

# Report & Proceedings Australia's Health

2009 Congress on National Health Reform • Parliament House of Victoria



# Australia's Health

**GAP/ACHR Congress on National Health Reform**

**Melbourne, Australia**

**30 November 2009**

**For more information, contact:**

**Global Access Partners Pty Ltd**

53 Balfour St, Chippendale, Sydney NSW 2008  
Phone +61 2 8303 2416 Fax +61 2 9319 5754  
Website [www.globalaccesspartners.org](http://www.globalaccesspartners.org)

**Australian Centre for Health Research Ltd**

114 Albert Rd, South Melbourne VIC 3205  
Phone +61 3 8682 6745  
Website [www.achr.org](http://www.achr.org)



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*DISCLAIMER: This Report represents a wide range of views and interests of the participating individuals and organisations. Statements made during discussions are the personal opinions of the speakers and do not necessarily reflect those of the organisers and sponsors of the Congress.*

# Executive Summary

Health care remains one of the major political, financial and social issues in Australia and other OECD countries. National surveys reveal a common contradiction between people's greater satisfaction with their personal experience of care and a high level of dissatisfaction with "the system" as a whole. The growing proportion of elderly people and those with chronic conditions, escalating costs and increased expectations make the need for a comprehensive health sector reform as urgent and compelling as ever.

In Australia, the process of developing reform options was led by the National Health and Hospitals Reform Commission (NHHRC) which presented its findings and recommendations to the Government in a report "**A Healthier Future for All Australians**" released in July 2009. Their blueprint for reform, including a vision for "*a sustainable, high quality, responsive health system for all Australians, now and into the future*", became subject of ongoing public consultation and engagement with the community, health professionals and health services.

**The GAP/ACHR Congress on Australia's Health**, held at Parliament House of Victoria on 30 November 2009, was brought together to review major aspects of proposed and possible reforms and improvements required for the successful evolution of the Australian health sector.

Organised by business policy network Global Access Partners (GAP) and the Australian Centre for Health Research (ACHR), in association with the Australian National Consultative Committee on e-Health, the Congress assembled a prestigious audience comprising representatives from state and federal government, key figures from research, industry and commerce sectors, hospitals, insurers, pharmaceutical companies, area and district health services, and consumer groups.



The centrepiece of the Congress was the presentation by **Dr Christine Bennett**, Chair of the National Health and Hospitals Reform Commission and Chief Medical Officer of Bupa Australia (see pages 18-19.). Dr Bennett offered an overview of the Commission's recommendations and a series of personal observations. She welcomed feedback and suggestions from informed parties, and urged action from stakeholders in advance of government legislation.

Key points arising from the Congress included:

## ► The Case for Change

Health reform has remained a priority for successive governments and may come to dominate the national agenda. An ageing population and spiralling costs and expectations threaten to overwhelm a bewilderingly complex system bedevilled by excessive bureaucracy, organisational boundaries, financial recklessness, entrenched vested interests and consumer impotence.

Measures to improve indigenous and mental health, obesity rates, accessibility to affordable dentistry and the experience and outcomes of those with complex and chronic conditions are particular priorities and can only be met by a clear sighted and

consistent commitment to fundamental and permanent change.

Unfortunately, although States and health professionals have expressed a willingness to embrace change in principle, many speakers feared that only an impending financial crisis would force the necessary overhaul in practice.

#### ▶ **Principles of Reform**

The Congress broadly supported the recommendations laid out by the Reform Commission under its four themes of assuming responsibility, connecting care, tackling inequalities and driving quality performance.

Improvements should build on existing practice, address future challenges, tangibly improve patient care and contribute to improving the health of all Australians. Measures should focus on the patient experience, drive allocative rationality and clarify the public/private balance to achieve choice, equity and greater efficiency. Reform must embrace clinical practice, customer service, digital transformation and financial arrangements to empower patients, connect providers, tackle inequalities and encourage the assumption of personal and stakeholder responsibility.

Improvements in governance are key to achieving these aims, and intelligent change management is vital, embracing collaboration with doctors, nurses and other health professionals and improved workforce planning and staff training.

Although the impact of each reform must be assessed before its widespread implementation, the adoption of long overdue measures cannot be indefinitely stalled.

#### ▶ **Commonwealth Funding and Medicare Select**

The Congress generally endorsed a transition to a single Commonwealth funding mechanism for public hospitals,

with many participants favouring a more radical and immediate transformation than currently planned.

A public hospital system funded by the Commonwealth and owned and run by the States should incorporate devolved governance to reflect the needs and views of the local community and health workers. This fundamental reform, first proposed in 1942, will split purchaser and provider and foster transparency, negate overt cost shifting and minimise waste and inefficiency. Australian healthcare should emphasise wellness and prevention, rather than sickness and treatment, to meet the goal of a 'Healthy Australia'. Citizens should be encouraged to take responsibility for their lifestyles and healthcare choices through new insurance options such as Medicare Select, enhanced health education and clear information regarding the real cost of treatment.

Medicare Select has the potential to form a “meso level” structure between “macro” funders and “micro” health providers to pursue “smart purchasing” of primary, hospital and specialist care and rehabilitation and sub-acute facilities. By offering citizens an individual choice, the new framework can drive innovation and efficiency and so ensure its overall sustainability. Market forces can offer dynamism, diversity and competition with the Commonwealth guaranteeing a tax funded safety net for those most in need.

Improving primary sector resources and “connecting care” could reduce the pressure on public hospitals by a fifth, with general practitioners (GPs), pharmacists, optometrists, physicians and allied health professionals all playing an enhanced role alongside telemedicine and other innovative solutions.

The Congress noted calls from the Australian Medical Association for a major programme of public hospital investment and national commitments to improve training, indigenous

health and meet targets, including a bed occupancy rate of 85%.

▶ **e-Health**

The Australian National Consultative Committee on e-Health supports a single, standardised and scalable platform for the electronic case management of chronic conditions. On a wider scale, e-health initiatives can integrate systems, reduce fragmentation, streamline service delivery, avoid duplication and improve the quality and safety of treatment. Their roll-out should start with e-prescribing and the sharing of essential patient health information between health care providers.

All verified and certified clinical providers, from hospitals and GPs to pharmacists and optometrists, could have office systems to access electronic patient records. This would not only allow e-scripting, but also aggregate a patient's information from multiple and diverse health care contacts. Each patient would have a unique identifier giving them control of their data and allowing different health care providers graduated levels of access depending on their need. The costs could be met by patients, taxation, workplaces and health funds.

Electronic health records (EHR) can empower individuals, connect care and generate the data required to improve resource planning and treatment analysis, but the purchase of new e-health technology will not repair dysfunctional administrative systems. Although innovative solutions may spontaneously develop 'in the field' through greater connectivity, the basic administrative systems themselves require careful and rational planning.

Healthcare is “information dense, but “relationship-centric” and so technology should be seen in terms of relationships rather than information, creating user friendly pathways for communication, rather

than static repositories of data which merely increase workloads without clear patient benefit.

Concern was expressed at the cost of EHR, and speakers urged greater consideration of their use in practice. Some favoured a shift from applications and devices to connecting the assets already deployed and achieving substantive benefits with the existing investment. Central government should enable connectivity rather than force implementation of particular systems on unwilling participants.

### Conclusion

Reforming the health system to meet the changing needs of the 21<sup>st</sup> century depends on improving organisational administration, changing funding methodology, embracing e-health technology and, above all, revitalising governance at every level.

Inspirational leadership can transform strategy into operations, policy into management and principles and concepts into outcomes.

If reform is seen as a constant learning experience, and driven by the active consent and enthusiastic participation of health service workers, a transformed and re-invigorated Australian health system can deliver high quality care for all its citizens into the future.

Although debate remains regarding the pace and precise detail of reform, failure to embrace the urgent need for change is not an option.

# Partners & Sponsors

The GAP/ACHR Congress on Australia's Health 2009 was hosted by Global Access Partners (GAP) and the Australian Centre for Health Research (ACHR), in association with the Australian National Consultative Committee on e-Health and a number of government and industry partners.

**GAP** and **ACHR's** joint initiatives in health and wellbeing between 2005-2009 have ranged from discussions of national health policy to the problems of implementing an Australia-wide e-health infrastructure and the potential applications of genetic testing in drug therapy to the management and long-term funding of chronic "lifestyle" diseases in an ageing population. In the lead up to the Congress, GAP and ACHR staged several executive roundtables on the topic of health reform and initiated a research project led by the **Task Force on Australia's Health** to review major aspects of proposed reforms to drive the evolution of the Australian health sector.

The **Australian National Consultative Committee on e-Health (ANCCeH)** played a key role in the development of the Congress' agenda. Established by GAP in 2004, the Committee comprises business and government executives and academics and aims to explore, define and promote better patient health outcomes through the application of information technology. Cross-jurisdictional and bi-partisan by nature, the ANCCeH engages in extensive stakeholder consultation, prepares policy submissions and reports, initiates projects and, in association with GAP, hosts major national conferences.

The Congress was co-sponsored by **GAP's partners** whose role extends beyond the event through membership in the ANCCeH and other advisory bodies facilitated by GAP.

Our thanks go to the following organisations (listed in alphabetical order) for their contribution and foresight:

- ▶ **Australian Centre for Health Research**
- ▶ **Australian Unity**
- ▶ **Cisco Systems**
- ▶ **Department of Premier & Cabinet, Victorian Government**
- ▶ **GlaxoSmithKline**
- ▶ **Integrated Wireless**
- ▶ **Intel Australia Digital Health Group**
- ▶ **Open Forum**

*(for more information on the organisers, sponsors and partners of the GAP/ACHR Congress on Australia's Health, see App. 3, pages 39-47)*

# Keynote Speakers

The GAP/ACHR Congress on Australia's Health operated as a high-level multidisciplinary think-tank, following the standard principles of parliamentary procedure. Each delegate was able to promote their point of view and share their experiences.

The programme of the Congress (*see App. 1, pages 31-32*). was built around **four plenary sessions** and **a working lunch**, under the following headings:

- ▶ **Reforming Health: What Australian health care might look like in 2015**
- ▶ **Paying for Health: Australia's current health insurance scheme and its alternatives**
- ▶ **e-Health and Better Health Outcomes**
- ▶ **Future Health System Reform**

The keynote speakers and session chairs of GAP/ACHR Congress on Australia's Health were (in alphabetical order):

**The Hon. Neil Batt AO**

Executive Director,  
Australian Centre for Health Research

**A/Prof Adrian Nowitzke**

Chief Executive Officer, Gold Coast  
Health Service District

**Mr Ken Baxter**

Director, TFG International

**Dr Andrew Pesce**

President, Australian Medical Association

**Dr Christine Bennett**

Chief Medical Officer, Bupa Australia

**Mr Andrew Podger AO**

President, Institute of Public Administration  
Australia

**Mr Peter Brockhoff**

Area Vice President, Australia & New  
Zealand, Citrix Systems Asia Pacific

**Dr Kaveh Safavi**

Global Head IBSG, Healthcare Practice, Cisco

**Mr Peter Fritz AM**

Managing Director, Global Access Partners  
Group Managing Director, TCG Group

**Mr Tamati Shepherd**

Director e-Health Programme  
Queensland Health

**Mr Michael Gill**

Director, Internet Business Solutions Group  
(IBSG), Cisco Systems  
Australia & New Zealand

**Prof Johannes Stoelwinder**

Chair, Health Services Management  
School of Public Health & Preventive  
Medicine, Monash University

**Mr David Kalisch**

Commissioner, Productivity Commission

**Ms Fran Thorn**

Secretary, Department of Health, Victoria

**Dr George Margelis**

Industry Development Manager, Intel  
Australia Digital Health Group

**Dr Teresa Wall**

Deputy Director General, Maori Health  
Directorate, New Zealand

**Mr John Meckiff**

General Manager  
Remedy Healthcare

**Ms Deborah Waterhouse**

General Manager, GlaxoSmithKline,  
Australasia

# Report of the Proceedings

The key points made by each speaker are outlined below. Full transcriptions of the speeches are available on request from GAP.

**Mr Michael Gill**  
**Director, IBSG, Cisco Systems**  
**Australia & New Zealand**  
**Chair, Australian National Consultative**  
**Committee on e-Health (ANCCeH)**



Michael Gill welcomed participants to the Congress and thanked the sponsors who had made the event possible. He highlighted the importance of home based primary care and e-health's potential to integrate the primary and acute sectors in future reform of the Australian health care system.

Mr Gill outlined support of the ANCCeH for a single, standardised and scalable platform for electronic case management for chronic conditions. He said e-health can be 'crystallised' by the National Broadband Network, but warned the opportunity would be lost if its designers failed to consider connecting hospitals, practices and other organisations. He set out the Congress' agenda of systematic reform, touching on innovation, financial incentives, implementation and electronic health, before praising Victoria's record in health administration. He then introduced the opening speaker, Ms Fran Thorn.

**Ms Fran Thorn**  
**Secretary**  
**Department of Health, Victoria**

Fran Thorn stressed the importance of healthcare reform to the national and state agenda. She flagged the forthcoming meeting of the Council of Australian Governments (COAG) and recounted Victoria's signing of the Australian Healthcare Agreement with the Commonwealth and a set of national partnerships on indigenous health, preventive measures, workforce planning, activity-based funding and the sub-acute sector agreed at the previous meeting. She contemplated the abundance of further proposals, with the state facing 123 recommendations from the National Health and Hospital Reform Commission and a similar number from the Preventative Task Force and the National Primary Health Care Strategy.

