004) together with a matching webpage providing greater accessibility to users. An online manuscript submission and tracking system went live on the day of publication.

The AHA's newsletter, *HealthCare Brief*, was also published in a new format during the year and the circulation of the popular weekly *e-HealthCare Brief* continued to expand.

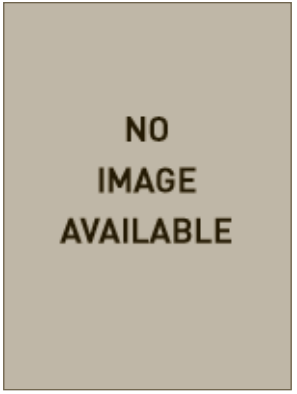
The 2004 Federal Election (9 October) focused the AHA on developing a comprehensive policy position on behalf of the public health sector, including an Election Report Card which analysed the health policies of Labor, Coalition, Greens, Democrats and Progressive Alliance. During the campaign, AHA joined the Australian Medical Association, Catholic Health Australia, Australian Salaried Medical Officers' Federation, Australian Nursing Federation, Royal College of Nursing Australia, Australasian College of Emergency Medicine and Australian Society of Geriatric Medicine in calling on the Federal Government and the Opposition to set a course for the long-term sustainability and efficiency of the nation's public hospitals. The groups sought greater cooperation between the Commonwealth and the States and Territories to deliver better public hospital services to Australian communities and patients.

On 1 July 2005, the AHA took over direct responsibility for New South Wales members following a decision of the NSW Health Services Association to relinquish its State Association status.

At the 2005 Annual General Meeting, Deborah Green completed a four year term as National President and was succeeded by Dr Stephen Christley, the Chief Executive, Northern Sydney Central Coast Area Health Service. In that year, Dr



Deborah Green



Dr Stephen Christley

Owen Curteis completed his term of office on the IHF Council and was succeeded by Professor Helen Lapsley.

In 2005, AHA received a grant from the Australian Council of Safety and Quality in Health Care to undertake a project called the *AHA Safety and Quality Communication Project* which included a series of very successful workshops on the *National Standard Credentialling and Defining the Scope of Clinical Practice* convened during October-November 2005 in every state/territory. The AHA worked in partnership with the state and territory health departments to conduct the workshops in each of the eight capital cities. Feedback received from participants was overwhelmingly positive, with over 90% of evaluation responses rating the workshops overall as either good or excellent.

2006 - 2007

During the first half of 2006 both the Victorian Healthcare Association and the Healthcare Association of Western Australia also relinquished their State Association status. These changes reflected the widespread changes in health service structures alluded to earlier and resulted in the Association, once again, radically altering its structure.

Consequently, as from 1 July 2006 the AHA, through the National Office and its state branches, has had direct responsibility for recruiting members in every State and Territory, as well as for delivering the full range of services and the Association's Constitution was changed to reflect this restructure.

Subsequently, the AHA activated an intense, and successful, recruitment campaign in 2006 – 2007 which resulted in a new state-wide category of member. The Queensland Department of Health set the example and South Australia, Tasmania, the Australian Capital Territory and the Northern Territory followed suit.

Thus the current membership structure once again resembles the original structure of the Association when it was founded sixty years ago, with the exception that many of the current institutional members are much larger corporate bodies, including area/regional health services and even state departments.

With this 2006 Constitutional amendment, the Association also made important changes to its governance arrangements. The five-member National Executive became the governing body, now known as the National Board, legally responsible for the ongoing administration of the organisation, facilitating the National Council to concentrate on the Association's policy agenda.

As this booklet goes to print, AHHA is once again actively engaged in two events that have galvanised the Association in the past. They are the 2007 Federal election campaign and planning for the 2008 Australian Health Care Agreements. AHHA has created Policy Think Tanks to ensure the expert views of members are reflected in our policies.

2000 - 2007: National Reviews And Enquiries

Since 2000, the Association has continued to participate in government reviews and inquiries and has made submissions on a diverse range of subjects of importance, including the following:

2000 - 2001

Australian Taxation Office - Health Industry Issues

Review of Collaboration of Primary and Community Health

2001 - 2002

Review of the Trade Practices Act and Doctors in Rural and Regional Australia

Review of Pathology Laboratory Accreditation Requirements

2003 - 2004

Submission on behalf of biomedical engineers for concessions under the Therapeutic Goods Act

Submission to ensure continued funding under the Medicare Benefits Schedule of certain Hyperbaric Oxygen Therapy treatments

2004 - 2005

Productivity Commission Study on the Impact of Advances in Medical Technology on Health Care Expenditure

Senate Select Committee on Mental Health

Australian Health Ministers Advisory Council Review of Future Governance Arrangements for Safety and Quality in Health Care

2005 - 2006

Productivity Commission Health Workforce Study

Submission on the proposed Australian Health and Social Services Access card.

