The Australian Healthcare and Hospitals Association celebrates 60 years. Excerpts from an historical review by Selby Steele

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> DUE TO rising costs and neglect in forward planning the financial position of Australian hospitals has never been worse. An additional reason for their present difficult situation is the political difference of policy between the various Governments, Federal and State. *From an editorial in The Australian Modern Hospital, 1949.*

The foundations of the AHHA

Echoes of this comment have resounded over the subsequent sixty years of the Australian Healthcare and Hospitals Association (AHHA). Undoubtedly one of the motivations for formation of the Association was the concern of the medical profession that a nationalised health scheme, similar to that being implemented in the United Kingdom, might be introduced in Australia. In 1944 the Prime Minister, Ben Chifley, stated that the government intended to introduce a full-time salaried medical service in Australia.

On 18 November 1946 Dr (later Sir) Herbert Schlink, a gynaecologist and Chair of the Board of Sydney's Royal Prince Alfred Hospital, convened a meeting of the Provisional Federal Council of the Australian Hospital Association (AHA) at The Royal Melbourne Hospital. This was followed in Sydney in February 1947 by the first Annual General Meeting at which membership of the Council was confirmed and a set of rules adopted. Sir Herbert became the Foundation President of the Association and remained in this position until 1958. The first members of the Association recruited by Dr Schlink were teaching hospitals in Sydney and Melbourne, whose boards were regarded as having considerable influence on government decision making.

The AHA had considerable influence in the early years, and the story of the Association's first forty years is admirably covered by Mary Dickenson and Catherine Mason in their book *Hospitals and politics: The Australian Hospital Association 1946–86*. There is less written about the AHA from 1986, and this is summarised below.

The two decades 1986 to 2006

With the move to Canberra in 1985, the AHA increased its government liaison activities, both with the Minister and Ministerial staff, and with the Opposition Spokesperson on health matters. The Association was involved with, or represented on, numerous bodies such as the Australian Institute of Health, the National Health Technology Advisory Council, the Standards Council of Australia, the Australian Council on Hospital Standards and the National Health and Medical Research Council.

At the 1986 Annual General Meeting, Mr Keith Bagley, a solicitor from New South Wales, was elected National President. Honorary Life Membership was conferred on Royce Kronborg, recognising the completion of his term as a councillor and President of the International Hospital Federation and his long and outstanding service to the Australian Hospital Association. The Association also made the first award of the Sidney Sax Medal to "encourage innovation and excellence in health care delivery". The inaugural recipient was Dr James Lawson (soon to take up the appointment of

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1 Notable participants in the 60 years of the Australian Healthcare and Hospitals Association

