

# AHSPPO Journal

March 2026

The Association of Healthcare Supply  
and Procurement Officers



WHAT'S NEW IN 2026

## A Review of the AMMA Future Solutions Roundtable

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What's The "Value" In Healthcare Procurement? | AHSPPO Member Insight Series  
President's Report | Industry Snapshots | Education Update

## HeartSave Y | YA and HeartSave myPAD AED

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# Snapshots



## Asia-Pacific to see fastest growth in SMRT sequencing through 2030

The Asia-Pacific region is expected to be the fastest-growing market for single-molecule (SMRT) sequencing technology through 2030, with the industry forecast to reach \$5.32B over the period. The growing market is supported by rising private investment in genomics, the expansion of genome centres, and the growth of advanced hospital centres. Additionally, there has been greater use of long-read sequencing in rare disease testing, complex variant resolution, cancer research, and translation studies.

# Snapshots

## Australia invests \$187.2m in health and medical research projects

Australia is investing A\$187.2 million through the National Health and Medical Research Council's Ideas Grants to fund 190 health and medical research projects, from early science to practical applications, including studies on disease prevention and treatments such as bowel cancer. The funding aims to drive innovation, improve patient care, and strengthen the health system, as part of broader efforts including the Medical Research Future Fund.



## Australia and Indonesia achieve WHO Listed Authority status in medical product regulation

Australia and Indonesia have been recognised by the World Health Organisation (WHO), confirming that

both Australia's Therapeutic Goods Administration (TGA) and the Indonesian Food and Drug Authority have met WHO's highest international standards in medical product regulation. The milestone strengthens international trust in both countries' regulatory systems and supports faster access to safe medical products worldwide. For Indonesia, this is a significant achievement, as it's the first middle-income country with a standalone regulator to receive this status.

# Snapshots

## Bolton Clarkes Better Balance Initiative is reducing residents' fall risk

A new initiative at Bolton Clarke Aged Care in Varsity Lakes, QLD, has been developed to enhance residents' confidence and independence through a 10-week balance-and-falls-prevention program. Exercise physiologist Charlie Gordon utilises a computerised floor mat, designed and manufactured in Australia, which measures residents' postural sway through 20-second tests. The Balance Mat has received approval from the Therapeutic Goods Administration as a Class 1 medical device and helps measure the program's mobility and performance.



## Bayside Health Begins Operations in Victoria

A new merger is uniting five existing Victorian health services under the new name of Bayside Health. The new single network will improve coordinated care across the region, expand access to services and clinical trials. Additionally, care will be delivered closer to home while retaining existing hospital names, staff and local care in one place.

# President's Report



## Welcome to the first Journal of 2026

As we begin the new year, we have another opportunity to reflect, renew, and continue strengthening the connections within our vibrant community. I hope the opening months of the year have been productive and rewarding for you all.

This year is especially meaningful as we celebrate AHSP0's 70th anniversary. It's a moment to acknowledge both how much we have changed and how far we have come. From our humble beginnings as a small trade union supporting hospital staff, AHSP0 has grown into a strong, engaged and respected professional community with more than 700 members. That growth is a testament to the commitment and collaboration of people like you.

As we honour our history, we look forward with optimism and excitement to what lies ahead. The changes facing our sector continue to evolve, but so does our collective strength, knowledge and ability to support one another. On behalf of the AHSP0 team, we are so grateful to share this journey with you.

Thanks, as always, for your support and for your ongoing participation and contributions to AHSP0 and to each other.



**ALDO SANTO**

# The Gap Between Knowing and Doing

Strategy & Risk in Australian Hospital Supply Chains



In this second edition, JP Rebola explores the gap between understanding and managing risk.



WORDS BY JP REBOLA

Most procurement and supply chain (P&SC) professionals in Australian hospitals can tell you exactly what good looks like. They understand the value of documented risk registers, category strategies, supplier relationship frameworks, escalation thresholds, and regular reviews with leadership. They know what needs to be done. The challenge is not knowledge, it is finding the time and organisational space to actually do it.

That is the central finding of the AHSPo Member Insight Series Edition 2, drawn from parallel surveys with hospital P&SC teams and healthcare suppliers conducted in December 2025 to January 2026.



The report covers two related but distinct questions: how mature is strategic planning in hospital supply chains, and how well supply risks are being identified and managed. The data reveals a function that is clear-eyed about its own gaps, constrained by the day-to-day, and increasingly out of step with the suppliers it depends on.