2007

Australian Commission on Safety and Quality in Health Care Review of Accreditation

The Association And Health Financing

Barry Catchlove

Hospital Funding

1985

Since its inception, the Australian Hospital Association has continually focussed on the financial limitations imposed on hospitals by the various forms of funding of the health system. In his 1985 - 1986 Presidential Report, Dr Barry Catchlove commented that:

> *'The organisation and funding of health care is in turmoil throughout the Western World. Governments of all persuasions are searching for solutions to what are in fact near insoluble problems given the economic constraints of the late 'eighties. These problems are being made worse by continual and real reductions in hospital funding. In the past, elections have meant new hospitals and services; today they usually mean a reorganisation and further cut-backs. The system is becoming tired of reorganisations, expert consultants, and associated costs, while the real problems facing hospitals and health care remain the same.'*

He referred to nurse shortages and bed closures as critical issues across the nation (due in considerable measure to the transfer of nurse education to colleges of advanced education and the introduction of the 38-hour working week). On the positive side, he observed the moves towards decentralising decision making to give hospitals, areas and regions more autonomy; as well as experimentation with alternative delivery and performance measurement systems.

1986

In its *Health Services Monograph No.33* of June 1986, the Association noted that factors contributing to the escalation of costs included changes in the numbers and types of patients being treated. Patients were becoming older and sicker, requiring more intensive treatment. The trend was demonstrated by the increasing proportion of patients with multiple diagnoses; an increase in the number of patients requiring admission to intensive care units; higher mortality rates; and longer lengths of stay for certain patients.

Earlier in February of the same year, significant press and television publicity was given by the Association to the financial problems faced by the nation's health services; the aim being to influence decisions made in relation to the preparation of the 1986 - 1987 Federal Budget and the impending renegotiation of the Medicare Agreements on cost sharing between the States and the Commonwealth.

In particular, the Association recommended to Government that urgent attention be given to funding public hospitals through a performance based mechanism, such mechanism taking account of changes in the volume and kind of work being done. Other emerging issues at the time were the impact on hospital costs of the devaluation of the Australian dollar; the shortage of nursing home beds (leading to 'blockage' of beds in acute hospitals); the impact of the AIDS epidemic; and an estimated additional cost of $200 million arising from the introduction of a recognised career structure for nurses in clinical areas.

The overall operating environment of public hospitals was illustrated by an AHA survey which revealed that, during 1985 - 1986, 59 per cent of hospitals were over budget; nearly a quarter had rendered beds either 'closed' or unavailable; two-thirds reported shortages of registered nurses; 45 per cent had too few salaried or visiting medical staff; 60 per cent of teaching hospitals had been affected by industrial disputes, as had 47 per cent of metropolitan and large country hospitals (the 'nurses dispute' in Victoria over pay and career structure had lasted 50 days).

When the contents of the new Medicare cost sharing Agreements were announced, the National Council noted that the general thrust of the Agreements accorded with the Association's policy in relation to specific purpose grants, although there was some concern over the general level of funding and the low Commonwealth commitment to capital works. There was still no nexus between service demand and funding, but the Association was pleased to note that the Commonwealth had made funds available for the development of cost-based case-mix systems.

The Association continued its representations to Government, strongly supporting the introduction of case-mix based payments for reimbursement of public hospital expenses.

1989

The difficulties associated with a deficit funding budgetary system were again stressed in the Association's submission to the Senate Select Committee on Health Legislation and Health Insurance, which opened its hearings in November 1989, as well as in its contribution to the concurrent Commonwealth Medicare Review.

These bore some fruit in that the Association received a grant from the Commonwealth Government to further develop case-mix funding for hospitals. Helen Owens was engaged to prepare a *Report on Quality Assurance Under Case-Mix Payment*; KPMG Peat Marwick acted as consultants to survey the use of computerised information systems in hospitals, with particular emphasis on product costing systems, and Health Solutions was engaged to prepare a basic information and education guide on case-mix through developing user friendly software that combined text, exercises and examples of case-mix information and its use.

1990

Peter Read, the Association's National Director, in an address to the Australian Institute of Political Science in August 1990, had hinted at a hopeful promise of things to come:

'….hospitals where there are proper information systems which allow managers to identify problem areas by intra- and inter-hospital comparisons; hospitals where managers know how much treatment does cost and more importantly how much it should cost; and hospitals where the incentives encourage efficient high quality care and where payment received has some relevance to the cost of treatment given.'

1991 - 1992

In his Presidential Reports in 1991 and 1992, Jonathan Tribe succinctly described the situation hospitals found themselves in at that time:

'Most health care providers are familiar with political statements of the type - 'the government today announced a 3 per cent reduction in hospital budgets, but the Minister for Health stated that efficiency gains would mean that the level and quality of services will be maintained'.

