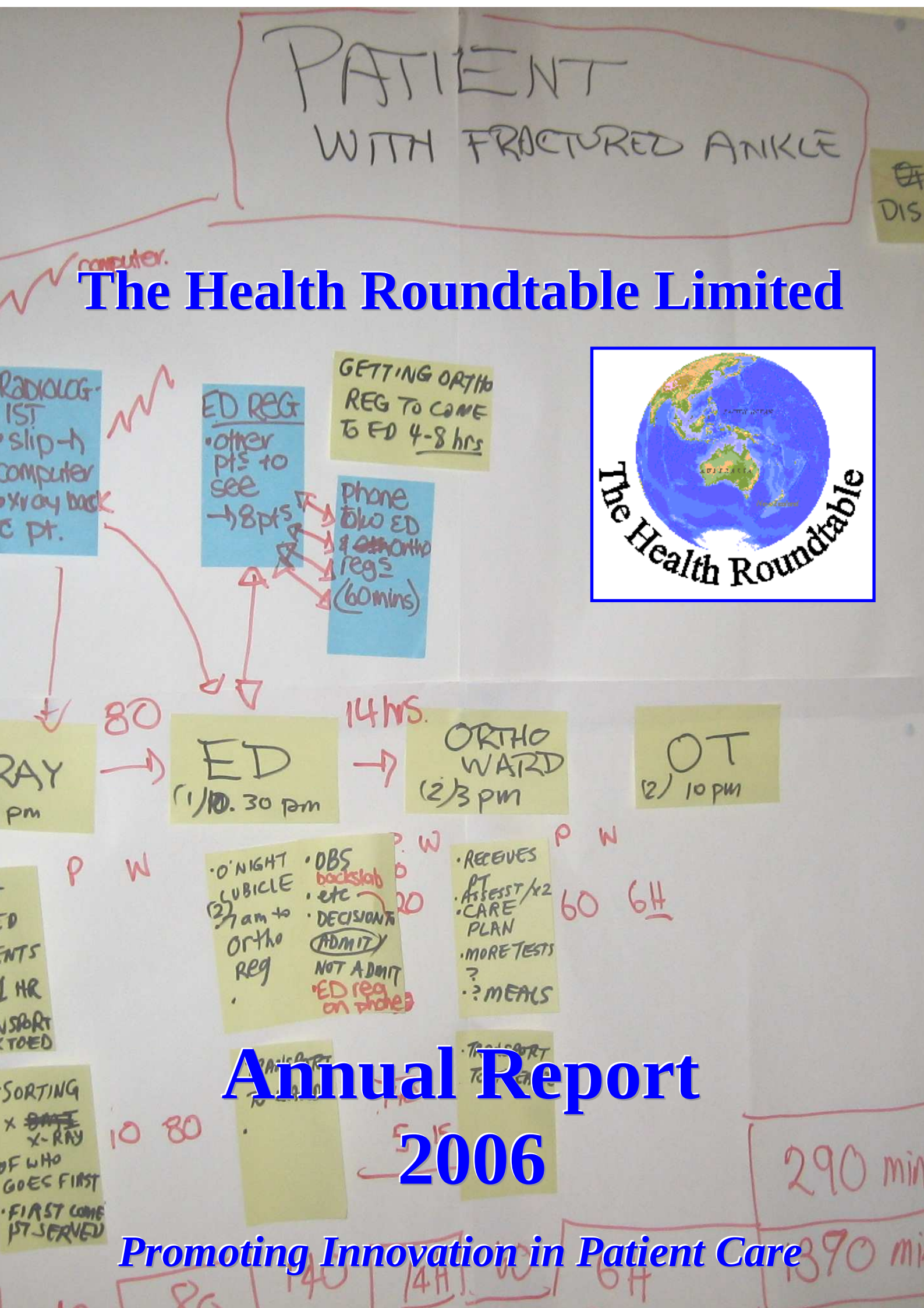
The Health Roundtable Limited



Annual Report 2006

Promoting Innovation in Patient Care

THE HEALTH ROUNDTABLE LIMITED

ACN 071 387 436
ABN 71 071 387 436

DIRECTORS' REPORT FOR 2006

Your directors submit the financial accounts of the Company for the calendar year ending 31 December 2006

DIRECTORS

The names of directors in office at the date of this report are:

Kaye Challinger
Margot Mains
Jennifer Williams
George Jepson
Kerry Stubbs
John O'Donnell
Michael Szwarcbord

PRINCIPAL ACTIVITIES

The principal activities of the Company during the financial year were:

- to provide opportunities for health executives to learn how to achieve best practice in their organisations
- to collect, analyse and publish information comparing organisations and identifying ways to improve operational practices
- to promote interstate and international collaboration and networking among health organisation executives

The Health Roundtable focuses on sharing innovations in patient care amongst its members so that they can treat additional patients and continue to improve the quality of patient care.

OPERATING RESULTS

The Health Roundtable Limited recorded a small deficit of $9,672 for the financial year ending in December 2005. This represents 0.7% of operating expenses during the year. The accumulated surplus in the Company decreased to $100,551 as of the end of the financial year.

The draw-down in the surplus in 2006 was planned by the Board of Directors and was used to subsidise member participation in the "Lessons Learnt" workshop held in May 2006. The overall financial strategy of the Board is to maintain a surplus of approximately $100,000 to provide a buffer to cover monthly fluctuations in income and expenses. The Health Roundtable makes no provision for income tax, as the company is exempt from income taxation.

Cover photo caption: "Current State Map" from the Lean Healthcare Program, September 2006.

REVIEW OF OPERATIONS

November 2006 marked the eleventh anniversary of the founding of The Health Roundtable, which held its first meeting in November 1995 with seven public hospitals represented. By the end of 2006, the number of member organisations had grown to 36 public health service organisations which encompassed 58 separate public hospital facilities. These organisations represent over 40% of public hospital activity in Australia and New Zealand.

John Hunter	NSW	Austin Health	VIC
Prince of Wales	NSW	Barwon Health	VIC
St George (2)	NSW	Bayside Health (2)	VIC
St Vincents (Sydney)	NSW	Eastern Health (3)	VIC
Southern Network (3)	NSW	Melbourne Health	VIC
Sydney West (4)	NSW	Northern Health	VIC
Auckland City DHB	NZ	Royal Women's (Melbourne)	VIC
Canterbury Health DHB	NZ	Southern Health (3)	VIC
Capital & Coast DHB	NZ	St Vincents Health (Melbourne)	VIC
Counties Manukau DHB	NZ	Fremantle	WA
Otago DHB	NZ	Royal Perth	WA
Health Waikato DHB (4)	NZ	Sir Charles Gairdner (5)	WA
Waitemata DHB	NZ	The Canberra Hospital	ACT
Gold Coast	QLD	Northern Territory Health (3)	NT
Mater Health Brisbane	QLD	Central Northern Adelaide (3)	SA
Prince Charles	QLD	Flinders	SA
Princess Alexandra	QLD	Royal Hobart	TAS
Royal Brisbane & Womens	QLD	**Regional Health Improvement Network (8)**	
Townsville	QLD		

() indicates number of separate facilities reported

One of the organisational members of The Health Roundtable is a collaborative group of regional hospitals which has formed the Regional Health Improvement Network (RHIN). RHIN has access to methodologies developed by The Health Roundtable, but conducts its own separate benchmarking activities.

At the end of 2006, the Board of Directors approved the applications of three new members to take effect at the beginning of the 2007 calendar year: Southern Hospital Network (NSW), Prince Charles Hospital Health Service District (QLD), and Northern Health (VIC).