The Victorian Government's commitment to improvement rests on the principles of building on existing practice, addressing the challenges of the future, tangibly improving patient care and contributing to improving Australian health. Ms Thorn praised the Victorian system as 'among the best in the world', encompassing Medicare and PBS, a mix of public and private service provision and shared funding of state-owned public hospitals. Victoria has adopted more formal devolution of public hospital and health service governance than other states, and has been more active in sub-acute facilities, cancer survival and chronic disease and readmission avoidance programs over the past decade than other jurisdictions.

Although Australia ranks in the top five OECD nations for life expectancy and cancer and cardiovascular survival rates, she acknowledged weaknesses including indigenous health, obesity, affordable dentistry and the experience and outcomes of those with complex and chronic conditions. Ms Thorn flagged the forthcoming challenges of the ageing 'baby boomer' generation, who will begin to retire in 2011 in poorer health, but with higher expectations than their predecessors. The number of senior citizens in Victoria will double by 2039, necessitating additional facilities and realigned approaches for chronic conditions. The co-ordination of care must involve enhanced workforce planning and development and a new era for e-health information management.



Victoria's priorities include the continued devolution of health service governance, a renewed focus on wellness and prevention and educating and training new health workers. Victoria seeks new arrangements for those with complex and chronic conditions, as the Australian health system can fail to deliver coordinated services across the patient journey. Although it works well with single treatments and discharges, it remains less effective for long term patients and struggles with linkages between hospitals and primary care providers and between the health system and aged care.

Ms Thorn believed the NHHRC options for voluntary enrolment of specific categories of patients, with measures to co-ordinate local care and transitions between the health and aged care systems, warrant

detailed consideration. This must cover a wide range of out-of-hospital providers including GPs, dentists, allied health workers and hospital outpatient services.

Since 2002 Victoria's HARP – the Hospital Admission Risk Program – has minimised the readmission of patients with complex and chronic conditions through the proactive management of at-risk patients. This provides for specialist multidisciplinary care in acute, community and domestic settings delivered through Primary Care Partnerships. This proven model of devolved governance and partnership in service co-ordination offers a way forward, but there is no 'one-size-fits-all' solution.

Ms Thorn envisioned 'special and additional services' for enrolled groups of patients and, possibly, an expanded range of patients for HARP type provisions with better technology to co-ordinate health records throughout the patient journey. She also saw a case for expanded 'case mix' Activity-Based-Funding alongside workforce realignment and planning.

#### **SESSION ONE - Reforming Health: What Australian health care might look like in 2015**

#### **Mr David Kalisch Commissioner, Productivity Commission**

Chairing the session, David Kalisch remarked on the complexity of the system in terms of public and private finance, accountability and responsibility and stressed the opportunities for structural reform.



## *“The five year vision”*

**Mr Andrew Podger AO**  
**President, Institute of Public**  
**Administration Australia**

Andrew Podger offered a pair of positive scenarios for 2015 based on the Commonwealth's acceptance of the bulk of the NHHRC's recommendations.



The first scenario envisioned the adoption of the *'Healthy Australia Accord'*. This would see a more comprehensive primary system and a well structured approach to aged, sub-acute and out-patient care funded by the Commonwealth. It would provide for a better managed public hospital system with shared funding, a modest expansion of dental provision, advances in IT and a firmer long-term approach to Indigenous health, preferably signalled by strengthening the Office for Aboriginal and Torres Strait Islander Health .

Mr Podger ruled out a major expansion of 'super clinics', but foresaw a mix of privately operated general practices offering a wide range of ancillary services; particularly in rural and regional areas. There would be no dramatic shift from fees for services although payment innovations may include greater rewards for achieving various population health outcomes and targets for service access. These changes would improve the co-ordination of care for chronically ill and at-risk people including the mentally ill and frail aged by rewarding the effectiveness of care as well as effort. Central funding will demand the

development of much improved regional planning processes.

If given full responsibility for aged care, the Commonwealth could implement a more comprehensive system of assessment, entitling people to appropriate services wherever they live. Supply-side controls may be relaxed, but demand-side measures might include accommodation bonds and fees for extra services, opening opportunities for provider innovation and competition. This should also forge closer links between hospital rehabilitation services, sub-acute care and long-term assessment and provision. Greater acceptance and availability of palliative care should lead to a more dignified and peaceful passing when all treatment options have been exhausted.

A national purchaser-provider model should lock-in the successful Victorian model of acute care, which includes independent, professional hospital boards employing CEOs capable of ensuring safety and efficiency. This will address the politicisation and bureaucratisation of hospitals seen in several States and Territories, encourage involvement by charities and churches and allow greater competition. Funding will be calculated according to both capacity and activity, particularly for hospitals with emergency departments that must handle substantial variations in workload. Mr Podger doubted the feasibility or affordability of the NHHRC model for dentistry, particularly by 2015. A more modest approach might focus on preventative care for children, services for chronically ill patients and perhaps a more general safety net arrangement.

The next five years should see tangible progress in health IT, with a new Medicare smart-card integrating personal health records to support coordinated care.

The direct funding by the Commonwealth of 40% of hospital activity costs should help Medicare Australia link MBS and PBS data bases to hospital information. This would

allow the development of risk-rated premiums for Medicare-covered services for different groups and demonstrate the cost-effectiveness of various approaches to caring for the chronically ill.

Reform has been slowed by the call to link medical administrative data to social security and tax information. As this offers few tangible benefits to the public and raises privacy concerns, it is unlikely to eventuate and should not draw attention from the health agenda.

Mr Podger offered three further proposals to focus on patients, rather than providers, achieve allocation efficiency and clarify the public/private balance to achieve choice, equity and greater efficiency. These comprised a 'sensible' regional planning network allowing the Commonwealth to take responsibility for primary care, the establishment of a unit to calculate risk-rated premiums for different groups of Australians linked to best practice care regimes and a trial replacement to the PHI rebate with a risk-rated premium in exchange for the health funds accepting full responsibility for the health care of members who agree to participate in the trial.

He regretted the rejection by the NHHRC of his second, more radical scenario, involving a complete Commonwealth assumption of funding, not least because it would provide a better platform for testing Medicare Select. He believed the Prime Minister had erred in framing a Commonwealth take over as a penalty for state mismanagement, rather than a sensible proposition for reform and argued that it would address existing boundary problems and avoid the risk of incremental action increasing duplication and bureaucracy.

A continuing reliance on 'co-operation' prolongs the stasis which has seen proposals for a Commonwealth take over of non-hospital aged care languish for nearly five years despite cross party agreement.

Mr Podger's preferred scenario would involve a Commonwealth financial take-over

within five years. This would comprise a financial deal involving renegotiation of the GST agreement in exchange for full financial responsibility by mid 2011, the establishment of a project team to manage the take-over by the end of 2013 and a further 2 to 3 year period to rationalise bureaucracies, establish consistent purchasing policies for hospitals services and establish an overall regional planning framework. This scenario would see a single Commonwealth funder and purchaser by 2015, giving a framework which focussed on patients, addressed gaps and inequities and opened opportunities to switch resources between primary, acute and sub-acute care according to patient needs and economic rationality. The framework would enable a coherent approach to co-payments and test the theoretically attractive, but unproven benefits of managed competition.

Although both scenarios were optimistic and required steadfast government commitment to change in the face of fickle public opinion and entrenched lobby groups, Mr Podger believed financial reality would force action and further delay or incremental timidity was futile.

### ***“The Biggest Loser and Mozart – a possible platform for radical reform?”***

#### **A/Prof Adrian Nowitzke Chief Executive Officer, Gold Coast Health Service District**

Prof Adrian Nowitzke offered a pragmatic view of reform from his perspective as CEO of the Gold Coast Health Service District, noting that problems cannot be solved with the same thinking which created them. As health spending tends to increase by 8% per annum while GDP increases by only 3.5%, projections suggest health will consume the entire state budget by 2040. Unfortunately, it is notoriously difficult for people to accept the need for change until conditions become critical, by which time it can be too late.

The Gold Coast is Australia's fastest growing region, its health service increases by 12.5% per annum and doubled between 2002 to 2007. The Queensland Government is investing over \$2 billion of health infrastructure for delivery by December 2012, doubling the number of hospital beds. Such modern hospitals require equally advanced administration, but such systems do not create themselves, it is not enough to merely have good doctors, nurses and managers and hope that a rational system emerges.



The Gold Coast approach rests on four pillars – clinical care, customer service, digital transformation and financial reform – and tackle entrenched hierarchies and old fashioned practices. Robina, a \$270 million expansion, has been designed without a paper-based medical records department for example, although the risks of forcing medical professionals to use new and unfamiliar systems were acknowledged. Prof Nowitzke said that doctors put clinical care ahead of financial considerations when prescribing expensive drugs or treatments, but warned 'we can't do it any more'.

He wanted to design a system, rather than let one emerge haphazardly, which eased the 'patient journey' rather than measure 'stop points' of waiting times along the way. This could best be done with a single funder and one person ultimately responsible for care in all sectors in a region to ease conflicts through intelligent supply chain management. He observed that funding for extra treatment could be found through the

elimination of internal waste, as well as additional tax funded expenditure.

Prof Nowitzke championed a health system based on partnership and cited the example *Project Mozart* may set. He wanted not only public and private health providers, but suppliers of transport, logistics and communications to become involved, closing his remarks with a quote by Henry Ford - *"Coming together is a beginning, staying together is progress, but working together is success."*

## Discussion

Delegates made the following points in the subsequent discussion:

- ▶ A single funder system will only succeed if given a considerable degree of flexibility at regional and local levels regarding service delivery.
- ▶ Suspicion of bureaucrats and committees on the part of health professionals can be counter productive, and a collaborative problem solving approach to achieve reform of a complex system with multiple drivers is required.
- ▶ An 'incremental' approach would see a regional framework with divisions of primary care, similar to the model proposed by the Commonwealth at COAG, although care should be taken to avoid the creation of another level of bureaucracy which merely gives an excuse for existing structures to evade responsibility.
- ▶ Some speakers believed that reforms 'acceptable to the masses' were doomed to failure, and advocated more radical change. The focus should be designing an ideal system, rather than tinkering with flawed components already in place.
- ▶ Empowering patients, connecting healthcare, tackling inequalities and taking responsibility were identified as priorities, with the need to formally measure outcomes in an effective way and develop inspiring leadership particularly important.

▶ The health care system can be seen as an “orchestra without a conductor”, and the problem of reconciling growing consumer expectations with limited health care resources in the light of competing demands for resources remains. Politics can not be divorced from such essentially political decisions.

▶ The health system belongs to the community, with its workforce its custodians. Goodwill alone drives many prevention programmes at present and incentives are required for further development. The proposed increase from 2% to 4% of total spending on prevention is insufficient. A system with one person in overall control would encourage preventative measures to reduce costs in the system as a whole.

▶ Some speakers praised the Commission's report, but questioned the focus of its four 'pillars'. Reform requires broad support to succeed and the Prime Minister's proposed referendum is key. The complexity of the insurance and public/private funding system is a major stumbling block, and a single Commonwealth funder could open up models such as Medicare Select and boost competition. Regional governance of funding, planning and outpatient resources should be the aim, rather than regionalised delivery.

▶ Others advocated radical grass-roots reform and warned against the danger of confirmation bias in discussions among those habituated to the current system. “Trade vocational ownership” could provide an internal barrier to reform. Patients demanded greater control of their care and e-health should be tailored for them, rather than presented as a tool for doctors and hospitals.

▶ Nurses had been under-represented in the debate, despite comprising 65% of the workforce. Nurses have a unique skill set and should be developed into a “more professional, more educated group” with

a growing role for nurse practitioners assisting doctors.

▶ More accurate methods for measuring risk premiums and the return on investment in preventative measures are required. Private insurance funds were beginning to manage financial risk by identifying and managing groups at risk, rather than merely “bumping up premiums”.

▶ Fears were expressed that concentrating power in the hands of the Federal Health Minister would see that individual held responsible for “every single thing that goes wrong anywhere in the health system in Australia”. The current pretence of uniform costs for aged care across the country has created a uniform subsidy system at variance with reality because of fears of the appearance of favouritism. The centralisation of control can create the irrationality, perverse incentives and intrusive bureaucracy it is designed to alleviate.

## SESSION TWO - Paying for Health: Australia's current health insurance scheme and its alternatives

**The Hon. Neil Batt AO**  
**Executive Director,**  
**Australian Centre for Health Research**



Introducing the session, Mr Batt observed that health reform had been a priority of successive governments without result, and lamented the excessive bureaucracy, financial recklessness and consumer impotence inherent in the current arrangements.

*“Sustaining Medicare – everyone needs to be involved”*

**Prof Johannes Stoelwinder**  
**Chair, Health Services Management**  
**School of Public Health & Preventive**  
**Medicine, Monash University**



Prof Stoelwinder analysed Medicare's viability as a publicly funded universal health scheme over the next twenty years and highlighted the financial and governance challenges to its sustainability. He believed the recommendations of the Commission needed to be strengthened to ensure the system's survival.

Australia currently spends 9.1% of GDP on health, near the OECD average. The 2007 Intergenerational Report projects that public spending will nearly double in 2046/47 while other studies put the figure as high as 12.5% of GDP by 2042, particularly if the Commonwealth becomes the sole funder of Medicare. The public will expect immediate access to advanced services regardless of cost, straining a system in which providers deliver a significant amount of inappropriate, inefficient and discretionary care, perhaps comprising almost a third of total expenditure.

Healthcare faces long standing problems of waiting list rationing and treatment delays, the fragmentation and complexity of chronic care and a lack of standardisation that makes the gains available from e-health and other organisational strategies hard to realise. These problems persist due to

failures of governance. Health professionals are the experts on the care required and, as the community supports and trusts their clinical autonomy, their representative organisations wield significant power. Special interest groups lobby within the political system to buttress and expand their power and budgets, with public hospitals, for example, skilled in playing the media to gain funding through increasing voter pressure on politicians.

