The health workforce
How can the people who make up our workforce best meet the healthcare needs of the nation?

ALSO IN THIS ISSUE
- Insight from a graduate nurse’s first month on the job
- What’s wrong with primary healthcare?
- Inside the dental workforce

Arts and Health
We look at what role the arts can play in keeping patients and healthcare workers healthy and happy

Plus!
How do you manage difficult employees?
A brief history of the Royal Hobart Hospital
The social determinants of health
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As is often remarked, many people embark on careers in healthcare out of a deep passion to help others; to alleviate pain and suffering and to improve people’s livelihoods and well-being. To achieve these goals, more often than not, that means working with others – sometimes with similar skillsets, roles and outlooks; and, at other times, with seemingly incongruous priorities, responsibilities, and standards.

Managing oneself or others is a challenge in any workforce. In the healthcare workforce, the situation is heightened because of the stresses involved in having – sometimes literally – people’s lives in your hands. With the election looming in September, it seems only fitting, then, to dedicate this issue of The Health Advocate to the health workforce, as it is one of the most central, pressing and perennial issues in healthcare.

With input from a range of perspectives on what are the key issues and how they might be better addressed in the future, readers gain a broad understanding of the real world dilemmas facing Australia’s healthcare workers. Writers range from Health Workforce Australia, senior clinicians and managers, through to a graduate nurse in her first month on the job. As always, it is interesting to contrast the opinions and perspectives from administrative bodies to those on the frontline.

In other news, we are farewelling our Chief Executive, Prue Power, after nearly 10 years at the helm of AHHA. All of us applaud her dedication to our Association, which has developed in innovative and successful ways under her leadership.

On Tuesday 24 September, the inaugural Deeble Institute Symposium on Federalism and Universal Healthcare will be held in Canberra. Please keep this date clear and watch our website and e-healthcare brief for registration details.

Our Policy Think Tank diary is full this year, with some dates now settled and the others being firmed up as follows. If you are interested in joining any of these Networks, please contact the AHHA office.

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<td>Community and PHC Network Policy Think Tank</td>
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<td>20 June</td>
<td>Acute Care Policy Think Tank - performance monitoring in health care</td>
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<td>16 July</td>
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AHHA in the news

Medicine costs leave a bad taste in the mouths of Australians

The AHHA supported the call by the Grattan Institute for an overhaul of pharmaceutical pricing in Australia. International comparisons show that Australians are paying too much for prescription drugs. New Zealand has a fixed drugs budget and an independent expert panel to make decisions about how that budget is spent. As a result, wholesale prices are more than six time cheaper in New Zealand than in Australia. By adopting the New Zealand approach and reducing the cost of generic medications, Australia could save $1.3 billion a year.

Primary care services need structured coordination

All sides of politics need to commit to a structure framework for the coordination and integration of primary care services. The integration of primary care, community-based and acute hospital services is a critical component of an efficient and effective health system. Without a clear structure to oversee and coordinate the integration of services, we risk duplication of services and effort, and emergence of services gaps which will impact on the most vulnerable in the community. “It is important that details on how primary care services will be funded and coordinated under a Coalition Government are made available as soon as possible. The AHHA looks forward to discussing the Coalition’s proposals with the Shadow Heath Minister,” said CEO Prue Power.

HAVE YOUR SAY...
We’d like to hear your opinion on these or any other healthcare issues. Write to us at admin@ahha.asn.au or PO Box 78, Deakin West, ACT, 2600
The AHHA called for the Commonwealth to reverse its decision to cut hospital funding based on flawed population statistics and extend its funding injection from Victoria to all states and territories. The Commonwealth’s funding cuts were based on a flawed interpretation of population statistics and could result in a reduction in service level and quality in public hospitals. AHHA also disagrees with the Commonwealth’s use of the ‘The AIHW Health Price Index’ to assess the costs to states’ public hospitals. This index covers the entire spectrum of the health system and is consistently lower than the hospital-specific index.

Study calls for private health funds to stop ‘free riding’ on Medicare

A financial loop-hole in private health insurance policies is enabling health funds to ‘free-ride’ on Medicare, according to a new commentary published in the Australian Health Review. The Government’s strategy of giving all Australians access to free or affordable public healthcare, while supporting choice through private sector options, has created a loophole in the system that allows insurance funds to act as ‘free riders’ on the public insurer, Medicare. Many insured people exercise their right to use public hospitals without using their insurance. As a consequence, PHI companies can collect premiums from this group of privately ensured patients while avoiding any financial responsibility for their treatment in public hospitals.

Chief Allied Health Officer welcomed but dental services still lack leadership

The AHHA welcomed the announcement by the Minister of Health of the establishment of the position of Chief Allied Health Officer. This announcement provides long overdue recognition of the contribution of allied health professionals to the well-being of all Australians. The AHHA further believes that the time is due for the establishment of a Chief Dental Officer and a high level committee to provide advice and direction to Government oral health policy and service provision. Australia is the only country in the region that does not have a Chief Dental Officer or equivalent advisory body. There is a need for a body to provide regular advice on the design, implementation and progress of the Commonwealth’s dental programs, particularly given that the significant level of funds will be expended in the coming year.
A productive workforce is fundamental to how our health system is going to face the future challenges of providing services in an equitable fashion to those who need them, where they need them, and at a reasonable time and cost. The Australian Health Workforce Institute (AHWI) was established in 2009 broadly to provide independent evidence on these types of issues, as well as how we train the future health workforce to place greater importance on team care, including providing ever more care outside the hospital sector – both public and private.

Our initial aims were very broad but included: mapping future health systems; defining the sources and characteristics of potential health workers (from Australia and global sources); developing innovative and flexible models of health care; working with jurisdictions and the private sector to develop and implement health workforce policy; skilling future health workforce researchers; and ensuring an evidence base to inform health workforce policy. While these are all laudable aims, we have recently become more focussed on the following four areas.

How health teams work
Getting teams to work together effectively is hard, but it can be done. Evidence suggests that successful team-based models of primary care require a combination of inter-professional education and learning; organisational and management policies and systems; and practice support systems. Outcomes of implementing team-based models are also influenced by the type and level of team leadership; team composition and capability; shared objectives, communication, and decision making; funding which rewards teamwork; and regulatory mechanisms that support and value teamwork.

To ensure evidence is put into practice, we have proposed a framework comprising five domains (theory, implementation, infrastructure, sustainability and evaluation) to assist policymakers, educators, researchers, managers and health professionals in supporting team-based models of primary care within the Australian health care system.

International flow of health workers
Recent studies show that, as a nation, we are still reliant on overseas doctors and nurses to provide health services, particularly in the aged care sector and in rural areas.

From 2005-06 to 2009-10, 34,870 migrant health professionals were sponsored as temporary 457 visa migrants, recruited to pre-arranged jobs, with a 99% immediate employment rate. The fields of nursing (15,960) and medicine (15,490) predominated. A further 2,420 visas were awarded to temporary international medical graduates (IMGs) in 2010-11: 1,190 for general medical practitioners and 1,230 for Resident.
(House) Medical Officers (the majority new appointments). In 2010-11, most such IMGs were recruited to Victoria (600), NSW (540), Queensland (500) and Western Australia (280). From 2004-05 to 2009-10, 15,940 General Skilled Migration category migrants with health qualifications were also selected on a permanent basis, primarily qualified in nursing (8,250), medicine (2,330) and pharmacy (2,080). A further 460 doctors were approved for entry in 2010-11.

Technology enhanced health workforce

In this world of increased global flows of workers and information, we see mobile health (m-Health) as having the potential to revolutionise the way we deliver health services; the mobile phone is the ‘disruptive’ technology that might actually allow patients to play a central role in their own health care. We are currently involved in projects that are looking at how mobile phone technology can help manage chronic diseases (for example, diabetes). These technologies need to be properly evaluated, but they have great potential for monitoring patients in the community and reducing unnecessary hospital admissions.

New models of care

New models of care using a range of assistant practitioners working closely with other team members need to be trialled and the health practitioners of the future have to be able to work collaboratively and be trained in using simulation and other such technologies. It is an enormous task, but unless we get health workforce right – including how we pay – we will not be able to deliver all the exciting advances that the biosciences keep providing.

Conclusion

Health workforce transformation is a big task and one that needs groups like HWA, AHHA, Commonwealth, state and territory governments, workforce agencies and others to partner in research and recognise the importance of ‘wicked solutions’. In

Mobile health (m-Health) is just one of the technologies that may revolutionise the way we approach healthcare.
Primary Care: A heart with no home...