Year	Presidents	Executive Director positions	*Australian Health Review* editors	Sidney Sax Medal recipients
1946–58	Sir Herbert H Schlink	*Honorary Secretaries* Sir Norman Paul (Sydney) J Beacham Kiddle (Melbourne)		
1947		*Honorary Secretaries* Dr HO Selle (Sydney) Colonel RE Fanning (Melbourne)		
1956–58		*1956 Honorary Federal Secretary* Dr S Hatfield		
1958–61	Mr John B Plant	*Honorary Federal Secretary* Dr Edgar Thompson		
1961–67	Mr Hamilton M Sleigh			
1967–69		*Honorary Federal Secretary /Executive Vice President* Mr Royce H Kronborg		
1969–71	Sir Alastair E Stephen			
1971–73	Dr C Douglas Donald			
1973–74	Sir Lincoln C Hynes			
1974–76	Mr Royce H Kronborg	*National Director (salaried)* Mr Trevor Elligett		
1976–78	Mr Douglas C Davidson			
1978–80	Mr Selby K Steele		*Foundation* Dr Barry Catchlove (1978–83)	
1980-82	Dr Donald S Child	Dr Errol Pickering		
1982–84	Mr John M Gibbs		Dr Johannes Stoelwinder (1983–84)	
1984–86	Dr Barry R Catchlove		Mr Jonathan Tribe (1985–87)	
1986–87	Mr Keith Bagley			1986 Prof James Lawson
1987–88		Dr John Morris	Mr Chris Richards (1987–93)	1987 Dr Donald Child
1988–89	Professor John Blandford			1988 Dr Ian Brand
1989–90		Mr Peter Read		
1990–91	Mr Jonathan Tribe			1990 Dr Bernard Amos
1991–92		Mr Peter Baulderstone		1991 Prof John Blandford
1992–93	Professor Mark Liveris			1992 Dr Diana Horvath
1993–95	Dr Diana Horvath		Ms. Ros O'Sullivan (1993–94)	1993 Mr Allan Hughes
			Dr Roy Green (1994–98)	1994 Dr John Deeble
1995–97	Mr Ronald Tindale			1995 Dr Rex Joyner 1996 Dr John Yu
1997–98	Mr John Smith	Professor Donald Hindle		1997 Dr Owen Curteis
1998–99		Mr Mark Cormack	Professor Don Hindle (1998-03)	1999 Mr Ronald Tindale
1999–01	Mr Allan Hughes			2000 Dr David Watson
2001–05	A/ Professor Deborah Green	Ms Prue Power	Professor Judith Dwyer & Dr Sandra Leggat (2003–06)	2001 Dr John Mulligan 2002 Dr Jack Sparrow 2003 Prof Stephen Duckett 2004 Prof Helen Lapsley
2005–	Dr Stephen Christley			2005 Prof Brendon Kearney 2006 Prof Bruce Barraclough
			Professor Sandra Leggat (2007–)	

Professor of Health Administration at the University of New South Wales). Two notable publications were launched during the year, namely *Hospitals and politics: the Australian Hospital Association 1946–86*, by Mary Dickenson and Catherine Mason and *The governance of hospital services*, also by Mary Dickenson.

In 1988 Mr John Blandford, Administrator of the Flinders Medical Centre in Adelaide, was elected National President. At that meeting it was resolved that the Memorandum and Articles of Association be altered to increase the effectiveness of the Association at state levels through a restructuring which provided an option of representation by either State Associations or State Branches. It provided for an incorporated State Association to be a member of AHA in its own right and to take the responsibilities previously held by a State Branch (State Association membership) and that, where no State Association existed, or where the members of that state did not wish to utilise the foregoing option, a State Branch would continue to function and to represent the interests of members at state level. Following this decision the New South Wales Branch Council resolved that it should amalgamate with the Hospitals and Health Services Association of New South Wales to form a new association. The South Australian Branch and the South Australian Hospitals Association amalgamated to become the Hospitals and Health Services Association of South Australia. In Victoria, the Victorian Hospitals Association (VHA) was appointed the State Association member for Victoria, following the winding up of the Victorian State Branch and the transfer of its assets to the VHA. The 1988 amendments to the Memorandum and Articles also gave legal effect to the existence of a National Executive and provided for the election of this Executive from among members of the National Council. Consequent upon these changes, the membership of the Association increased by 30% in 1988–89 and by a further 27% in 1989–90. This was largely due to the extra members brought in by the new category of State Association membership.

1988 was the year of the Bicentenary celebrations, and AHA combined with the Australian College of Health Service Executives and the Australian Association of Nurse Administrators to hold a joint Congress in Queensland that was attended by over 800 delegates. As well as a revamped *Hospital Brief*, a twice yearly publication called *Bulletin Board* commenced. The Association's video library had expanded to one hundred and forty titles. At the 1990 Annual Meeting Mr Jonathan Tribe, Executive Director of The Royal Melbourne Hospital, was elected National President.

Throughout the two decades from 1986, the Association regularly participated in, or presented its views to, numerous government reviews or inquiries, and made submissions to appropriate authorities on a diverse range of subjects of importance to members. As well as these actions by the National Office, the State Associations or Branches made numerous representations on matters of interest or concern within their own states.