Two weeks prior to the discussion of the Australian Health Care Agreement at COAG in November 2009, the AMA ran a 'media blitz' on its "Public Hospital Report Card", calling for an immediate injection of \$3billion. The Premiers followed two days before the meeting with a demand for \$2.4billion and an annual increase of 9%. In the event the Commonwealth agreed to inject \$2.55 billion and fund increases of 7.3% for the next 5 years, a target which may well prove unsustainable. There is no counter to these pressures in the political process, with the public trusting medical interest groups more than its own representatives. The Howard Government oversaw similar increases in hospital funding, despite being accused of starving the system of funds.

The Rudd Government established the National Health and Hospitals Reform Commission which backed "one health system", with all public funding provided by the Commonwealth. Its mandate did not cover private funding. The Commission urged COAG to adopt a "Healthy Australia Accord" agreeing the respective roles of Commonwealth, State and Territory governments. It envisioned the Commonwealth progressively assuming funding responsibility for public hospitals, initially covering 40% of each episode of care, although many state politicians oppose greater Commonwealth control, and the assumption of at least 40% Commonwealth funding for public hospitals may prompt the states to indulge in higher expenditures. Finally, it advocated further research into a tax funded health plan called Medicare

Select, rooted in the 'managed competition' regime proposed by US Economist Alain Enthoven in the 1970s and partially implemented in the Netherlands today. Kevin Rudd announced a further six months of consultation prior to a special COAG meeting to assess the States' views, hinting at a referendum if agreement was not forthcoming.

Medicare Select would form a “meso level” structure between “macro” funders and “micro” providers to pursue “smart purchasing” across all elements from primary care, disease management programs, specialist and hospital care to rehabilitation and sub-acute facilities. This was preferred as an alternative to State Government health departments taking the role, as they do in Canada, or regional health authorities purchasing services on behalf of a geographical area as with the NHS in Great Britain as neither of these systems offer citizens an individual choice and thus provide no competitive framework to drive efficiency and improved service delivery.

All Australian residents would remain covered by Medicare, with citizens given the option of joining an alternative health and hospital plan, taking their Medicare funding, adjusted for their risk, with them. These plans would be developed by private health insurance funds and perhaps by State Governments or health provider groups such as the Catholic health group. Although this would offer improved choice and create competition, its continued reliance on taxation meant “political games' would merely shift from the State to Federal stage. Prof Stoelwinder favoured a more radical approach to encourage greater price competition by adopting more features of the Dutch model.

He advocated hypothecating 7% of taxation as a Medicare levy, creating an explicit link between economic growth and health spending. The addition of a compulsory and substantial community-rated direct premium of around \$2,000 per adult would then create intense price competition between

plans. Income tax would be reduced accordingly to leave each individual's tax burden the same. These arrangements would engage consumers in the allocation of health spending and move the battle between interest groups from politics and the media to the market place. Competing plans, rather than public sector bureaucracies, would balance consumer preference and provider relationships, while the Commonwealth, as the single funder, would decide the scope of the basic Medicare package. The Dutch experience has controlled cost increases while eradicating waiting lists and could reap the same benefits here.

#### *“Practicalities and politics of implementation”*

**Mr Ken Baxter**  
**Director, TFG International**

The next keynote speaker, Mr Ken Baxter, believed that only the spectre of financial collapse could spur radical reform, given healthcare's entrenched vested interests. He recounted how the transfer of health responsibilities from the States to the Commonwealth had been proposed by Prime Minister Curtin in 1942 but, despite the support of the Opposition and State premiers, the measure had been defeated by referendum. In 1953 the Minister of Health, Sir Earl Page, proposed amendments to the National Health Act similar to those proposed today. Mr Baxter believed reforms had failed due to the accretion of a complex piecemeal bureaucracy and the dearth of accurate data with which to weigh options for change.

He revealed that New South Wales employed as many as 30,000 people in health service administration, compared to 11,000 in Victoria. He said strained relations between States and Commonwealth stymied reform while many functions should either be carried out by local government or abandoned altogether.



Mr Baxter favoured a review of the fundamental functions of government to a reliance on line budgeting held hostage by entrenched vested interests. Public hospitals in New South Wales are borrowing from forward appropriations and shifting funds from capital allocations to running costs in the expectation that public and media pressure will force politicians to make good the deficits in the future. The system is subject to no penalties and is under no pressure to improve.

Mr Baxter praised the Victorian system as far in advance of other states and saw potential in *Project Mozart*.

### Discussion

▶ Australia can learn from the lessons of reform in the Dutch and German systems, but battles between States and Commonwealth will persist as long as Australia retains the current model of federation. The theoretical benefits of Medicare Select are still unproven in Australia and the Dutch history of sickness funds with broad responsibilities differs from Australia's private health insurance offering more limited coverage. The principles of consumer sovereignty and engagement in the Dutch system, rather than their historical structure, are relevant to Australia.

▶ The states have, to varying degrees, devolved health accountability and responsibility, but politicians still exploit the resonance of health issues with the public.

Problems are not solved by management consultants, but by politicians and stakeholders taking personal responsibility for their primary functions and leaving day to day public relations and crisis management to a unit tasked with immediate responses.

▶ The current system lacks incentives for patients to minimise costs. Medicare patients gain no sense of treatment costs from handing over a card for bulk billing and are unaware that the Medicare levy and surcharges cover a fraction of the programme's cost. Persuading consumers to engage with such costs is complex, as co-payments would reduce frivolous use, but discriminate against those on low incomes. Payment mechanisms could drive incentives for patients and doctors. All countries face the conundrum of maintaining universality of high quality care in the face of spiralling costs and increasing expectations. Better treatment cost information could discourage patient drug hoarding.

Pensioners believe a PBS script to be worth \$5.30 when its true cost averages \$42.80. Pharmacists must share responsibility for reducing costs, but do not write scripts or approve drugs for usage.

▶ Demand management and customer education can enable informed decision making. Innovation can be generated 'in the field' rather than be dispensed from central bodies or imposed through regulatory regimes, although Victoria has seen successful centralised initiatives. The Commonwealth and some states have attempted to manage demand, reduce hospital admissions and encourage consumer self responsibility and future methods could include pricing, preventative health care programmes and withholding treatment from those abusing the service. "No nonsense" triage by strong willed nurses in Emergency Rooms could weed out time wasters, but health decisions have a moral dimension other sectors lack.

▶ Customers will pay for good service, which can often consist of reassurance and information from a GP. Technological

solutions could reassure the 30% of patients who visit their doctor or emergency room for emotional support, rather than treatment.

- ▶ The re-planning of the Royal North Shore Hospital and the dismantling of its community health services was criticised.
- ▶ Privatisation in public services in Holland had skewed the treatment of mild disorders such as anxiety and depression towards hospitalisation to generate revenue and hindered the funding of complex, long-term care. Transparent accountability systems, including an independent mental health commission reporting to the Prime Minister and State Premiers, may be valuable to prevent this in Australia.
- ▶ A single funder, to unify public sector funding in a complex system of myriad service providers, is favoured by many. A government-run bureaucracy would be subject to political lobbying while a new structure of consumer choice would allow direct engagement by the public. Payment arrangements should provide positive incentives whatever their source, otherwise consumer-driven health care would merely increase demand, rather than manage it.
- ▶ A series of small country hospitals have gradually declined and disappeared and funding of several city hospitals has been wasteful and illogical for decades. Property rights mean the 'social infrastructure' of pharmacists and physiotherapists can not be reformed 'overnight', but the States' habitual indifference to managing their own assets distorts the picture. Premiers habitually announce the one-off capital cost of new projects, rather than their total expenses. These hidden expenditures mean future infrastructure spending will be severely limited.
- ▶ Private and public models could co-operate rather than compete.
- ▶ Australia has made bold reformist steps in the past, including the GST and Medibank, but may still not be prepared for such radical change in healthcare. Healthcare systems may be 'too big to fail' and, as in the banking

sector, only a crisis may precipitate long overdue reform.

- ▶ Lines were drawn between a system driven by consumer demand and one in which people were educated to make rational purchasing decisions. Younger generations already search the Internet for information on a perceived illness and present a doctor with their own, usually fallacious, diagnosis and treatment regime. A personal, conversational approach is often most effective, but doctors are reimbursed for discrete time periods and so have no incentive to give patients more time.
- ▶ Clear career trajectories for clinical nurses would encourage the recruitment and retention of high quality staff. Nurse practitioners could be given Medicare provider numbers to increase their power and autonomy. Many nurses who have recently re-entered the workforce due to the recent downturn may leave once more as the economy recovers and so the problem of future shortages of health workers in an ageing workforce offering other opportunities remains. Health careers could be marketed in terms of personal interaction and satisfaction, rather than financial remuneration.
- ▶ Properly funded preventative programmes could create a true 'health' system, rather than a 'sickness system'. Subsidies would encourage the proliferation of such programmes and it was agreed that the approach would be useful if funded on outcomes.
- ▶ The “mezzo” organisations of New Zealand were praised for their success in reducing costs and increasing the take up of services. It remained to be proven if the costs of creating new systems would be justified by the benefits they brought to the community.

## LUNCH

**Dr Christine Bennett**  
**Chief Medical Officer, Bupa Australia**



Dr Christine Bennett, Chair of the National Health and Hospital Reform Commission, revealed that discussions in the Commission had been diverse and robust, but that a common focus on improving healthcare for Australians had united all concerned. She believed the existing system had reached a tipping point, and although it still offered a high level of care, its structural flaws had to be addressed to meet customer demands and changing needs. Content that the Commission had drawn criticism for both undue radicalism and conservatism, Dr Bennett believed its proposed reforms would endure a decade and tackle the challenges of an aging population, soaring costs, increasing expectations, changing patterns of disease and looming workforce shortages. Its 123 recommendations pursued 4 themes of assuming responsibility, connecting care, tackling inequalities and driving quality performance.

Dr Bennett believed citizens could be encouraged to embrace personal responsibility for their health through a greater focus on wellness and the development of the *Healthy Australia* goals. She wished to improve health literacy and empower consumers to make informed lifestyle and healthcare decisions.

“Connecting care” could reduce the pressure on public hospitals by a fifth through alternative options in primary healthcare with GPs, pharmacists,

optometrists, physicians and allied health professionals all playing an enhanced role. She emphasised the importance of sub acute care in rehabilitating patients and said improving choice and competition in aged care could release between 10 and 15% of hospital beds. Together with improvements in sub acute and advanced care planning, 3000 acute beds could be released to treat 160,000 more cases a year. She acknowledged persistent inequalities in the system and that universal entitlement did not equate to universal access. Indigenous and rural health provision, mental health and the cost of dentistry remained problematic and the intellectually disabled suffered from a 20 year deficit in average life expectancy.

Driving quality performance depended on improved leadership and governance, financial reform and new incentives. With a tightening labour market, Dr Bennett underlined the importance of gaining full value from the workforce which remained the sector's most important asset.

She hoped to see a 'wellness' rather than an 'illness' system, prioritising prevention and healthy lifestyles and the enlightened management of chronic problems, and believed that a single public funder of public health care would optimise allocative efficiency. This goal would be gradually realised with the Commonwealth initially assuming responsibility for the primary sector and outpatient and ambulatory and aged care. She saw Medicare Select as the key to driving choice, competition, innovation, efficiency and sustainability.

Dr Bennett favoured the creation of individually controlled electronic health records, aggregating and organising the information gained from every contact with the health system. On the macro level, she called for the “smart use” of information held in databases in Canberra. This knowledge should be combined, linked and made available to health care providers,

planners and funders to enable rational decision making.

She looked forward to the COAG meeting on 7 December 2009, which would be followed by further discussions and a second COAG meeting in March-April 2010, to formalise agreements between the States and Commonwealth. She welcomed feedback and suggestions from informed parties and urged action from stakeholders in advance of Government legislation as reform could be driven at a local as well as national level.

In answer to questions from the audience, Dr Bennett praised the willingness of States to contemplate a range of changes in funding arrangements and flagged her own preference for a range of publicly owned enterprises offering a fully integrated service in a single Commonwealth payer system. She saw Medicare Select acting like a regional purchasing authority available to all and envisioned a future in which people with chronic and complex care needs or mental illness could select a plan which would purchase all their health care for them. She confirmed the Commission had explicitly rejected the notion of 40 to 100 regional health authorities independently purchasing services they also owned.

She anticipated a system in which all verified and certified clinical providers - hospitals, GPs, pharmacists, optometrists, chiropractors, etc. - had office systems to access electronic patient records. This would not only allow e-scripting and e-prescribing, but also would aggregate a patient's information from multiple and diverse health care contacts. Each patient would have a unique identifier allowing different health care providers different levels of access depending on their need. This should improve continuity of care and reduce wasteful duplication of testing. The costs could be met by patients, taxation, workplaces and health funds. Dr Bennett foresaw a universal entitlement and service obligation applying to all Australians,

possibly shaped by community priorities as well as questions of sustainability and affordability. Market forces would offer diversity and competition with the Commonwealth offering a safety net for those most in need.

She praised Victoria's relatively robust public health system and its provision of community health and sub acute care. Its governance offered professionalism, clear accountability and activity based funding, but she admitted this structure might not transfer to other regional contexts.

Dr Bennett complimented the innovations in the Northern Territory regarding shared electronic health records and chronic disease management, and Western Australia's record in health promotion, falls prevention, networking and ante natal care in indigenous populations. She praised Queensland's drive for quality and accountability, South Australia's efforts to boost community based services to minimise hospital admissions, and New South Wales' clinical senate and GP Linked programmes. She saw the professionalism of local health enterprise governance as key, and favoured health providers' CEOs, rather than politicians, assuming accountability for service provision.