What is stopping the streamlining of the primary healthcare system?

All recent health reform reports, including the Federal Health and Ageing Department’s National Primary Care Strategy, explicitly identify the need to improve and increase the range of primary health care models within the healthcare system overall. Specifically, there is an expressed need to grow shared care models, develop integrated approaches and improve coordination and navigation, beyond the acute sector. These are to be underpinned by the knowledge, experience and entitlements of consumers.

Commonly, these needs and motivations are shared by primary and allied health care practitioners also. Rarely, if ever, does one encounter a physiotherapist, nurse, social worker or oral health therapist who does not seek (or lament missed) opportunities to integrate and coordinate care across the system. At its simplest, it is very often this motivation that brings us to the primary care sector in the first place.

The trends, pressures and barriers that prevent our skill and enthusiasm from translating into the most aligned, dynamic and efficient primary healthcare system possible, are widely documented. To a great extent, these are similar to that of the workforce generally: shortages and mal-distribution; requirements for skills development; ageing workforce; and growing demands for flexible work arrangements over the life cycle.

There are, however, some inhibitors to streamlining the primary healthcare system that are more specific to primary healthcare workers.

Although most primary and allied health care workers are expected to be highly trained, not to mention passionate and dedicated, this is rarely, if ever, matched by coherent and consistent employment and remuneration. Training opportunities are generally poorly aligned to available settings or models of care.

This makes career direction difficult to envisage, embark upon, and maintain.

While private practice can sometimes be made to match the income and flexibility required by the individual, other choices tend to be as fragmented and haphazard as our primary healthcare system is generally. This is especially the case where the motivation is a particular community of interest – the aged, homeless, refugees, those with chronic disease.

An individual may find a rewarding and supportive workplace in a specific primary care entity for a time (a community health centre, for example). However, attempting to determine a career pathway that allows for cross-sectoral, multi-disciplinary opportunity across the system can be much more difficult.

Typically, those who work outside the acute or private sector in integrated models of care – e.g. nurses, social workers, occupational therapists, physiotherapists, dieticians, oral health therapists – fall into their chosen setting or model rather than being supported to consider and plan for these opportunities as legitimate professional choices.

Consequently, staff often find it difficult to build on their knowledge and experience and contribute this to the system over time.

Without question, this is due to the fact that the system as a whole remains incoherent with regard to the place of primary care. As a consequence, career and educational opportunities remain misaligned, remuneration significantly below that of other specialist sectors, and job security and professional support poor.

This situation is made worse by virtually every relevant policy framework re-asserting that it is this very interest in specific populations and models of care that the system most needs.

One could forgive frontline staff their scepticism.
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* The draw will take place on 7 July 2013 and the winner of the iPad will be notified by email.
Health Workforce Australia

What is its role in meeting the healthcare needs of the nation?

Health Workforce Australia (HWA) is a Commonwealth statutory authority established in 2010 by the Council of Australian Governments. Its goal: to address the challenges facing Australia’s health workforce by delivering a coordinated national program of reform.

Currently, the health workforce is under tremendous pressure because of an ageing population, growth in chronic disease and increased community expectations. There are also challenges from rapidly changing technology; new approaches to training and education; an uneven distribution of the workforce; looming shortages in some professions and specialties; and entrenched work practices.

In 2010, Australia’s Health Ministers requested that HWA undertake a national workforce planning exercise, known as Health Workforce 2025 Doctors, Nurses and Midwives (HW2025). The findings were published in three volumes in 2012 and provided Australia’s first, long-term, national projections for doctors, nurses, midwives and medical specialties. The report found:

- A potential, national shortage of 109,000 nurses and 2,700 doctors by 2025 under current policy settings;
- The current training system has extensive bottlenecks and is inefficient;
- There will be insufficient postgraduate medical training places for the number of graduates seeking them;
- There is an uneven distribution of the medical workforce across Australia, which is affecting rural and regional communities;
- Australia will continue to remain highly dependent on migration of international health professionals; and
- A growing trends towards specialisation and sub-specialisation means there are not enough generalists to meet the healthcare needs of Australians, especially in rural and remote communities.

“We cannot afford to continue business-as-usual approaches. Reform is essential if we are to have a health workforce able to meet community needs... HWA will lead national work over the next two years to turn these policy responses into a program of tangible, robust reform.”

Mark Cormack, Chief Executive Officer of HWA

- Boosting productivity of the workforce and maximising their use;
- Improving distribution to ensure the health workforce is placed in areas and specialties where they are needed;
- Building the evidence base for health workforce reform through planning, research and evaluation;
- Providing leadership to influence national policy and programs on health workforce innovation and reform; and
Working in collaboration with governments and non-government organisations across health and education sectors.

In November 2012, Health Ministers approved a series of policy responses to address the issues arising from HW2025. They are:

**Improved productivity through workforce innovation and reform:**
- Develop evidence to inform a comprehensive national approach in response to the projected nursing imbalance; and
- Support an ongoing implementation program of nationally coordinated workforce redesign, change management and adoption to progress workforce reforms nationally.

**Improved mechanisms for the provision of efficient training:**
- Align training and workforce needs;
- Drive efficient and effective training;
- Establish the National Medical Training Advisory Network (NMTAN) which aims to:
  - Provide a mechanism to advise on improved coordination of medical training;
  - Produce five-year rolling medical training alignment plans;
- Ensure stronger links with the health service needs of the community; and
- Address the current imbalances in the workforce.

**Addressing barriers and enablers to workforce reform:**
- Analyse health workforce industrial arrangements and agreements to identify opportunities for reform; and
- Analyse Commonwealth, state and territory legislation to identify factors that support or hinder flexible use of the workforce.

**Streamlining clinical training funding:**
- Develop nationally consistent approaches to clinical training funding, supported by the establishment of efficient training pathways; and
- Streamline existing funding within the context of activity based funding for teaching and training in public hospitals.

**Considerations for achieving national self-sufficiency:**
- Analyse the implications of differing levels of self-sufficiency in the health workforce and the impact on other policy priorities including workforce distribution and training reform.

“HWA will lead national work over the next two years to turn these policy responses into a program of tangible, robust reform,” Mr Cormack said. “We are already working hard with our stakeholders to develop immediate responses. These include the development of NMTAN, a nursing retention and productivity study, our workforce redesign work on expanded scope of practice, aged care and the Health Professionals Prescribing Pathway.”

Stakeholders can engage with HWA through its website hwaconnect.net.au – which features every HWA initiative during its consultation phase. The website has already hosted consultations on HPPP, Health Leads Australia and a survey on Integrated Regional Clinical Training Networks. Current consultations include a discussion paper on the NMTAN and another on the nursing productivity and nursing study. For more information about HWA, visit www.hwa.gov.au.

Written by Rob Johnson, a senior writer for Health Workforce Australia.
Rethinking our dental workforce

How do we increase the supply of dental services to those without current access to them?

Dental diseases are among the most prevalent and costly diseases in our community. While oral health care in Australia is world class and offers high quality care to those who can afford it, those who can’t must rely on public services, where the wait is often too long. There is serious need to deal with this problem; to increase supply of services to those who currently have poor or no access to care and, ultimately, to reduce demand through a much more preventive-oriented system.

Currently, there are approximately 994 oral health therapists, 1044 dental therapists and 1065 dental hygienists in Australia. All three practitioner types provide primary oral health care services (examination, diagnosis, treatment planning, preventive and health promotion services), with therapists providing restorative services (fillings) and hygienists providing treatments and maintenance care for periodontal conditions; the most common dental services in Australia. Clearly, they make an important contribution to the oral health workforce.

Research over many years has also shown that: they provide services (within their scope) to the same quality as dentists; reliably recognise the boundaries of their practice and refer appropriately; can diagnose and plan treatment care in the most complex patients including those with complex medical histories and polypharmacies; and provide care that is acceptable to patients. Their practice is situated in a primary health care/public health paradigm that emphasises prevention and health promotion, offering the opportunity to re-orient oral health services into more preventive models of care given the appropriate funding models. They graduate from university dental or health science faculties following a three year undergraduate degree and are registered for practice by Australian Health Practitioners Authority (AHPRA). They currently have poor or no access to care and, ultimately, to reduce demand through a much more preventive-oriented system.

