HARC
Better hospitals through better research
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From the Editor's chair

Welcome to the first edition of the HARC e-Bulletin for 2012. As the first three months of the year drew to a close, debate continued over the most cost-effective and equitable ways to spend our scarce healthcare dollars. The impact of patient choice, measuring patient-reported outcomes, the economic burden of healthcare, and how to improve the services we provide, all emerged as key points of discussion.

There was much to report, but here are some highlights from the quarter:

- An Australian study of patients in western Sydney and the latest Bureau of Health Information report both highlighted the significant out-of-pocket costs that act as a barrier to care for those grappling with chronic health conditions
- US clinicians joined forces to educate the public about costly and wasteful healthcare interventions
- Concerned Cochrane reviewers called for a major rethink on publication bias and the impact it has on systematic reviews
- The UK's Health and Social Care Bill, which will overhaul the NHS, was finally given Royal Assent, but a review published in the BMJ said it was too early to make a call on whether extending competition would improve hospital quality
- As activity-based funding plans progress in Australia, modelling from Belgian researchers showed that accounting for socioeconomic status in the populations hospitals serve does make a difference to resource allocation.

We hope you find the research, reports and reviews covered in this edition as interesting and thought-provoking as we did.

Kellie Bisset
Editor
HARC e-Bulletin

Spending health dollars wisely

Clinicians join evidence push to help eliminate wasteful and costly interventions

A new campaign to promote evidence-based healthcare and help reduce waste in the US health care system has seen nine medical speciality societies join the American Board of Internal Medicine Foundation in publishing 'Top 5' lists of questionable tests, treatments or services.

The Choosing Wisely campaign, launched in Washington this month, has attracted support from the American Academy of Allergy, Asthma & Immunology; American Academy of Family Physicians; American College of Cardiology; American College of Physicians; American College of Radiology; American Gastroenterological Association; American Society of Clinical Oncology; American Society of Nephrology; and the American Society of Nuclear Cardiology.

The Choosing Wisely website has published the lists from each group, which contain advice such as 'do not diagnose asthma without spirometry', 'do not prescribe antibiotics for sinus infections of less than seven days' and 'don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present'.

A viewpoint published in *JAMA* said other societies and consumer and physician organisations had asked how to become part of the campaign, which is attempting to engage physicians and patients in conversations about tests and procedures that should rarely be used. Doctors' decisions account for about 80% of healthcare expenditure, they said, yet they do not always have the most current information on effectiveness and may need help communicating these matters to their patients.

Avoiding the pitfalls of patient-reported outcome measures

"The ultimate measure by which to judge the quality of a medical effort is whether it helps patients (and their families) as they see it," according to Don Berwick, the highly respected health quality expert and former administrator of the US Center for Medicare & Medicaid Services. Patient-reported outcome measures, or PROMs, are a way to collect this information, and are increasingly being collected internationally as part of the clinical trials process or by clinical registries.

But as Kings Fund chief economist John Appleby writes in a *BMJ* feature, a particular focus on PROMs for chronic, long-term conditions as well as elective surgery sets the English NHS apart from other efforts in this area, making it fertile ground for this type of information. By June 2011, the NHS had collected nearly a quarter of a million records on patient's assessment of their health status before and after surgery. Appleby writes that as more data is collected, questions are emerging about how to compare the health gains of different procedures. For example, for the first full year of data, half of groin hernia patients reported improved health-related quality of life and the other half reported either no change or poorer health after surgery. Conversely, nearly nine out of 10 hip replacement patients and eight out of 10 knee replacement patients reported an improvement after surgery.

Appleby argues it is tempting to suggest that the NHS "should switch from hernia repairs to hip replacements" when making value-for-money decisions. But he says this temptation to fund some procedures at the expense of others should be avoided if the NHS is to continue to provide a comprehensive service.

"There is no doubt however, that as PROMs data expand and links are made to other data on costs, the value we get from different healthcare interventions – something that has remained largely hidden – will start to expose potential trade-offs and increasingly difficult decisions," he said.

