A new look for *Australian Health Review*

WE ARE DELIGHTED to welcome you to the new look of the Journal. In recognition of the importance of *Australian Health Review* to management and policy decision makers in Australia, the Australian Healthcare Association has initiated some major changes to assist us to better meet our readers' needs. The journal is now being produced with the support of AMPCo, the Australasian Medical Publishing Company. The changes in print format and presentation of papers will be accompanied by a more interactive website, and authors and reviewers will soon notice a more streamlined editorial and production process.

It is also a pleasure to welcome Mr Gary Day, of the Queensland University of Technology, to the new role of book review editor for the journal. Gary's appointment will enable the journal to include more regular coverage of significant books and reports.

The librarians and archivists among our readers will note that we have started a new volume (number 28) for the occasion. Volume 28 will have three issues, which, combined with those in volume 27, will make 5 issues for 2004. The next volume (number 29) will start in 2005.

A time to look back

As *AHR* moves into a new era, it is fitting that this issue includes a special supplement edited by Allan Hughes, former president of AHA and former editor of *AHR*, which showcases the perspectives of many of the journal's former editors (*page 110*).

Research articles

As usual, this issue of *AHR* provides a variety of important papers. Richardson and Segal review the impact of policies on private health insurance and the PBS for the health system as a whole (*page 34*). Mulligan and Braunack-Mayer's review of the evidence for protecting patient confidentiality (*page 48*) is a timely reminder, given recent debate on confidential medical care for young people.

Joiner and Bartram discuss factors influencing nursing stress (*page 56*); Rutherford and Rissel report on bullying (*page 65*); and Anderson addresses gender differences in decision-making by senior management (*page 73*). The impact of case management on hospital utilisation in Hong Kong is discussed by Leung et al (*page 79*); and Williams and Leslie report on the patterns of delayed discharge from ICU (*page 87*). Durey and Lockhart present a case study of community consultation in the bush (*page 97*).

Reflecting on a difficult journey

In recognition of the need for continuing improvement in the sector's approach to quality and safety, and methods of responding to emerging problems, we have included both invited commentaries and a peer-reviewed paper touching upon the recent events at the Camden and Campbelltown Hospitals in New South Wales, and their implications for future practice (*page 7*). In approaching this topic, we were very aware of the distress of the patients and families involved, and also of the difficulties endured by staff at the hospitals. Tough

experiences can generate deep learning — we hope that the papers we publish here contribute to that process. If the level of response to Anne Cahill's paper on her experiences as a patient, published in the last issue, is any guide, we think these papers will be of great interest to a broad audience.

Although the papers express different perspectives, important points are made about the underlying issues, the processes and the outcomes of current approaches to quality and safety in Australian hospitals. The sector continues to learn from the experience of other industries, but needs to ensure concepts and tools are appropriately adapted to the provision of health care in all its complexity. Some of the shortcomings of our current approaches include:

- The lack of general agreement throughout the system on what comprises an error or an adverse event. Many of us are aware that not all 'safety compromising events' are recorded and included in quality improvement processes (Sheridan 2003). From system to system and hospital to hospital there is often an almost arbitrary approach to documenting and investigating adverse events, which limits our ability to learn to improve.

- The fact that adverse event analysis completed for one purpose may be inappropriate and more importantly, misleading, for other purposes (Rasmussen 2003). Although there is a move to ensure consistent application of the principles of root cause analysis, standardisation has not been achieved, and may not even be possible given the nature of human behaviour and social interaction. In addition, our satisificing behaviour and system constraints may limit investigations so that contributing factors further upstream to the delivery process are missed.

- The inherent tension in the system between the need for individual accountability (consistent with our approach to regulation of the health professions) and the need for open disclosure and blame-free reporting in a learning environment.

- The difficulties in achieving accurate and immediate feedback (that is not compromised by parallel processes of investigation for other purposes), in spite of its known value for learning and quality improvement.

- Finally, the difficult contradictions for practicing health professionals that arise in a system where organisational and system outcomes, such as improving efficiency and reducing costs, can conflict with the pursuit of high quality, safe health care delivery (Sheridan 2003).

Perhaps the most important message from these papers is that provision of health care is dependent on people — people working in organisational and system contexts. As Donald Berwick has so precisely stated "every system is perfectly designed to achieve exactly the results it gets" (Berwick 2003, p. 449). It is easy to identify significant system and organisational disincentives to the provision of quality health care, and until Australia has the courage to address them, similar events to those at the 'Cams' hospitals, the Royal Melbourne, the King Edward Memorial and others will continue.

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Editors, *Australian Health Review*

References

Berwick DM 2003, Improvement, trust, and the healthcare workforce, *Quality and Safety in Health Care,* vol.12, p. 448.

Rasmussen J 2003, The role of error in organising behaviour, *Quality and Safety in Health Care,* vol.12, p. 377.

Sheridan T 2003, The role of error in organising behaviour [Commentary], *Quality and Safety in Health Care,* vol.12, p. 377. □