There are, of course, some current debates around their practice models. One relates to the age limit of people who can receive restorative services (in some states, only people over 5 years old and under 18 years old) despite evidence from Victoria and elsewhere that they can provide excellent quality services to preschoolers and young adults and with a small amount of additional training, provide restorative services to all adults. This would significantly increase public sector capacity and translate the successes of the school dental service across the adult population. In addition, funding organisations, such as insurance companies and Medicare, do not directly rebate their services; their services are currently billed under dentists’ provider numbers. This imposes a cost layer to billing and creates a bundled service model which often lacks cost efficiency. It also hides the true data about their contribution to service provision.

Training numbers in the oral health professions are low and there are arguments to support the notion that increasing oral health therapist numbers and decreasing dentist training numbers to achieve greater numerical parity would offer better service orientation in line with community needs. There are many opportunities to utilise the existing skills and oral health workforce resources better and more broadly across the health sector, in hospitals, residential care and health outreach settings to ‘unbundle’ service provision and extend the capacity of the system.

2. AIHW (2013). Dental Workforce 2011, National Health Workforce Series No 4, Cat no HWL 50, Canberra.
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As I hiked the 1.5km from the car park to the hospital doors, I realised what studying for a three year degree had gotten me … lots of exercise! Once inside, I followed the trail of nurses rushing to tend to patients calling for showers and pills. Walking into handover was like walking into a foreign country and not understanding the language. All I could make out was ‘your patient has an ABUHIOH, YHFJDUO, TGDHDI with a history of diabetes, heart disease, liver failure, peripheral vascular disease and lung cancer.’ Even through this ‘broken English’, I could tell that the rise of patients with comorbidities, as described in my textbooks, was a very real phenomenon (and that the enormous cost of my textbooks was finally paying off!).

While I was busily checking the emergency equipment, a quiet voice said ‘could you please check this medication with me.’ I instinctively apologised, saying that I was student and, therefore, unable to check medications. Suddenly, I felt very silly, realising that I might struggle to let go of my student days. I’m still at the initial stage when the responsibilities of being a healthcare professional seem very overwhelming. These responsibilities will no doubt become part of me, especially when putting on my uniform and pass gives every person in the hospital a reason to stop and ask me directions.

It’s definitely something I’ll have to get used to, albeit in a somewhat haphazard way. Seven days on, three days off, seven days on, two days off, five days on, two days off … welcome to the world of shift work! Yet to adjust to this ever-changing schedule, my life has gone a little topsy-turvy. I’ve found myself cooking dinner for my family at breakfast time and eating toast for dinner, stopping for just 10 minutes to rehydrate on an evening shift.

Every spare moment is spent ironing clothes, cooking food, cleaning the house and spending time with family. All this is squeezed into whatever moments I have between the self-directed learning modules that all graduate nurses are expected to complete, as well as other mandatory staff training for all new staff members. It truly does take patience, determination and support to keep new nurses like me going.

I’ve now experienced first-hand how all nurses have ‘one of those days’ – the days when nothing seems to go right, and you go home not knowing anything about your patients. All you know is that you did everything you could to keep them comfortable and no one died. On these days, I come home, have a good cry, and tell my family that I can’t do it anymore; that I want a 9-5 job so that I can have regular sleep. This usually ends with me dozing off on the couch late at night, only to wake up thinking that things aren’t always as bad as they might first seem. Being a nurse somehow gives every person you know the confidence to tell you their entire medical history at the local club and expect you to know exactly why their INR levels might be low this week. In spite of the stresses, I’ve seen that the trust placed in me by others and the help that I can provide makes nursing a very rewarding occupation.

One month in, as I sit down and rest my swollen ankles, I can’t help but think that I just might have a pretty great job after all.
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Super benefits

Super heroes

The added extras that super funds provide access to now can be of real benefit to your employees

Superannuation is one of those things that people can pay a lot of attention to, or very little. Many people think of super only as savings for retirement and don’t take advantage of the member benefits they can tap into now.

Individual employees generally have the option to choose their own superannuation fund. However, many don’t and rely on their employer’s choice of default fund. Choosing the right fund can give your employees access to benefits that are of very real value to them.

When choosing a default super fund for your organisation, the investment performance and level of fees should be your main considerations. But there can be little difference between funds based on these criteria. What can differentiate funds today are the added benefits members can access now. And there are some very interesting benefits out there.

Many super funds have arrangements with a financial institution to give members access to discounted banking products, including credit cards, home loans, and personal loans with lower interest rates. Members may also be able to take advantage of savings and term deposit accounts with higher interest rates.

Many super funds also have arrangements to provide discounted insurance products, including health insurance and in some instances, discounted insurance for home and contents, cars and travel. Then there are the unique benefits, which range from free access to the Best Doctors program to discounted flowers. There are benefits for employers as well, including free seminars for employees provided in the workplace.

The Nurses Award 2012 and the Health Professionals and Support Services Award 2010 specify the funds that employers must make contributions to if an employee fails to choose a fund.

We’ve done a round up of the members benefits some of these funds offer so you can compare what your fund provides for employees compared to others.
<table>
<thead>
<tr>
<th>Fund</th>
<th>Annual admin fee</th>
<th>Fees</th>
<th>Income protection insurance</th>
<th>Death and disability insurance</th>
<th>Discounted health insurance</th>
<th>Discounted banking products</th>
<th>Access to financial advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Super</td>
<td>$78</td>
<td>$35 withdrawal</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes, through the Super Members Health Plan.</td>
<td>Yes, through ME Bank.</td>
<td>Yes, Provided by Industry Fund Financial Planning and others.</td>
</tr>
<tr>
<td>Catholic</td>
<td>$78 Annual Administration Fee</td>
<td>Withdrawal Fee: $75</td>
<td>Joining fee: $0</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes – Limited advice (any member – at no extra cost)</td>
</tr>
<tr>
<td>First State Super</td>
<td>$130.00 per year</td>
<td>$0</td>
<td>Yes (Optional)</td>
<td>Yes</td>
<td>Yes: Automatic Death &amp; TPD cover</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Hip</td>
<td>$65 – management fees also apply</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes, Through Super Members Health Plan.</td>
<td>Yes, through ME Bank.</td>
<td>Yes, HESTA members have access to advice about choices within their super account at no extra cost and comprehensive advice from HESTA Financial Planners on a fee-for-service basis.</td>
</tr>
<tr>
<td>HESTA</td>
<td>$57.20 Management fees also apply</td>
<td>$55 withdrawal</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes, Mercy Super members have access to a comprehensive scaled advice service.</td>
</tr>
<tr>
<td>Mercy Super</td>
<td>$65</td>
<td>$30 withdrawal</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes, Provided by NGS Financial Planning</td>
</tr>
</tbody>
</table>
### Extra member benefits

- Run only to profit members
- Low Fees
- Investment Choice - 18 investment options
- Information Seminars
- Financial planning

### Benefit for employers

- Dedicated call centre
- Workplace visits - seminars
- Regular reports and updates
- Free ‘Clearing’ house for eligible employers

### Contact details and hours of operation

- Phone: 300 300 273; 8am to 8pm AEST weekdays
- SuperRatings 10 Year Platinum Performance 2003-2013
- SuperRatings Super of the Year 2013; SelectingSuper AAA rating
- Chant West Five Apples
- Money Magazine Best Innovative Product 2013

### Special awards in the previous two year

<table>
<thead>
<tr>
<th>Special awards</th>
<th>Contact details and hours of operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>SuperRatings Platinum Super 2012, 2013</td>
<td>1300 655 062; 8:30am to 5:30pm AEST, weekdays</td>
</tr>
<tr>
<td>SuperRatings 7 Year Platinum Performance 2006-2013</td>
<td></td>
</tr>
<tr>
<td>SuperRatings Super of the Year Finalist 2012, 2013</td>
<td></td>
</tr>
<tr>
<td>Roy Morgan Best Industry Super Fund for Customer Satisfaction 2011</td>
<td></td>
</tr>
<tr>
<td>Chant West Five Apples</td>
<td></td>
</tr>
<tr>
<td>SelectingSuper AAA rating</td>
<td></td>
</tr>
<tr>
<td>SuperRatings Pension Fund of the Year 2012</td>
<td></td>
</tr>
<tr>
<td>Money Magazine Pension Fund of the Year 2012</td>
<td></td>
</tr>
</tbody>
</table>

### All profits to members

- Low fees
- Online account access
- Free information seminars
- Great value financial planning
- Comprehensive insurance cover
- Choice of 12 investment options including two Socially Responsible Investment (SRI) options
- Transfer your other accounts into First Super
- You can stay with us when you change jobs and through retirement

### Need to know

- No employer fees or charges
- Simple data-transfer solutions
- Flexible payment arrangements
- Online education services and industry updates
- Workplace employee education seminars
- Workplace employee training sessions
- Regular HR and payroll seminars to provide an overview of new facilities and fund changes
- Dedicated employer relationship officers to answer administration queries
- Individual appointments with our account managers to help manage superannuation obligations and needs

### Free access to the Best Doctors® unique service for members and immediate family.

Face-to-face visits to answer questions. Financial planning seminars and retirement planning seminars can be provided in the workplace.