'Governments frequently 'buy off' industrial disputes without acknowledging the costs this forces hospitals to bear.....The Federal Government's Medicare policy gives little encouragement for people to take private health insurance and the level of private cover had declined to 43.5 per cent of the population by June 1991. This is a 3.5 per cent reduction or 222,000 fewer Australians with private cover than three years ago. Private health insurance is important to public hospitals in two ways. Firstly, it provides about $600 million in revenue from private patients treated in public hospitals. Secondly, it reduces service demands by funding $1,200 million

for treatment in private hospitals. While governments have been mostly opposed to greater private funding of health services on equity grounds, they are also reluctant to indicate where the priorities for publicly funded health services should lie.

'Regrettably, the continual 'talking-down' of the public hospital system is a key feature of debate about publicly funded health care. Politicians, the media and health insurance funds, amongst others, seem to delight in denigrating public hospitals' performance as a justification for pursuing their own ends. They appear to have lost sight of the tremendous increases in hospital productivity and efficiency and the advances in technology which have occurred. A more balanced appraisal of our system is required to allow a more appropriate consideration of constructive alternatives to the way our health system is currently managed.'

These Presidential remarks presage future changes in the structure of health services throughout Australia, as well as the increasing attention the Association would give to the impact on service provision of the steady decline in revenue received from privately insured patients.

By 1992, waiting lists in public hospitals had increased and the level of private health insurance continued to fall. The National Director's Report for 1992 pointed out that this meant that two million more Australians were now relying on public hospitals for treatment than five years previously.

In March 1992, the Association joined with the Private Hospitals Association of Australia to launch what was called Operation: Hospital Survival stating that:

> *'…while our constituency and objectives are not identical, there was mutual concern that the current Medicare arrangements and declining health insurance levels were adversely affecting both public and private hospitals.'*

The document published jointly by the two associations, titled *Time To Act* pointed out that, among other things, public hospital productivity had increased substantially – for example, in Victorian public hospitals the number of patients who were treated had increased by 24 per cent between 1986 - 1987 and 1990 - 1991, despite severe funding restrictions. Here, the limited funding growth during the period was absorbed by wage increases rather than by application to resources which would expand the capacity to treat more patients.

Waiting lists had increased by 30 per cent over the four year period. Public hospital stock and equipment had fallen below acceptable levels with less than 2 per cent of the health dollar being of a capital nature. While the more complex public hospitals were operating at over 85 per cent occupancies, the major private hospitals were relatively underutilised with an average occupancy of 65 per cent. This reflected the fall in the level of private health insurance to 37.5 per cent of the population in December 1991. It

was also noted that the Commonwealth Government's National Health Strategy paper had found that a large proportion of 'high' income people did not have private health insurance.

The joint AHA-APHA document recommended a radical modification to hospital funding. Low income earners would continue to be covered by Medicare without paying a health insurance levy. If they chose to take out private health insurance they would receive a $200 rebate from the Government. Overall premium rates for private insurance would be sufficient to cover treatment in either a public or private hospital. The level of premium required was not specified but it was suggested personal contributions be subsidised by Government, with the amount of subsidy falling as personal income increased; high income earners receiving no subsidy. Apart from low income earners, all others would incur a tax penalty if they did not take out private health insurance.

The scheme was intended to achieve virtual full cover of the population and to introduce a more equitable progression of premiums in relation to income. All private patient care in public hospitals would be funded by private health insurance and the public beds would be funded by state government subsidy, under a cost sharing agreement with the Commonwealth.

In April 1992, the national directors of the AHA and the APHA visited health ministers and opposition spokespersons in all states. Strong representations were made about the problems facing both public and private hospitals. Almost all politicians accepted the associations' analysis of the problems; although not all believed that a greater role for private health insurance was an effective solution.

1994 - 1995

In their policies for the 1994 federal election, neither the Government (Labor) nor the Opposition (Coalition) undertook to pursue the difficult task of restructuring public-private and Commonwealth-State responsibilities in health. This was seen by the Association as a missed opportunity, given the level of inquiry and advice both parties had been subjected to during the Government's term of office.