Governance processes for the organisation were strengthened in 2006, with the approval of a new Constitution at the April 2006 Annual General Meeting. The new Constitution replaced the original Articles of Association adopted in 1995, and established three distinct categories of membership in The Health Roundtable:

- Organisational Membership
- Personal Membership
- Associate Membership

The Constitution now delineates separate roles for Organisational and Personal members. Organisational Membership is open to publicly-funded health service organisations. Personal Membership is offered to a senior executive within an Organisational Member. Voting rights on issues affecting the operation of The Health Roundtable are vested in Personal Members only.

Personal Members of The Health Roundtable as of the date of this report are as follows:

Organisational Member	Personal Member
Auckland District Health Board, NZ	Margaret Dotchin
Austin Health , Victoria	Brendan Murphy
Barwon Health , Victoria	Max Alexander
Bayside Health, Victoria	Jennifer Williams
Canterbury District Health Board, NZ	Nigel Millar
Capital & Coast District Health Board, NZ	Margot Mains
Central Northern Adelaide Health Service , SA	Kaye Challinger
Counties Manukau District Health Board, NZ	Geraint Martin
Eastern Health, VIC	Tracey Batten
Flinders Medical Centre, SA	Michael Szwarcbord
Fremantle Hospital and Health Service, WA	Mark Platell
Gold Coast Health Service District, QLD	Jeff Hollywood
Health Waikato District Health Board, NZ	Jan Adams
John Hunter Hospital, NSW	Michael DiRienzo
Mater Health Services, QLD	John O'Donnell
Melbourne Health, VIC	Peter Brennan
Northern Health, VIC	Andrew Perrignon
Northern Territory Acute Health	Peter Campos
Otago District Health Board, NZ	Vivian Blake
Prince Charles Hospital, QLD	(vacant)
Prince of Wales Hospital, NSW	George Jepson
Princess Alexandra Hospital, QLD	David Thiele
Royal Brisbane and Women's Hospital, QLD	Judy Graves
Royal Hobart Hospital, TAS	Craig White
Royal Perth Hospital, WA	Phillip Montgomery
Royal Women's Hospital, VIC	Dale Fisher
Sir Charles Gairdner Hospital, WA	David Russell-Weisz
Southern Health, VIC	Linda Sorrell
Southern Hospitals Network, NSW	Sue Browbank
St George Hospital, NSW	Sue Shilbury
St Vincent's Health, VIC	Nicole Feely
St Vincent's Hospital, NSW	Kerry Stubbs
Sydney West Area Health Service, NSW	Andrew Baker
The Canberra Hospital, ACT	(vacant)
Townsville District Health Service, QLD	Ken Whelan
Waitemata District Health Board, NZ	Dave Davies
Regional Health Improvement Network	(vacant)

Under the new Constitution, Associate Membership can be offered to a wide range of organisations and individuals, subject to approval of the Board of Directors. There were six individuals who were personal members of The Health Roundtable under the terms of the original Articles of Association, but were not affiliated with an Organisational Member at the time of the adoption of the new Constitution. Each of these individuals became Associate Members. Associate Membership status provides the opportunity to participate in selected activities as authorised by the Board of Directors.

Associate Members of The Health Roundtable as of the date of this report are as follows:

- David Dean
- Bill Kricker
- David Rubenstein
- Colin MacArthur
- Michael Walsh
- Pat Martin

There are no Organisational Associate Members at this time.

The Directors and Members selected five major topics for review in 2006:

- How to Develop and Implement Sustainable Improvements in Patient Flow
- Work and Workforce Redesign
- Lessons Learnt in Models of Care, Surgical Management, and Support Services
- Improving Emergency Patient Flow and Developing More Meaningful Indicators
- Improving Patient Safety Systems and Procedures

A total of 436 people from member organisations throughout Australia and New Zealand participated in one or more Roundtable meetings. Approximately half of the attendees at each Roundtable are new to the collaborative process used in our meetings.

In addition, we conducted over 50 webcast/teleconferences with individual health service teams and benchmarking groups during the year to augment the face-to-face meetings.

The Health Roundtable also continued to expand its data benchmarking and analysis activities during the year. Overall volume of benchmarking data collected by The Health Roundtable is shown in the table below:

Emergency Presentations (not admitted as inpatients)	1.2 million
Inpatient Admissions (including costing and mental health subgroups)	2.4 million
Allied Health Interventions	3.4 million

Data provided by members are analysed for differences in administrative practices and clinical practices. These differences are then discussed with the members and are highlighted in a variety of reports and analytical tools. All members have access to all data as well as the identities of their fellow members, so that they can contact each other directly to learn about innovations in patient care and in administrative practices.

Benchmarking activities during 2006 included:

- Inpatient Length of Stay Comparisons (Casemix Reports)
- Clinical Costing Comparisons
- Key Performance Indicators
- Allied Health Activity Comparisons
- Mental Health Key Performance Indicators

In September 2006, The Health Roundtable Board of Directors reviewed its management outsourcing contract with Chappell Dean Pty Limited, and agreed to renew the contract for an additional two years through December 2008. This contractual approach enables The Health Roundtable to facilitate innovation sharing amongst members at an agreed fixed-price cost per participating organisation for each service in the annual program. Chappell Dean provides a network of consultants, analysts, and administrative staff as well as the services of Dr David Dean, who is seconded to serve as General Manager of The Health Roundtable. Key people providing assistance to Chappell Dean and The Health Roundtable during 2006 include:

- **Michael Har**t, Mixstatics – Data Processing Analyst
- **Duncan Stuart**, Healthier Outcomes Network International – Clinical Consultant
- **Bindy Steuart**, Home Typing & Secretarial Service – Report Preparation
- **Peter Reeves**, Inspirit – Operational Consultant
- **Pieter Walker**, IPIC – Operational Consultant
- **Nicholas Smeaton** – Website Administrator
- **Fabian Chessell**, Syscorp– Project Manager
- **Greg Launder**, EKOW– Systems Analyst
- **Brian Dolan**, Dolan & Holt Consultancy – Meeting Facilitator
- **Michael Blatchford**, Lean Australia – Process Engineer
- **Margaret Dean**, Chappell Dean – Accounts Administrator

Two major new initiatives were begun in 2006 by The Health Roundtable with the support of Chappell Dean. The first is the Activity BarCoding system, which has been developed to reduce the administrative time required to capture Allied Health activity data. The concept is to replace keyboard entry of data with a key-chain sized barcode scanner to capture patient and activity information as well as the time of day using a built-in clock. Pilot tests of the new system suggest that each Allied Health professional could reallocate 15 minutes of administrative time to patient-care time every day through the use of such a system.