## 45% of Hospital Teams Have No Formal Risk Practices. None.

Not one documented risk register, no structured supplier risk assessments, no regular risk review at leadership level, no contingency plans with critical suppliers. That is where 45% of hospital respondents sit when asked about their formal supply risk practices. Among the remaining hospital respondents who reported at least one practice in place, 33% reported maintaining a documented supply risk register, and 12% reported regular supply risk discussion at executive or board level. These are not mutually exclusive categories but rather the most commonly reported practices among those who have something, meaning roughly one in nine hospital P&SC teams has supply risk formally on the agenda with leadership.

The risk gap is not a knowledge gap. When asked, hospital respondents demonstrate a solid grasp of what good risk management looks like. The issue is structural. Firefighting consumes the week. Expediting, stock-outs, ERP issues, and urgent

requests are not occasional interruptions, they are the operating rhythm for most hospital P&SC teams. Both strategic work and risk planning fall into the same category, important, understood, and perpetually tomorrow's problem. Strategic work gets deferred because it requires stepping back from daily urgency. Risk planning gets deferred because it rarely feels urgent until it is.

As one Director of P&SC at a private hospital network put it. "We're confident in our strategy, we just spent the last three months chasing stock-outs and fixing ERP issues instead."

The path forward does not require a transformation program or new headcount. It requires creating deliberate space, starting with a one-pager setting out 1-year, 3-year, and 5-year strategic priorities for the P&SC function, a protected weekly session that does not get eaten by BAU, and a quarterly review cadence that treats both strategy and risk as live documents rather than filing cabinet artifacts. Small, consistent effort compounds. A strategy that exists and is revisited quarterly is infinitely more useful than a perfect document that lives in a drawer.





## Executives Do Not Understand Supply Risk, And That Is Partly on P&SC

67% of hospital respondents rated their executive or board's understanding of supply risk as poor or very poor, and a further 22% rated it moderate. Only 11% said good, and nobody said excellent. This is not about disengaged executives. Hospital leadership teams operate in a world of financial performance, clinical outcomes, workforce pressure, and reputational risk. Supply chain risk competes for airtime with all of that, and it often loses, not because it is less important, but because it is harder to frame in language that cuts through a boardroom.

Hospital P&SC professionals live in the detail of single-source dependencies, lead times, geographic concentration, and freight fragility. These risks are real and urgent at an operational level, but in an executive forum they can sound technical, abstract, and low priority next to a budget blowout or a sentinel event. The translation move is not complicated, but it requires

a deliberate shift. Saying "we have 12 single-source suppliers" is operational detail. Saying "if supplier X fails, three surgical categories go offline for six to eight weeks" is a supply risk executives can act on.

A separate survey question found that 44% of hospital respondents identified limited executive attention, or supply risk simply not being understood at leadership level, as a key driver behind their organisation accepting risky supply positions. The feedback loop is corrosive. If leadership does not understand supply risk, they will not resource it, and without that resourcing, hospital P&SC teams lack the capacity to build the reporting structures that would make the risk visible. The gap compounds.

The fix is not more data. It is better framing and a shared internal language so we don't have misunderstandings, for example when terms like cost avoidance and cost out are considered the same thing to stakeholders in the room. Until that foundation is in place, P&SC leaders need to act as translators, not just reporters, actively converting operational detail into the language of financial and clinical risk that executives are set up to act on.

## Suppliers Are Well-ahead on Both Strategy and Risk Maturity

When asked to self-rate their strategy and risk maturity, 75% of supplier respondents rated themselves as high and a further 13% as very high, with the remaining 12% rating themselves moderate. Among hospital respondents, the picture was almost the reverse. 33% rated themselves as low or very low, 56% as moderate, and just 11% as high. No hospital respondent rated themselves as very high.

Before reading this as a scorecard, the structural reason matters. For a supplier, business strategy and supply continuity is the business, and risk discipline is commercially existential. For hospitals, supply chain is one enabling function among many, competing for resources and attention with clinical governance, finance, workforce, and infrastructure. The gap in strategic and risk maturity is predictable, but that does not make it comfortable.

The maturity gap extends to upstream supply chain visibility, which sits squarely in the risk domain. 63% of supplier respondents reported strong visibility into tier-2 and key tier-3 suppliers, while only 33% of hospital respondents said the same, with many reporting limited visibility of even some tier-1 suppliers. 74% of hospital respondents reported finding out about supply problems only when they hit, a further 22% said they sometimes receive early warnings but many issues still blindsides them, and only 4% reported usually receiving early warning. Only 13% of supplier respondents said hospital customers regularly ask them for structured risk information, which suggests the upstream signal exists but is not being asked for.

The demand visibility problem runs in the other direction. 43% of supplier respondents reported getting adequate forward demand visibility from hospital customers. The remaining 57% were split between those receiving forecasts that are often inaccurate or change late, and those receiving little to no forecast at all. Zero supplier respondents reported receiving high-quality forecasts with early notice of key changes. Hospital teams lack upstream risk signals. Supplier teams lack reliable downstream demand signals. Both sides are operating with partial information, and what each needs largely sits with the other party.