The National President for 1992–93 was Professor Mark Liveris, Deputy Vice-Chancellor (Health Sciences), Curtin University and President of the Board of Royal Perth Hospital. He was followed by Dr Diana Horvath, Chief Executive Officer of the Central Sydney Area Health Service, who held the position for the succeeding two years.

AHA publications

Over the years the Association's publications have provided valuable information to members, as well as serving as background material for many of the discussions and debates occurring in the wider community and in government concerning health policy and financing. The flagship publication is *Australian Health Review*, now in its twenty-ninth year. The Journal aspired, from its commencement, to be the major academic journal in Australia for articles relating to health policy and practice, with encouragement of publication of information based on empirical studies. It is published quarterly and has maintained a consistently high standard since inception, this standard being nurtured by a number of excellent editors (see Box) and guest editors, the latter generally being invited to oversee issues devoted to a particular theme. In 1986, *Australian Health Review* was accepted by Excerpta Medica for inclusion in its abstract service. The Journal is now available

online and it has a wide range of subscribers among those involved in health service management, health policy development and universities and colleges providing education and training in health management and service provision.

The other long-standing regular publication of the Association is the monthly *Healthcare Brief*. In February 1993, a "new look" *Hospital Brief* was published which incorporated the old *Hospital Brief* and the *Bulletin Board*. It was considered this better met the needs of both the hospital executive and board member readership. Multiple copies were circulated to all institutional members. Like *Australian Health Review*, it is now available online.

Until December 1998, irregular monographs and key issues papers were published when serious analysis, review or discussion of particular subjects was required. Since that time topics requiring special attention have tended to be published as "stand alone" documents. One such document was the Waste Audit Manual, prepared in 1994 after successful tendering for a grant from the Commonwealth Environment Protection Agency. A successor to this consultancy was the 1997 production of the first edition of the Greenhouse Challenge Healthcare Workbook, prepared by Energetics Pty. Ltd in collaboration with the AHA. The Association was the first health organisation to assimilate information about the environment and produce it in a readily accessible form. The project was the outcome of a facilitative agreement with the Australian Government, acting through its Greenhouse Challenge office. The Association committed itself to encouraging and assisting its members to participate in Greenhouse Challenge, and to raising general awareness within the industry of greenhouse issues. A Hospitals Greenhouse Challenge Project Officer was located at the AHA premises, his role being to support both public and private hospitals in entering into cooperative agreements relating to the monitoring and reduction of emissions.

Impact of health sector restructuring on the membership base

Mr Ron Tindale, Deputy Chief Executive Officer of the Western Sydney Area Health Service, was elected National President in 1995. In his 1996 Presidential Address he alluded to the implications of the changes taking place in health service structures.

> Virtually all States are reorganising the scale of their management and governance units. The increasing political significance of the Health portfolio means that any government looks for board members who endorse their objectives and priorities. The same holds true for managers and anyone who is a senior government employee or appointee. The most knowledgeable, dedicated managers have the most responsible positions in their own organisations — with all the associated work pressures. Government needs their insights into health management, financing and delivery problems — either through bodies like AHA or as direct members of committees and working parties. These people have the breadth of knowledge; the grasp of detail; and the personal credibility to make a real contribution to improving the organisation of our health system. Government and bodies like the AHA need to rethink how they build their input into decision making processes.

He suggested greater attention to collaboration with other representative bodies (even in physical location to achieve economies in sharing overhead costs), increased utilisation of external consultants for specified research or policy development and concentration on those issues which were deemed to be of the most significance to public hospitals and health services.

On 9th December 1996 the corporate name was changed to the Australian Healthcare Association. The move recognised that the nature of health service had changed, with the restructuring and development of hospitals and other entities as components of area health services, networks and regional services. This new aggregation of services aimed to provide integration and coordination across a wide spectrum of health services.