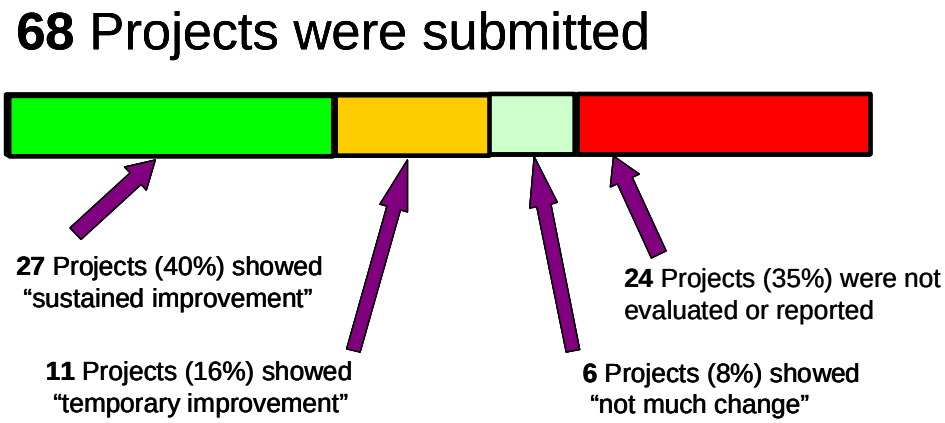
The second initiative is the Lean Healthcare Program, which has been developed to provide middle-managers in health services with the skills they need to make improvements in patient care services. Operational improvements in patient care have been a key goal of The Health Roundtable from its inception. However, it is clear that many healthcare professionals lack the management tools and skills to analyse process flows and to work with teams to identify innovative solutions. To overcome this gap, we have developed a 3-month program to develop these critical skills using the "Lean Thinking" tools that are now being adopted as standard management practices in leading organisations around the world. The first cohort of 23 participants graduated from the Program in November 2006.

Key highlights from our activities in 2006 are included on the following pages. More details may be found at our website (www.healthroundtable.org.au) which has both a publicly-accessible library of key innovations, as well as a members-only library of reports detailing specific innovations in each of the areas covered since The Health Roundtable was founded in 1995.

Key Findings and Insights from Roundtable Activities in 2006

March 2006
Making Sustainable Changes in Patient Flow

HRT0601 – Making Sustainable Changes



- Key observations were that frequent reorganisations and leadership changes made it difficult to maintain momentum for key projects, and that reliance on staff education for improvement was not as successful as redesigning delays out of the patient flow process
- However, many member hospitals have had success with initiatives such as: Event-driven discharge, 23-hour surgical services, positioning Allied Health staff in the Emergency Department for early intervention, and setting up separate streams of patients in Emergency based on likelihood of admission to a bed.

April 2006
Work & Workforce Redesign

HRT0602 – Work Redesign Initiatives

Key Strategies Implemented	Outcomes
National Travelling Nurse Rotation Consortium – rotation plan for OS nurses	30 EFT paediatric nurses and midwives per annum rotating through hospitals across Australia
Nurses and Radiographers trained to insert PICCs	120 cases done ↓ Waiting list from 15-4 days ↓ Zero complication Rate
Creation of Clinical Assistant Positions	TAFE accredited certIII course ↑ Efficiencies – call times
Building Positive Attendance – attendance management strategy	↓ Sick leave ↓ Replacement labour costs ↓ Workcover claims
Operating Theatre Scrub & Scout Role for Enrolled Nurses	Positive participant feedback Retention of trained ENs

- Members at this Workshop forecasted increasing shortages of highly specialised staff in coming years due to "baby boomer" retirements
- Delegates discussed a wide range of initiatives that are underway to redesign roles for alternative staff categories

May 2006
Lessons Learnt Workshops

HRT0603 – Lessons Learnt

Stream 1: Models of Care			
1a Improving hospital care of complex chronic patients	**1b** Improving community care of complex chronic patients	**1c** Improving emergency medical patient journeys	**1d** Improving acute mental health patient journeys.
Stream 2: Surgical Management			
2a Improving elective patient scheduling	**2b** Improving elective patient journeys through the hospital	**2c** Improving emergency surgical patient journeys	**2d** Balancing elective and emergency surgical demand
Stream 3:Clinical Support Services and Risk Management			
3a Improving diagnostic test ordering practices	**3b** Improving management of high-cost drugs	**3c** Improving patient and hospital risk assessment practices	**3d** Improving risk reduction effectiveness (closing the loop)

- Every two years, The Health Roundtable conducts a review of prior initiatives to check progress and provide a way for newer members to learn of innovative ideas to solve their problems. In 2006, twelve half-day workshops were held with 38 presenters and 93 attendees.
- The workshops provided time for all participants to have detailed discussions on key initiatives and to develop action plans for their own initiatives.

July 2006
Improving Emergency Patient Flow

HRT0604- Emergency Models of Care

Examples of Projects Developed at the Roundtable

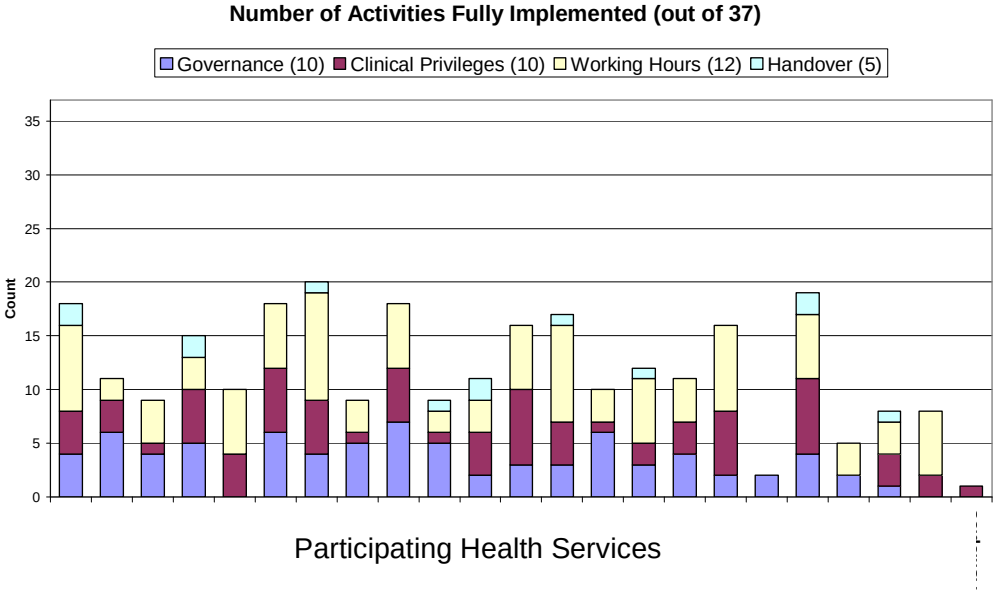
80% of patients ready to leave ED in 8 hrs by using a traffic light system and improving streaming process.
*80% of patients admitted to their home ward within 6 hours from **ED***
*Introduce a mandatory transfer-out system from wards when **ED** is in overload*
*Within 3 months, transfer 80% of patients from **ED** to the ward within 30 minutes from the time they are ready for transfer*
*When **ED** is in overload, move 80% of admitted patients to the ward within one hour*
Discharge patients going home from ED within 4 hours of arrival
Establish Day of Discharge Unit for all discharged inpatients to make beds available earlier in the day

- Dramatic improvements in Emergency Department throughput are occurring at many hospitals, with initiatives such as patient streaming, early involvement by senior staff, nurse-initiated diagnostics, and replacement of the traditional "take" system with a team based approach.
- At the conclusion of the Roundtable, each delegation developed project goal statements capturing at least one key idea to be implemented.