Medicare grants to public hospitals in 1994 - 1995 were limited to an increase of only 2 per cent even though Commonwealth spending for its own-purpose programs rose rapidly (Medicare benefit increased by 10 per cent and pharmaceutical benefits by 12 per cent). Diana Horvath, in her National President's Report of that year commented that:

> *'…..the problem for both the Federal Government and Opposition, as well as for many professional groups, is that they are locked into a health care paradigm that existed for a few decades in the 1950's, 1960's and1970's. Medicare and Medibank were largely borrowed from the Canadian national health insurance reforms of the 1960's - when ready access to doctors and hospitals was*

regarded as the main requirement of good health policy. For the opposition parties the answer is mostly more of the same, but with greater private funding to replace taxpayer spending. Modern health care has moved onward from that time, both technically and socially. Birth centres, keyhole surgery, positive health education, day admissions, cancer chemo-therapy and other acute care delivered largely by nurses through hospital-in-the-home programs are all changes that do not sit well with existing medical and hospital financing structures. The AHA must focus its priorities clearly on a seamless health system that exists well beyond hospital walls and boundaries.'

1996

Following its accession to government in 1996, the Coalition introduced a rebate incentive scheme to encourage a higher uptake of private health insurance. Of particular concern to the AHA at the time of its introduction was the intention of the Government to introduce a 'claw back' provision to the Australian Health Care Agreements which meant that the level of Commonwealth funding to the States would fall if the level of community participation in private health insurance rose beyond certain defined percentages. The Association's position was that, even if a higher participation in voluntary insurance occurred, disincentives for the insured to use their insurance should be minimised. The existence of medical gaps, lack of informed financial consent and high excess policies all served to discourage policy holders from using their health insurance. This had significant revenue consequences for the public hospital system and would work against the stated aim of reducing pressure on public hospital beds.

Another potential initiative of the new Government was its intention to remove the sales tax exempt status from public hospitals. The AHA lobbied very strongly against this move. Fortunately the decision was reversed prior to implementation, thus avoiding a massive increase in public hospital costs.

1998

In 1998, the Association published *Redesigning the Future: An Australian Healthcare Association Discussion Paper on Health Policies for Australia*. This was regarded by the Association (which had recently changed the word 'Hospital' in its title to 'Healthcare') as a key document in furthering the future debate on health

policies. It was proposed, among other things, that there should be discussions at senior government and health provider levels of issues such as:

- The method of funding the health system (including a review of whether a separate Medicare levy within a general taxation system was still relevant);
- The length and comprehensiveness of planning negotiations and consultations relating to renegotiation of cost sharing agreements;
- The desirability of integration of capital and non-capital funding processes - both on a short term and long term basis; and
- Whether groupings of health providers, to be termed Integrated Care Providers, should be established, through which all funding should be channelled.

2000 - 2001

The Government finally introduced a deadline of July 2000 for people to take up Lifetime Cover at the base rates of contribution. In March 2000, private health insurance membership had fallen to only 32.2 per cent of the population. The following September quarter showed a marked jump to 45.8 per cent.

In the 2001 - 2002 budget, the Government formalised a decision not to enforce the 'claw back' provisions that would otherwise have led to a reduction in grants to the States of $990 million per annum.

Australian Health Care Agreements

(Formerly The Australian Medicare Agreements)

Throughout the two decades from 1986, the Association had persisted in its efforts to achieve changes to the Australian Health Care Agreements which would ensure more funding certainty for public hospitals and an extension of the scope of the agreements to encompass the totality of Federal and State health programs.

The Agreements did not reflect joint responsibility for an integrated health system - what the AHA called a 'National Health Care Package'. Such a Package would set down protocols for guaranteed access to services currently delivered by both Federal and State governments including: emergency and admitted care in public hospitals, inclusive of appropriate after-care and diagnostic services; primary and specialist medical care through the Medical Benefits scheme; pharmaceutical products; dental care; mental health services; care for the aged (both residential and community based); and community / primary health care.

In 2002 - 2003, prior to the implementation of the current cost sharing agreement, the AHA conducted a national series of seminars for member organisations and key industry stakeholders to provide an analysis of the Australian Healthcare Agreements and to provide an opportunity for the industry to identify national priorities, future directions and incentives for service improvement in the development of the 2003-2008 Agreements.

It is interesting to note that, even as this summary of Association activities is being compiled in mid 2007, the State health ministers are criticising the Commonwealth for short changing them on funding under the cost sharing agreement. Despite considerable and lengthy tendering of advice, the wheels of change in this area 'grind exceedingly slow.'

The AHA And The GST

Around the turn of the century was the time when the Commonwealth Government's Goods and Services Tax (GST) was in the final stages of refinement and implementation.

The Association had hoped that the introduction of this tax might benefit hospitals and health services because of the growing revenue base to the States arising from the intergovernmental agreement on tax distributions. In this regard the Association and its members were perhaps too optimistic!

The legislation provided for hospital and health care services to be GST free to patients. For the industry this required implementation of a complex administrative and business practice change regime that came into full effect on 1 July 2000.