At the 1998 AGM, National President John Smith voiced concern about the financial implications of the changing membership base:

> The aggregations of many hospitals and health services have resulted in fewer member entities with consequent pressure on State Associations to reduce membership fees for these aggregated services. In turn, these reductions impact on the AHA at a national level and the services that it can provide. National Council has worked hard to ensure that AHA responds appropriately to these pressures by establishing priorities, developing business and financial plans and working closely with the States to provide effective services and representation for the membership.

In the following year it was reported that the Association had reduced staffing and overhead costs, returning a modest surplus for the year and stressing the importance of finding a balance between affordable membership fees and a value-for-money range of membership products and services. One new product was a workshop facilitation service, available to members on an "expense only" basis.

Mr Allan Hughes, Chief Executive Officer of Ballarat Health Services, and from 1985 to 1995 the Chief Executive Officer of the Victorian Hospitals Association, became National President in November 1999, at a time when the Commonwealth Government's Goods and Services Tax was in the final stages of refinement and implementation. The Association had hoped that the introduction of this tax might benefit hospitals and health services because of the growing revenue base to the states arising from the intergovernmental agreement on tax distributions. In this regard the Association and its members were perhaps too optimistic! The legislation provided for hospital and health care services to be GST free to patients. For the industry this required implementation of a complex administrative and business practice change regime that came into full effect on 1st July 2000.

In partnership with other health organisations AHA was also active in lobbying and advocacy throughout 1999–2000 in relation to the implications for members of the amendments to fringe benefits tax (FBT) legislation. Part of this involved the publication of *FBT reforms — a guide for the health sector*. It was widely distributed to the health and community sector and galvanised a national response to the impacts of the proposed amendments. The new FBT legislation had significant implications for the public health care industry. The capping of FBT exemptions for salary packaging arrangements pertaining to public hospital and health care organisations represented a substantial financial and industrial challenge for the industry.

A new millennium

In September 2001 Ms Deborah Green, Chief Executive Officer of the South Eastern Sydney Area Health Service, was elected National President. During the succeeding months the medical indemnity scene in Australia reached a crisis point with the imminent collapse of Australia's largest medical indemnity insurer, UMP. The Prime Minister called a national summit in April 2002, at which AHA was a participant. AHA's major concerns in this area were the management of clinical risk, improvement of quality management processes, and a more open approach to the management of adverse incidents. This was intended to lead to a national education and training program and its eventual incorporation into accreditation and risk management protocols. The year 2001–02 also saw a major focus on workforce issues, with two concurrent national inquiries into the shortage of nurses: the Senate Community Affairs Inquiry into Nursing and the National Review of Nursing Education. The AHA provided input to both.

The following year, 2003, was one of radical change in the operations of the Association. The apprehensions concerning membership raised by Ron Tindale in 1996 were now a reality. Widespread amalgamations of smaller corporate entities into larger regional governing bodies had resulted in a fewer members or potential members and a higher aggregate fee for each one. In addition, the autonomy and independence of some corporate entities had been diluted as a consequence of governments devolving direct services management to "arms length" statutory bodies. This had reduced, or even eliminated, their propensity to join their industry association. The fact that AHA's

institutional members were, in many instances, becoming state government entities was influencing the capability of managers to be active members of the Association. There was also growing competition from other representative bodies in niche areas of the Association's market.

The National Council implemented cost reductions and consolidation of assets, including sale of the buildings in the Australian Capital Territory and South Australia and restructuring of the National Office functions, including some outsourcing of membership, administration and corporate support functions to State Associations and Branches to allow for greater concentration on policy, advocacy and government relations. This was designed to pursue development in areas relating to the core business of AHA, such as Internet communications, conferencing, publications, project work, sponsorships and advertising.