### SESSION THREE - e-Health and Better Health Outcomes

**Dr George Margelis**  
**Industry Development Manager**  
**Intel Australia Digital Health Group**

Chairing the session, George Margelis defined e-health as the use of information and communication technologies in the delivery of health care and remarked on the growing number of people with clinical backgrounds at work in the IT industry. He believed e-health to be a far more challenging proposition than the habitual comparison to the banking industry implied, and said its focus was shifting from technical efficiency to practical effectiveness for patients.

#### *"Rewriting the boundaries of health information"*

**Mr Tamati Shepherd**  
**Director e-Health Programme**  
**Queensland Health**

Tamati Shepherd outlined Queensland's e-health provision, remarking that Australia's e-health policy had altered little over a decade, with agreement on the potential of electronic health records and health identifiers and the need for privacy safeguards and a standards based approach.

Queensland has invested heavily in ICT infrastructure, with an annual \$100 million budget boosted by \$243 million over 4 years in 2007. This has produced benefits for clinicians, patients and support staff, particularly in the realm of mental health. Patients with mental health conditions have records which can be viewed anywhere in the state, an important advance given the significant population travelling between Cairns and Brisbane on a seasonal basis.

X rays taken in the Torres Straits Islands can now be analysed in Townsville, while a chronic disease management system used

with young Islanders may reduce future hospitalisations by up to 40%. A shift to prevention and the use of information systems to foster collaboration can transform healthcare in the indigenous communities.



State-wide electronic discharge summaries are improving continuity of care between acute (hospital) and primary (GP) domains and a state-wide breast screening programme linked to an imaging data system is improving rates of cancer detection. Queensland Health is about to permit the electronic transmission of referrals, a radical step forward from its previously secretive attitude to information distribution. Doctors will also be able to access waiting times in outpatients departments, allowing appointments to be booked with regard to access and viewed immediately as with an airline booking system.

The next wave of initiatives will include the expansion of electronic medical records and a scanning system to abolish paper charts. The patient administration system will enable each patient to maintain a single ID across the state. Electronic medical record viewers will enable any clinician to access a patient's state-wide record, be it in a primary or community health care centre, a large hospital or from their home. Innovations are assessed by the benefits they will accrue and each investment, including infrastructure such as wireless technology, is mapped to its impact on access, safety, quality, and productivity.

The success of the Queensland e-health agenda depends on four elements - people, processes, policy, and a standards-based integrated technology platform. The change management required has been undertaken in partnership with PriceWaterhouseCoopers to avoid such problems as nurses being trained in EHR, but remaining unfamiliar with the Windows system they ran in, as happened in New South Wales. Queensland introduces new processes with paper before moving them to the electronic realm, recognising that the implementation of new systems will not fix broken processes. It uses simulation centres to assess work-flows, human factors and patient safety before new systems are launched, but such innovations are then introduced without endless delay. Mr Shepherd revealed *“we’ve stopped asking permission and we’ve just started doing.”* He believed that bold action could remove artificial barriers between health providers, be they junior practitioners, private specialists or other professionals. In conclusion, he argued that *“we have reflected on reports and recommendations on reports for a long time now - it’s time to commit to action.”*

*“Why is this taking so long?”*

**Dr Kaveh Safavi**  
**Global Head IBSG, Healthcare Practice**  
**Cisco USA**



Kaveh Safavi recalled that *“the promise of e-health has been five years away for at least the past 15 years”*. Grand plans are seldom implemented as written and reform

inevitably involves making continuous modifications and corrections along the way. He offered 5 lessons drawn from the past 15 years of experience in the United States and elsewhere.

Firstly, Mr Safavi recommended shifting the focus from applications and devices to connecting the assets already deployed and achieving substantive benefits with the existing investment. A Commonwealth study shows that 80% of Australian primary care practices have electronic health records, compared with less than a quarter in the US and Canada. However, experience in Queensland demonstrates that primary care physicians still generate around 5 pieces of paper for every referral as the 'electronic filing cabinet' is not connected to other stakeholders and *“without a highway system, even the best cars go nowhere.”*

In advocating action, rather than the creation of static repositories, Mr Safavi observed that while the American Kaiser and Intermountain systems both integrate hospitals, physicians and insurance organisations, the Intermountain system achieves this without a CPOE system and with relatively rudimentary electronic health records by focussing on process improvement and interventions at critical points, particularly medication. The Kaiser system relies more heavily on EHR and is only now beginning to extract value from the billion dollars invested in it.

Secondly, Mr Safavi urged delegates to consider technology in terms of relationships rather than information. He termed healthcare *“information dense”*, but *“relationship-centric”*. Sociological research showed that patients sought care and compassion in equal measure and patient satisfaction derives from metrics which are seldom collated, e.g. the responsiveness of a nurse to a call for pain medication. American health workers stress the importance of missing or broken equipment, navigating labyrinthine hospital layouts and finding the people or documents they need as crucial to their efficiency and morale,

factors ignored by the grand plans for EHR and similar schemes. The successful implementation of EHR, therefore, would not fundamentally improve the experience of either patients or staff despite the grandiose claims made for its potential impact.

Nurses spend a third of their time trying to locate the people they need to complete their tasks, and only 20% of their shift engaged in the face to face patient care they are trained for. This results in hospitals spending 20% more than they need to on expensive mobile physical assets - wheelchairs and IV pumps – as staff tend to secrete them away to be sure of finding them when required. This is not a problem which EHR will solve.

Thirdly, Mr Safavi said technology had to become easier to use. Health IT has tended to introduce complexity into everyday tasks, rather than reduce it as promised. Technology, from healthcare to games such as Wii, become widely accepted when a general audience finds it easy to use. American experience shows that a physician's office introducing an EHR and practice management system will actually increase its work load by 18%, due to its complexity. The success of future innovation depends on improving ease of use.

Fourthly, Mr Safavi called on government to understand and serve its function as a public utility, but not to force implementation on unwilling participants. Instead of throwing money at the problem, it should step back, set standards and allow an open eco-system to develop. It should facilitate experimentation, not least because the technologies are not fully matured.

Finally, Mr Safavi stressed the importance of access and equity in e-health. Telemedicine, by providing care at a distance – could address the fundamental problem of limited supply and infinite demand, and a robust infrastructure, reliant on high quality

connectivity still to be achieved in many rural areas, could revolutionise care. It will be particularly useful for younger generations, reared on the Internet, mobile phones and virtual communication. He saw the task as tacking a boat into the wind with an endless series of smart, refined adjustments. Given sufficient will and ingenuity, progress to the destination could always be made, despite the prevailing conditions. Reform required a commitment to continuous learning, rather than a master plan with a final clear destination and a specified set of procedures imposed to reach it.

## Discussion

▶ Although health administration in New South Wales is routinely criticised, it was observed that 41 NSW hospitals have functional electronic medical records (EMR), 40 more than the rest of Australia. EMR will be fundamental to Queensland's hospitals, 5,500 primary health care clinicians and 4000 GPs and throughout the non-hospital clinical environment from sub-acute and acute care to rehabilitation and aged care. The 'one chart per patient' approach on the Gold Coast has proved highly successful and will be even more productive when digitised and placed online.

▶ No individual has a single document holding all their financial records, but the ability to use information and make transactions is enabled by standardisation and connectivity. A national e-health strategy focused on connectivity could profitably involve indigenous communities in the Northern Territory, for example, but need not imply a similar structure for everyone. The Reform Commission recommends a national Electronic Health Record for all Australians by 2012 at a cost of around \$1.4 billion, and the money may be more productively utilised elsewhere. The national e-health strategy should concentrate on high-priority solutions, rather than the record in itself. Massive

expenditures on EHR could be wasted, if proper consideration is not given to their use in practice and their effect on treatment and outcomes. Expensive IT programmes cannot solve problems caused by dysfunctional organisations. Clinicians often object to the 'time and motion' studies required to maximise efficiency and the use of 'process experts' requires delicate management. Simple problems such as failing to advertise outpatient clinic opening times will not be solved by EHR.

- ▶ More drug sales should be electronically recorded. The linking of key medicines to the record could improve the management of chronic disease.
- ▶ There is a danger that every State is investing in myriads of IT solutions to solve similar problems. The States could collaborate in joint purchasing to leverage their investment across multiple jurisdictions and reap the rewards in cost savings and better process designs. Duplication has been recognised as a problem and progress on the issue made since 2005 with senior administrators and ministers now more willing to share experience between jurisdictions. However, questions of power, control and sovereignty are inevitable and co-operation between stakeholders remains a low priority in the absence of a compelling common benefit. Clinicians see new processes as increasing the workload, rather than easing it, and politicians are unwilling to give up power in the cause of greater connectivity. Plans to allow every citizen of the European Union access to their medical record in any member country were mired in political, rather than technical, delay. Technological improvements are pointless in the absence of process reforms.
- ▶ Between 2 and 4 billion dollars have been spent in Australia on health related IT over the past 15 years, but the full benefits have not been reaped due to disputes over sovereignty and inconsistencies in Commonwealth management. Without clear guidance from ministers and secretaries regarding the information they require, it

remains impossible to design the IT systems needed to produce it.

- ▶ Electronic records have been “five years off” for the last 15 years and many records are inadequately completed, rendering them useless for their purpose. Specific programmes can tackle identifiable problems, but there is little evidence that ubiquitous EHR will produce better patient outcomes, let alone a universal panacea. Furthermore, information and drug opt-outs allowed by person-controlled health records will hamper their effectiveness in driving efficiency and routing out abuse and misuse.
- ▶ EHR allows clinicians to engage in conversation about a case freed from constraints of geography and time. The technology should be judged on its ability to facilitate such conversations, rather than be an 'electronic filing cabinet'. The Internet's connectivity allows solutions and innovations to emerge, given some baseline common standards, at low cost in unanticipated directions. Health connectivity, rather than centralisation or decentralisation, is therefore the key, while the laborious construction of centralised systems leads to obsolete and forgotten projects, such as the French Viatel scheme.
- ▶ Most nurses still lack basic Internet access at work, so talk of Web 2.0 solutions is moot when most health workers did not have access to Web 1.0. Small practical steps, rather than grandiose plans, may prove most productive on the ground. Once workers are given access, they quickly embrace the technology and develop new solutions.



## SESSION FOUR - Future Health System Reform

### *“Practical Immediate Health Reform”*

**Dr Andrew Pesce**  
**President**  
**Australian Medical Association**



Dr Andrew Pesce acknowledged that health reform was a ubiquitous clarion call, but said change would only be embedded when supported by those tasked with its operation. This in turn depended on their co-operation being gained through negotiation and consultation throughout the process. He lamented the glacial speed of reform and outlined the AMA's response to the Commission's recommendations in the form of a priority investment plan.

He wished to abolish the 'blame game' by the Commonwealth fully funding a public hospital system owned and run by the States, with improved local governance to reflect the needs and views of the local community and health workers. A split between purchaser and provider would foster transparency, negate overt cost shifting and help minimise waste and inefficiency. The creation of a single public funder for public hospital services and primary and aged care would be a logical first step and ensure the adequacy of funding in one area could not be used as an excuse for poor patient access in another.

Dr Pesce advocated the continuation of existing fee-for-service MBS and PBS arrangements and pointed out the irony of academics criticising fee-for-service payment systems for doctors, while advocating a

similar scheme for hospitals. The AMA believes Commonwealth funding should incorporate sufficient loadings, adjustments and flexibility to reflect the disparate circumstances of individual hospitals and that such funding should also support research and development, training and capital funding for public hospital infrastructure.

The AMA wish to see national targets and performance indicators developed by the Commonwealth and States and clinician input translated into service planning to take account of local needs. An independent audit report should then allow performance to be measured against the agreed national targets.

Dr Pesce highlighted the importance of the Commission's target of 85% bed occupancy. Although the Commonwealth has recently provided additional funds for new beds, there is no comprehensive and coordinated strategy to open and staff them, and so the AMA advocates a stock take to ensure the target is met and a 'bed watch' system to maintain it. He revealed that the “access block” seen in emergency departments results from the inability to move inpatients, rather than an excess of patients entering the emergency room. He wanted 90% of patients to wait no more than 8 hours before reaching an in-patient bed or being transferred to another hospital for admission.

The AMA supports the roll-out of e-health initiatives to integrate systems, reduce fragmentation, streamline service delivery, reduce duplication and improve quality and safety. The roll-out should start with e-prescribing and the sharing of essential patient health information between health care providers. Greater education and support for health professionals would further engage them in the e-health revolution.

He supported the Commission's focus on multi-disciplinary primary care and believed

that general practice could lead the way, if given the necessary infrastructure. Citizens see their GP for prevention advice, sickness, injury and chronic disease management, and the nation's 7000 general practices are a massive resource which could be developed through Commonwealth support. Existing practices could develop into primary care centres similar to the comprehensive centres envisioned by the Commission, or provide specific additional services tailored to local needs. Enhanced infrastructure could support improved community-based training, on-site collaborative care and integrate nurse practitioner services, buttressing the GP's leading role while expanding the range of community services they provide.

Dr Pesce identified a lack of vocational training places compared to the numbers expected to graduate from medical schools and so urged action to expand the training infrastructure and improve workforce planning, in collaboration with doctors, to match training places with anticipated demand.

He supported improvements in indigenous healthcare in remote communities, with additional grants to Aboriginal primary care services, more training opportunities for indigenous medical students and improved pay and conditions for doctors wishing to work in the sector. He advocated the funding of hundreds of new indigenous medical practitioners and for community groups and non-government organisations to close the 'indigenous health gap'. To further improve services in rural and remote areas, he said the government should support the rural rescue package developed by the AMA with the Rural Doctors Association of Australia.