The AHA assisted the industry in a number of ways. It published and distributed GST and Health with input from Blake Dawson Waldron Lawyers. This was the first detailed guide to the legal and business implications of the new tax system produced for the hospital and healthcare industry. With the support of the Commonwealth Treasury, the AHA, in conjunction with its affiliated state association, the Healthcare Association of Western Australia, delivered a comprehensive package of educational material and advisory services. This included an Australian Taxation Office approved *Business Skills Guide for the Hospitals and Healthcare Sector*.

In addition, the AHA delivered 43 seminars in all States and Territories in rural and metropolitan areas. They were attended by more than 1,400 representatives of healthcare organisations. The seminar program was a collaborative effort with the Australian Private Hospitals Association, Women's Hospitals Australia and the Australian Association of Paediatric Teaching Hospitals. The seminars were greatly appreciated by participants and evaluations indicated that they had assisted organisations to prepare for the new tax system.

The Australian Taxation Office also established a Health Sector Consultative Committee, which worked with the AHA and other national health industry bodies to develop consistent rulings and interpretations of the legislation. On behalf of the industry, the AHA was able to provide guidance and advice to the ATO in the development of its official interpretation of the legislation. This was released towards the end of the financial year and represented an authoritative, yet practical, set of guidelines for members.

The AHA And The FBT

In partnership with other health organisations the AHA was also active in lobbying and advocacy throughout 1999 - 2000 in relation to the implications for members of the Fringe Benefit Tax (FBT) Reforms. Part of this involved the publication of *A Guide for the Health Sector* amendments to Fringe Benefit Tax legislation. It was widely distributed to the health and community sector and galvanised a national response to the impacts of the proposed amendments.

The new FBT legislation had significant implications for the public healthcare industry. The capping of FBT exemptions for salary packaging arrangements pertaining to public hospital and healthcare organisations represented a substantial financial and industrial challenge for the industry. With bipartisan political support for the Government's legislation it was a difficult task to successfully lobby for the legislation to retain the FBT exempt status of the public healthcare sector.

The focus of the AHA's advocacy efforts was, therefore, on compensation for the impact of the new legislation on the public healthcare sector. While the introduction of the FBT cap became law, a $240 million package of compensation for the public and not for profit sector was announced in the subsequent 2000-2001 budget. Although the result did not reflect the hoped-for outcome, it was a significant improvement on the original Government position. Definitions of 'hospital' in the legislation also enabled some community health member organisations and rural services with a significant percentage of aged care activity to receive a higher exemption level for FBT than that available to most hospitals.

The Association's Services and Activities

Association Publications

Over the years the Association's publications have provided valuable information to members as well as serving as background material for many of the discussions and debates occurring in the wider community and in government concerning health policy and financing.

The flagship publication is *Australian Health Review*, now in its twenty-ninth year. The journal aspired, from its commencement, to be the major academic journal in Australia for articles relating to health policy and management practice, publishing peer-reviewed articles based on empirical studies. It is published quarterly and has maintained a consistently high standard since inception, this standard being nurtured by a number of excellent editors and guest editors, the latter generally being invited to oversee issues devoted to a particular theme. A list of editors is shown in Appendix C.

In 1986, the *Australian Health Review* was accepted by Excerpta Medica for inclusion in its abstract service. In 2007, AHR was selected for coverage in the Science Citation Index Expanded (SCIE) of Thomson Scientific. The goal of Thomson Scientific is to cover 'the world's most important and influential research'. The journals they select meet standards for publishing, editing, diversity and citation data. AHHA was proud that A*ustralian Health Review* received this recognition. In addition, a journal covered in the SCIE receives an impact factor and *Australian Health Review* will get its first impact factor in 2009. Impact factors are calculated by the Institute for Scientific Information and published in the Journal Citation Reports. The impact factor is calculated by dividing the number of citations in the tracked literature that a research journal receives, by the number of articles it publishes.

Academics and authors are more likely to publish in journals with higher impact factors.

The journal is now available on-line and it has a wide range of subscribers among those involved in health service management, health policy development and universities and colleges providing education and training in health management and service provision.

The other long standing regular publication of the Association is the *HealthCare Brief* (originally called *Hospital Brief*). In February 1993, a 'new look' Hospital Brief was published which combined the news from the old *Hospital Brief* with the more in-depth articles from the *Bulletin Board*. It was considered this better met the needs of both the hospital executive and board member readership. Multiple copies were

circulated to all institutional members. Like *Australian Health Review* it is now available on-line.

Until December 1998, irregular *Monographs* and *Key Issues Papers* continued to be published by the Association when serious analysis, review or discussion of particular subjects was required. Since that time topics requiring special attention have tended to be published as 'stand alone' documents under their own subject heading. One such document was the *Waste Audit Manual*, prepared in 1994 after successfully tendering for a grant from the Commonwealth Environment Protection Agency.