On 30 June 2003 settlement occurred for sale of the building at 42 Thesiger Court, Deakin. Staff numbers were reduced and the National Office took a sublease in the premises of Canberra-based Client Solutions, at the same time engaging that firm in a consulting capacity for support in areas such as strategic campaign management, high level representation, specialised policy advice and communications. By the end of 2003 the Victorian Healthcare Association had received the AHA's library material and the Health Services Association of New South Wales was working with AHA to set up a cooperative relationship on matters relating to Council, Congress and the *Australian Health Review* management and administration. Smaller savings strategies were also implemented, such as reducing the number of face-to-face Council meetings and hard copy editions of *Healthcare Brief*.

Online services to members had gradually expanded. A complete rebuild of the website was completed in December 2002. During 2002–03 the AHA decided to enter into an arrangement with the Health Services Association of New South Wales and the Victorian Healthcare Association to outsource certain corporate and membership support functions. The New South Wales body was unable to sustain the resources required and restoration of these functions to the National Office required the appointment of an additional staff member. As a consequence, space requirements necessitated a move to the Association's current office at 99 Northbourne Avenue, Canberra.

In July 2004 the AHA gathered together a group of esteemed professionals in the health system and related areas; as the inaugural meeting of what has come to be known as the AHA Think Tank. The group's purpose is to discuss, analyse and recommend innovative policy solutions relating to the health system, with a view to these proposals being presented to government. The group meets at four monthly intervals and is becoming nationally recognised and respected as an influential voice in Australian health policy.

At the 2005 Annual General Meeting, Deborah Green completed a four-year term as National President and was succeeded by Dr Stephen Christley, the Chief Executive, Northern Sydney, Central Coast Area Health Service. In 2005–06 the Association again radically altered its structure. On 1 July 2005 the AHA took over direct responsibility for New South Wales members from the New South Wales State Association. During the first half of 2006 both the Victorian Healthcare Association and the Healthcare Association of Western Australia also relinquished their State Association status. These changes reflected the widespread changes in health service structures alluded to earlier. Consequently, the AHA, through the National Office and its State Branches, has had direct responsibility for recruiting members in every state and territory, as well as for delivering the full range of services. Thus the current membership structure once again resembles the original structure of the Association when it was founded sixty years ago, with the exception that many of the current institutional members are much larger corporate bodies, such as Area Health Services.

The Association and health financing 1986 to 2006

Since its inception, the Australian Healthcare and Hospitals Association has continually stressed to government the financial limitations imposed on

hospitals by the various forms of funding of the health system. In his 1985–86 Presidential Report Dr Barry Catchlove commented that

> the organisation and funding of health care is in turmoil throughout the Western World. Governments of all persuasions are searching for solutions to what are in fact near insoluble problems given the economic constraints of the late eighties. These problems are being made worse by continual and real reductions in hospital funding. In the past elections have meant new hospitals and services; today they usually mean a reorganisation and further cutbacks. The system is becoming tired of reorganisations, expert consultants, and associated costs, while the real problems facing hospitals and health care remain the same.

Dr Catchlove referred to nurse shortages and bed closures as critical issues across the nation (due in considerable measure to the transfer of nurse education to colleges of advanced education and the introduction of the 38-hour working week). On the positive side he observed the moves towards decentralising decision making to give hospitals, areas and regions more autonomy; as well as experimentation with alternate delivery and performance measurement systems.

In February 1986 significant press and television publicity was given by the Association to the financial problems faced by the nation's health services; the aim being to influence decisions made in the preparation of the 1986–87 Federal Budget and the impending renegotiation of the Medicare Agreements on cost sharing between the states and the Commonwealth. In particular, the Association recommended to government that public hospitals be funded through a performance-based mechanism, taking account of changes in the volume and kind of work. Other emerging issues included the impact on hospital costs of the devaluation of the Australian dollar; the shortage of nursing home beds (leading to "blockage" of beds in acute hospitals); the impact of the AIDS epidemic; and a potential estimated additional cost of $200 million arising from the introduction of a recognised career structure for nurses in clinical areas.