### Phone: 1300 654 099; 8am to 7pm AEST weekdays. www.hsipuper.com.au

### SuperRatings Gold Super 2012; SelectingSuper AAA rating; HIP Super Pension nominated for 2012 Retirement Product of the Year by Selecting Super.

### National workplace and evening education and advice.

- 24/7 online account access, online member statements.
- Death income protection cover, and benefits payable, until proposed Age Pension age of 67 — HESTA is the first to do this.
- Life events option: members can apply to increase their insurance following key life events, without providing health evidence.
- Professional recognition for health and community services through national HESTA awards.

### Core Post — HESTA’s default investment option — has MySuper authorisation, making compliance easier for employers.

- Local offices in every state/territory to support employers.
- National workplace education and advice service for employees.
- Online super induction module for new (and existing) employers.
- Professional recognition for health and community services through five national HESTA awards programs.
- Online contribution payment options, suit all organisation sizes.

### HESTA: Free call 1800 813 317 from Australian landlines, 8am to 6pm AEST weekdays. HESTA Income Stream: 1300 734 479, 8am to 6pm AEST weekdays.

### HESTA maintains the highest rating from all ratings agencies including:

- HESTA — AAA SelectingSuper Quality Rating, SuperRatings 10-year platinum performance rating.
- HESTA Team recognition — AST’s 2012 Super Investment Award for Excellence, Platinum Communication Award, Communications Campaign Award, Business Development Award, Leadership Development Award.

### Superannuation education seminars can be provided in the workplace

Face to face visits to answer questions, cleaning-house, superannuation education sessions can be provided for free in the workplace.

### Superannuation education seminars can be provided in the workplace

- 1300 888 891; 8.30am to 5pm AEST Mon-Thurs.
- 1300 388 891; 8.30am to 5pm AEST Mon-Thurs, 8.30am-4.30pm Fri

### Chant West “top ten” for insurance and pension 2013;

In the US and UK, and increasingly in Australia, there is growing support for the incorporation of arts and health programs in hospitals and aged care facilities. Such programs encompass a range of creative activities, including painting, craft, music, singing, storytelling, theatre, dance and poetry writing and documenting life stories. Arts and health programs also help create a more welcoming environment for all who live and work in these facilities. Such measures include strategic placement of quality artwork in communal areas and patient rooms, creative signage to facilitate wayfinding, and the provision of sculpture gardens for rest and respite.

Aside from benefiting patient moods and recovery, arts and health programs have been shown to play a vital role in maintaining health and well-being of staff, improving motivation and performance, reducing burnout and enhancing recruitment and retention prospects. The American Hospital Association presents compelling statistics about nursing staff in the United States (US) that are relevant to Australia. It suggests that over the next 20 years, as Baby Boomers reach retirement age and beyond, the demand for aged care will grow by 40%, while the nursing workforce is growing at a rate of only 6%. This translates into a potentially more stressed and overtaxed workforce and more dissatisfied patient populations.

According to multiple studies in the US, job dissatisfaction is the primary reason for nurse turnover, and high turnover rates result in a nursing shortage, with the logical conclusion that the higher the turnover rate, the larger the shortage.

The principal reason for nurse dissatisfaction is not remuneration; instead job stress, nurse-doctor collaboration, and autonomy are more influential factors. A major component of job stress is feeling overworked, with 82% of nurses working overtime, according to a 2004 survey by the American Nurses Association. Caregivers are also being asked to do more due to the nursing shortage.

Of course, nursing shortages can lead to negative patient outcomes. Aiken et al (2002) determined that each additional patient, over a patient-nurse ratio of 4:1, is associated with a 7% increased chance of failure to rescue (i.e. patient deaths that could have been avoided if a nurse had been available to accurately assess the
Compared to the cost associated with replacing a valued member of staff, the cost of an arts program in a health setting is relatively low. When you add the health and well-being benefits for patients and staff, then the business case for arts and health programs is much greater.

Programs that reduce a nurse’s workload by helping patients and residents to relax through engaging in creative activities that improve well-being and alleviate pain and anxiety. This, in turn, reduces patients’ reliance on nursing staff and carers. A less demanding and more relaxed patient results in a nurse with improved job satisfaction. An arts and health program can also improve communications between nurses, doctors and management, to help nurses have a sense of being heard, valued and in control of their working environment, including its appearance. Compared to the cost associated with replacing a valued member of staff, the cost of an arts program in a health setting is relatively low. When you add the health and well-being benefits for patients and staff, then the business case for arts and health programs is much greater. The lesson is clear for hospital administrators: avoid losing one specialist nurse from a hospital or aged care facility and the average cost of an annual arts and health program is most likely covered.

To learn more about the efficacy and cost effectiveness of arts and health programs in primary and acute health settings and aged care facilities, and meet the people behind best practice case studies in Australia and overseas, we invite you to attend 5th Art of Good Health and Well-being international arts and health conference, 12 – 14 November 2013, College of Fine Arts, University of NSW, Sydney (www.artsandhealth.org).

To contact Margret, email her at Margret@artsandhealth.org telephone 0416 641 482.

Managing difficult employees

Legal insight from Robin Young1 and Alison Choy Flannigan2 of Holman Webb Lawyers

This article aims to identify and crystallise some legal issues around managing employees when they become ‘difficult’. This may include underperformers, serial complainers, high absentees, bullies, those who don’t take instruction well, those who disclose confidential information, those who fail to disclose conflicts of interest or engage in corrupt conduct, those with history, squeaky wheels, social butterflies, skylarkers, the dishonest and the fraudulent.

The Legislation
The Fair Work Act 2009 (Cth)(FWA) regulates ‘national system employers’ such as private companies and some public health services (e.g. Victoria). Many public health sectors are regulated under state law and policy. The NSW public health sector, for example, operates under the Public Sector Employment and Management Act 2002 (NSW) and The Health Services Act 1997 (NSW) and is regulated by NSW Health policies and the Industrial Relations Act 1986 (NSW). These laws, awards and enterprise agreements govern the employment relationship and contain provisions concerning remuneration, leave, termination, dismissal, redundancy, general protections, industrial action and other conditions of employment.

Performance Management
Performance is subjective and often involves perception which, if negative, may result in conflict. Policies and procedures are the rules which govern the process. They should ensure fairness, consistency, statutory compliance and efficiency. Failure to apply the rules may lead to internal disputes escalated to higher management and external disputes leading to litigation. The result is lost time, additional cost and potential cultural damage. Processes that govern performance must be sympathetic to the statutory framework that governs Equal Employment Opportunity, entitlements and work health and safety. Staff must be informed of the process, how it works, who does what, how it effects them and potential outcomes. Surprises are bad, and transparency, communication and good record-keeping are crucial.

Leave and genuiness of illness
It is unlawful to terminate employment because of temporary absence/illness. Under the FWA, this is defined as three months (including workers compensation). To be eligible for sick leave, employees must provide evidence of illness and employers are entitled to be satisfied regarding the state of health, although not necessarily a full medical analysis.

Work Health and Safety
National harmonisation of workplace health and safety (WHS) laws is well advanced. Key points are a primary duty of care qualified by reasonable practicability to safeguard health and safety; an end to the reverse onus of proof; obligations for company officers to exercise due diligence; obligations of notification, consultation, codes of practice and enforceable undertakings.

WHS obligations may be relevant to skylarkers, bullies and those who won’t comply with safe work methods and organisational procedures. Failure to comply with WHS instructions may result in discipline. Careful investigation and implementation of policies and model Codes of Practice will ensure that employers are not hamstrung.