A successor to this consultancy was the production, in 1997, of the first edition of the *Greenhouse Challenge Healthcare Workbook*, prepared by Energetics Pty. Ltd in collaboration with the AHA. The Association was the first health organisation to assimilate information about the environment and produce it in a readily accessible form.

The project was the outcome of a facilitative agreement with the Australian Government, acting through its Greenhouse Challenge office. The Association committed itself to encouraging and assisting its members to participate in Greenhouse Challenge, and to raising general awareness within the industry of greenhouse issues. A Hospitals Greenhouse Challenge Project Officer was located at the AHA premises to support both public and private hospitals in entering into cooperative agreements relating to the monitoring and reduction of emissions.

The *Board Member Education Kits* have been another long standing and popular publication. Their purpose is to provide board members with a detailed understanding of their role, the structure of the health system and a range of practical guides to assist them in performing their important duties. The format enabled ongoing update, refinement and addition of new modules as the need arises. With the abolition of most public sector boards in Australia, these Kits have become less relevant. They will be replaced in 2008 with the addition of a special Governance Section in *Australian Health Review* targeted at senior managers and clinicians in today's workplaces.

Association Services

The Association continues to provide a wide range of services to its members including the following:

- National congresses which, over the years, have drawn large attendances and have featured an outstanding array of speakers;
- Lobbying to government on many issues, both small and large - such as recent representations on the standardisation of oxygen cylinder outlets and the implications for capital and development funding of loss of public hospital charitable status;
- Dissemination of a variety of publications (in hard copy and on-line);
- Facilitation and conduct of workshops and seminars;
- Representation of the Association on numerous government and other bodies;
- Retention of Australian representation on the Council of the International Hospital Federation;
- Participation as a member of the Asian Hospitals Association;
- Promotion and demonstration of good practice through its community outreach and innovation awards;
- Recognition of outstanding service to the health field through its annual awarding of the Sidney Sax Medal, and
- Collection of information and views from members.

Conclusion

The Association's contribution to the development of health policy in Australia has been significant. Over the years the essence of many of its comments to Government have been noted and adopted. Its paramount concern is, of course, to ensure that health services receive due recognition and financing in the face of the many competing demands placed on governments. Such concern will no doubt carry it forward in harmony with its stated Vision of ensuring that:

All Australians have access to effective health services of high quality that are appropriate and responsive to their needs and coordinated across all settings (home, residential facility or hospital) and that the services are efficiently delivered by capable personnel and adequately resourced to ensure sustainability and safety.

Appendices
Appendix A

A Synopsis Of The First 40 Years Of The Association

The story of the Association's first forty years is admirably covered by Mary Dickenson and Catherine Mason in their book Hospitals and Politics: The Australian Hospital Association 1946 - 1986. This story is encapsulated in the Appendix to their book and is titled Significant Events in the History of the AHA. An amplified version of that Appendix follows.

1946	Inaugural meeting of the Provisional Council of the AHA.
1947	First Annual General Meeting of the AHA. Dr H.H. Schlink elected President. In his foundational address Dr Schlink presented a theme that the AHA maintains today: *'The Australian Hospital Association wishes to serve the welfare of the nation by developing methods and programmes for making better hospital care available to all.'*
1948	Commonwealth benefit of six shillings per patient per day increased to eight shillings; but hospitals still consider this to be inadequate.
1949	International Hospital Federation (founded prior to World War II) resumed activities after a wartime suspension of activities and AHA joined. First issue of the Association's journal *Australian Modern Hospital* published. Visit by Edna Huffman, a medical records expert from the USA. She provided a report to AHA, conducted a training program, and stimulated the development of training for medical record librarians.

1950	AHA submission to the Federal Government on the provision of a National Health Financing Scheme (the Earle Page scheme based on voluntary insurance). The Association endorsed voluntary insurance, sought direct Commonwealth capital funding and the establishment of a body to 'control and standardise' hospitals throughout Australia, but recommended that hospital boards be entirely independent of government. A scheme for rating of hospitals on a 'points' system trialled in Melbourne and Sydney.
1952	Visit by R.J. Stull, an expert in hospital administration from the University of California, sponsored by AHA, to report on teaching hospitals in Australia. Stull delivered a scathing report on obsolete equipment, overloaded electrical systems, sub-standard casualty areas, inadequacy of physical facilities and patient care programs, and deficiency of student lecture rooms. He recommended post-graduate training in hospital administration, abolition of the 'honorary' system of medical staffing and that capital funding be provided, in large part, by the Commonwealth Government. John Plant, Victoria, proposed that AHA embrace the interests of non-teaching, as well as teaching, hospitals and that a national secretariat should be established in Canberra, but these views not encouraged by Herbert Schlink.
1953	Visit by A.E. van Steenwyk and W.S. McNary from the USA, sponsored by AHA and Federal Government, to promote private, non-profit voluntary insurance. A visit by Dr M.E. McEachern, Director of Professional Relations of the American Hospital Association and Professor of Hospital Administration at North-western University, Chicago (known as 'the father of hospital administration') to report on the financing of medical education, establishment of post graduate training in surgery, other clinical specialties and hospital administration; as well as hospital accreditation. He favoured institutional autonomy; the development of professional, group-based accreditation and assessment of clinical performance; voluntary insurance; private practice in public hospitals; and tertiary training in hospital administration.
1955	Last issue of *Australian Modern Hospital* published.
1956	First issue of *National Hospital* published.
1957	After some years of negotiation a post-graduate program in hospital administration at the University of New South Wales was announced, following a visit by Professor Gerhard Hartman of the University of Iowa, who advised on the framework of the course.