In the *Health Services Monograph* No.33 of June 1986 the Association noted that factors contributing to the escalation of costs included changes in the numbers and types of patients being treated. Patients were becoming older and sicker, requiring more intensive treatment. The trend was demonstrated by the increasing proportion of patients with multiple diagnoses; an increase in the number of patients requiring admission to intensive care units; higher mortality rates; and longer lengths of stay for certain patients. The overall operating environment of public hospitals was illustrated by an AHA survey which revealed that during 1985–86, 59% of hospitals were over budget; nearly a quarter had unavailable beds; two-thirds reported shortages of registered nurses; 45% had too few salaried or visiting medical staff; and 60% of teaching hospitals had been affected by industrial disputes, as had 47% of metropolitan and large country hospitals (the "nurses" dispute in Victoria over pay and career structure had lasted 50 days).

AHA continued representations to government, strongly supporting the introduction of casemix-based payments for reimbursement of public hospital expenses. The difficulties associated with a deficit funding budgetary system were again stressed in the Association's submission to the 1989 Senate Select Committee on Health Legislation and Health Insurance, as well as in the contribution to the concurrent Commonwealth Medicare Review. These bore some fruit in that the Association received a grant from the Commonwealth Government to further develop casemix funding for hospitals. Helen Owens was engaged to prepare a Report on Quality Assurance Under CaseMix Payment; KPMG Peat Marwick acted as consultants to survey the use of computerised information systems in hospitals, with particular emphasis on product costing systems; and Health Solutions was engaged to prepare a basic information and education guide on casemix.

By 1992 public hospital waiting lists had increased while the level of private health insurance continued to fall — two million more Australians now relied on public hospitals for treatment than five years previously. In March

1992 the Association joined with the Private Hospitals Association of Australia to launch what was called Operation: Hospital Survival stating that "while our constituency and objectives are not identical, there was mutual concern that the current Medicare arrangements and declining health insurance levels were adversely affecting both public and private hospitals." The document published jointly by the two associations, titled *Time to act,* recommended radical modification to hospital funding. Low income earners would continue to be covered by Medicare without paying a health insurance levy. If they chose to take out private health insurance they would receive a $200 rebate from the government. Overall premium rates for private insurance would be sufficient to cover treatment in either a public or private hospital. The level of premium required was not specified but it was suggested personal contributions be subsidised by government, with the amount of subsidy falling as personal income increased; high income earners receiving no subsidy. Apart from low income earners, all others would incur a tax penalty if they did not take out private health insurance. The scheme was intended to achieve virtual full cover of the population and to introduce a more equitable progression of premiums in relation to income. All private patient care in public hospitals would be funded by private health insurance and the public beds would be funded by state government subsidy, presumably under a cost sharing agreement with the Commonwealth.

In April 1992 the national directors of the AHA and the APHA visited health ministers and opposition spokespersons in all states. Strong representations were made about the problems facing both public and private hospitals. Almost all politicians accepted the associations' analysis of the problems although not all believed that a greater role for private health insurance was an effective solution. In their policies for the 1994 federal election neither the Government (Labor) nor the Opposition (Coalition) undertook to pursue the difficult task of restructuring public/private and Commonwealth/state responsibilities in health. This was seen by the Association as a missed opportunity.

Medicare grants to public hospitals in 1994–95 were limited to an increase of only 2% even though Commonwealth spending for its own-purpose programs rose rapidly (Medicare benefit by 10% and pharmaceutical benefits by 12%). Diana Horvath, in her National President's Report of that year commented that

> the problem for both the Federal Government and Opposition, as well as for many professional groups, is that they are locked into a health care paradigm that existed for a few decades in the 1950's, 1960's and1970's. Medicare and Medibank were largely borrowed from the Canadian national health insurance reforms of the 1960's — when ready access to doctors and hospitals was regarded as the main requirement of good health policy. For the opposition parties the answer is mostly more of the same, but with greater private funding to replace taxpayer spending. Modern health care has moved onward from that time, both technically and socially. Birth centres, keyhole surgery, positive health education, day admissions, cancer chemotherapy and other acute care delivered largely by nurses through hospital-in-the-home programs are all changes that do not sit well with existing medical and hospital financing structures. AHA must focus its priorities clearly on a seamless health system that exists well beyond hospital walls and boundaries.