Dishonesty
Employers should respond to dishonesty in the workplace notwithstanding the potential issues that may arise in relation to disciplinary action and termination. The Corporations Act and the Crimes Act impose obligations on corporate conduct. It is an offence to conceal a serious indictable offence and to accept a benefit in return for not reporting such conduct.

Workers Compensation
Workers compensation legislation imposes statutory obligations out of which parties may not contract and employers must be alert to ensure that premiums are controlled and that employee rights are not compromised. Where an employee exercises a right by making a workers’ compensation claim, employers must ensure they comply with relevant laws and provide suitable work. In NSW, for example, it is an offence to terminate employment because of incapacity/injury within six months; an employee may seek reinstatement within two years; and no compensation is payable for psychological injury resulting from reasonable conduct in relation to certain employment matters.
Prior History
Lack of due diligence or disclosure at the commencement of employment may cause problems. This can be avoided by implementing pre-employment protocols such as checking qualifications, obtaining CVs, reference checks and agreeing that the employer relies on the information provided being accurate.

Confidential Information
After employment ends, employees have obligations regarding use and disclosure of confidential information based on express or implied terms and statutory duty. All health care organisations should have policies and procedures in relation to confidentiality and privacy.

Conflicts of interest
Conducting a rival business whilst employed or not disclosing a material conflict of interest may breach a duty to the employer. An employee may undertake steps in relation to plans after the employment terminates. Public sector employees are also subject to anti-corruption laws.

Restraints
There is a presumption against enforceability of post-employment restraints and an employer must prove that a restraint is reasonable and valid. Enforceability depends upon a legitimate interest to protect the business of the employer and what is a reasonable protection of that interest.

Anti-Discrimination
Anti-Discrimination laws prohibit discrimination on prescribed bases including race, sex, disability and age. This applies to the selection of job applicants, the terms and conditions of employment, during employment or dismissal. While an employee may hide a previous injury for fear of discrimination, dismissal may not be unlawful discrimination on the grounds of disability if an employee is unable to perform the ‘inherent requirements’ of the role.

Policies
Policies concerning employment entitlements, investigation, discipline and grievance handling are invaluable. An employer must afford a reasonable, fair and transparent process. Employers should be aware that they also must comply with policies and not apply practices which they are unable or unwilling to follow.

Conclusion
There are risks for employers in managing employees with different personalities, issues, histories, foibles and nuances. Understanding the laws is important. Understanding the employee is just as important. Good policies and procedures is necessary, but proper implementation is critical.
A brief history of Australia’s second oldest hospital and its staff, by Emily Longstaff
It began in 1804 as a series of tents and wooden huts in the early months of British settlement in Tasmania, better known then as Van Diemen’s Land. Nowadays, the Royal Hobart Hospital (RHH) stands as the second oldest hospital in Australia (apart from Sydney Hospital). It also has the proud legacy of being Tasmania’s largest hospital, and its longest running non-military institution.1

Through its various guises over the years, ranging from the ‘convict’, ‘colonial’, ‘public’ and ‘government’ hospital, the RHH has developed a rich history.

The first purpose-built brick and mortar institution for ‘the reception of sick convicts and other persons who cannot procure medical aid’ was erected in 1820.2 It was constructed through convict labour on the site of a battle between aborigines and early settlers.3

Undoubtedly, the then Colonial Hospital appears to have been a rather grim place. Overcrowding meant that patients often had to sleep on the floor; some thought the overall setting to be filthy, having ‘an appearance of poverty and wretchedness – a desolate and an unhappy aspect about the place’.4 Some areas, like the women’s quarters, were even regarded as ‘positively revolting’.5

These summations, while unsettling, are not entirely surprising. The original hospital building was woefully ill-equipped with just four small rooms and the health of the convict and pauper population at the time was generally poor. Moreover, qualified nurses were not introduced to the hospital until the mid-1870s. Until then, patients were unlucky enough to be attended by rough, untrained, sometimes drunk and corrupt, convict nurses.6 How reassuring this must have been...

Another somewhat graphic aspect of a hospital operating in a 19th Century convict settlement was the dissection of hanged murderers – the only type of criminal to be given this punishment in addition to execution. This practice of punitive dissection can only be attributed to a few hospitals in the British colony, of which the RHH is one.7

Out of these (some say dark, I say intriguing) beginnings came a much lighter era, with the newly crowned ‘Royal Hobart Hospital’ opening its doors in 1939. Like a phoenix from the ashes, the impressive ‘aeroplane’ shaped hospital was set to revitalise the community by doing away with the ‘depressing drabness’...
of the old facilities. With this new fandangled construction came great adulation. Whereas the old hospital was considered ‘the most out of date in Australia’, the new one was ‘the most modern and biggest all-electrically equipped in the Southern Hemisphere’.

Such celebration stands in marked contrast to the tragedy which befell the hospital on April 28, 1996. Here, the Port Arthur Massacre sent the hospital into Code Brown, urging staff to respond to a devastating external emergency – a mass shooting in the heart of one of Tasmania’s most popular tourist spots.

In this trying time, staff attended to all of the 22 injured victims, the 35 deceased, as well as the perpetrator. They also had to manage conflicting emotions, public outrage, and the barrage of local and international media that ensued. The professionalism of hospital staff during and after this highly traumatic period has been highly commended, even though extent of the stress and pain endured by all of those involved may never be resolved.

Still, as the years press on, so does RHH. Since 1968, it has been the major teaching hospital of the University of Tasmania and the state referral centre for a range of specialised clinical services (neurosurgery, cardiothoracic surgery, hyperbaric and diving medicine, burns, neonatal intensive care and high risk obstetrics). Consequently, the RHH has had to remain at the forefront of medical care. Like any hospital, there have been a series of upgrades and redevelopments as technologies change and systems evolve.

The RHH has worked hard to improve access to patient histories and clinical information and to reduce storage space. In 2006, it successfully established one of the first and most effective medical record digitisation schemes in Australia. Overall, the space saved by the complete digitisation of all paper records is said to equate to around six kilometres of shelving. Today, the RHH is in the midst of a $586 million redevelopment to bring about ‘a quantum change in its operations’. The redevelopment, financed by the Tasmanian Government and Commonwealth Health and Hospital Fund, is set to be the biggest health infrastructure project in Tasmanian history. It is providing state-of-the-art facilities for staff and patients as well as a boost to the local construction industry and wider economy.

A far cry from tents and wooden huts...
The Social Determinants of Health Alliance (SDOHA) has welcomed the recommendations contained in the Report of the Senate Standing Committee on Community Affairs Inquiry into Australia’s domestic response to the World Health Organization’s (WHO) Commission on Social Determinants of Health report: Closing the gap within a generation.

SDOHA was formed in October 2012 with the goal of working with governments to improve health outcomes for all Australians, and especially among those who are subject to social or economic disadvantage. With over 25 member organisations, including the AHHA, the Alliance includes Australia’s leading health equity researchers and leading health promotion, social service and health service organisations and advocates.

The Senate Report makes five recommendations, mirroring the recommendations proposed in AHHA’s submission to the Inquiry.

Some aspects of the report were disappointing, such as the lack of commitment to a ‘health in all policies’ approach. The Committee acknowledged the benefits of this approach but was non-committal on how this should be structured, limiting its recommendation to the adoption by governments of ‘administrative practices that ensure consideration of the social determinants of health in all relevant policy development activities.’

The report also stated that ‘...in spite of the evidence presented to the committee arguing that the Commonwealth is taking numerous measures to address the social determinants of health, evidence for these claims appears to be minimal’.

The single mention of social determinants in the Department of Health and Ageing’s Annual reports for 2010-11 and 2011-12, was cited as an example of the Department’s lack of focus on the issue.

The Committee also recognised that ‘the need for a social determinants approach lies not only within, but beyond, the health portfolio.’ However, the Committee seemed themselves unable to break the health department focussed paradigm as the Department of Health and Ageing appears to be the only Australian Government department providing a submission or represented at a public hearing. On the whole, support by all members of the Committee for action to address social determinants is an important step and the election policies of all parties will be scrutinised to see who is prepared to put the words into action.