National disease registries are a good investment

An editorial in *The Lancet* highlights the important role disease registries play in improving outcomes. Citing a study in Health Affairs, which analyses 13 registries in Australia, Denmark, Sweden the UK and the US (covering the areas of cataract, heart disease, hip and joint replacement, cancer and cystic fibrosis), the editorial said Sweden had reduced the incidence of revision hip arthroplasty to 10% since introducing the Swedish Hip Arthroplasty Register in 1979. About 7500 revisions were avoided in 2008–09, saving US$140 million in costs.

"If the US could reduce its revision burden of hip arthroplasty to 10% by 2015, it would save $2 billion of a predicted total cost of $24 billion. Governments of more countries should follow Sweden's example," the editorial said.

Does competition between hospitals improve clinical quality?

The UK Government's controversial Health and Social Care Bill was finally given Royal Assent last month after much debate about its long-term impact on the UK National Health Service. The new Act will create an independent NHS Board, aims to promote patient choice, gives GPs more power to commission services on behalf of their patients and proposes to reduce NHS administration costs. But in a review published in the *BMJ,* academics from the London School of Economics said it was still unclear what effect promoting patient choice has in elective surgery outcomes. They examined evidence on the effects of hospital competition on the quality of care within the NHS during two different eras: the internal market in operation from 1991 to 1997 and the "New Labour" hospital market introduced by the Blair Government and developed from 2002 onwards. The authors reviewed the literature on the performance on NHS markets and found that the effect of patient elective surgery choice on the quality of elective surgery was not captured by studies that use hospital mortality as an outcome variable. Rather, the effect of choice

should be tested with surgery-specific measures such as patient-reported outcome measures. While the studies conducted assumed that competition gave hospitals incentives to improve elective surgery, the authors said it was equally plausible that competition for elective surgery might divert management effort and negatively affect the quality of other hospital services. The "chain of causation" was not properly understood, they said, with gaps in our understanding of how purchasers, managers and clinicians responded to competition and how that affected outcomes.

"...we believe there are strong grounds for introducing patient choice into the NHS as an end in itself, given its potential to empower patients and give them greater control over the conditions of their care," the authors wrote. However, they said, how patient choice has affected elective surgery outcomes was an open question and this meant the exact role it should play in policy making remained unclear. "More research is required before conclusions can be drawn about the effect of recent reforms on hospital quality, let along the about the merits of [Health Secretary] Mr [Andrew] Lansley's proposals to further extend competition."

Bevan G, Skellern M. Does competition between hospitals improve clinical quality? A review of evidence from two eras of competition in the English NHS. BMJ 2011; 343:d6470

The economic impact of chronic disease

Sicker adults in NSW face considerable barriers to healthcare

More than 40% of NSW sicker adults or their families have spent more than $1000 out-of-pocket on medical care, the Bureau of Health Information's 2011annual performance report has found. *Healthcare in Focus 2011: How well does NSW Perform?* said this was a higher percentage than in nine other countries. It showed that 17% of NSW sicker adults said concerns about costs discouraged them from seeing a doctor for a specific medical problem, 16% had not filled a prescription because of cost and cost had caused 19% to skip a medical test, treatment or follow up that was recommended by a doctor.

"We've found 15% of NSW sicker adults with a chronic condition are hospitalised or visit an emergency department, which is twice as high as France. In NSW, hospitalisation rates for chronic conditions such as diabetes and respiratory disease are high relative to most countries," Bureau Chief Executive Dr Diane Watson said.

Chronic illness and disability: a hidden economic burden

The amount of money Australians spend on out-of-pocket healthcare costs compares unfavourably with other high-income countries and action needs to be taken to reduce health-related economic hardship, according to a perspectives piece in the *Medical Journal of Australia*.

Researchers from the George Institute and the Menzies Centre for Health Policy said out-of-pocket spending as a proportion of total health expenditure was 18.2% in Australia – above the OECD median of 15.8%. This disproportionately affected certain patient populations, mainly due to costs that are not considered health-related, such as transport. But they said evidence was not comprehensive and a consistent approach should be taken to recoding personal and household illness-related costs and identifying their impact on health and wellbeing.

"The existence of universal publicly funded healthcare and social security arrangements has possibly encouraged complacency among researchers and policy makers about tackling this issue," they wrote.