1958	J.B. Plant, a board member of The Royal Melbourne Hospital, succeeded Mr Herbert Schlink as President. Dr Edgar Thomson appointed Honorary Federal Secretary.
1959-60	Moves to establish hospital accreditation in Australia revived by the AHA Branches in NSW and Victoria.
1961	Hamilton Sleigh (later Sir Hamilton), also a board member of The Royal Melbourne Hospital, elected National President following the death of J.B. Plant. Dr Norman Rose, Medical Superintendent of Sydney Hospital, elected as AHA representative on IHF Council. Dr Rose died in office and was succeeded by Dr Edgar Thomson for the balance of the term.
1962	After many years of AHA lobbying, the Universities Commission initiated capital works funding for medical schools on a triennial basis and provided funds subsidising, to a minimal extent, identifiable running costs associated with under-graduate medical training.
1967	Royce Kronborg elected Honorary Federal Secretary and Treasurer. He remained Honorary Federal Secretary (later Executive Vice President) for seven years and made a major contribution to the revitalisation and development of the Association. Kronborg has noted that when he commenced as Honorary Federal Secretary, he was told by both Hamilton Sleigh and Edgar Thompson that there was such a mutual dislike between them that communication was virtually impossible - this was the probable reason for the lack of reported activity between 1961 and1967! Kronborg has also recalled that membership was small, total funds being a mere $15,000. Dr Edgar Thomson instructed him 'not to squander [the funds] as it had taken a long time to accumulate'. The task confronting Royce Kronborg was daunting if he were to develop the AHA into a strong, creditable and effective organisation. A vastly increased membership was required, representing a wide spectrum of hospitals throughout Australia; no mean task because the state health departments generally were opposed to the concept of a hospital lobby group.
1968	Visibility, credibility and finances improved when two hundred and forty delegates attended the Association's first national congress and trade fair, held in Sydney. Dr Edwin Crosby, Executive Vice President, and Dr George Graham, President of the American Hospital Association, spoke at the congress. A Joint Steering Committee on Hospital Accreditation formed with representatives of the Australian Hospital Association and the Australian Medical Association.

1969	Alastair Stephen, New South Wales, elected National President. Royce Kronborg elected to the Council of the International Hospital Federation.
1970	Robert Spivey appointed Office Manager. Membership base broadened considerably in the late 1960s. The International Hospital Federation Regional Congress was held in Sydney, with 840 delegates, including 120 from 24 overseas countries.
1971	Douglas Donald, Victoria, elected National President.
1972	AHA stimulated to develop new policy positions following election of Labor Government on a platform of major changes in health and social services.
1973	Sir Lincoln Hynes, New South Wales, elected National President. The newly established Hospitals and Health Services Commission provided $30,000 towards developing a system of hospital accreditation in Australia. AHA South Australian Branch established.
1974	Federal Council resolved to alternate the Presidency between board members and chief executive officers. Royce Kronborg, Victoria, elected National President. Trevor Elligett appointed as first Executive Director and a national secretariat established in Sydney. The Australian Council on Hospital Standards incorporated as a separate body, but with AHA representation on its Council. Errol Pickering appointed Executive Director of ACHS. A Bill was tabled in Federal Parliament to create a Health Insurance Commission to introduce universal health insurance. This was fiercely opposed by Opposition parties, ultimately resulting in an historic double dissolution and the Bill being passed by a joint sitting of both Houses. Royce Kronborg became a part-time Commissioner and ultimately Chairman in 1978 -80.