For more information:
Web: www.socialdeterminates.org.au
Twitter: @SDOHAlliance

AHHA Submission Recommendations | Senate Inquiry Report Recommendations
---|---
That the Australia Government makes a formal statement of support for the recommendations of the Commission. | That the Government adopt the WHO Report and commit to addressing the social determinants of health relevant to the Australian context.
That the Australian Government, in collaboration with States and Territories, develop an action plan to implement the Commission recommendations. | That the government adopt administrative practices that ensure consideration of the social determinants of health in all relevant policy development activities, particularly in relation to education, employment, housing, family and social security policy.
That the Australian Government immediately develop and implement a ‘health in all policy’ approach and require the completion of Health Impact Assessments (HIAs) to inform policy development and legislative change. | That the government place responsibility for addressing social determinants of health within one agency, with a mandate to address issues across portfolios.
That all National Partnership Agreements include a Health Improvement Dividend section to identify and quantify the impact of the social determinants of health and health outcomes arising from the Agreements content. | That annual progress reports to parliament be a key requirement of the body tasked with responsibility for addressing the social determinants of health.
That an Australian Commission on the Social Determinants of Health be established to coordinate inter-Agency action and report annually on progress to address the social determinants and reduce health inequity. | That the NHMRC give greater emphasis in its grant allocation priorities to research on public health and social determinants research.

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BY ANDREW MCAULIFFE
Senior Director, AHHA
Policy & Networks

In depth

AHHA policy
On the Social Determinants of Health
Most people in the health sector agree it is vital for evidence to find its way into policy and practice as quickly as possible. Researchers have found, however, that on average there is a 17 year time lag in translating health research findings into practice. Clearly, this needs to change.

The Deeble Institute for Health Policy Research is doing its bit to speed up the process of getting research into policy and practice. One of the ways it is doing that is by producing Health Policy Evidence Briefs. These Evidence Briefs are short, easy to read publications that synthesise and interpret the available evidence on a particular topic. They are written in plain English, so they are easy to understand even if you are not an expert in the field. They are balanced, objective, and authoritative, as they are always written by an expert in the field.

Since it was established in late 2011, the Deeble Institute has published nine Evidence Briefs on a wide range of topics, such as:
- Food labelling and how it influences food choices;
- Fiscal policy levers and their role in improving diets and preventing obesity;
- The arts and its role in healthcare;
- Midwifery models of care;
- Alcohol warning labels;
- Policies and laws on involuntary treatment for people with schizophrenia;
- Case management and outcomes for people with schizophrenia; and
- Effectiveness of health services accreditation.

We have a number of new Evidence Briefs in the pipeline, but if you are interested in writing one or commissioning one on a topic that is important to you, please get in contact with us (details below). We would be happy to discuss your ideas with you.

As well as producing Evidence Briefs, the Deeble Institute is working with policymakers, practitioners and researchers to develop research proposals.

We are committed to working collaboratively (even though it can sometimes be more difficult than working in isolation) because we want to make sure that the research that gets done in Australia is relevant to those who use it. If you are interested in getting involved in our research program – it is a great way to get started in research and hook up with some expert researchers across Australia – we would love to see you at one of the AHHA’s Policy Think Tanks this year.

A list of the upcoming Policy Think Tanks can be found on page five of this magazine.

For more information on the Deeble Institute and its Evidence Briefs, contact:
Dr Anne-mare Boxall, Director, Deeble Institute for Health Policy Research.
Email: aboxall@ahha.asn.au
Twitter: @DeebleInstitute

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JustHealth Consultants (JHC) is a consultancy business complementing the products and services offered by the Australian Healthcare and Hospitals Association. JHC manages a range of high quality coordinated services at competitive rates. These services are specifically designed to support new and existing healthcare organisations across the sector to meet the complex governance, organisational and quality assurance requirements of today’s rapidly changing environment.

Our expert team can assist you and your organisation to perform at your best and to prepare you for future challenges.

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**Activity Based Funding advice:** we can examine your practices and offer advice to improve outcomes

**Organisation improvement consultancies** such as:
- Leadership development, coaching and mentoring;
- Business process improvement;
- Strategic and business planning;
- Organisation design and structuring;
- Management practices and internal and external communications;
- Accountabilities and reporting;
- Planning and review of financial practices and systems;
- Service delivery improvement;
- Managing human resources; and
- Change management facilitation – we are able to guide you through change management processes arising from Government policies or restructuring requirements.

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Professor Stephen Leeder, University of Sydney

**“I am grateful for the experience and academic rigour that JHC brought to this project”**
CEO, Medicare Local

**Want to know more?**
The JHC Secretariat facilitates an efficient and seamless coordination and administration service between the client and consultant. This includes matching, introductions, scheduling, project management and facilitation of a high quality partnership.

**Contact:**
Terrie Paul, Director tpaul@ahha.asn.au or telephone 02 61620780.
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Healthcare is the people providing it. Not just those paid to work in healthcare, or even unpaid carers, important though they are; but also arguably patients as carers for themselves. There is an unrecognised and unsupported need and opportunity in the last two groups. However, I wish to concentrate on the first of these groups, and that, gentle reader, probably means you!

The World Health Organisation defines health as ‘a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity’. \(^1\) Pills, prostheses and surgery may address disease and infirmity, but it is interaction with other people that provides well-being. I continue to be astonished by how under-recognised and under-addressed this second point is: The opportunity to match the psychosocial skills of the workforce to the psychosocial needs of patients.

My perception is that many healthcare workers are unhappy in their work. Perhaps this is true of the broader workforce today and healthcare is just part of the mass. Perhaps it is a result of the transference of distress from the people we care for. Whatever the cause, I assert that one is less able to care for others if one is unhappy and uncared for oneself.

The importance of patient perceptions of, and involvement with, health services is increasingly recognised. It is therefore important to establish whether staff mood and culture in health services relates to patient perceptions, and even technical outcomes from healthcare. There is evidence that patients are more likely to follow medical advice when given by a healthcare worker whom they trust. The existence of trust goes to relationship. There is also evidence that staff turnover (and thus staff cost) is lower among employees who are happy with their work than those who are not. If staff mood and culture are important determinants of health outcomes then we need to understand and manage them to improve health.

There is a joke about tourists travelling through Ireland who stop to ask a local for directions. The advice they receive is 'if I wanted to get there, then I wouldn't start from here!' This reflects the third major challenge and opportunity for the health workforce: our workforce is not designed in a way that supports better health. The people who determine the need for a service benefit from it and, as a result, unnecessary services are provided. Funding follows providers not consumers, so services are less available in parts of Australia where providers find it unattractive to live and work.

If we want a better health system, we need to start with the people providing healthcare.
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It’s Australian. And it’s super.
It is hard to get excited about a ‘science’ with all the credibility of astrology that has so spectacularly failed to do anything about the endemic staff-related problems (sorry, ‘opportunities’) that plague healthcare.

For as long as I can remember in my 35 years+ in nursing, we have experienced an endless cycle of boom and bust with student or staff numbers being slashed one month, only to have a major recruiting campaign the next. During all of these years, we had departments of Workforce Planning and small armies of planners, doubtlessly beavering away with some goal in mind while mercifully protected from any accountability for positive outcomes. Now, in our brave new post-COAG world, we have HWA, otherwise known as Health Workforce Australia, not ‘Here Wego Again’, as you may have thought.

A charitable assessment is that this quango will go the way of all the others, either via its own demonstrated irrelevance or thanks to external political interference in the name of ‘reform’.

But Workforce Planning should not be the lost cause that it is. Heaven knows, there are plenty of ‘workforce issues’ that should occupy our attention. Let’s take clinical leadership in nursing for starters. If we in Australia want to avoid the train wreck revealed in forensically excruciating detail by QC Sir Robert Francis in the UK’s Francis Report II, then we better start taking clinical nursing leadership seriously.

Virtually every research study and report into ‘Ward Culture’ and patient care standards over the past 30 years has identified the ‘Ward Sister’/Ward Manager/Charge Nurse as the lynchpin of the service. This role is the single most important determinant of ward culture, clinical standards, staff morale and almost any other indicator of great service that you could imagine. Yet every group of senior clinical nurses that I talk to bemoan their lack of power and influence to set and maintain the standards that they would wish to see. In short, we are demanding that clinical nursing leaders accept responsibility for standards of care and ‘ward workforce quality’ that they are powerless to enforce.