But major reform, such as the recently proposed National Disability Insurance Scheme had some potential to address illness-related hardship. Small-scale strategies could also help, they said. Targeted interventions such as income support and subsidies could help catch those that fall through the cracks.

We can't afford my chronic illness: the out-of-pocket burden of managing COPD

Out-of-pocket health costs have steadily increased in Australia over the past 25 years and, despite our universal healthcare system, this burden has become an urgent problem for many chronically ill people, such as those with COPD.

This paper, published in the *Journal of Health Services Research & Policy,* says rising co-payments for medications and medical consultations, poorly subsidised health support for items such as home oxygen, and eligibility barriers for existing social support are making chronic illness management "seriously economically stressful".

The cross sectional study set out to examine the economic consequences of out-of-pocket spending on COPD, which in 2003, accounted for 46% of Australia's chronic respiratory disease burden. All 656 patients enrolled in the Respiratory Ambulatory Care Service in western Sydney – a pulmonary rehabilitation and support program for patients with serious COPD – were invited to participate. There were 218 completed questionnaires (response rate 38%) and 169 (78%) respondents reported economic hardship while managing their condition.

Hardship was measured in terms of the household's inability to pay at least one living or medical expense in the previous year and use of financial coping strategies to pay living expenses in the same period. Out-of-pocket expenditure was defined as the total amount of their own money respondents spent on both medical and non-medical expenses. The out-of-pocket burden was described as low (<5%), moderate (5%–10%), and catastrophic (>10%).

Of those who experienced hardship, 46% had catastrophic levels of out-of-pocket spending. Expressed another way, catastrophic levels of out-of-pocket spending made people 7.5 times more likely to experience economic hardship (95% CI, 1.2 – 46.3) than people with a low out-of-pocket burden. The average out-of-pocket amount spent per quarter was AUD$487. Twenty seven per cent of respondents reported being unable to pay for medical or dental expenses, 18% could not afford medication, 27% were unable to afford rent or mortgage and 19% could not pay utility bills.

The authors said higher levels of out-of-pocket spending were partly due to the presence of co-morbidity – 99% of respondents had at least one other chronic illness. "Co-morbidity is now the rule, not the exception, as seen in this study," they said. "Within this context, worsened by increasing co-payments for medical care and medications – which have risen faster in Australia than in any other OECD country – and inadequate coverage for essential self-management supports (e.g. transport, medical equipment), we have the makings of a serious social problem."

Essue B, Kelly P, Roberts M, Leeder S, Jan S. We can't afford my chronic illness! The out-of-pocket burden associated with managing chronic obstructive pulmonary disease in western Sydney, Australia. J Health Serv Res Policy 2011; 16 (4): 226 – 229.

Improving services with better measurement

Cochrane researchers raise serious concerns over the impact of publication bias

New methods for conducting systematic reviews are urgently needed according to Cochrane reviewers, whose attempt to update their long-standing review of neuraminidase inhibitors (NIs) for influenza left them unable to verify the data underlying manufacturer and government claims about the effectiveness of oseltamivir (Tamiflu).

Despite being on the list of WHO essential drugs, and governments having spent billions of dollars stockpiling oseltamivir in preparation for an influenza pandemic, the reviewers said there were legitimate reasons to doubt the drug's claims of effectiveness. They said the risk of reporting bias in published clinical trials meant previous Cochrane reviews of NIs might also be unreliable.

Claims of oseltamivir's effectiveness were based on clinical trial evidence included in a published non-systematic meta-analysis of 10 manufacturer-funded clinical trials of oseltamivir for the treatment of influenza in people of all ages (Kaiser 2003). However, eight of these trials were never published. As a result, the Cochrane reviewers took the unusual step of seeking unpublished clinical study reports from the manufacturer, Roche, and regulatory documents, some of which were obtained via US and European

Freedom of Information laws. They did not succeed in accessing all the information sought, despite five requests to Roche, but did identify under-reporting of harms, and concluded that there were substantial problems with the design, conduct and availability of information from many of the trials. They chose not to proceed with a planned meta-analysis of all the oseltamivir data and instead analysed the effects on symptoms (shortened by about 21 hours) and hospitalisations (no evidence of effect). The manufacturer of zanamivir (Relenza), GlaxoSmithKline, offered to provide the reviewers with individual patient data and it was decided to assess zanamivir trials in detail in a separate review.