1975	Last issue of *National Hospital* published. It was succeeded by *Australian Hospital*.
1976	Douglas Davidson, New South Wales, elected National President. The Association incorporated under the Australian Capital Territory Companies Ordinance. The Australian Hospital Association Reference Centre established within the Biomedical Library at Monash University. Kellogg Foundation provided a three year grant of $149,000 in support of the Centre. This service continued until 1982 when AHA decided it was unable to continue external funding support. By then the Australian MEDLARS network had made on-line retrieval more available.
1978	Selby Steele, Victoria, elected National President. First issue of *Australian Health Review* published with Dr Barry Catchlove as founding editor. AHA Western Australian Branch established.
1979	Last issue of Australian Hospital with which AHA associated. Association makes major submission to "Jamison" Inquiry into the Efficiency and Administration of Hospitals.
1980	Dr Don Child, New South Wales, elected National President. Errol Pickering appointed Executive Director.
1981	International Hospital Federation Congress held in Sydney with attendance of some 1,000 delegates.
1982	John Gibbs, South Australia, elected National President.
1983	National Secretariat moved to Canberra. AHA Tasmanian branch established.
1984	Dr Barry Catchlove, Victoria, elected National President.
1985	Official opening of Association's own building in Canberra. Following completion of this building, the Association's total assets at 30 June, 1986 rise to $579,585

Appendix B

Association Presidents

1946 - 1958	Sir Herbert H. Schlink
1958 - 1961	Mr John B. Plant
1961 - 1969	Mr Hamilton M. Sleigh (later Sir Hamilton)
1969 - 1971	Sir Alastair E. Stephen
1971 - 1973	Dr C. Douglas Donald
1973 - 1974	Sir Lincoln C. Hynes
1974 - 1976	Mr Royce H. Kronborg
1976 - 1978	Mr Douglas C. Davidson
1978 - 1980	Mr Selby K. Steele
1980 - 1982	Dr Donald S. Child
1982 - 1984	Mr John M. Gibbs
1984 - 1986	Dr Barry R. Catchlove
1986 - 1988	Mr Keith Bagley
1988 - 1990	Professor John Blandford
1990 - 1992	Mr Jonathan Tribe
1992 - 1993	Professor Mark Liveris
1993 - 1995	Dr Diana Horvath
1995 - 1997	Mr Ronald Tindale
1997 - 1999	Mr John Smith
1999 - 2001	Mr Allan Hughes
2001 - 2005	A/ Professor Deborah Green
2005 -	Dr Stephen Christley

Appendix C

Association Honorary Secretaries and National (Executive) Directors

1946	Sir Norman Paul (Sydney) and J. Beacham Kiddle (Melbourne) – Honorary Secretaries
1947	Dr H.O. Selle (Sydney) and Colonel R.E.Fanning (Melbourne) – Honorary Secretaries
1956	Dr S. Hatfield - Honorary Federal Secretary
1958 - 1967	Dr Edgar Thompson - Honorary Federal Secretary
1967 - 1974	Mr Royce H. Kronborg - Honorary Federal Secretary; Executive Vice President
1974 - 1980	Mr Trevor Elligett (first salaried National Director)
1980 - 1987	Dr Errol Pickering
1987 - 1989	Dr John Morris
1989 - 1990	Mr Peter Read
1991 - 1997	Mr Peter Baulderstone
1997 - 1998	Professor Donald Hindle
1998 - 2002	Mr Mark Cormack
2002 - current	Ms Prue Power

Appendix D

Australian Health Review Editors

1978 - 1983	Dr Barry Catchlove (Foundation Editor)
1983 - 1984	Dr Johannes Stoelwinder
1985 - 1987	Jonathan Tribe
1987 - 1993	Chris Richards
1993 - 1994	Ros O'Sullivan
1994 - 1998	Dr Roy Green
1998 - 2003	Professor Don Hindle
2003 - 2006	Professor Judith Dwyer and Dr Sandra Leggat
2006 -	Dr Sandra Leggat

Guest Editors

John McLelland, Sidney Sax, P.W. Bates, Geoffrey Prideaux, Ray James, Colin Tyler, Eric van Beurden, Helen Owens, Chris Selby-Smith, David Dunt, Wayne Cahill, Julie Hamblin, Neil Henderson, Peter Baulderstone, Judy Lumby, John Deeble, John Smith, Vince Fitzgerald, Ian McAuley, Jeffrey Braithwaite, Francis Sullivan, Stephen Bolsin, Weeramanthri et al, John Pilla, Hans Lofgren

Appendix E

Recipients Of The Sidney Sax Medal

1986	Professor James Lawson
1987	Dr Donald Child
1988	Dr Ian Brand
1990	Dr Bernard Amos
1991	Professor John Blandford
1992	Dr Diana Horvath
1993	Mr Allan Hughes
1994	Dr John Deeble
1995	Dr Rex Joyner
1996	Dr John Yu
1997	Dr Owen Curteis
1998	No award in 1998
1999	Mr Ronald Tindale
2000	Dr David Watson
2001	Dr John Mulligan
2002	Dr Jack Sparrow
2003	Professor Stephen Duckett
2004	Professor Helen Lapsley
2005	Professor Brendon Kearney
2006	Professor Bruce Barraclough