The conversation that bridges this gap is not complicated. Hospital teams can ask key suppliers for a one-page risk profile covering upstream dependencies and geographic concentration, and add one question to the quarterly business review along the lines of "what should we be worried about in the next six months." Suppliers can share even a directional rolling demand forecast in return. The signal exists on both sides. It is not being asked for or exchanged.



**The fix is not more data. It is better framing and a shared internal language so we don't have misunderstandings.**



## COVID Lessons Did Not Stick

The last five years gave Australian healthcare supply chains a crash course in fragility. During COVID, collaboration increased, approval chains shortened, and hospital P&SC teams got temporary licence to act with urgency. The question is whether any structural change to strategy or risk management came from it, and the data suggests mostly not.

66% of hospital respondents reported that their organisation handled significant supply disruption mainly through short-term fixes, with 22% making some lasting changes and 12% making substantial structural changes to strategy or governance. Supplier observations of their hospital customers were largely consistent, with 62% of supplier respondents believing hospital customers largely reverted to old behaviours, 25% observing some lasting change, and 13% observing major lasting change.

This is not about blame. When a crisis passes, organisations revert to the incentives and routines they actually have. If those routines did not include resilience planning or formal risk practices before the disruption, there is no structure to anchor the lessons learned. Memory is not a risk management strategy. People move roles, institutional knowledge fades, and the manager who navigated a six-month PPE shortage may not be in the same seat when the next disruption hits. If those lessons live in someone's head rather than in a documented playbook or a standing review cadence, they are effectively lost.

The groundwork that could reduce the impact of the next disruption is straightforward. Actionable business continuity plans with real contacts and escalation pathways, a named owner, a refresh cycle, and a scenario workshop that surfaces the gaps documents alone will miss.

## Cost Dominates Procurement Decisions. Risk Gets Transferred.

Every supplier respondent, unanimously, identified cost reduction as the primary focus of their hospital customers in procurement and contracting decisions. Service levels ranked second among supplier observations, followed by supply resilience. Among hospital respondents, 76% also reported cost reduction as their leading organisational focus for P&SC, with data and reporting capability and supply resilience ranking behind it.

Cost discipline is not the problem. The problem is when cost is weighted so consistently ahead of service, continuity, and downstream consequence that supply risk does not disappear, it gets transferred. Suppliers absorb that transferred risk through tighter margins, reduced buffer stock, or less investment in the service layers that support continuity. The hospital sees a lower price but does not see what it may have just traded away.

Competitive tendering dynamics and short planning horizons reinforce this pattern. Hospital P&SC teams are measured on cost outcomes, tendering frameworks reward price, and continuity and service levels get treated as assumptions rather than variables because they are harder to quantify. That assumption holds until it does not, and when it fails, the cost of a supply disruption in emergency sourcing, cancelled procedures, and clinical workarounds almost always exceeds the savings that created the exposure.

Adding one risk question to a tender evaluation is not radical. Ask what happens if the supplier fails for four weeks and what the fallback would be. If the answer is unclear or uncomfortable, that is a supply risk worth pricing before the contract is signed.

## What This Adds Up To

The findings across these five areas point to the same underlying tension. Hospital P&SC teams understand what good strategy and risk management looks like, but the operating environment does not yet create the conditions for them to build it. The gap is not knowledge, it is capacity, language, structure, and incentives. Each of those is addressable, not all at once, and not without leadership support, but addressable.

The current position, where nearly half of hospital teams have no formal risk practices, where hospital executives overwhelmingly do not understand supply risk, and where both hospitals and suppliers are operating with partial visibility into each other's constraints, carries a cost that will eventually surface. The question is whether it surfaces as a decision or as a disruption.



**The full AHSPo Member Insight Series Edition 2 report, including detailed findings and practical recommendations, is available via the QR code below or [CLICK HERE](#).**



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“Bringing together passionate minds to discuss and debate topics dear to all our hearts is brilliant for us as individuals in procurement and for the profession as a whole.”