It is easy to go all misty-eyed remembering the powerful and influential ‘Ward Sisters’ or ‘Charge Nurses’ that we worked with many years ago when it was actually possible to know who was ‘In Charge’ of a ward or Unit without needing an Enigma decoder. Nowadays, try, as a Health Advocate reader, to work out any meaningful difference between a Nurse Manager, Nurse Consultant, Clinical Nurse Specialist, Nurse Practitioner, Designated Nurse, Clinical Services Co-ordinator and any of the other profusions of puffery out there. Then, imagine attempting this as a patient.

It is time to get power, authority and accountability back into the hands of highly trained and educated, passionate, visionary, driven, demanding and clearly identifiable clinical nursing leaders. Stop calling them ‘Ward Managers’ and get their centre of gravity back to standards of care, safety, quality patient experience, evidence informed practice and promoting human dignity. Give them hiring and firing powers and the autonomy and resources to run their ward to achieve these aims. Stop micromanaging them but hold them accountable for achieving these exacting standards and, if they are unable to do so, replace them.

That would give us a nursing workforce to be reckoned with.

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

Why is it that Workforce Planning is such a lost cause in healthcare?

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Emily Burgess reviews *Ultimate Wellness: The 3-step plan* by Professor Kerryn Phelps

When asked to review *Ultimate Wellness* I must admit, I was sceptical. Quite often, health and wellness books are far from evidence-based and are written by people lacking appropriate qualifications or experience. The promotion of ‘the latest diet’ tends to be nothing more than fancy marketing for the same old information we have been advising for years. But because the old advice is generally not terribly sexy or exciting, publishers and media latch on to the latest craze like it’s a miraculous new revelation. This is exactly what I expected from *Ultimate Wellness*, but I have been pleasantly surprised!

Kerryn Phelps manages to promote the ‘same old’ health advice while still being inspiring and exciting. The 3 steps – AUDIT, REBOOT and SUSTAIN – work you through how to get your health on track through practical and useful advice that is realistic and can be taken on board by a range of individuals; from those who need to make considerable alterations to their lifestyle, to those who only require minor modifications.

My passion for health is holistic, so I believe in considering all aspects of health and well-being when assessing any condition. I therefore appreciate that there are chapters on a range of topics such as: alcohol, smoking, stress, mental health, illicit drugs, sleep, nutrition, food intolerance and allergy, exercise, immunity and spirituality/connection. There is also a whole section on complementary treatments such as acupuncture, physical therapies, herbal medicine and supplements.

Professor Phelps explains the differences between Western medicine and complementary therapies excellently and promotes the benefits of both equally. While she is quick to stress the importance of seeing a GP for the initial diagnosis, she endorses a full array of allied health and complementary practitioners. She has an entire chapter dedicated to ‘Choosing the right health professionals’, and her way of explaining the differences (e.g. ‘Dietitian, Nutritionist or Naturopath?’ and ‘Physiotherapist, Osteopath or Chiropractor?’) is by far the most unbiased and un-offensive I have come across. This is usually a very touchy topic which sees health professionals ‘walking on eggshells’ when trying to explain the differences and benefits of each.

A good feature of *Ultimate Wellness* is its structure, which allows readers to skim through chapters that aren’t relevant to them, i.e. non smokers and those who don’t take illicit drugs are directed to skip to the next chapter. This allows readers to grasp the book’s concepts in a timely manner without getting bored and quitting before reaching the end.

To retain attention, Professor Phelps also uses popular words that the general public love, and that health professionals hate, such as ‘detox’ and ‘liver cleanse’. She is, however, quick to back these buzz-words up with her definition of a sensible program (as opposed to the usually ridiculous and unachievable). She then concludes the 3 steps by writing about ‘Your New Normal’, which is a concept I discuss regularly with clients.

*Ultimate Wellness: The 3-step plan* doesn’t offer any new or ground-breaking information, but it doesn’t pretend to either. It simply presents the basics of getting well and staying well in an interesting, user-friendly format. It is refreshing to see a book on health that is actually factual, current and evidence-based. All in all, *Ultimate Wellness* is an interesting read and will definitely be added to my recommended reading list this year.

Emily Burgess is the founder of The Art of Balance health coaching. She is an Accredited Practising Dietitian, Accredited Nutritionist, Accredited Exercise Physiologist and Personal Trainer. For more information, go to www.theartofbalance.net.au.
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› For registered and enrolled nurses working in aged care wishing to attend a short course, workshop or conference relating to the care of older people.

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Aged Care Nursing Scholarships (ACNS) are funded by the Australian Government. ACN, Australia’s professional organisation for all nurses, is proud to work with the Department of Health and Ageing as the fund administrator for this program.
The Stream Leader for Medical Devices at CSIRO talks to The Health Advocate.

Scott Martin

AHHA: Tell us a little bit about what you do
SM: It’s my job to find and support ways in which CSIRO can contribute to the development of the medical device industry. In practice, this means one of two routes: either finding medical applications for our research capability (such as exploring the possible medical imaging advantages of TeraHertz imaging); or, engaging with medical device companies/end users/medical professionals to learn about their challenges and establish activities with CSIRO scientists and engineers.

AHHA: What are some of your most significant recent projects?
SM: One project, led by Dr John Arkwright, was the development of a gastrointestinal (GI) catheter for diagnosis of dysphagia (swallowing disorder). It is currently being used as a research tool to investigate a wide range of bowel disorders in the lower GI tract, measuring pressure at many points along its length (typically up to 1m long).

Another of our teams has received funding from the Science and Industry Endowment Fund (SIEF) to develop low cost diagnostics for infectious diseases, targeted at low resource settings such as developing nations. Like the way dogs can smell illicit drugs (and have been able to smell cancer), we are developing chemical sensors to diagnose infectious disease from chemical ‘fingerprints’ (similar to taste or smell) of breath and urine. Our partners, the Nossal Institute for Global Health, bring expertise in delivering mobile phone based health solutions. Combined, we work to meet our team goal of a diagnostic sensor integrated with a mobile phone.

Scott Martin therefore, reduce the tsunami of health costs that we hear about every day.

AHHA: What have been the major highlights of these projects so far?
SM: The GI catheter attracted commercial interest and our licensees are well on their way to regulatory approvals and product launch. The technology was recognised nationally in the 2011 Eureka Prizes where it won the prize for innovative use of technology. Our SIEF project got properly up and running this year after hiring research nurses at hospitals, building special PC2 laboratories for working with potentially infectious patient samples, and getting all the agreements and ethics approvals in place. We’re now in the middle of the experimental work. The scenarios work has fed into government panels in ageing. We received a great deal of interest as well as Commonwealth funding to extend the work to further explore the role of technology in each scenario.

AHHA: What challenges have you encountered with these projects?
SM: Post-GFC, small to medium enterprises have reported reducing access development funding such as venture capital. However, I am sensing a renewed recognition of the opportunity presented by our local medical device industry in terms of jobs and exports, with more funding opportunities emerging.

AHHA: How does your work fit within the broader Australian Healthcare system?
SM: My role revolves around devices, so for me it’s all about current and future needs for technological products and services. CSIRO’s interest in health and healthcare is much broader: from resistant starch for wellbeing and innovative new materials for tissue regeneration, to cell therapies for diabetes. Previous CSIRO achievements include identification of the Hendra virus and the development of extended wear contact lens materials and the Relenza anti-flu drug. CSIRO’s recently launched Digital Productivity Flagship is already the largest coordinated health services research activity in Australia. It is working closely with clinical partners to improve access to health services via broadband and mobile communication platforms, developing tools for operational and clinical productivity, optimising the use of precious resources and improving patient safety and health outcomes.

AHHA: What do you have in store for the next few years?
SM: In addition to continuing engagement with medical device companies, I would like to continue to expand my engagement with end users and providers in community and aged care. I would also like to take the scenarios foresighting work further again. In addition, I’ll continue committee service with AusMedtech NSW, which provides valuable networking and representation for the industry.
There are fresh concerns about emerging antibiotic-resistant superbugs after it was revealed a Melbourne hospital became contaminated with ‘the new plague’: Carbapenem-resistant Enterobacteriaceae, or CRE. The outbreak was traced to sinks in the intensive care unit.

Thousands of people living with younger onset dementia will receive vital support thanks to a $16.8 million grant to Alzheimer’s Australia for the National Younger Onset Dementia Key Worker program. It will give patients, their families and carers a primary point of contact to help them find services like community based care and social support.

The Australian Government is providing $11 million over five years for the expanded Medicare Healthy Kids Check, to give parents the opportunity to seek medical advice about health and wellbeing issues (for example; speech, sleeping patterns and mobility).