August 2006
Improving Patient Safety Systems & Procedures

HRT0605 -- Improving Quality & Safety

By 2006, the lead hospitals have fully implemented about half of the "good practices" surveyed



- Improving safety & quality processes has been a major focus of member health services for several years. The Health Roundtable has identified a suite of 37 indicators of "good practices" from national and international guidelines (see next two pages).
- Some participating health services have already implemented over half of these practices, while others were just beginning the process. Delegates at the Roundtable shared and compared their practices and developed action plans to improve the safety of their patient care.
- Specific projects identified by members included:
  - Reducing preventable deaths to 0 in specific areas of the hospital as a first step
  - Standardising mortality and morbidity review meetings across all specialties
  - Having all clinical units provide reports on their morbidity / mortality
  - Reducing repeat adverse major events to 0
  - Achieving 100% review and follow-up actions on all abnormal results for histopathology, cytology, radiology, endoscopies
  - Reducing delays or inappropriate treatment of patients after hours by 80%
  - Providing context-appropriate structured handover at all inpatient facilities for all patients
  - Completing credentialing 100% of Medical Staff

Health Roundtable Patient Safety Systems Checklist 2006

Clinical Governance	1.	A formal clinical governance framework and detailed policies have been developed and implemented for this organisation.
	2.	All staff have ready access to the organisation's clinical governance framework and policies.
	3.	We can demonstrate that the Hospital is perceived by staff to have an open and non-punitive environment that promotes reporting of all adverse and sentinel events.
	4.	We use a form of structured analysis (e.g. root cause analysis) for all sentinel events that includes "systems issues" that may have given rise to the event.
	5.	The Governing Body or Executive conducts mortality reviews for every specialty at least annually.
	6.	The Governing Body or Executive conducts morbidity reviews for every specialty at least annually
	7.	The Executive follows an established process to review, approve, and track to completion every quality improvement recommendation resulting from analysis of major adverse events
	8.	We have a single organisation-wide committee (e.g. Clinical Governance or Patient Safety) that is responsible for at least annual clinical audits of patient care in each specialty which include, at minimum, details of numbers and types of cases to be examined, the process for selecting cases and the follow-up of results of the clinical audit
	9.	The medication charts used in our organisation are standardised to match those used at other hospitals throughout our regional area (or nationwide).
	10.	A review is always conducted to ensure that every new surgical technique will have adequate staffing, facilities, equipment and volume.
Clinical Privileges	1.	Our Clinical Privileges Committee approves and maintains current documentation of clinical privileges granted to each medical staff member.
	2.	Our Medical Credentialing and Clinical Privileges Committee makes its credentialing and privileges information readily accessible to all clinical staff (nursing, medical and allied health).
	3.	We monitor procedures performed annually and enforce practice consistent with the credentialing and privileges list.
	4.	We review clinical privileges of all senior medical staff at least every three years, including the use of recent audits of their clinical performance data benchmarked with peers.
	5.	We centrally review performance evaluations for all registrars at least annually.
	6.	We conduct and return performance appraisals to residents before they leave a clinical area.
	7.	We record attendances of residents at educational meetings, as a part of performance appraisal.
	8.	We allocate all registrars to a consultant mentor, to meet at least monthly and serve as the registrar's training supervisor.
	9.	We review the competence of clinical nursing staff at least every three years by a structured process similar to that used for medical staff.
	10.	We review the competence of allied health staff at least every three years by a structured process similar to that used for medical staff.

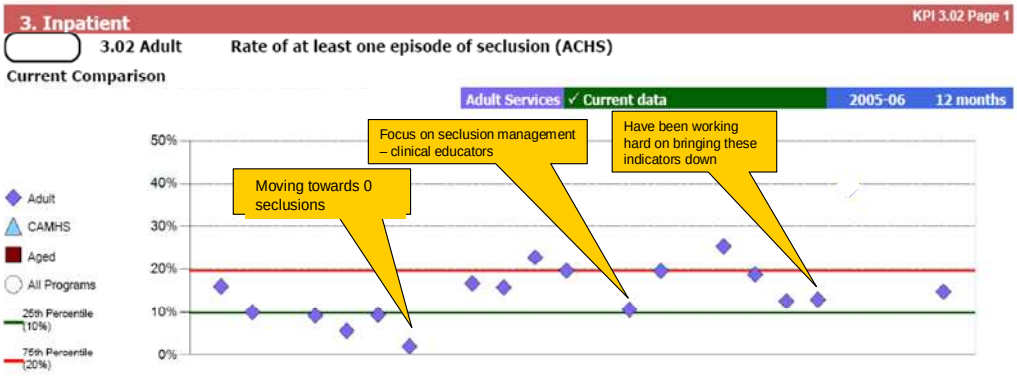
Health Roundtable Patient Safety Systems Checklist 2006, continued

Junior Doctor Working Hours	1.	Hours of work of junior medical staff and registrars are structured so that work periods do not exceed 24 hours in total, including planned rest and sleep time.
	2.	Work shifts are limited to a maximum of 12 consecutive hours (including overtime and call backs) with at least 11 hours of continuous rest periods between shifts.
	3.	All medical staff (including consultants) have a minimum 24 hours rest in every 7 days or a minimum 48 hour rest in every 14 days.
	4.	Total working hours for junior doctors (including overtime and call backs) are limited to a maximum of 58 hours or less per week.
	5.	Medical staffing in the hospital at night is accomplished through rostered time on site in designated shifts, rather than relying on "on call" systems
	6.	Medical staff rostered for work in the hospital at night are expected to be pro-active in seeking out problems (rather than sleeping) as well as to respond to emergencies.
	7.	Our rosters for medical staff in the hospital at night are based on recognised national or international standards.
	8.	A multi-disciplinary "hospital at night" or "out of hours" team provides centralised clinical management from 10 pm to 8 am every weekday and throughout weekends.
	9.	The "hospital at night" or "out of hours" team has a physical control centre that provides a single point of call for all clinical problems identified in the wards.
	10.	The "hospital at night" or "out of hours" team has a clearly identified medical leader who is vested with the authority to delegate and allocate work to all junior doctors on the team.
	11.	The person available with the most appropriate skills on the scene is empowered to assess patients in the first instance, whether this is a senior nurse or a junior doctor.
	12.	We review or audit the working hours of medical, nursing and allied health staff at least annually to identify potential high-risk situations and take corrective action.
Multi-disciplinary Handover	1.	There is a written policy/protocol for the handover of all patients at each stage of the patient's journey through the hospital, and through each work shift.
	2.	Handover occurs each night at a designated time and location with a multi-disciplinary, in-person, confidential discussion of patients between the outgoing and incoming clinical teams.
	3.	The handover process each night is led clinically by a senior registrar and managerially by a senior nurse in line with a formal protocol.
	4.	Tasks are identified and distributed to the night team during the handover process, making everyone aware of who is responsible for each task.
	5.	Surgical hand-over includes a "correct patient, correct site" protocol which includes: checking the consent form, marking the surgical site, confirming patient identification, taking a "team time out" for verification in the operating theatre, and ensuring appropriate and available diagnostic images.