"The modified approach in this Cochrane review grew out of a realisation that prior methods employed to review NIs were inadequate," the authors said. "There seems no compelling reason to think that the lessons learned are limited to these particular drugs."

A positive start for the Australian National Hand Hygiene Initiative

Australia's successful national roll-out of the World Health Organization's "5 Moments for Hand Hygiene" program could be a useful blueprint for other health-related culture-change programs, its organisers say. Writing in the *Medical Journal of Australia*, the group responsible for the initiative reported widespread, sustained improvement in hand hygiene compliance among health care workers in Australian public and private hospitals.

The program was based on five key "moments" when hand cleaning is necessary: before touching a patient; before a procedure; after a procedure or body fluid exposure risk; after touching a patient; and after touching a patient's surroundings.

In late 2010, the overall national rate of hand hygiene compliance was 68.3% in 521 hospitals (representing 90% of acute Australian public non-psychiatric hospital beds and 50% of acute private hospital beds). This compared with a rate of 63.6% at the start of the National Hand Hygiene Initiative. However, the data were influenced by Victoria, where a hand hygiene audit tool has been in place for some years. For non-Victorian sites, overall mean baseline rates were 43.6% and 53.5% in audit periods 1 and 2 during 2009. They improved to 67.8% at the end of 2010.

Nursing staff achieved the best overall compliance rates (73.6%). Rates for medical staff increased only slightly from a baseline of 50.5% to 52.3%. This was significantly lower than the rate for all non-medical healthcare workers (70.9%). The authors said the data "raised important concerns about the assumed leadership role of medical staff in terms of hand hygiene compliance" although they said the reasons for this lower compliance "were likely to be complex and require further investigation".

The first two years of the Initiative have also seen a decline in methicillin-resistant *S. aureus* bacteraemia (MRSAB) rates, which were stable for the 18 months prior to the initiative. The authors noted that while MRSAB rates could not be definitively linked to the initiative and may have been caused by other factors, the general decline was consistent with reports from previous Australian and international hand hygiene culture-change programs and further declines in national SAB rates are expected.

Grayson ML, Russo PL, Cruikshank M, Bear JL, Gee CA, Hughes CF, Johnson PDR, McCann R, McMillan AJ, Mitchell BG, Selvey, CE, Smith RE, Wilkinson IJ. Outcomes from the first 2 years of the Australian National Hand Hygiene Initiative. MJA 2011; 195 (10): 615 – 619.

Activity-based funding should take socioeconomic status into account

Activity-based funding of hospitals is becoming increasingly popular, with many countries such as the UK, Canada, Belgium and Australia adopting case-based funding models. Under Australia's National Health Reform Agreement, the Independent Hospital Pricing Authority is steering the process of devising a National Efficient Price for hospital services.

In light of the continued debate over the impact of activity-based funding, and concerns over whether diagnostic classifications fail to properly account for patient care needs, Belgian researchers examined their country's hospital financing scheme to evaluate whether resource allocation to hospitals was fair.

In this paper, published in the Journal of Health Services Research & Policy, the researchers describe their design of a resource allocation formula based on the Belgian financing scheme, where non-medical activity is paid based on a normative number of in-patient days. Using data on in-patient discharges from 60 hospitals and a sample of 443,448 discharges, they measured the association between length-of-stay

and socioeconomic factors (where length-of-stay was a proxy measure of care needs and costs). Using generalised linear models, they measured whether hospitals would be financially penalised or rewarded, depending on whether or not their payment was adjusted for the socioeconomic characteristics of their patient population.

They found that both patient socioeconomic status and a hospital's area socioeconomic profile had a significant impact on length-of-stay and hospitals treating low-income patients were financially penalised as a result. They concluded socioeconomic factors should be considered when determining a hospital's resource allocation. Without this, they said, incentives existed for hospitals to engage in "cream skimming" where higher SES patients were favoured over those with lower SES.