Tasmania’s Premier, Lara Giddings, and the Greens leader and minister, Nick McKim, have joined forces to champion the cause of voluntary euthanasia. They are the first leaders in government to do so for more than 15 years.

Over 280,000 Australian schoolboys will be eligible to start receiving free Gardasil® vaccinations this year to protect them against cancers and disease caused by the human papillomavirus (HPV). Vaccination will protect boys from cancer and genital warts, and continue to reduce the rates of cervical cancer among women.

The Victorian and Federal Governments have accused each other of cutting health funding. Dr Deeble, one of the architects of Medicare, says all the infighting around healthcare funding reveals a deeper strategy by the states and Commonwealth to have each pay more of a share under the new funding model that starts next year.

Poor sleep can have a dramatic effect on the human body, say UK researchers. Studies show that activity of hundreds of genes is altered when people’s sleep is cut to less than six hours a day for a week. Heart disease, diabetes, obesity and poor brain function have also been linked to substandard sleep.

More than 122,000 people have taken out private hospital cover in the six months since the introduction of income testing of the private health insurance rebate, Minister for Health Tanya Plibersek said. “More than 10.7 million Australians have hospital cover, the highest number in 37 years. The figures make a joke of Tony Abbott’s negative claims that 1.6 million people would drop their private hospital insurance.”

The Australian Dental Association is outraged and dismayed at governments’ lack of leadership to support the well-established scientific evidence that proves fluoridation of water supplies is safe. “The Queensland and now other state governments’ decision to permit ill-informed local councils to choose to stop fluoridation of water supplies represent a failure to protect the public’s oral health,” the Association said. AHHA agrees.
Salary Packaging
If you work for a public hospital, not-for-profit organisation or a Public Benevolent Institute (PBI), you could be taking advantage of salary packaging (also known as salary sacrifice). Salary packaging is an Australian Taxation Office approved means of paying for a range of everyday items using your pre tax income – this means you save money by paying less tax!
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The future of healthcare workforce
The Australian Healthcare Workforce Solutions Forum will run from 30-31 July 2013, Parkroyal Darling Harbour, Sydney
www.arkgroupaustralia.com.au
COST: $995 plus GST to attend the forum
One-day Interactive Forum and Two Post Forum Workshops
Hear from:
- Genea
- Murdoch Childrens Research Institute
- UnitingCare Community
- ACT Government–Health Directorate
- Change Factory
- Medibank Private
- The University of Sydney
- Northern Sydney Local Health District

The focus of the forum is on the challenge that health sector in Australia is currently facing - the ageing workforce, and to build resilience through leveraging training and development to up-skill staff, effective change management and better communication.
Heinz beans

Heinz Baked Beans soft textured beans in a traditional rich tomato sauce. Nutritious and in a convenient shelf stable 2.95kg can, they are high in protein and fibre and rich in folate. Heinz Baked Beans have recently been reformulated and are now also wheat free. Serve in a variety of ways - buffet style, as part of a hot breakfast or as an ingredient in meals like chilli con carne or jaffles.

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New McCain Sweet Potato Wedges – the fresh new addition to your menu

New Sweet Potato Wedges from McCAIN are sure to be a talking point when you add them to your menu.

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New Sweet Potato Wedges have a superior crunch compared than the standard potato wedge – they’re a source of fibre, cholesterol free and free of artificial colours or flavours. Sweet potato is one of the world’s most nutritious vegetables, with a unique texture and flavour. McCAIN is the only manufacturer offering Sweet Potato Wedges, following its successful launch of Sweet Potato Fries into the foodservice market.

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Every carton of McCAIN Sweet Potato Wedges you buy also earns you ten My McCAIN Fries Advantage points. Collect and redeem points for more than 3,000 reward items at www.mymccainfriesadvantage.com.au.

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Palliative care conference

We invite you to attend the 12th Australian Palliative Care Conference: Palliative Care – everyone’s business on 3rd – 6th September 2013.

It’s a great time to come to Canberra – not only will you join over 700 delegates from across Australia and the world in sharing best practice, hearing the latest research, being challenged by keynote speakers and building valuable networks, but you’ll get to join Canberra’s biggest celebration in 100 years.

2013 is Canberra’s centenary and the city is celebrating all year with some great events. We’re doing our bit too! Join us at the conference when we host a glamorous event in the most iconic venue in Australia: the Centenary Gala Ball in the Great Hall at Parliament House. And the best news is – it’s included in your registration.

Registration for the most important event in the palliative care calendar is now open! To register go to www.dcconferences.com.au/apcc2013/registration.
Who’s moving

Help is on its way for NSW as Ray Creen, formerly CEO of the South Australian Ambulance Service, moves to Sydney to take up the key appointment as CEO of the Ambulance Service of NSW. NSW also extends a warm ‘bienvenue’ to Dr Jean-Frederic Levesque who has been appointed as the new Chief Executive of the Bureau of Health Information. He is currently Scientific Director of Analyses and Evaluation of Health Systems in Quebec’s Institute of Public Health in Canada.

Raju Narayan, former Divisional President of International Operations at Parkway Pantai, is joining Virtus Health as Director of International Business Development and will be based in Singapore.

More locally, Brendan Ayres, formerly with Ortho Group, is joining Virtus Health as State Managing Director of IVF Australia, based in Sydney.

Professor Keith McNeil has departed Metro North Health District in Brisbane, and Australia, to become Chief Executive of Cambridge University Hospitals, including Addenbrooke’s Hospital and Rosie Maternity Hospital in the United Kingdom.

Peter Mangles, former CEO of Pulse Health and more recently General Manager of International SOS’s operations at Freeport in Indonesia, has also moved to the UK as General Manager of Northern Europe with International SOS.

Heading overseas as well is Nick Champness, former Chief Operations Officer of Healthscope Pathology, who joins Abu Dhabi Health Services Company, SEHA.

Scott McLachlan, former Director of Operations at Hunter New England Health, is now CEO of Western NSW Local Health District.

Debra Cerasa is the new CEO of MS Australia. Debra was CEO of the Royal College of Nursing Australia.

Paul Monaghan, formerly with Queensland Health, is moving across to Greenslopes Private Hospital in Brisbane as Director of Corporate Services.

Kimberley Pierce, Executive Director of Clinical Services Redesign at Ernst & Young, is to be the new CEO of the new Sunshine Coast University Private Hospital, operated by Ramsay Healthcare.

Phil Green, formerly Finance Manager with Genea, has relocated to Christchurch as Chief Financial Officer of Conrad Medical Systems.

Belinda Moye is moving within SA Health. Belinda has previously been CEO of SA Country Health and is now CEO of the Southern Adelaide Local Hospital Network. Christine Dennis is travelling north. From her position as CEO of Southern Adelaide Local Hospital Network, Christine now takes up the role of Executive Director of Royal Darwin Hospital.

Simon James, former CEO of Brisbane Private Hospital, has been appointed CEO of Greater Metro South Medicare Local.
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.

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

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

Our focus is on improving safety and quality for patients and consumers in all healthcare settings. To do this we are working to achieve 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.

Membership Fees 2013 – 2014

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*Fee includes GST - valid from 1 July 2012 to 30 June 2013
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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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Be recognised as a leader in infection prevention

Announcing the 2013 HAI WATCHDOG* Awards

Kimberly-Clark Health Care created the HAI WATCHDOG* Awards to recognise HAI champions who make a difference in reducing and preventing these serious, often life-threatening Healthcare Associated Infections (HAIs).

Any HAI prevention program implemented between 1 September 2012 and 30 August 2013 is eligible.

The winning entries will receive a $1,500 educational grant for their facility from Kimberly-Clark and will be eligible for:

- Healthcare industry and local community recognition through news releases and features on www.haiwatchdog.com
- A commemorative plaque for first place winners.

2013 HAI WATCHDOG* Award Categories are:

Clinician’s Choice Award (may not be directly measured by specific HAI rate changes):
- This special category is determined by online voting

Panel-Judged (measurable changes in HAI rates over time):
- ICU Infection Prevention Initiative
- OR Infection Prevention Initiative
- CSSD Infection Prevention Initiative
- HAI Prevention Initiative – Facility Wide

DEADLINE FOR ENTRIES: 30 September 2013
Open to Australian and New Zealand hospitals

Submit your entry and view past global entries at the new and improved www.haiwatchdog.com

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