In 1998 the Association published *Redesigning the future: an Australian Healthcare Association discussion paper on health policies for Australia*. This was regarded by the Association (which had recently changed the word "Hospital" in its title to "Health Services") as a key document in furthering the future debate on health policies. It was proposed, among other things, that there should be discussions on the method of funding the health system (including a review of whether a separate Medicare levy within a general taxation system was still relevant), the renegotiation of cost sharing agreements, the integration of capital and non-capital funding processes — both on a short-term and long-term basis, and groupings of

health providers through which all funding could be channelled.

Following its accession to government, the Coalition introduced a rebate incentive scheme to encourage a higher uptake of private health insurance. Of particular concern to AHA at the time of its introduction was the intention of the government to introduce a "claw back" provision to the Australian Health Care Agreements which meant that the level of Commonwealth funding to the states would fall if the level of community participation in private health insurance rose beyond certain defined percentages. The Association position was that, even if a higher participation in voluntary insurance occurred, disincentives for the insured to use their insurance should be minimised. The existence of medical gaps, lack of informed financial consent and high excess policies all served to discourage policy holders from using their health insurance. This had significant revenue consequences for the public hospital system and would work against the stated aim of reducing pressure on public hospital beds. Another potential initiative of the new government was its intention to remove the sales tax exempt status from public hospitals. AHA lobbied very strongly against this move. Fortunately the decision was reversed before implementation, thus avoiding a massive increase in public hospital costs.

From 1986 the Association persisted in efforts to achieve changes to the Australian Health Care Agreements which would ensure more funding certainty for public hospitals and an extension of the scope of the agreements to encompass the totality of Federal and state health funding programs. A National Health Care Package would set down protocols for guaranteed access to services currently delivered by both federal and state governments including: emergency and admitted care in public hospitals, inclusive of appropriate after-care and diagnostic services; primary and specialist medical care through the Medicare Benefits Scheme; pharmaceutical products; dental care; mental health services; care for the aged (both residential and community-based); and community/primary health care.

Before the implementation of the current cost sharing agreement, the AHA conducted, in 2002–03, a national series of seminars for member organisations and key industry stakeholders to provide an analysis of the Australian Healthcare Agreement and to provide an opportunity for the industry to identify national priorities, future directions and incentives for service improvement in the development of the 2003–2008 Agreement. It is interesting to note that, even as this summary of Association activities is being compiled in mid 2007 the state health ministers are criticising the Commonwealth for short changing them on funding under the cost sharing agreement. Despite considerable and lengthy tendering of advice the wheels of change in this area "grind exceeding slow".

To better reflect the breadth of the constituency, in 2007 the Association's name was changed to the Australian Healthcare and Hospitals Association. A new image was adopted to represent the long-standing history of the Association, dedication to high quality professionalism, loyal service, collaboration, and the important role of the AHHA in linking people through networks.

The Association's contribution to the development of health policy in Australia has been significant. Over the years the essence of many of the comments to government has been adopted. The paramount concern is, of course, to ensure that health services receive due recognition and financing in the face of the many competing demands placed on governments. Such concern will no doubt carry the AHHA forward in harmony with the stated vision of ensuring that all Australians have access to effective health services of high quality that are appropriate and responsive to their needs and coordinated across all settings (home, residential facility or hospital) and that the services are efficiently delivered by capable personnel and adequately resourced to ensure sustainability and safety. □