Their analysis showed that SES influenced length-of-stay regardless of disease severity. Length-of-stay was greater for patients from underprivileged areas and who were admitted to hospitals with a higher percentage of underprivileged patients (95% CI).

"We show that unfair resource allocation is high when the payment system adjusts only for APR DRGs [All Patient Refined Diagnosis-Related Groups] but decreases dramatically when APR DRGs and SE factors are taken into account," the authors said.

Perelman J, Closon M. Impact of socioeconomic factors on in-patient length of stay and their consequences in per case hospital payment systems. J Health Serv Res Policy 2011; 16 (4): 197–202.

What makes a successful clinical network?

Clinical networks are being implemented widely in Australia and other countries as a way to improve health service delivery and patient outcomes. However, limited research exists on what constitutes a successful network and what factors or conditions networks need to achieve their outcomes.

To address this evidence gap, Australian researchers have begun the largest study of clinical networks undertaken internationally and will examine the factors that contribute to networks' success.

Since 2004, the Agency for Clinical Innovation (previously the Greater Metropolitan Clinical Taskforce) has led the development and establishment of voluntary collegial clinical networks in NSW. These networks will be the focus of the study.

A study protocol published in Implementation Science said the research would be the first to combine quantitative and qualitative methods in this subject area. It said success was based on a conceptual model and defined as: the extent to which there is evidence of impact on healthcare and outcomes; evidence of impact on system-wide change; the number of quality improvement initiatives undertaken and the quality of their design; whether users perceived the networks to be effective and valuable; and the value of any additional resources leveraged.

The study would rate each network's impact on quality of care and system-wide change but overcoming the "apples and oranges" problem of heterogeneity across networks would be challenging, the authors said.

"The findings will form the basis of strategies to improve less effective networks and to ensure that any new networks are established as well as possible," they said.

Results from a qualitative study of stakeholder views of clinical networks, published in BMC Health Services Research, identified five key factors that were important conditions for the establishment of successful clinical networks. These were: building relationships; effective leadership; strategic, evidence-based work plans; adequate resources; and ability to implement and evaluate network initiatives.

"It's a big jigsaw puzzle and you have to have one person, I think, who knows all the pieces of the puzzle," one interviewee commented.

'Effective network structure, organisation and governance' was the main underlying theme that emerged from the face-to-face semi-structured interviews with 27 participants, including senior policy makers, health service managers and network participants and managers.

The group also identified the desirable outcomes of clinical networks as 'changing the landscape of care' and 'connecting and engaging'.

McInnes E, Middleton S, Gardner G, Haines M, Haertsch M, Paul Christine L, Castaldi P. A qualitative study of stakeholder views of the conditions for and outcomes of successful clinical networks. BMC Health Services Research 2012; 12:49

Haines M, Brown B, Craig J, D'Este C, Elliott E, Klineberg E, McInnes E, Middleton S, Paul C, Redman S, Yano E. Determinants of successful clinical networks: the conceptual framework and study protocol. Implementation Science 2012; 7:16

Treatment efficacy issues continue to make headlines

FDA safety changes to statin labels attract widespread attention

Safety changes in the FDA's labelling of statins announced in March received widespread media interest. Labelling was revised to remove the need for routine periodic monitoring of liver enzymes in patients taking the drugs, but new warnings on cognitive and blood sugar effects received the most attention. The FDA advised that statin labels would now include information about some patients experiencing memory loss and confusion.

"These reports generally have not been serious and the patients' symptoms were reversed by stopping the statin. However, patients should still alert their healthcare professional if these symptoms occur," the advice said. It also said labels would now contain a warning on the potential for a small increased risk of increased blood sugar levels and of being diagnosed with type 2 diabetes.

The FDA said in a statement that it wanted to assure healthcare professionals and patients that statins continued to provide important benefits in lowering cholesterol. The news was an interesting addition to the continuing discussion over the role of statin treatment in patients at low risk of cardiovascular disease. A useful summary of the issues around the FDA warning and the broader debate was published on Croakey. The reports follow a large study of high-risk patients published in The Lancet (summarised below), which looked at the long-term efficacy and safety of simvastatin.