September 2006
Mental Health Bench-marking Group

HRT0606 Mental Health Benchmarking Group

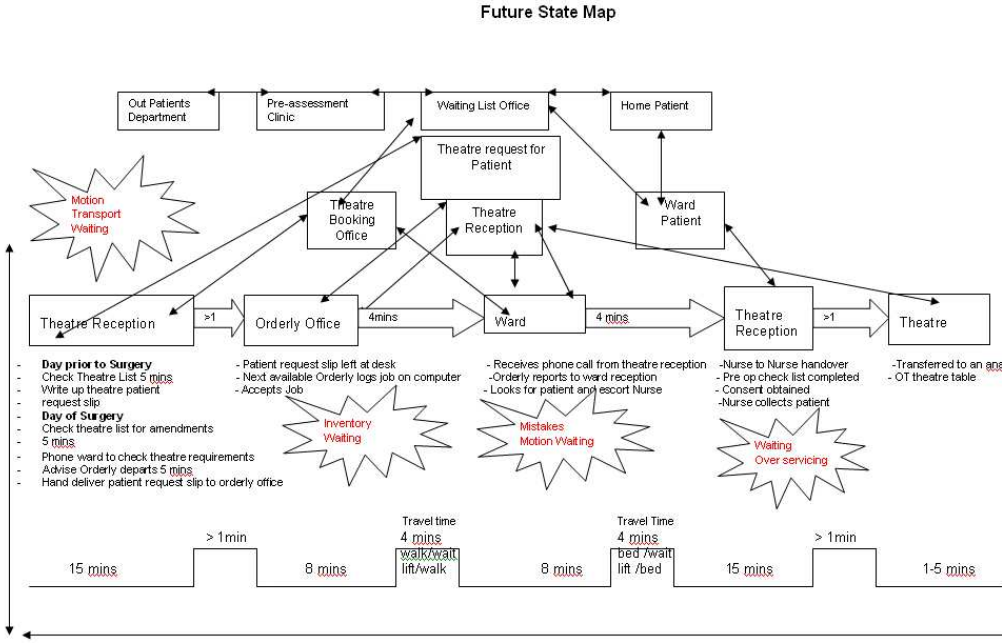
Focus of the 2006 Workshop was Aggression Management – KPIs used to stimulate discussion



Participating Mental Health Services

- The Mental Health Benchmarking Group was formed within The Health Roundtable in 2005 and expanded to include 25 mental health services across Australia and New Zealand in 2006.
- The Health Roundtable is assisting with data processing and analysis, and with facilitation of a roundtable discussion of a key topic chosen by the group. In 2006, the topic was aggression management and the use of seclusion practices as a technique to control aggressive patient behaviour.

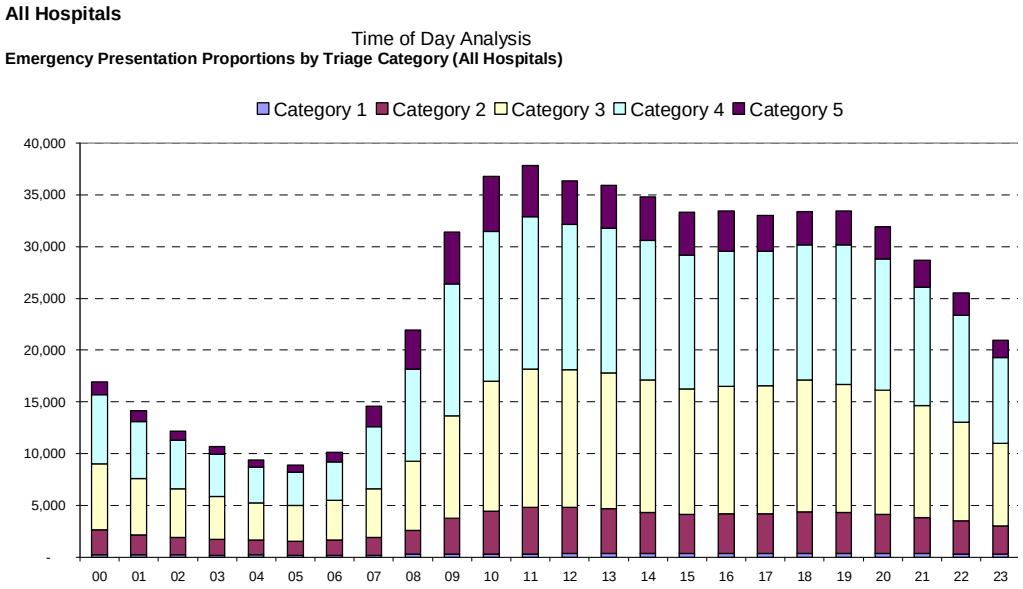
September – November 2006
Lean Healthcare Program



The Health Roundtable launched its first management development program in 2006 with a group of 23 participants from eight health services. The three-month program was designed to provide practical tools to identify wasted time and effort in patient care, and to use standard "lean thinking" concepts to reduce this waste.

October 2006
Emergency Data Analysis

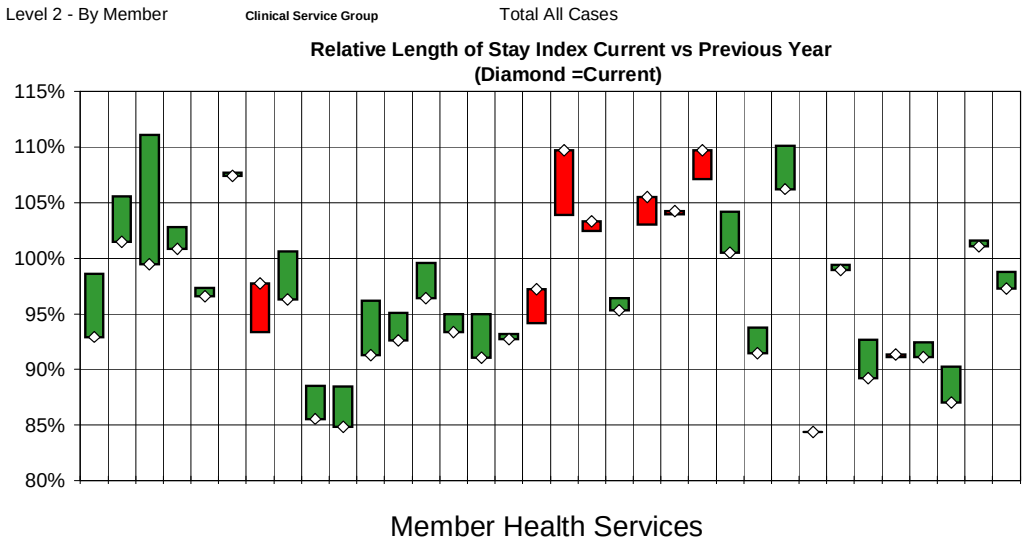
Emergency Presentation Analysis



The Health Roundtable has augmented its data collection to include emergency presentations, which allows analysis of trends by hour of the day, as shown above for 2005/2006, and by patient category. This information is proving helpful to member health services in predicting demand.

October 2006
Relative Length of Stay Comparisons

Relative Stay Index – All Members 2005/06



In October 2006, comparative data for the 2005/2006 financial year was distributed to member organisations to highlight their relative length of stay using internal benchmarks that adjust for patient complexity, service mix, age groups, arrival and discharge mode. This information is made available in a variety of reports at the DRG, Discharge Department, Clinician, and Hospital level. It is used for service planning as well as clinical audit activities.

October 2006 Key Performance Indicator Scorecards

Roundtable Scorecard **Aug 06 V2**

Emergency Indicators
- Triage 1 Time to be seen
- Triage 2 Time to be seen
- Triage 3 Time to be seen
- Triage 4 Time to be seen
- Triage 5 Time to be seen

- Time to Disposition - All Pats
- Time to Ward - Adm Pats
- Median Time to Analgesia

Wait List Indicators
- Before Admission
- After Admission
- Cancel from OT List

Intensive Care Indicator
- Re-admission to ICU < 72Hrs

Patient Information Management
- % Records Coded by 15th Month

Clinical Indicators
- Re-presentation to ED
  - After Admission
  - After Attendance
- Remain > 14 Days
- Returns to Operating Theatre
- INR > 5
- Pressure Ulcers -Ungraded
- Occupancy

WorkForce Indicators
- Sick Leave - Nursing
- Sick Leave Other

- Turnover - Nursing
- Turnover - Other

- Workers Comp - Nursing
- Workers Comp - Other

- % Agency Nurses

Financial
- Costs attributed to Acute Patients
- Private Patients

In April and October, the Health Roundtable provides KPI scorecards to each member organisation to highlight opportunities for performance improvement. Detailed comparisons alert organisations that are having difficulty to those who are doing well. This promotes rapid collaboration on innovative ideas.