Dr Pesce identified "other forgotten people in the system", particularly those in sub-acute care, and urged improvements in restorative services and post-hospital support for rehabilitation and convalescence. He also supported a

no-fault, comprehensive national disability insurance scheme to cover the cost of long-term care for people with serious disabilities in addition to the national aged care program.

He supported the Commission's proposed initiatives to expand early intervention for young people with mental health issues, but criticised the lack of attention paid to acute mental health care - often required on an in-patient basis - during initial diagnosis, stabilisation or while patients were at risk of relapse through changes in medication. He believed the government should reassess the number of psychiatric in-patient beds required in the public hospital system, further integrate psychiatrists into community-based care and offer targeted funding for psychiatric nurses and psychologists to collaborate with GPs.

In summary, Dr Pesce believed the AMA's investment plan of incentives, infrastructure and ongoing funding to be practical and necessary and urged its immediate implementation to improve the standard of Australian health care.

***"Bedfellows or combatants: the balance between innovating health technology and maximising the value of the health dollar"***

**Ms Deborah Waterhouse**  
**General Manager, GlaxoSmithKline,**  
**Australasia**

Debra Waterhouse weighed the balance between health innovation and value for money. Those who pay for healthcare are demanding evidence of the effectiveness of the services they purchase from both government and drug companies.

There is a growing emphasis on preventative measures, rather than intervention, and healthcare solutions in preference to 'products' to treat a particular illness. These demands are becoming more insistent as the population ages and treatment options

expand, while the general community seeks value from its onerous burden of tax. Simply increasing expenditure is no longer seen as intrinsically beneficial and the pharmaceutical industry is under particular scrutiny as drugs are often an uncapped budget allocation. Increasingly, new initiatives must be funded by savings in other areas, rather than extra public spending.



The pharmaceutical industry has traditionally opposed any reforms which threaten its revenue, issuing dire warnings of reductions in drug innovation to forestall the imposition of spending limitations. Pharmaceutical and biotechnology companies spend in excess of 10% of turnover on R&D and six of the top ten global spenders on R&D are pharmaceuticals. A new drug can absorb over \$1 billion over 13 years of development, while \$200 billion worth of products are losing their 20 year patents in next four years.

Ongoing demographic pressure and the recent global financial crisis have forced governments to reassess health costs, but breakthrough treatments for chronic diseases, HIV, oncology and neurology emerge only because the industry assumes it will obtain a return on its investment. Furthermore, the industry's R&D productivity is now in steep decline – last year over \$50bl was spent on R&D and less than 20 NCE were approved by FDA, while in 1982 less than \$US2bl was spent on R&D for same number of NCEs approved.

The pharmaceutical industry is under unprecedented pressure from governments of all persuasions through the non-approval of new drugs, price caps, cuts and rebates and tightened patient targeting. Australia led the world in the early 1990s in evaluating the economic and medical benefit of new drugs to maximise the value of every health dollar, and a 2009 report shows the Australian government pays 19% less than the OECD average for new drugs. Other spending will be assessed as stringently as medicines and vaccines in the future as governments seek to cut costs across the board.

Allied to their commitment to original research and development, many companies have banked on developing 'me too' drugs based on the R&D of other organisations to offer to the PBAC. Companies are now initiating meetings with purchasers at a much earlier point in product development to mitigate some of the risk involved while providing government bodies with early insights into future healthcare solutions. Researchers are increasingly offered benefits linked to the delivery of a “reimbursable product” – e.g. one which governments value and will pay for.

The industry has to work to build trust with the community and government, and should never take for granted its right to exist. The new environment demands collaboration from all sides.

### *“Collaborative Models of Care – the Introduction of the Medical Home”*

**Mr John Meckiff**  
**General Manager**  
**Remedy Healthcare**



John Meckiff explained that his company, Remedy Healthcare, a disease management business started by Australian Unity in 2009, provides telephone-based self-management guidance to people diagnosed with chronic disease. He recounted the case of a coronary patient whose acute heart failure had been picked up by the service and, while admitting this had been fortuitous, cited reports which showed significant improvements in care linked to telemedicine.

Such telemonitoring services needed to be integrated with primary healthcare providers, GPs and pharmacies to maximise their effectiveness and reforms in hospital emergency admittance, to allow more conditions such as pneumonia and cellulitis to be managed at home, and better discharge planning to avoid re-admittance were also required.

Mr Meckiff echoed calls for ICT to be deployed as a productivity tool to facilitate the swift distribution of information, rather than an static repository.

## Discussion

- ▶ Greater training in health informatics would be beneficial.
- ▶ Improved management will transform strategy into operations, policy into practice and principles and concepts into outcomes.
- ▶ Regions vary in their enthusiasm for the proposed reforms. New South Wales was identified as “the most dysfunctional state in terms of interaction between the top level decision making and the clinicians at the ground”. Many NSW Health professionals are dissatisfied with hospital management structures, but their concerns are dismissed by government as having been orchestrated by the AMA.
- ▶ Research undertaken for Medicines Australia suggests citizens find health reform too complex an issue to engage with and rely on the government 'sorting it out.'

- ▶ Mental healthcare had trail blazed 'hospital in the home' schemes in the 1960s, and such schemes can promote medication compliance and family engagement and keep vulnerable patients out of hospital.

- ▶ Management is a specialist area in itself and it should not be assumed that skilled doctors or nurses will automatically make good managers. Current administrative priorities tend to reflect current political imperatives, rather than real consumer demand.

- ▶ Many doctors have little understanding of markets, although many managers are no better versed in business or economics. Large profits in the pharmaceutical industry are seen as suspect when they would be praised in any other sector. The pharmaceutical industry forms an easy target for governments seeking to save money. PBS allows the exact measurement of expenditure on scripts and the rational assessment of their costs and benefits.

- ▶ Health investment can be championed as beneficial for both individuals and the national economy. Doctors, managers and other stakeholders have different skill sets and only by working together can the goals of better service at sustainable cost be realised.

## Special Address

**Dr Teresa Wall**  
**Deputy Director General, Maori Health Directorate, New Zealand**



Dr Teresa Wall remarked on the complexity of Australia's system, before offering her experience of Maori health provision. Maori health indices were poorer than those of the general population, but the New Zealand Public and Health Disability Act 2000 has required district health boards – which both fund and provide services – to work to reduce inequalities. The Maori Health Research team commission research into the state of care and monitor the system.

New Zealand has invested \$2.4 billion over the last 7 years to build a system with low access costs and a focus on primary health care. Data suggests that lowering costs has significantly improved access for indigenous and low income groups, not least for dental care.

There have also been steps to increase Maori participation in governance and decision making and develop the Maori health workforce. Dr Wall argued that the collection of ethnic data was vital in monitoring progress and suggesting areas which required urgent attention. Most health systems are data rich but information poor. She reminded participants that *“if we always do what we've always done, we're always going to get what we've always got.”*

### Closing Remarks

**Dr George Margelis**  
Industry Development Manager, Intel  
Australia Digital Health Group

Dr Margelis observed that people instinctively resist change, with human bodies hard-wired for homeostasis and evolutionary change occurring over extended frames. He likened health reform to evolutionary change with only the fittest destined to survive. Although healthcare has been seen as unique, offering one-to-one physical and emotional contact unlike any other industry, economic realities demand that new models must be sought in the future.



Other industries, such as banking, have revolutionised their practices through technology, and medicine has to follow their example. This requires change from doctors who began their careers 20 years ago, as well as newly qualified staff. Dr Margelis called on those present to take action where they could to drive change and innovation, not least by sharing best practice with colleagues, management and government and arguing the case of reform.

**Mr Peter Fritz AM**  
Managing Director, Global Access Partners  
Group Managing Director, TCG Group

Mr Fritz concluded the Congress by thanking the participants, event organisers and sponsors. He invited those present to GAP's summit on Australia's economic well-being in September 2010, noting its inclusion of health issues and timing at the beginning of the budget session.



# The Steering Committee

The Steering Committee of government and business executives and health experts worked over a year on the Congress' programme, goals and objectives, topics for discussion and a continuity strategy, to ensure outcomes are achieved beyond the event.

The members of the Steering committee for the GAP/ACHR Congress on Australia's Health 2009 were (in alphabetical order):

**The Hon. Neil Batt AO**

Executive Director  
Australian Centre for Health Research

**Mr Ken Baxter**

Director, TFG International  
Chair, Task Force on Australia's Health

**Mrs Olga Bodrova**

Project Manager  
Global Access Partners

**Ms Alison Boldys**

Assistant to the Chairman,  
Australian Unity  
Assistant to the Executive Director,  
Australian Centre for Health Research

**Mr Peter Fritz AM**

Group Managing Director  
TCG Group  
Managing Director  
Global Access Partners

**Catherine Fritz-Kalish**

General Manager  
Global Access Partners

**Mr Michael Gill (Chair)**

Director, Internet Business  
Solutions Group, Cisco Systems  
Chair, Australian National Consultative  
Committee on e-Health

**Dr Stan Goldstein**

Head of Clinical Advisory  
BUPA Australia

**Ms Alison Gordon**

Manager, Client Services  
Global Access Partners

**Mr Alex Gosman**

Director  
Government & Corporate Affairs  
GlaxoSmithKline

**Mr Robert Lippiatt**

Executive Director  
SPC Consulting Group

**Dr George Margelis**

Industry Development Manager  
Digital Health Group  
Intel Australia

**Mr Peter Thomas**

Director  
TFG International

# Participating Organisations

100 delegates from the following 78 organisations participated in the GAP/ACHR Congress on Australia's Health (for the full list of delegates, see App. 4, pages 48-51):

- ▶ Aged & Community Services Australia
- ▶ Aged Care Association Australia
- ▶ Australian Centre for Health Research
- ▶ Australian Food and Grocery Council
- ▶ Australian General Practice Accreditation
- ▶ Australian Health Services Alliance
- ▶ Australian Healthcare Association
- ▶ Australian Medical Association
- ▶ Australian Unity
- ▶ Baker IDI Heart and Diabetes Institute
- ▶ Brisbane South Division
- ▶ BUPA Australia Group
- ▶ Cancer Care Centre, St George Hospital
- ▶ Catholic Health Australia
- ▶ Centre for Health Innovation
- ▶ Cisco Systems, Australia & New Zealand
- ▶ Cisco Systems, USA
- ▶ Citrix Systems Asia Pacific
- ▶ CRS Australia
- ▶ Deloitte Actuaries & Consultants
- ▶ Deloitte Economics
- ▶ Deloitte Touche Tohmatsu
- ▶ Department of Broadband, Communications & the Digital Economy, Australian Government
- ▶ Department of Climate Change, Environment, Energy & Water, ACT Government
- ▶ Department of Human Services, Victorian Government
- ▶ Department of Premier & Cabinet, Victorian Government
- ▶ Direkt Consulting Pty Ltd
- ▶ Eastern Health, Victoria
- ▶ Enterprise Intelligence
- ▶ Fit (Slovenia) International
- ▶ Fitness Australia
- ▶ General Practice Victoria
- ▶ GlaxoSmithKline
- ▶ Global Access Partners
- ▶ Global Health Limited
- ▶ GMHBA Health Insurance
- ▶ Gold Coast Health Service District, Gold Coast Hospital
- ▶ GP Partners
- ▶ Health Informatics Society of Australia
- ▶ Healthways International
- ▶ HICAPS
- ▶ HP Enterprise Services
- ▶ IBM Australia
- ▶ Information Integrity Solutions
- ▶ Institute of Public Administration
- ▶ Integrated Wireless
- ▶ Intel Australia
- ▶ Janssen-Cilag Pty Ltd (Periaqua)
- ▶ Joint Technology Partners
- ▶ Lateral Economics
- ▶ Maori Health Directorate, New Zealand
- ▶ Medibank Private
- ▶ Melbourne East General Practice Network
- ▶ Mental Health Services Conference Inc.
- ▶ Microsoft Australia
- ▶ Mileage Media
- ▶ Monash University, Faculty of Medicine, Nursing and Health Sciences
- ▶ Monash University, School of Public Health & Preventative Medicine
- ▶ National e-Health Transition Authority
- ▶ Navy Health
- ▶ Nous Group
- ▶ Open Forum
- ▶ Pharmacy Guild of Australia
- ▶ Precedence Health Care
- ▶ Productivity Commission
- ▶ Queensland Health, Information Division
- ▶ Remedy Healthcare
- ▶ Safe Climate Australia
- ▶ Society for Knowledge Economics
- ▶ SPC Consulting Group
- ▶ St John of God
- ▶ St Vincent's Centre for Nursing Research
- ▶ State Services Authority, Victoria
- ▶ TCG Group
- ▶ TFG International
- ▶ The Age
- ▶ University of Sydney, Faculty of Medicine
- ▶ Western Sydney Area Health Service

# Appendices

## Appendix 1 - Programme

8:30am	Registration	<b>Legislative Assembly Chamber</b> Parliament House of Victoria, Spring St, Melbourne
9:00am	Welcome and Introduction	<b>Mr Michael Gill</b> Director, Internet Business Solutions Group (IBSG) Cisco Systems, Australia & New Zealand Chair, Australian National Consultative Committee on e-Health
9:10am	Opening Address	<b>Ms Fran Thorn</b> Secretary, Department of Health, Victoria
9:25am	<b>Session One</b>	<b>Reforming Health: What Australian health care might look like in 2015</b>
	Session Chair	<b>Mr David Kalisch</b> Commissioner, Productivity Commission Australian Government <i>“The five year vision”</i> <b>Mr Andrew Podger AO</b> President, Institute of Public Administration Australia <i>“The Biggest Loser and Mozart – a possible platform for radical reform?”</i> <b>A/Prof Adrian Nowitzke</b> Chief Executive Officer Gold Coast Health Service District
9:55am	Discussion	
10:30am	Morning Tea	
10:50am	<b>Session Two</b>	<b>Paying for Health: Australia’s current health insurance scheme and its alternatives</b>
	Session Chair	<b>The Honourable Neil Batt AO</b> Executive Director Australian Centre for Health Research <i>“Sustaining Medicare – everyone needs to be involved”</i> <b>Prof Johannes Stoelwinder</b> Chair, Health Services Management, School of Public Health & Preventive Medicine, Monash University <i>“Practicalities and politics of implementation”</i> <b>Mr Ken Baxter</b> Director, TFG International Chair, GAP Task Force on Australia’s Health
11:35am	Discussion	

