Australian Health Care Reform Alliance (AHCRA) Newsletter

February 2007
The AHCRA newsletter is a quarterly publication with over 160 subscribers. You have received this because you subscribed on our website www.healthreform.org.au. If you would like to unsubscribe, please email health@choice.com.au with 'unsubscribe' in the subject header.

Welcome message from the Chair

On behalf of the AHCRA Executive I welcome you to our first newsletter of 2007. The Executive has already held two meetings by teleconference this year.

We are committed to providing you with an opportunity to attend a world-class **Summit**, *Reform in the Australian Health Care Sector*, at Old Parliament House on 30-31 July 2007 so mark it in your diary.

In the lead up to the Summit we are investigating methodologies to conduct small-scale community consultations. These will be self-funded by AHCRA through the membership fees which are being introduced this year. The e-newsletter will continue to be free to those who subscribe.

If your organisation is not yet a member but interested in joining please contact health@choice.com.au for more information.

2007 is an important year for AHCRA: we need to consolidate our presence as a force for reform and develop more detailed reform proposals. AHCRA is committed to pursuing consumer and clinician driven reform of our health system so that it delivers equitable health outcomes.

I hope you'll join us for the journey.

Message from a member organization

*We take contributions from member organizations about their work. In this issue, Gordon Gregory from the **National Rural Health Alliance** writes about rural health issues. If you would like to contribute, please email health@choice.com.au with 'newsletter' in the subject header.*

The need for improved access in the bush

Regardless of income, education, culture or geographical location, Australians have a right to accessible health services according to need. People in rural, regional and remote areas are currently among those affected by poor access to services, poor continuity of care and the lost opportunities for clarity and collaboration between the levels of government involved in health.

Thirty per cent of Australians live in rural Australia, including the 3 per cent in remote regions. People in these areas have poorer health outcomes and a higher incidence of risk

factors such as poor nutrition, inferior health-related infrastructure, little access to specialist services, high rates of smoking, alcohol and other drug misuse, and inappropriate attitudes to risk-taking behaviours.

A man born in far western NSW can expect to live 13 years less than one born in Mosman, Sydney. One reason is that poor access to health services results in less timely interventions and lower rates of recovery and survival. The same rate of incidence of illness or accident therefore results in worse effects.

The principles being promoted by AHCRA will improve access to health services for rural people, improve the efficiency of health expenditures and so increase the value of our bid for 'a 30 per cent fair share' of resources. Adoption of the AHCRA principles and program will ultimately improve the health of people in rural and remote areas.

Rural and remote communities are extremely diverse and a 'one size fits all' approach is not effective. Some rural and remote areas are already taking the lead in breaking down a silo approach to health, including in workforce education and training, funding models, integrating practice nurses in general practice, and in working effectively across jurisdictional boundaries.

Whatever changes are effected in health systems, safety and quality for rural people remain paramount. A two-tier system (metropolitan-rural) is not acceptable.

Because some 70 per cent of the nation's Indigenous people live in rural, regional and remote areas, the Indigenous health emergency is in part a rural and remote issue. As early as the 1830s a far-sighted colonial administrator argued that "the very *first* use of revenue generated from the land should be for the amelioration of the Aboriginal condition."

As part of what needs to be done to improve Indigenous health outcomes, AHCRA proposes increased support for the community-controlled Indigenous health sector, additional culturally-appropriate education and training for health professionals, and a stronger focus on chronic disease care and public health policies as they relate to Indigenous people.

News from the Executive
1. AHCRA Executive membership

The AHCRA Executive was elected in May 2006. It consists of the following individuals, not organisations.

Health Professionals
Fiona Armstrong (Australian Nursing Federation)
Jill Sewell (Royal Australasian College of Physicians)
Kerren Clark (Australian Physiotherapy Association)
Michael Kidd (Royal Australian College of General Practitioners)

Prue Power (Australian Healthcare Association)
Tim Woodruff (Doctors Reform Society)

Consumer Groups
Gregor Macfie (Australian Council of Social Service)
Kathy Kendall (Health Consumers Network)
Tony McBride (Health Issues Centre)
Viola Korczak (CHOICE)

Rural
Gordon Gregory (National Rural Health Alliance)

Kerren Clark is the Chair and Jill Sewell is the media spokesperson.

2. The Summit
The AHCRA has committed to holding a National Health Reform Summit on the 30 and 31st of July 2007 at Old Parliament house in Canberra.

AHCRA's aims in running the Summit are:

- to develop and agree concrete proposals for health care reform in Australia
- to refine AHCRA's existing principles and proposals, and to broaden the membership base of the Alliance
- to contribute to the momentum for health reform in political, community and professional circles

The Summit is open to all, not just AHCRA members. Further details, including the program, will be posted shortly.

3. Working groups
Members of AHCRA will contribute to six working groups;

1. Health Workforce (convened by Fiona Armstrong)
2. Primary Health Care (Jill Sewell)
3. Community Engagement (Tony McBride)
4. Rural Health (Gordon Gregory)
5. Indigenous Health (Kathy Kendall)
6. Integration of Health Services (Prue Power)

Each group is chaired by a member of the executive, listed in brackets above. AHCRA members are asked to email the leader of the working group they are interested in joining by the end of February so that the groups can start preparing for the conference.

4. Community consultation
Community consultations will be organised in some states. They will initially be held in NSW, Victoria and Queensland before the Summit, with other states to follow. This group is headed by Tony McBride from the Health Issues Centre. He is co-ordinating workbooks and handouts for the workshops.

In Victoria, we anticipate a Rotary club to be involved in a three hour consultation about healthcare reform. In other states, other groups will be engaged so that a cross section of the population can be consulted.

We will report on the findings in coming newsletters.

5. Membership fees
This is the first year that membership fees are being introduced. The fees will be used to employ a part time project officer to advance the work of AHCRA. The fees are due at the beginning of each calendar year and are paid on a sliding scale as follows:

Annual membership fee ($)	Annual budget ($)
20	Unfunded organisations
100	<10,000
200	10,000 to <25,000
250	25,000 to < 100,000
500	100,000 to < 1 million
1000	1 million to <2 million
1500	2 million to <4 million
2000	> 4 million

If you would like to become a member and contribute to the work of the Alliance, please email health@choice.com.au. In order to become a member, the organisation has to commit to the AHCRA principles (link) and be endorsed by the Executive.

6. Constitution
AHCRA now has a constitution, which is available on the homepage of our website (link). The constitution was drafted by Kathy Kendall from the Health Consumers Network with contributions from the membership. The Alliance membership has approved it and it was endorsed by the executive in January 2007.

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