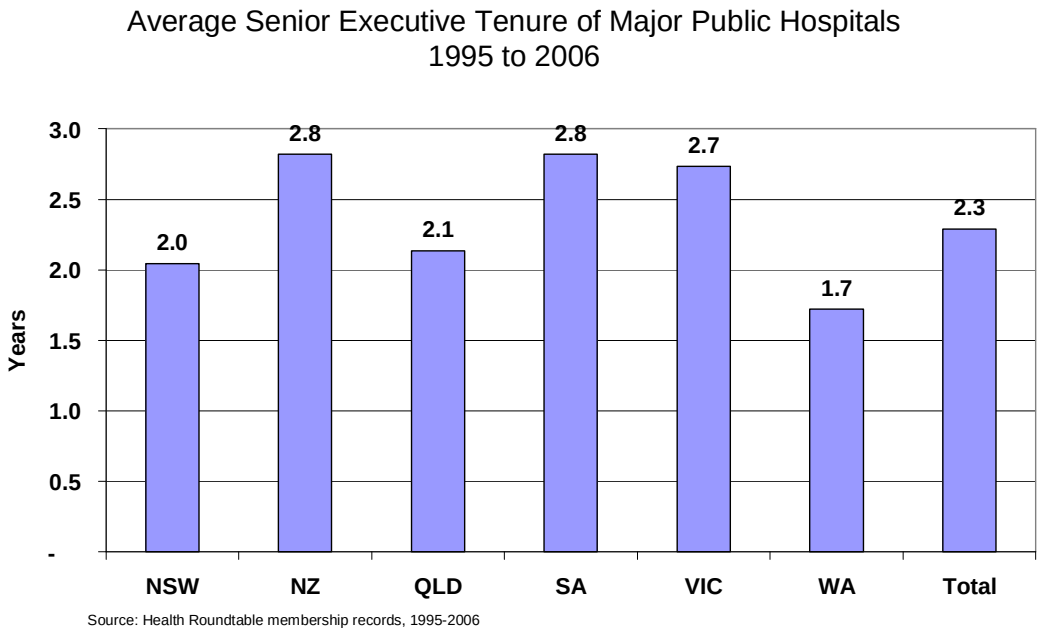
December 2006 Allied Health Benchmarking Group

Allied Health Screening Report

Family	Description	Your Episode Count	Percent Episode with Any Allied Health Activity	Median Allied Health Minutes per Episode: Pre-Time	Inpat Time	Post Time	Median LOS when Allied Involved	Median Inpat Time per Day	Percent of episodes and Minutes/Episode by department: PHYSIO %	PHYSIO Min	SOC WK %	SOC WK Min	NUTR %	NUTR Min	SPEECH %	SPEECH Min	OCC TH %	OCC TH Min
H08	LAPAROSCOPIC CHOLECYSTECTOMY	278	15%	40	70	60	7.0	12	56%	45	51%	60	15%	70			20%	75
H40	ENDOSPIC PR BLEED OES VARICES	24	42%		135		6.8	19	70%	100			60%	55			50%	60
I03	HIP REVISION OR REPLACEMENT	215	99%	60	300	672	7.1	33	100%	230	12%	90	19%	80	12%	75	37%	90
I04	KNEE REPLACEMT & REATTACH	115	100%	31	210	90	4.3	34	100%	175							37%	72
I24	ARTHROSCOPY	65	42%		30	30	0.3	30	100%	30								
I25	BONE,JOINT DXTIC PR INC BIOPSY	4	75%		140		13.0	17										
J62	MALIGNANT BREAST DISORDERS	147	7%		195	52	4.6	36	60%	82	60%	120	60%	68			80%	45
J67	MINOR SKIN DISORDERS	178	12%		138	80	7.4	23	55%	95	59%	110	36%	120			41%	60
K60	DIABETES	287	43%	45	130	60	5.1	27	37%	60	38%	60	79%	90	12%	90	16%	90

Member health services interesting in comparing allied health activity provide their data which is then merged with inpatient casemix episode records. The Health Roundtable then provides a series of reports to highlight differences at the DRG level where the organisation may be providing higher or lower levels of Allied Health service than other organisations.
The Health Roundtable's goal is to highlight such differences and encourage informed debate within and amongst the members on what is best for the patient.

Executive Turnover Continues



Our healthcare industry's ability to be ready for major demographic changes depends on a clear strategic vision and consistent leadership to translate that vision into reality. Unfortunately, most major healthcare organisations are suffering from a lack of continuity in senior operational leadership, with average tenure of senior executives amongst our member facilities now down to 2.3 years.

Lean Healthcare Graduation November 2006

Our first graduating class of 23 participants from the Lean Healthcare Program included Michael Butler and Fran Brockhus of Eastern Health in Victoria. They are shown above receiving their Certificates of Completion with the coaching team of Pieter Walker, Michael Blatchford, and David Dean.

SPONSORSHIP

The Health Roundtable offers corporate organisations the opportunity to participate in its activities to learn more about the issues facing major teaching hospitals. In 2006, the following organisations supported one or more of the activities of The Health Roundtable, which helped to defray administrative costs. In return, they were given the opportunity to participate in meetings where there is no direct conflict of interest, and have agreed to abide by the Health Roundtable Honour Code to protect the confidentiality of all Roundtable discussions. The Health Roundtable welcomes appropriate participation in its discussions of key issues by health industry vendors.

The Cerner Corporation is a leading global Healthcare Information Technology company which, for the past decade, has had offices located in the Asia Pacific region with its head office in Sydney. With over 50 associates throughout the region, Cerner is committed to making the right information available at the right time to make the best clinical decision.

Within the region and around the world, Cerner is working to transform health care delivery systems by increasing the quality of care, improving efficiencies, eliminating medical error and connecting the individual to the system with innovative information solutions.

Phillips Fox is delighted to support the Health Roundtable. Our pro bono partnership with the Health Roundtable further strengthens our continuing commitment to the Australian and New Zealand health sector. Phillips Fox is one of the largest legal firms in Australasia. Founded in 1864, today we number some 190 partners, 1500 staff, in 10 offices across Australia, New Zealand and Vietnam.

Our health practice serves clients in both the public and private sectors across Australia and New Zealand. Many of our health lawyers have worked in the health sector, using their 'hands on' experience of the complex interplay of law, policy, regulation and 'politics' of health to provide high quality, practical and cost effective legal advice. Dr Tim Smyth in our Sydney office would be pleased to discuss with you how Phillips Fox can assist you and your organisation.

Roche Products Pty Limited (Australia) is part of the International F. Hoffmann-La Roche Group worldwide that was founded in 1896 in Basel, Switzerland. Roche has grown from a small drug laboratory into one of the world's leading research-based Healthcare companies and is known for many innovative contributions to medicine.

Arranged in two operative divisions, our global mission today and tomorrow is to create exceptional added value in healthcare. These two units are: Pharmaceuticals and Diagnostics.

Executive Fitness Management (EFM) is the market leader in providing on-site health and fitness programs to organisations including private and public hospitals. EFM has 35 on-site locations and over 50 corporate clients including The Royal Adelaide Hospital, Flinders Medical Centre, The Royal Melbourne Hospital, Kingston Health, and Cabrini Health. Services include on-site health and fitness clubs, back to work rehabilitation programs, executive personal training, corporate massage and staff health screenings.