12:30pm	<b>Lunch</b>	<b>Queen's Hall, Parliament House</b>
	Introduction	<b>Mr Peter Brockhoff</b> Area Vice President, Australia & New Zealand Citrix Systems Asia Pacific
	Keynote Address	<b>Dr Christine Bennett</b> Chief Medical Officer, Bupa Australia
1:45pm	<b>Session Three</b>	<b>e-Health and Better Health Outcomes</b>
	Session Chair	<b>Dr George Margelis</b> Industry Development Manager Intel Australia Digital Health Group <i>"Rewriting the boundaries of health information"</i> <b>Mr Tamati Shepherd</b> Director, e-Health Programme, Queensland Health <i>"Why is this taking so long?"</i> <b>Dr Kaveh Safavi</b> Global Head IBSG, Healthcare Practice, Cisco USA
2:20pm	Discussion	
3:00pm	<b>Session Four</b>	<b>Future Health System Reform</b>
	Session Chair	<b>Mr Michael Gill</b> Director, IBSG, Cisco Systems, Australia & New Zealand Chair, ANCCeH <i>"Practical Immediate Health Reform"</i> <b>Dr Andrew Pesce</b> President, Australian Medical Association <i>"Bedfellows or combatants: the balance between innovating health technology and maximising the value of the health dollar"</i> <b>Ms Deborah Waterhouse</b> General Manager, GlaxoSmithKline, Australasia <i>"Collaborative Models of Care – the Introduction of the Medical Home"</i> <b>Mr John Meckiff</b> General Manager, Remedy Healthcare
3:55pm	Discussion	
4:25pm	Special Address	<b>Dr Teresa Wall</b> Deputy Director General, Maori Health Directorate, New Zealand
	Closing remarks	<b>Dr George Margelis</b> Industry Development Manage Intel Australia Digital Health Group
4:40pm	Vote of thanks	<b>Mr Peter Fritz AM</b> Managing Director, Global Access Partners Group Managing Director, TCG Group
4:45pm	Close	

## Appendix 2 – Speakers’ Profiles



**The Hon. Neil Batt AO**

Executive Director  
Australian Centre for  
Health Research

Neil Batt joined the Australian Centre for Health Research (ACHR) as Executive Director upon launch. In a distinguished political career, he is a former Tasmanian Deputy Premier, Treasurer and Ombudsman for Tasmania and was the National President of the Australian Labor Party. As former Resident Director of TNT Ansett Group in Western Australia and TNT in Victoria, and a former Chairman of Heine Management Limited and CSL as well as General Manager Victoria of the Australian Health Insurance Association, he has also had a notable executive career.



**Mr Ken Baxter**

Director  
TFG International  
Chair, GAP Task Force  
on Australia’s Health

Ken Baxter is Chairman of TFG International Pty Ltd, Director of Baxter & Associates Pty Ltd, Chairman of PNG Energy Development Ltd, Director of XRF Scientific Ltd & The Traffic Group Ltd, and the Tasmanian Symphony Orchestra. Previously Ken held positions of non-Executive Director of Hydro-Electric Corporation of Tasmania and Air Niugini Ltd, and served as Policy Adviser to the Chief Secretary of the PNG Government. A former Secretary of Victorian Department of Premier & Cabinet and Director-General of NSW Premier’s Department, Ken also worked as Commissioner of the Australian National Railways Commission, Chairman of the Australian Dairy

Corporation and the Australian Dairy Research and Development Corporation. In 2008, TFG International Pty Ltd released a report into *‘The Operation and Future of the Australian Health Care Agreements (AHCAs) and the funding of public hospitals’* for the Australian Centre for Health Research Ltd. It drew on the extensive experiences Ken Baxter and his colleagues had with AHCAs and the Australian health sector & Commonwealth-State relations.



**Dr Christine Bennett**

Chief Medical Officer  
Bupa Australia

Dr Christine Bennett was appointed as Chief Medical Officer of Bupa Australia in June 2008. Prior to that she was MBF’s Group Executive, Health and Financial Solutions and Chief Medical Officer since 1 May 2006. Dr Bennett has over 25 years of health industry experience in clinical care, strategic planning and senior management. Prior to joining MBF Dr Bennett was the CEO of Research Australia and she has held chief executive positions in public, private and social enterprises including Chief Executive at Westmead – Australia’s largest teaching hospital. Dr Bennett also has experience as a commercial consultant and advisor in health and biotech industries for KPMG Australia, is a Fellow of the Royal Australasian College of Physicians and on the board of HeartWare, a publicly listed medical device company. Dr Bennett has an active commitment to and involvement in medical professional issues, social policy and medical research. In February 2008, Dr Bennett was appointed by the Prime Minister Kevin Rudd to be Chair of the National Health and Hospitals Reform Commission that provided advice to governments on a long term blue print for the future of the Australian health system.



**Mr Peter Brockhoff**

Area Vice President  
Australia & New  
Zealand, Citrix  
Systems Asia Pacific

Peter Brockhoff is responsible for the strategic development and direction of Citrix Systems across Australia and New Zealand (ANZ), providing marketing and sales leadership throughout the region, including a focus on Customers & Partners. His responsibilities also include driving growth through new market opportunities, integrating new products into the region and ensuring the company's development, especially at the enterprise level and in key vertical markets. Peter joined Citrix in 2001. Since then he has held a number of leadership roles in channel, government and enterprise sales within Australia and New Zealand. Before becoming Area Vice President, he was instrumental in leading the ANZ Enterprise Sales Teams to record growth, while introducing various channel initiatives to help Citrix partners enhance their skill set and increase their sales across a diverse product line. Peter has more than 26 years of experience in the technology industry. Prior to joining Citrix, Peter was with IBM for over 15 years, where he held senior positions in sales and channel management as well as senior account executive roles.



**Mr Peter Fritz AM**

Managing Director  
Global Access Partners  
Group Managing Director  
TCG Group

Peter Fritz is Managing Director of GAP, and Group Managing Director of TCG - a diverse group of companies which over the last 37 years has produced many breakthrough discoveries in computer and communication technologies. In 1993, some of the 65 companies in the Group were publicly floated on the Australian Stock Exchange as TechComm Group Limited (now called Utility

Computer Services UXC), with great success. Another former TCG company floated on the New York Stock Exchange in November 1997 for US\$600m, making it the largest technology company to be established in Australia until that time. In 2000 Peter established Global Access Partners (GAP) - a not-for-profit organisation which initiates high-level discussions on the most pressing social, economic and structural issues and challenges across a broad range of Australian economic sectors. Peter Fritz also chairs a number of influential government and private enterprise boards and is active in the international arena, including having represented Australia on the OECD Small and Medium Size Enterprise Committee. He is the holder of six degrees and professional qualifications, is a recipient of the Order of Australia, and has received many other honours.



**Mr Michael Gill**

Director, Internet Business  
Solutions Group  
Cisco Systems  
Australia & New Zealand

Michael is deeply involved in health from two perspectives: how connectivity can improve health outcomes and using Internet technologies for chronic care. He is responsible for Australia and New Zealand for Cisco's Internet Business Solutions Group (IBSG) whose mandate is to generate independent thinking across the sector. Michael brings over 20 years of experience across both public and private sectors. He has worked throughout the South Pacific, United States of America, India, Singapore, Hong Kong, The People's Republic of China and New Zealand. In recent years Michael has been heavily engaged with innovations in health planning and delivery in Australia, New Zealand and Singapore, in particular. New Zealand is the first country to have developed a national architecture for health connectivity. Across the health sector he has built extensive relationships with a variety of senior health decision makers and provided strategy advice linking architecture and ICT innovation with improved health outcomes at a systemic level. He maintains a strong interest in the use of internet technologies in the areas of aged care and mental health. Michael is a former chartered

member of the Institute of Management Consultants, member of the Market Research Society of Australia, former member of the Institute of Public Administration and former board member, Fabric Inc, families in crisis, ACT. Michael holds a degree in Statistics and Sociology and postgraduate qualifications from the Australian National University.



**Mr David Kalisch**  
Commissioner  
Productivity Commission

David Kalisch was appointed a full-time Commissioner of the Productivity Commission in June 2009. Previously, David had been a Deputy Secretary in the Department of Health and Ageing, with responsibility for portfolio strategies, acute care policy and hospital financing, health workforce, mental health and the South Australian and Western Australian offices of the Department. David is an economist who has worked in a range of social policy areas in the Commonwealth Departments of Employment, Social Security, Prime Minister and Cabinet, Family and Community Services and Health and Ageing since the early 1980s. This has included research and analysis, policy advising and program management in areas as diverse as labour markets and employment policy, retirement incomes, family assistance, children's services, welfare reform, and health services. He has also worked in the Employment Programs Division and the Social Policy Division of the Organisation for Economic Cooperation and Development (OECD) and at the Australian Delegation to the OECD in Paris. David has been a member of the Board of the Australian Institute of Family Studies, the Australian Institute of Health and Welfare and the National Blood Authority. He has a Bachelor of Economics (Honours) degree from the University of Adelaide.



**Dr George Margelis**  
Industry Development  
Manager, Intel Australia Digital  
Health Group

George took on the role of Industry Development Manager for Intel's new Digital Health Group in November 2005. For him it was an opportunity to take an active role in changing the way healthcare was delivered in Australia. Prior to moving to Intel Australia he was very active in the healthcare informatics arena as the CIO of a private hospital group in Sydney, manager of an innovative software development group developing solutions for healthcare providers and consumers, and board member at the state and national level of the Health Informatics Society of Australia. He is a registered medical practitioner having graduated from the University of Sydney. He is also a registered optometrist and holds a graduate degree in E-Business from the University of Southern Queensland. He ran a successful software company during the heady days of the late 80's and early 90's and has been an active computer enthusiast from the late 70's when he acquired his first PC, a Sinclair Z80.



**Mr John Meckiff**  
General Manager  
Remedy Healthcare

John Meckiff is General Manager of Remedy Healthcare, a preventative healthcare business and wholly owned subsidiary of Australian Unity Limited. John is a qualified Physiotherapist with 10 years clinical experience in both the public and private sectors and also holds an MBA from Melbourne Business School. Prior to his role at Remedy, John was Director of Evidence Based Solutions, a healthcare consultancy and had previously worked as a Manager at Mitchell Madison Group and Deloitte Consulting. Over 8 years, John has consulted to a broad range of clients in healthcare including Sanofi-Aventis,

Barwon Health, Western Health, St John of God Hospital, Australian Unity Health, Medibank Private and Cabrini Hospitals. He has also consulted to a broad range of clients in financial services, telecommunications and general insurance.



**A/Prof Adrian Nowitzke**

Chief Executive Officer  
Gold Coast Health  
Service District, Gold  
Coast Hospital

Dr Adrian Nowitzke is the Chief Executive Officer of the Gold Coast Health Service District in Queensland. He is a specialist neurosurgeon and an Associate Professor of Surgery. Married, with two young children, he has a passion for serving the community and a love and respect for the privilege of being a provider of healthcare. As the project owner of one of Australia's largest healthcare infrastructure building programs, and the CEO of a rapidly growing Service, he has a pragmatic lens regarding the challenges of driving reform in the healthcare industry.



**Dr Andrew Pesce**

President  
Australian Medical  
Association

Dr Andrew Pesce was elected Federal President of the Australian Medical Association (AMA) in May 2009. The AMA represents the interests of more than 27,000 medical practitioners from all specialties and locations across Australia. Dr Pesce is an Obstetrician and Gynaecologist who works both in private and public practice. He has been Clinical Director of Women's Health for Sydney West Area Health Service since 2006. Dr Pesce's priorities as AMA President include engaging with government to influence national health policy debate for the benefit of

patients, the medical profession and the broader community. He is also committed to increasing the AMA's membership base. In 2006, he was awarded the AMA President's Award for his work representing the profession during the medical indemnity crisis. Dr Pesce was Chair of the AMA Medical Indemnity Taskforce from 2003 to 2007 and was appointed to the Federal Government's Medical Indemnity Advisory Panel in 2003 and to the Medical Indemnity Review Panel in 2006. Dr Pesce was the Obstetricians and Gynaecologists Craft Group representative on AMA Federal Council from 2001 to 2007 and an AMA Executive Councillor from 2005 to 2007. He was Chair of the Ministerial Expert Advisory Committee on Pregnancy Counselling from 2007-2009 and Chair of the National Association of Specialist Obstetricians and Gynaecologists from 2006 to July 2009. Dr Pesce graduated from The University of NSW in 1983 and became a Fellow of the Australian and New Zealand College of Obstetricians and Gynaecologists in 1990. He was awarded the Chris Hudson Fellowship for 1991-92, which enabled him to train at Whipps Cross and St Bartholomew Hospitals in London.