Prolonged statin treatment is efficacious and safe in high risk patients: study

A paper published in *The Lancet* shows that prolonged statin treatment results in larger absolute reductions in vascular events and these benefits continue for at least five years after treatment ceases, without any negative consequences.

The authors noted that while large randomised controlled trials have previously shown that using statins to lower LDL cholesterol levels rapidly reduces vascular morbidity and mortality, there is limited evidence about the long-term efficacy and safety of this treatment regime.

They conducted an extended follow up of participants in the Heart Protection Study, following 20,536 patients at high risk of vascular and non-vascular outcomes who were allocated 40mg simvastatin daily or placebo. The mean in-trial follow up was 5.3 years (SD 1.2) and the post-trial follow up of surviving patients was 11 years (SD 0.6).

During the in-trial period, patients taking simvastatin had an average LDL cholesterol reduction of 1.0 mmol/L and a proportional drop in major vascular events of 23% (95% CI, 19–28; p<.0001). The cumulative proportions of participants in each treatment group who had major vascular events diverged during this period, and the difference remained over the 11 years of follow up.

Also, the absolute reduction in all-cause mortality that emerged with simvastatin allocation during the five-year in-trial period persisted roughly unchanged after 11 years of follow up, the researchers said.

The authors noted that concerns have been raised that lower blood cholesterol levels could be associated with an increased risk of cancer or some other non-vascular outcomes.

However, during the in-trial and post-trial periods combined, there were no significant differences in cancer incidence at all sites (relative risk 0.98 [0.92–1.05]), any sites cancer mortality (1.01 [0.92–1.11]), or non-vascular mortality (0.96 [0.89–1.03].

The authors said the results "provide compelling evidence that five years of statin therapy is not associated

with the excesses of any particular type of non-vascular death, site specific cancer or other major non-vascular morbidity. Moreover, although 11 years might still not be long enough for deleterious effects on cancer to emerge fully, no adverse trend was noted, even during the later years of post-trial follow up".

Heart Protection Study Collaborative Group. Effects on 11-year mortality and morbidity of lowering LDL cholesterol with simvastatin for about 5 years in 20 536 high-risk individuals: a randomised controlled trial. The Lancet 2011; 378: 2013–2020.

Report round-up

Australia has a high prevalence of chronic disease risk factors

Most people have at least one risk factor for chronic disease, according to a new AIHW report, *Risk factors contributing to chronic disease*, released this month.

More than 90% of people do not consume enough fruit and vegetables, about 50% don't consume enough fruit and nearly 60% don't undertake sufficient levels of physical activity, the report found. It also showed that more than 80% of Australians spend more than 3 hours each day sitting during their leisure time, regardless of whether they undertake sufficient physical activity. The report highlighted the potential for lifestyle behaviour changes that may lead to health gains for individuals and the population.

ABS report shows high levels of patient satisfaction with healthcare providers

Patient Experiences in Australia 2010–2011, a report released by the Australian Bureau of Statistics, has found that 80% of patients who visited an emergency department in the previous 12 months, and 87% of admitted patients, felt that doctors and specialists had "always or often" spent enough time with them. Older patients (over 75) were more likely to think ED doctors had spent enough time with them (93%) than patients aged 25-34, of whom 73% thought enough time had been taken. On the question of whether hospital doctors and specialists "always or often" listened carefully, people from the most disadvantaged areas had lower satisfaction (87%) than those from the least disadvantaged areas (92%).

Medical workforce snapshot shows gender balance continues to shift

The proportion of women in the medical workforce continues to increase, with the figure rising to 37% in 2010 (up 3% since 2006), the AIHW *Medical Workforce 2010* report shows. The overall supply of doctors has also increased in that time, from 346 to 366 full-time equivalent medical practitioners per 100,000 population. While average weekly hours declined slightly from 43.5 hours to 43.3 hours, specialists in training continued to work the longest, at 49.9 hours. Men slightly dropped their hours (46.4 to 46.2) and women increased theirs (37.8 to 38.5). Of those medical practitioners employed as non-clinicians (6.4% of the total), almost a third (30.8%) were researchers and a quarter were administrators (24.9%).