The Health Roundtable maintained its international affiliate membership in the University Healthsystem Consortium, a collaborative group of over 80 academic medical centres in the USA. This affiliation has provided valuable methodological assistance and insights to the organisation and its members across Australia and New Zealand.

The Health Roundtable continued to operate on a sound financial basis in 2006, with income and expenses arising as planned.

AFTER BALANCE DATE EVENTS

No matters or circumstances have arisen since the end of the financial year which may significantly affect the operations of the Company, the results of those operations, or the state of affairs of the Company in subsequent financial years.

DIRECTORS AND AUDITORS INDEMNIFICATION

During the 2006 accounting period, The Health Roundtable paid premiums to insure itself and each of the Directors and Officers of the company against liabilities for costs and expenses incurred by them in defending any actual or alleged breach of duty, breach of trust, neglect, error, misstatement, misleading statement, omission, breach of warranty of authority claimed against them while acting in their individual or collective capacities.

The total amount paid for the insurance in 2006 was $2,265

MEETINGS OF DIRECTORS

During the 2006 calendar year, the Board of Directors met on 5 April, 22 September, and 14 November. The Board created an Audit and Compliance Committee to develop a risk management strategy, and to carry out audit and compliance activities in 2005. During 2006, the Audit Committee held meetings on 22 February, 13 March, 5 April, 11 August, and 14 November. We express our appreciation to Mr Ross Cooke for the insights he is providing as an external member of the Audit & Compliance Committee.

DIRECTORS' BENEFITS

No director has received or become entitled to receive, during or since the financial year, a benefit because of a contract made by the company with: a director, a firm of which a director is a member, or an entity in which a director has a substantial financial interest.

INFORMATION ON OFFICERS AND DIRECTORS SERVING DURING 2006

OFFICERS:

Associate Professor Kaye Challinger, Director and President
(Appointed 16 October 1998, re-elected 5 April 2006, elected President 6 April 2005)

Associate Professor Challinger is the Executive Director, Acute Services, within the Central Northern Adelaide Health Service.

Ms Margot Mains, Director and Vice President
(Elected 25 November 1999, re-elected 5 April 2006, elected Vice President 6 April 2005)

Ms Mains is Chief Executive Officer of Capital & Coast District Health Board in New Zealand.

Ms Kerry Stubbs, Director and Treasurer
(Appointed 25 November 2003, re-elected 6 April 2005)

Ms Stubbs is Chief Executive Officer of St Vincent's Public Hospital in Sydney.

Dr David Dean, Company Secretary (from 5 April 2006)

Dr Dean is General Manager of The Health Roundtable Limited, serving in that capacity since its inception in 1995.

DIRECTORS

Ms Jennifer Williams, Director
(Elected 27 November 1998; re-elected 5 April 2006)

Ms Williams is Chief Executive of Bayside Health in Victoria.

Mr George Jepson, Director (from 16 November 2005)
(Elected 4 May 2004 and served to 6 April 2005. Appointed to fill vacancy on 16 November 2005)

Mr Jepson is the Executive Director of Prince Henry / Prince of Wales Hospital in Sydney.

Mr Michael Szwarcbord, Director (from 16 November 2005)
(Appointed 16 November 2004 and served to 6 April 2005. Appointed to fill vacancy on 16 November 2005)

Mr Szwarcbord is Chief Executive of the Flinders Medical Centre in South Australia.

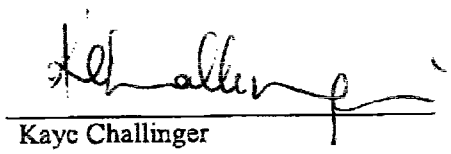
Dr John O'Donnell, Director (from 16 November 2005)
(Appointed 16 November 2004 and served to 6 April 2005. Appointed to fill vacancy on 16 November 2005)

Dr O'Donnell is Chief Executive of Mater Health Services in Brisbane, Queensland.

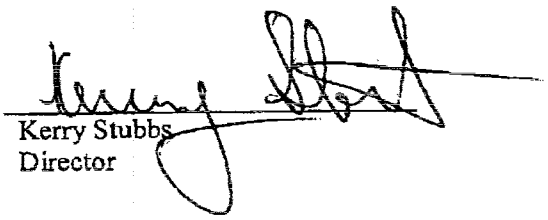
Mr John Mollett, Director and Honorary Secretary (from August 2005 to April 2006)
(Elected 4 May 2004, and re-elected 6 April 2005). Appointed Honorary Secretary 15 August 2005)

Mr Mollett is General Manager of The Canberra Hospital. On 1 March 2007, Mr Mollett resigned from the Board of Directors due to a change of employment.

Signed in accordance with a resolution of the Board of Directors.



Kayc Challinger
Director



Kerry Stubbs
Director

Date: 7 March 2007

The Health Roundtable Limited ABN 71 071 387 436

Financial Statements

For the year ended 31 December 2006

Ronald Smith & Co
Chartered Accountant
Suite 101, 10 Edgeworth David Avenue
Hornsby 2077

Phone: 94771650 Fax: 94776649

The Health Roundtable Limited ABN 71 071 387 436

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The Health Roundtable Limited ABN 71 071 387 436

Detailed Profit and Loss Statement

For the year ended 31 December 2006

	2006 $	2005 $
Income		
Special project income	36,250	38,500
License & Sponsorship income	30,750	32,500
Subscription fees income	1,171,800	1,167,500
Membership fees	7,100	7,300
Delegate Rego fees	96,647	80,670
Interest received	30,709	26,652
Total income	1,373,256	1,353,122
Expenses		
Audit fees	2,450	2,505
Bank Fees And Charges	59	32
Filing Fees	65	40
Management & Office expenses	33,752	35,492
Insurance	2,265	2,184
Subscription program expenses	1,192,800	1,163,500
Hotel and Venue costs	96,133	91,580
UHC Membership costs	19,154	16,783
Special project costs	36,250	38,500
Total expenses	1,382,928	1,350,616
Profit (Loss) from Ordinary Activities before income tax	**(9,672)**	**2,506**

The accompanying notes form part of these financial statements.

The Health Roundtable Limited ABN 71 071 387 436

Balance Sheet As At 31 December 2006

	Note	2006 $	2005 $
Current Assets			
Cash assets	3	96,422	136,899
Receivables	4	53,464	25,936
Current tax assets		46,633	46,553
Total Current Assets		**196,519**	**209,388**
Non-Current Assets			
Other	5	1,035	1,035
Total Non-Current Assets		**1,035**	**1,035**
Total Assets		**197,554**	**210,423**
Current Liabilities			
Payables	6	9,603	28,200
Other	7	87,400	72,000
Total Current Liabilities		**97,003**	**100,200**
Total Liabilities		**97,003**	**100,200**
Net Assets		**100,551**	**110,223**
Equity			
Retained profits		100,551	110,223
Total Equity		**100,551**	**110,223**

The accompanying notes form part of these financial statements.

The Health Roundtable Limited ABN 71 071 387 436

Statement of Cash Flows

For the year ended 31 December 2006

	2006 $	2005 $
Cash Flow From Operating Activities		
Receipts from customers	1,315,019	1,342,722
Payments to Suppliers and employees	(1,386,205)	(1,395,632)
Interest received	30,709	26,652
Net cash provided by (used in) operating activities (note 2)	(40,477)	(26,258)
Net increase (decrease) in cash held	(40,477)	(26,258)
Cash at the beginning of the year	136,899	163,157
Cash at the end of the year (note 1)	96,422	136,899

The accompanying notes form part of these financial statements.