**Mr Andrew Podger AO**

President, Institute of Public  
Administration Australia

Andrew Podger is National President of the Institute of Public Administration Australia and Adjunct Professor in public administration at both the ANU and Griffith University, and Visiting Professor at Xi'an Jiao Tong University. Before his retirement from the Australian Public Service in 2005, Andrew chaired a task force for the Prime Minister on the delivery of health services in Australia. Prior to that, he was the Public Service Commissioner for three years following six years as Secretary of the Department of Health and Aged Care. He has also headed the Departments of Housing and Regional Development and Administrative Services. Andrew has completed a wide range of consultancies including chairing a review of military superannuation, advising on budget reform in the Philippines and public service

reform in Timor Leste, and chairing a review of the culture of Australian Defence Force training establishments. He has also published articles and spoken frequently on public administration and social policy. His most recent publication is a book on the role of departmental secretaries.



**Dr Kaveh Safavi**  
Global Head IBSG  
Healthcare Practice, Cisco

Kaveh Safavi is vice president and global lead of the Healthcare Practice for the Cisco Internet Business Solutions Group (IBSG), the global strategic consulting arm of Cisco. Kaveh's leadership experience spans the USA healthcare sector - from physician offices and hospitals, to insurers, to the boards of biotech companies. He is a frequent speaker, has published numerous papers and articles, and is a popular source for the healthcare media. Dr Safavi is board-certified in internal medicine and pediatrics. His clinical experience includes four years at the University of Michigan Medical Center, Internal Medicine and Pediatric Residency Program. He possesses medical and law degrees, from Loyola University and DePaul University, Chicago USA, respectively.



**Mr Tamati Shepherd**  
Director  
e-Health Programme  
Queensland Health

Tamati Rangi Shepherd (Tam) has a background in ICT, Law and Political Science with degrees from Victoria University in Wellington. Tam has held a number of leadership roles in the public and private sectors over the past 15 years, including key roles in transformation projects in the welfare, taxation and healthcare sectors. Tam is the Queensland Health Senior Director for e-Health and is responsible for the

implementation of Queensland's e-Health Strategy. He brings to this role deep public and private sector expertise in New Zealand as a Manager in the welfare portfolio and Australia as the head of the e-Health Branch of the Commonwealth Department of Health and Ageing and as former lead consultant with CISCO's Internet Business Solutions Group ANZ. Tam was in charge of significant Federal/National programs as an Assistant Secretary, including the development of the work test and child care subsidy programs in New Zealand; implementation of GST for the ATO; Electronic Health agenda in Australia, Broadband for Health; Chair of the Australian Government inter agency committee on electronic health initiatives; Chair of the National e-Health Committee; Member of the Cabinet Committee on identification management and access card.



**Prof Johannes Stoelwinder**  
Chair, Health Services  
Management  
School of Public Health &  
Preventive Medicine  
Monash University

Professor Johannes (Just) Stoelwinder is Chair of Health Services Management, School of Public Health and Preventive Medicine, Monash University and a Non-Executive Director of Medibank Private Limited. Just was the foundation Chief Executive Officer of the Southern Health Care Network and of the Monash Medical Centre in Melbourne. He has been a Director of a number of public and private sector health care organisations and has been a consultant to academic, government and private clients in Australia, Canada, USA and the UK. Just has published extensively on health policy, organisational change, management development, quality and safety, managing health professionals and management accounting in journals, monographs and textbooks.



**Ms Fran Thorn**  
Secretary  
Department of Health  
Victoria

Fran Thorn has been appointed Secretary of the Department of Health after heading the Department of Human Services since March 2007. Between 2005 and early 2007, Fran was Secretary of the Department of Innovation, Industry and Regional Development. Prior to this, she was with DSE as Under Secretary, Portfolio Performance. From 2002 to mid-2004, she was a Deputy Secretary of the Policy and Cabinet Group in the Department of Premier and Cabinet. Between 1996 and 2001, Fran Thorn was a Director of KPMG Consulting in Australia and then Hong Kong. While at KPMG, Fran primarily consulted to the education sector and government, providing advice on policy implementation, program evaluation strategy, costing and refocusing service delivery and future directions at government and the funded-institution level. Before joining KPMG, Fran spent 17 years in public sector administration—with about half of that in post compulsory education and training—where she held senior management roles with major policy development, budget, staffing, program management and strategic planning functions. She has been actively involved in managing implementation of reforms in government service delivery in education and training at a system-wide level and in the management of human resources at a public sector-wide level.



**Dr Teresa Wall**  
Deputy Director General  
Maori Health Directorate  
New Zealand

Dr Teresa Wall is of Te Rarawa and Te Aupouri descent and has been with the Ministry since 1997. She has over 20 years experience working in the health sector in a number of roles. She began her health sector career in

nursing and in particular renal nursing. Teresa's previous role was Manager, Māori Health Policy. She was responsible (with the Public Health Directorate) for the development and dissemination of the inequalities tools across the Ministry and District Health Boards, and provided input towards the Ministry's response to the Ministerial review of ethnically targeted policies and programmes. Teresa also led the review of the National Kaitiaki Group following the Gisborne Cervical Screening Inquiry and represented the Ministry on a number of inter-agency officials groups.



**Ms Deborah Waterhouse**  
General Manager  
GlaxoSmithKline  
Australasia

Deborah began her career with GlaxoSmithKline (GSK) in 1996. Since then, she has progressed through increasingly senior positions in Sales, Marketing, Human Resources and Research and Development, in the UK, Europe and Australasia. Deborah became General Manager of GSK Australia and New Zealand in August 2008 when she, her husband and two young children moved to Melbourne. GlaxoSmithKline (GSK) is a world leading, research-based pharmaceutical company, operating in 117 countries and employing over 100,000 people worldwide whose goal is to improve the quality of human life by enabling people to do more, feel better and live longer. In Australia, GSK employs more than 1500 people, is one of Australia's top 20 industrial R&D contributors and works proactively to shape the healthcare environment through partnerships with government, the scientific research sector and the broader Australian community.

## Appendix 3 – Sponsors’ Profiles

### Australian Centre for Health Research



ACHR was established in 2005 to represent views of the many and varied elements that comprise public and private sector health in Australia. The Centre’s key objectives are to initiate and promote public discussion among all stakeholders, fund research projects, test research outcomes through workshops and seminars, develop programmes for desirable health reform and present these to government.

Over the last three years, the Centre funded a number of nationally significant research projects, including ‘e-health and the transformation of healthcare’ (Prof. Michael Georgeff), ‘Examination of the Australian Healthcare Agreements’ (TFG International), ‘Medicare Choice – lessons for Australia from the reforms of health insurance in the Netherlands’ (Prof J. Stoelwinder) and ‘Improving the Quality Use of Medicines in Pharmacogenomics’ (by Deloitte Economics in association with the National Pharmacogenomics Consultative Group facilitated by GAP).

The ACHR has been supported by a number of large, medium and small health funds, as well as private hospital groups, as well as receiving Federal Government support.

## Australian Unity



Australian Unity is a national healthcare, financial services and retirement living organisation providing services to more than 560,000 Australians, including some 330,000 members nationwide.

In the financial year ending 30 June 2009, Australian Unity's revenue was more than \$600 million. It employs more than 1,300 staff nationally.

Australian Unity's history as a trusted mutual organisation dates back almost 170 years. It has grown organically—by continually evolving and providing the services and products needed by the communities it serves—as well as through successful strategic mergers and diversification into new business activities.

Its business approach can be summed up as developing and providing health, financial and lifestyle services capable of making a difference to the wellbeing of members, customers, employees and communities.

### **Remedy Healthcare Group**

Remedy Healthcare Group (Remedy) is a preventative health business which provides programs for people diagnosed with chronic disease such as congestive heart failure, coronary artery disease and osteoporosis.

The programs are supported by a sophisticated chronic disease management software system (CDMS). This new technology will provide decision support to better manage a patient's chronic conditions. It also enables the patient to have access to and share their medical information with relevant care providers.

Wholly owned by Australian Unity, Remedy, which was launched in June 2009, operates as a separate business entity to the health fund.

Cisco



***Connecting the people, resources, and information that power healthcare***

For more than 20 years, Cisco has supported healthcare organisations in their mission to deliver affordable, accessible health services by helping them optimise the use of people, resources, and information.

Cisco technologies connect patients and clinicians as well as hospitals, clinics, and other healthcare organisations with solutions that are the foundation for communications and collaboration, a key strategy to transform the healthcare system. Cisco takes part in global healthcare initiatives that improve access to information and expertise, connecting people with medical resources quickly and saving time and money. Cisco has a long history of working with healthcare industry leaders to connect applications, systems, services, devices, and medical technologies and provide a common platform for information access and communications.

As a worldwide leader in networking, Cisco is well positioned to improve the future of healthcare through technologies that transform how people connect, access information, and collaborate. Cisco technologies can benefit all stakeholders, from patients and clinicians to hospitals, payers, life sciences and research organisations. Innovations in technology that support new health and health service approaches address the challenges of the healthcare industry to manage costs and affordability, improve the quality of care, and provide better access to healthcare services. Through our vision and innovative network technologies, Cisco is helping to bring about a future in which healthcare stakeholders across the continuum of care can respond to patients more efficiently, expand innovative healthcare initiatives, and continue to transform care and the care experience.

[www.cisco.com/go/healthcare](http://www.cisco.com/go/healthcare)

## Global Access Partners (GAP)



GAP is a not-for-profit company based in Sydney, with a high-level network of government, industry, academia and community partners across Australia and around the world. Established in 2000, it specialises in new approaches to public policy development and the facilitation of government / industry / community interactions on the most pressing social, economic and structural issues and challenges across a broad range of Australian economic sectors.

Through its pioneering 'Second Track' Process programme of initiatives, GAP seeks to foster links between community, government and academia to streamline the process of 'fast-tracking' solutions to key issues, increase stakeholder participation in policy formation and decision making, and develop novel, cross-disciplinary approaches to regulatory problems by engaging key stakeholders in high-level discussions and research.

GAP's diverse initiatives and ventures include long-term programmes and one-off projects in regulation and public policy, industry policy, healthcare, knowledge capital, innovation, information and communication technology, security & privacy, sustainability & climate change, education, deliberative democracy, and philanthropy & social investment, to name a few.

GAP runs national and international conferences, multidisciplinary forums and executive roundtables, coordinates community & stakeholder research projects and feasibility studies, and oversees pilot projects to trial new business ideas. GAP's online think-tank, Open Forum, is a well-established online platform with an extensive community network, uniquely positioned to attract and engage the target audience and informed contributions.

GAP's partners include Federal and State governments, major corporate enterprises and industry bodies. Every dollar invested by government in GAP initiatives leverages two dollars from the private sector.

[www.globalaccesspartners.org](http://www.globalaccesspartners.org)

## GlaxoSmithKline



GlaxoSmithKline is one of the world's leading research-based pharmaceutical and healthcare companies, committed to improving the quality of human life by enabling people to do more, feel better and live longer. We are one of the world's leading producers of prescription medicines, vaccines and consumer healthcare products. Our business employs 110,000 employees in over 114 countries.

GSK heritage companies have operated in Australia since 1886. In Australia, we have two operating groups – GSK Pharmaceuticals, based in Boronia, Victoria and GSK Consumer Healthcare, based in Ermington, NSW. In 2007 our annual turnover was over \$A1.5 billion with a total capital expenditure of \$A39, million. As a company we exported over \$A545 million to overseas markets.

GSK Australia is one of the leading suppliers of medicines and vaccines to the Australian Government, providing treatments for conditions such as asthma, COPD, diabetes, HIV/AIDS, infections (antibiotics), breast cancer, pain relief, dental care as well as a wide range of vaccines to prevent childhood illnesses. We also market other products, many of which are among the market leaders: Panadol (pain relief), dental products such as Sensodyne and Macleans, smoking control products Nicorette and Zyban and nutritional healthcare drinks such as Lucozade, Ribena and Horlicks.

In 2008 we invested approximately \$A48 million in R&D and supported 63 clinical studies with 900 patients over 100 research sites and 190 investigators. Approximately 16 of these studies were Phase I studies and 47 active Phase II-IV R&D studies. GSK is one of the top 15 industrial R&D contributors in Australia. The GSK Boronia manufacturing site is "state of the art" with nearly \$A100 million having been invested in upgrades and new capacity, such as the Relenza manufacturing line, in the past five years.

GSK is a major contributor to the medicinal opiate market. The poppy industry was pioneered by GSK Australia since late 1960's and today we contract 800 farmers to grow up to 10,000 hectares of poppy crop in Tasmania annually. GSK is also proud to work with a wide range of community and patient support groups across a variety of different disease areas such as cancer, asthma, diabetes, HIV and mental health. We share a vision with patient organisations for a healthcare system that provides the best standard of care for preventing, treating and managing disease and ensures patients have timely access to the most effective treatments, services and information on disease.

In 2008, GSK provided a total of \$882,000 to support a variety of activities with 19 patient groups across a variety of disease areas such as cancer, asthma, diabetes, HIV and mental health. Activities undertaken ranged from the funding of patient hotlines and development of treatment guideline, to projects on prevention, education and disease awareness.

[www.gsk.com.au](http://www.gsk.com.au)

## Integrated Wireless



### ***Specialist provider of mission critical wireless communications***

Integrated Wireless is an Australian company focused on delivering ruggedised wireless solutions to the Healthcare, Agedcare, Industry and Manufacturing, Corrective Services, Retail, Hospitality and Educational sectors. Integrated Wireless, formerly known as Ascom Nira, has operated in Australia for almost 20 years providing reliable paging, wireless duress and mobile voice communications solutions.

With over 1,000 clients, throughout Australia and New Zealand, using a wide variety of our wireless Duress, Messaging and Voice Communications systems, Integrated Wireless is a major force in the wireless applications market. Integrated Wireless solutions integrate tightly with our clients vital support systems and assists them to protect their employees while increasing their productivity.