Forthcoming events

Australian Healthcare Leadership for Challenging Times: 14–15 May 2012, Sydney

Run by the Australian Healthcare and Hospitals Association, this workshop will examine how to save costs through quality improvement and will explore what works and what doesn't when developing and implementing improvement plans. Delegates are requested to bring any current or planned project with them in order to gain the maximum impact from this workshop, which will provide an opportunity to gain input from people who have delivered highly successful change initiatives and improvement projects. Visit the website for further details.

2012 National Australian Conference on Evidence Based Clinical Leadership: 13–14 August 2012, Adelaide

This conference will bring together the experiences of evidence-based researchers and reviewers, guideline developers, clinicians, educators, policy makers, administrators and consumers to work toward improving techniques and methods of getting evidence into practice. For more information visit the website.

Population Health Congress 2012: 10–12 September, Adelaide

The conference will address themes such as how translational research and knowledge transfer are shaping the future of population health, how inequalities and social determinants are being addressed and with what effect, the social and health impacts of changing demographics in Australia and New Zealand, global health, climate and economics, and new approaches to population health policy and practice. Visit the website for more information.

7th International Conference on Rapid Response Systems and Medical Emergency Teams: 7–9 May 2012, Sydney

The conference, auspiced by the Australian Commission on Safety and Quality in Health Care, will explore issues associated with recognising and responding to clinical deterioration of patients in hospitals. Administrators, researchers and health care team members involved with recognising and responding to clinical deterioration will find this conference useful. This includes people working in areas such as critical care, emergency and general wards, rapid response, medical emergency, ICU liaison and critical care outreach, risk, quality and patient safety, resuscitation and clinical outcomes and hospital management. For further information visit the website.

The 8th Australasian Redesigning Healthcare Summit; solving problems – delivering innovation: 8–10 May 2012, Brisbane

Run by the Australasian Lean Healthcare Network, the Australasian Redesigning Healthcare Summit is established as a leading forum for learning and sharing the lessons from healthcare redesign. In 2012 international speakers from health and other industries will combine with local champions of innovative redesign to create a diverse program. The summit will run concurrently with Lean Enterprise Australia, increasing delegate access to international speakers and networking opportunities. The summit will bring together clinicians, healthcare executives, leaders and managers, redesign, quality, safety and improvement teams and clinical and non-clinical service providers. Online registration facilities and the updated summit program are available on the website or by email.

Australasian College of Health Service Management Congress 2012: 15–17 August, Gold Coast

The aim of this Congress is to present new thinking on the main challenges faced by health managers and health facility designers and planners. As decision-making becomes increasingly complex, existing workforce profiles are evolving, and as demand to improve the safety of health care continues to grow, health care managers must do better than to merely keep the status quo. More detail is available on the website or by email.

45 and Up 9th Annual Collaborators Meeting 2012: 12 October, Sydney

45 and Up Study partners, research collaborators, supporters and other interested parties are invited to join the Sax institute's 45 and Up team to hear the latest on the study's progress. The latest research projects to use the Study's data, and a comprehensive update on Study's progress will be presented at the meeting. Further detail will soon be available on the Sax Institute website.

Australian Association of Gerontology 2012 National Conference: 20– 23 November 2012, Brisbane

The Association's 45th national conference will emphasise the importance of challenging and breaking through perceived boundaries in ageing that determine the limits of research, policy and practice. This

conference is designed to connect, challenge, and inspire the exchange of innovative ideas between older people, researchers, practitioners, educators, industry, voluntary and community organisations and policy makers. For further information, and to submit an abstract, visit the website or email.

Network to Network 2012 – the Second Australasian Clinical Networks Conference: 21-23 November, Sydney

The Agency for Clinical Innovation will host the Second Clinical Networks Conference in November and is calling for abstracts by 31 May. Keynote speakers include Shane Solomon, Professor Andrew Morris (Chief Scientist, Scotland) and Dr Nick Goodwin (The King's Fund).

Themes to be explored include strategies used by effective networks to support implementation, evaluating the outcomes of clinical networks, and how effective clinical networks contribute to stability during times of national and state health reform.

More information is available on the website or by email.

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