The Health Roundtable Limited ABN 71 071 387 436

Statement of Cash Flows

For the year ended 31 December 2006

	2006	2005

Note 1. Reconciliation Of Cash

For the purposes of the statement of cash flows, cash includes cash on hand and in banks and investments in money market instruments, net of outstanding bank overdrafts.

Cash at the end of the year as shown in the statement of cash flows is reconciled to the related items in the balance sheet as follows:

Corporate Cheque Account	10,382	136,899
Online Saver Account	86,040	
	96,422	136,899

Note 2. Reconciliation Of Net Cash Provided By/Used In Operating Activities To Operating Profit After Income Tax

Operating profit after income tax	(9,672)	2,506
Changes in assets and liabilities net of effects of purchases and disposals of controlled entities:		
(Increase) decrease in trade and term debtors	(27,528)	16,252
Increase (decrease) in trade creditors and accruals	(18,597)	(22,902)
Increase (decrease) in other creditors	15,400	(18,500)
Increase (decrease) in sundry provisions	(80)	(3,614)
Net cash provided by (used in) operating activities	**(40,477)**	**(26,258)**

The Health Roundtable Limited ABN 71 071 387 436

Notes to the Financial Statements

For the year ended 31 December 2006

Note 1: Statement of Significant Accounting Policies

This financial report is a special purpose financial report prepared for use by directors and members of the company. The directors have determined that the company is not a reporting entity.

The report has been prepared in accordance with the requirements of the following Australian Accounting Standards.

AASB 1031:	Materiality
AASB 110:	Events after the Balance Sheet Date

No other Australian Accounting Standards, Urgent Issues Group Interpretations or other authoritative pronouncements of the Australian Accounting Standards Board have been applied.

The financial report has been prepared on an accruals basis and is based on historic costs and does not take into account changing money values, or except where specifically stated, current valuations of non-current assets.

The following specific accounting policies, which are consistent with the previous period unless otherwise stated, have been adopted in the preparation of this financial report:

(a) Property, Plant and Equipment

Property, plant and equipment are carried at cost, independent or directors' valuation. All assets, excluding freehold land and buildings, are depreciated over their useful lives to the company.

(b) Inventories

Inventories are measured at the lower of cost and net realisable value. Costs are assigned on a first-in first-out basis and include direct materials, direct labour and an appropriate proportion of variable and fixed overhead expenses.

The Health Roundtable Limited ABN 71 071 387 436

Notes to the Financial Statements

For the year ended 31 December 2006

	2006	2005

Note 2: Revenue

Operating Activities:

Other sales revenue	1,342,547	1,326,470
Interest revenue	30,709	26,652
	1,373,256	**1,353,122**

Note 3: Cash assets

Bank accounts:		
- Corporate Cheque Account	10,382	136,899
- Online Saver Account	86,040	
	96,422	**136,899**

Note 4: Receivables

Current

Trade debtors	53,464	25,936
	53,464	**25,936**

Note 5: Other Assets

Non Current

Preliminary expenses	1,035	1,035
Less: accumulated amortisation		
	1,035	**1,035**

The Health Roundtable Limited ABN 71 071 387 436

Notes to the Financial Statements

For the year ended 31 December 2006

	2006	2005

Note 6: Payables

Unsecured:		
- Trade creditors	9,603	28,200
	9,603	28,200
	9,603	**28,200**

Note 7: Other Liabilities

Current

Advance payments	87,400	72,000
	87,400	**72,000**

Note 8: Auditors' Remuneration

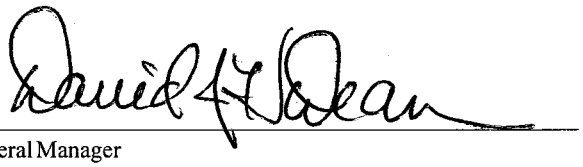
Remuneration of the auditor of the company for:		
Auditing or reviewing the financial report	2,450	2,505
Other services		
	2,450	**2,505**

The Health Roundtable Limited ABN 71 071 387 436

General Manager's Declaration

I, David Dean, General Manager of The Health Roundtable Limited, declare that in my opinion:

1. the financial records of the Health Roundtable Limited for the financial year have been properly maintained in accordance with section 286; and
2. the financial statements, and the notes referred to in paragraph 295 (3) (b), for the financial year comply with the accounting standards; and
3. the financial statements and notes for the financial year give a true and fair view; and
4. any other matters that are prescribed by the regulations for the purposes of this paragraph in relation to the financial statements and the notes for the financial year are satisfied.



General Manager
David Dean
Dated: 7/3/2007

The Health Roundtable Limited ABN 71 071 387 436

Directors' Declaration

The directors have determined that the company is not a reporting entity and that this special purpose financial report should be prepared in accordance with the accounting policies prescribed in Note 1 to the financial statements.

The directors of the company declare that:

1. the financial statements and notes, present fairly the company's financial position as at 31 December 2006 and its performance for the year ended on that date in accordance with the accounting policies described in Note 1 to the financial statements;
2. in the directors' opinion, there are reasonable grounds to believe that the company will be able to pay its debts as and when they become due and payable.

This declaration is made in accordance with a resolution of the Board of Directors.

Kaye Challinger
Director

Kerry Stubbs
Director

Dated: 7/3/2007

The Health Roundtable Limited ABN 71 071 387 436

Independent Auditor Report

Scope

We have audited the attached financial report, being a special purpose financial report comprising the Directors' Declaration, Statement of Financial Performance, Statement of Financial Position, Statement of Cash Flows, and Notes to the Financial Statements, for the year ended 31 December 2006 of The Health Roundtable Limited. The company's directors are responsible for the financial report and have determined that the accounting policies used and described in Note 1 to the financial statements which form part of the financial report are consistent with the financial reporting requirements of the company's constitution and are appropriate to meet the needs of the members. We have conducted an independent audit of the financial report in order to express an opinion on it to the members of the company. No opinion is expressed as to whether the accounting policies used, and described in Note 1, are appropriate to the needs of the members.

The financial report has been prepared for distribution to members for the purpose of fulfilling the directors' financial reporting requirements under the Corporations Act 2001. We disclaim any assumption of responsibility for any reliance on this report or on the financial report to which it relates to any person other than the members, or for any purpose other than that for which it was prepared.

Our audit has been conducted in accordance with Australian Auditing Standards. Our procedures included examination, on a test basis, of evidence supporting the amounts and other disclosures in the financial statements, and the evaluation of significant accounting estimates. These procedures have been undertaken to form an opinion whether, in all material respects, the financial report is presented fairly in accordance with the accounting policies described in Note 1, so as to present a view which is consistent with our understanding of the company's financial position, and performance as represented by the results of its operations and its cash flows. These policies do not require the application of all Accounting Standards and other mandatory professional reporting requirements to the extent described in Note 1.

The audit opinion expressed in this report has been formed on the above basis.

Audit opinion

In our opinion, the financial report presents fairly, in accordance with the accounting policies described in Note 1 to the financial statements, the financial position of The Health Roundtable Limited as at 31 December 2006 and the results of its operations for the year then ended.

Signed on : 28/3/2007

Ronald Hamilton Smith, Charterred Accountant
Ronald Smith & Co
101/10 Edgeworth David Ave. Hornsby NSW