Integrated Wireless builds solutions using the **ascom** range of wireless hardware and software applications, locally developed software and hardware and technology from partners such as Innovaphone, Konftel, Wavecom, Daviscomms, Meru Networks, and WiPath.

With offices in Sydney, Melbourne and Brisbane and partners in all other states and territories Integrated Wireless provides a complete customer support structure which includes sales and after sales service. Integrated Wireless provides “round the clock” support to many of Australia's busiest hospitals, biggest prisons and successful manufacturers.

Integrated Wireless development team specialises in the development of mission critical Java applications and resilient appliance based hardware solutions. Their design and service personnel possess a wide range of wireless (UHF, DECT and WiFi) skills in conjunction with IP Telephony and integration capabilities.

#### **DURESS:**

- ▶ Comprehensive solution
- ▶ Wireless and Wired duress
- ▶ Campus and Wide Area based
- ▶ Ruggedised and Resilient
- ▶ Escalation and Logging

#### **VOICE COMMUNICATIONS:**

- ▶ High speech quality
- ▶ PBX telephone functionality
- ▶ Push-to-talk
- ▶ Ruggedised and Resilient
- ▶ Speech recording

#### **MESSAGING:**

- ▶ One way, Two way and Interactive messaging
- ▶ Campus and Wide Area based
- ▶ Ruggedised and Resilient
- ▶ Escalation and Logging

**Intel Australia  
Digital Health Group**



Around the world, healthcare costs are rising. Too many people lack access to high-quality healthcare services. Paper-based workflows introduce errors and hamper productivity. Ageing populations and swelling rates of chronic disease threaten to overwhelm even the most efficient healthcare systems.

Intel is delivering innovative leaps in digital technologies to help address those challenges.

We share the vision of leaders who recognise technology's potential to evolve healthcare toward more proactive, consumer-centric models of care as well as the potential to improve the quality, cost, and accessibility of healthcare services. In homes and hospitals, clinics and pharmacies, we collaborate with healthcare leaders to better connect people and information, and enable new models of care.

## Open Forum



Open Forum is an interactive discussion site for the issues which matter to Australian public policy debate. Our community of bloggers and readers includes people of all ages, from all over Australia, of all political shades and stripes.

Having grown organically since its public launch in July 2007, Open Forum enjoys an impressive blogger database and a very high level of readership comprising senior business executives, government policy makers, academics, thought leaders and community advocates, as well as interested private citizens.

Unlike other websites with a similar format, Open Forum has no political affiliations or hidden agenda. We believe that this independence is fundamental to the success of any policy development forum. Our user-generated content allows us to explore areas which are of relevance to the regulatory process, track citizen sentiment around a particular issue and use these as the basis for briefing notes and recommendations to government agencies.

Open Forum is very proud to provide an independent platform for online engagement to Australian Government Ministers, Departments and Agencies.

In 2009 the Secretariat from the Federal Attorney General's Office chose Open Forum to host an online discussion forum on behalf of the National Human Rights Consultation Committee. The National Human Rights Online Consultation was endorsed by AGIMO as the third in its series of online consultation trials. Over a six week period the online consultation received 12,622 visits from 8,932 people from 57 towns and cities across Australia, while the forum generated 456 individual submissions from 128 people.

Open Forum currently operates under the patronage of the Global Access Partners, NSW Surveyor General, Standards Australia, and MBF Foundation.

[www.openforum.com.au](http://www.openforum.com.au)

## Department of Premier & Cabinet, Victorian Government



The Department of Premier and Cabinet (DPC) and Secretary is responsible to the Premier, who is also Minister for Multicultural Affairs and Veterans' Affairs. DPC advises on whole-of-government matters and on issues specific to the Premier's portfolio. It also coordinates whole-of-government initiatives to implement the policy agenda.

The Department consists of four groups: Policy and Cabinet Group; Government and Corporate Group; National Reform and Climate Change Group; and Arts Victoria.

Arts Victoria oversees the state-owned cultural agencies: Australian Centre for the Moving Image, Geelong Performing Arts Centre, Museum Victoria, National Gallery of Victoria, State Library of Victoria, the Arts Centre, as well as the Public Record Office Victoria.

The Department also supports the following portfolio agencies:

- Office of the Governor
- Office of the Ombudsman
- Office of the Chief Parliamentary Counsel
- State Services Authority

The Department also advises the Minister for the Arts and the Minister for Environment and Climate Change.

DPC's role is to:

- provide strategic, rigorous and innovative policy advice to the Premier on all matters;
- assist the Victorian Government to maintain sustainable growth and create a vibrant society via key policy and projects;
- deliver strategic policy leadership and advice to make informed decisions;
- develop whole-of-government initiatives and manage Victoria's relationships with Australian and overseas governments;
- promote community engagement in government decision-making; and
- coordinate services and programs for the Government's arts policy.

DPC delivers its services in three key output areas:

- strategic policy advice and projects;
- public sector management and governance; and
- support for arts and cultural development.

## Appendix 4 – List of Delegates

**The Hon. Neil Batt AO**

Executive Director  
Australian Centre for Health Research

**Mr Ken Baxter**

Director, TFG International

**Mr Alan Bennett**

Industry Leader, Government &  
Defence, Australia & New Zealand  
HP Enterprise Services

**Dr Christine Bennett**

Chief Medical Officer  
BUPA Australia Group

**Mr Keith Besgrove**

First Assistant Secretary,  
Telecommunications,  
Network Regulation & Australia Post  
Division, Department of Broadband,  
Communications & the Digital Economy  
Australian Government

**Mr Steve Blume**

Project Manager, ACT Solar Power Facility  
Department of Climate Change,  
Environment, Energy & Water  
ACT Government

**Mr Ken Boal**

National Director, Government  
Operations, Cisco Systems

**Mrs Olga Bodrova**

Project Manager  
Global Access Partners

**Ms Alison Boldys**

Assistant to the Chairman  
Australian Unity & Executive Director  
Australian Centre for Health Research

**Mr Allan Boston**

Executive Director  
Melbourne Services  
St John of God

**Mr Craig Bosworth**

Director of Strategy  
Healthways International

**Mr Peter Brockhoff**

Area Vice President  
Australia and New Zealand  
Citrix Systems Asia Pacific

**Mr Patrick Callioni**

Managing Director  
Enterprise Intelligence

**Ms Margaret Carmody**

General Manager  
CRS Australia

**Ms Kate Carnell AO**

Chief Executive Officer  
Australian Food & Grocery Council

**Dr Beverly Castleman**

**Dr David Charles**

Chair, Deloitte Economics

**Mr Yang Chow**

Department of Premier &  
Cabinet, Victoria

**Dr Stephen Clark**

Chief Executive  
Australian General Practice Accreditation

**Mr Malcolm Crompton**

Managing Director  
Information Integrity Solutions

**Dr David Dembo**

Leader - Health and Human Services  
Public Sector Group  
Microsoft Australia

**Ms Sonia Dixon**

MBF Foundation Manager  
BUPA Australia Group

**A/Prof David Dunstan**  
Head, Physical Activity & VicHealth  
Research Fellow  
Baker IDI Heart & Diabetes Institute

**Mr Peter Fitzgerald**  
Department of Premier & Cabinet  
Victoria

**Ms Isabel Frederick**  
Head of Strategy, Architecture & Security  
Information Technology  
Medibank Private

**Mr Peter Fritz AM**  
Group Managing Director,  
TCG Group

**Prof Michael Georgeff**  
Chief Executive Officer  
Precedence Health Care

**Mr Michael Gill**  
Director, Internet Business  
Solutions Group , Cisco Systems

**Dr Stan Goldstein**  
Head of Clinical Advisory  
BUPA Australia

**Ms Alison Gordon**  
Manager, Client Services  
Global Access Partners

**Mr Alex Gosman**  
Director, Government & Corporate  
Affairs, GlaxoSmithKline

**Dr Nicholas Gruen**  
Chief Executive Officer  
Lateral Economics

**Mr Roger Gurr**  
Director, Mental Health  
Western Sydney Area Health Service

**Dr Mukesh Haikerwal**  
National Clinical Lead  
National e-Health Transition Authority

**Ms Linda Horiuchi**  
Senior PR Consultant  
Cisco Systems

**Mr Andrew Howard**  
Head of Architecture & e-Health Strategy  
National e-Health Transition Authority

**Ms Erica Hughes**  
Managing Director  
Safe Climate Australia

**Mr Gabriel James**  
Market Access Director  
Janssen-Cilag Pty Ltd (Periaqua)

**Mr Michael Jenkins**  
Partner, Corporate Finance  
Deloitte Touche Tohmatsu

**Ms Kate Johnson**  
Senior Policy Officer  
National e-Health Transition Authority

**Mr David Kalisch**  
Commissioner, Productivity Commission

**Ms Melanie Kelly**  
Director, Deloitte Economics

**Ms Megan Kennedy**  
Marketing Manager, Health & Life Sciences  
IBM Australia

**Mr David King**  
Chief Executive Officer  
Australian Health Services Alliance

**Ms Shelley Kleinhans**  
Manager, Health Systems Improvement  
GP Partners

**Ms Barbara Konda**  
Director, Fit Institute, Founder & Author  
Fit (Slovenia) International

**Dr Michael Legg**  
President, Health Informatics  
Society of Australia

**Dr Winston Liauw**  
Medical Oncologist  
Clinical Pharmacologist  
Cancer Care Centre, St George Hospital

**Mr Robert Lippiatt**  
Executive Director  
SPC Consulting Group

**Ms Katherine Loftus**  
Social Policy Branch  
Department of Premier & Cabinet  
Victoria

**Mr Brendan Lovelock**  
Business Development Manager  
Health, Cisco Systems

**Mr Stephen Lynch**  
Chief Operating Officer  
Global Health Limited

**Dr George Margelis**  
Industry Development Manager  
Digital Health Group  
Intel Australia

**Ms Kate Marie**  
Chief Executive Officer  
Mileage Media

**Mr Patrick McCormick**  
Senior Consultant, Nous Group  
State Services Authority, Victoria

**Mr Peter McMahan**  
Client Sales Executive  
HP Enterprise Services

**Mr John Meckiff**  
General Manager  
Remedy Healthcare

**Ms Lisa Middlebrook**  
Executive Manager, Strategy & Policy  
Global Access Partners

**Ms Greg Millane**  
Chief Executive Officer  
HICAPS

**Ms Vivienne Miller**  
MHS Conference Director  
Mental Health Services Conference Inc.

**Mr Nick Miller**  
Health Editor, The Age

**Mr Greg Mundy**  
Chief Executive Officer  
Aged and Community Services Australia

**Mr Tim Murphy**  
Head of Government Affairs  
GlaxoSmithKline

**Mr Bill Newton**  
Chief Executive Officer  
General Practice Victoria

**A/Prof Adrian Nowitzke**  
Chief Executive Officer  
Gold Coast Health Service District  
Gold Coast Hospital

**Ms Helen Owens**  
Department of Premier & Cabinet  
Victoria

**Dr Andrew Pesce**  
President, Australian Medical Association

**Mr Simon Phemister**  
Department of Premier & Cabinet  
Victoria

**Ms Wendy Phillips**  
Executive Director  
Pharmacy Guild of Australia

**Mr Andrew Podger AO**  
President, Institute of Public  
Administration, Australia

**Ms Prue Power**  
Executive Director, Australian  
Healthcare Association

**Ms Vicki Poxon**  
Chief Executive Officer  
Brisbane South Division

**Mr John Rashleigh**

Managing Director  
Navy Health

**Mr Paul Ray**

Head of Hospital & Medical Risk  
BUPA Australia Group

**Mr John Rimmer**

Partner, Joint Technology Partners

**Mr Stuart Rodger**

Partner & Health Practice Leader  
Deloitte Actuaries & Consultants

**Ms Sally Rose**

Blogger-in-Chief, Open Forum

**Clinical A/Prof Alan Rosen**

Psychological Medicine  
Northern Clinical School  
Faculty of Medicine, University of Sydney

**Mr David Rowlands**

Principal, Direkt Consulting Pty Ltd

**Dr Kaveh Safavi**

Global Head, IBSG HealthCare  
Cisco Systems

**Mr Kos Sclavos**

National President  
Pharmacy Guild of Australia

**Mr Peter Self**

Health Account Leader  
Cisco Systems

**Ms Marianne Shearer**

Chief Executive Officer  
Melbourne East General Practice Network

**Mr Tamati Shepherd**

Director of eHealth  
Information Division  
Queensland Health

**Mr Leo Silver**

Managing Director  
Integrated Wireless

**Ms Perry Sperling**

Principal Advisor  
Australian Medical Association

**Ms Laretta Stace**

Chief Executive Officer, Fitness Australia

**Ms Cathie Steele**

General Manager, Centre for  
Health Innovation

**Prof Johannes Stoelwinder**

Chair, Health Services Management  
School of Public Health & Preventative  
Medicine, Monash University

**Ms Fran Thorn**

Secretary, Department of Human Services,  
Victorian Government

**Mr Patrick Tobin**

Director, Policy Catholic Health Australia

**Mr Steve Vamos**

President, Society for Knowledge Economics

**Ms Teresa Wall**

Deputy Director General  
Maori Health Directorate, New Zealand

**Ms Deborah Waterhouse**

General Manager, Australasia, GlaxoSmithKline

**Ms Justine Waters**

Head of Health Leadership  
BUPA Australia Group

**Dr Heather Wellington**

Director, GMHBA Health Insurance

**Dr Linda Worrall-Carter**

Professor & Director  
St Vincent's Centre for Nursing Research

**Mr Rod Young**

Chief Executive Officer  
Aged Care Association Australia

**Dr John Zelcer**

Director, Eastern Health, Victoria