ALDO SANTO, PRESIDENT



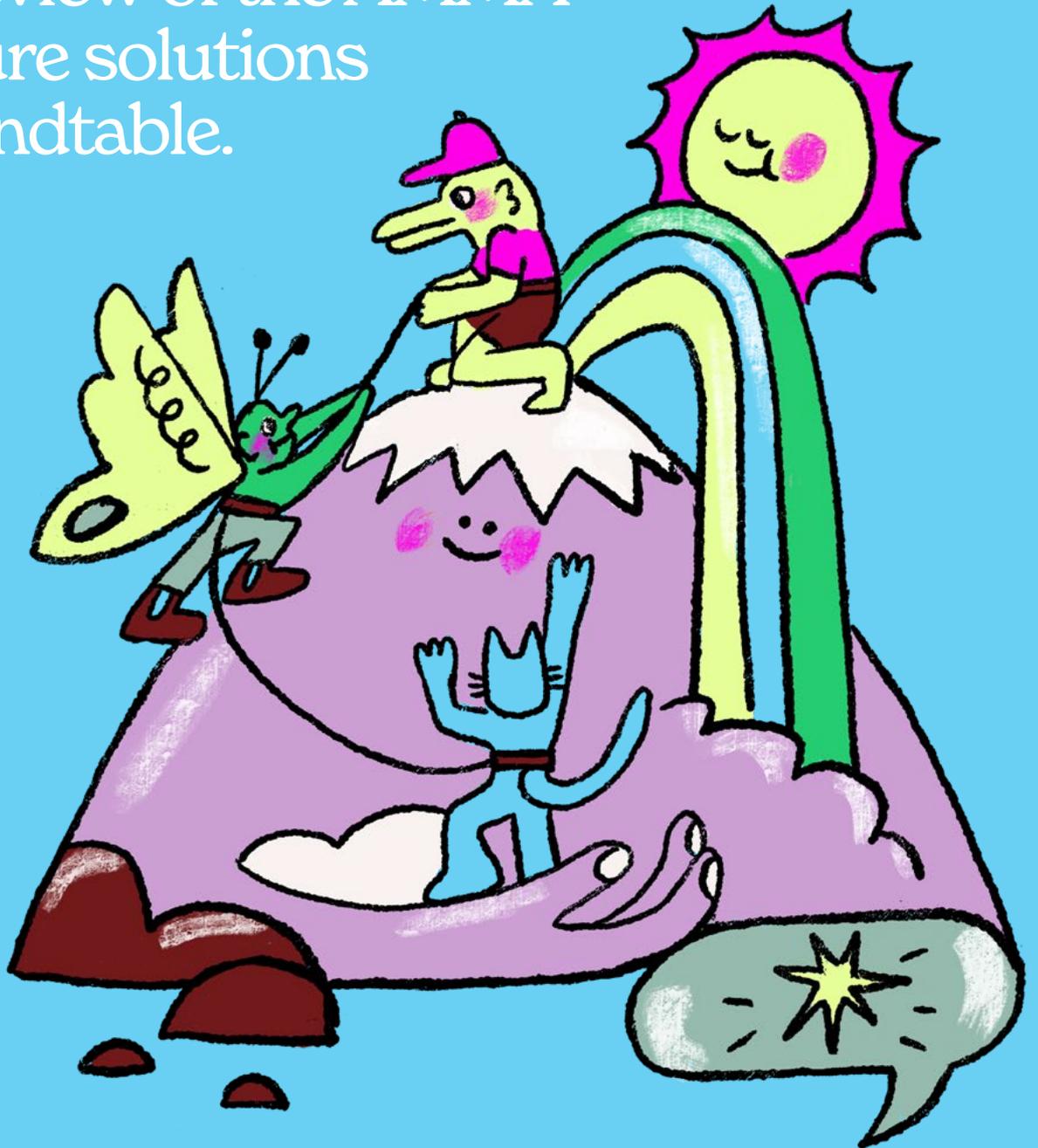
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# FROM CHALLENGE → OPPORTUNITY

A review of the AMMA  
future solutions  
roundtable.



Written by Staff Writer Jaime Watts



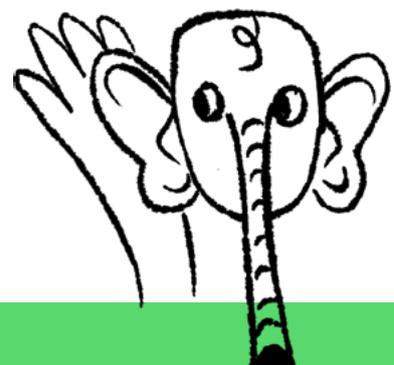
## Locally made medtech helps support a robust, innovative, and responsive healthcare system made for Australians.

But achieving this doesn't happen in isolation. It requires collaboration, shared ambition and commitment to supporting local capability. That is the Australian Medtech Manufacturing Alliances' (AMMA) vision, and that's why, in late 2025, they brought together the brightest minds across medtech, healthcare and industry for the inaugural Medtech Showcase and Future Solutions Roundtable.

The Roundtable sparked thought-provoking conversations, new connections, and inspiring showcases of Australian medtech capability. Across the day, participants explored a central question: how can Victoria's health system better harness local medtech capability to deliver greater value, resilience, and innovation?

Discussions centred on three key themes: leveraging local capability to strengthen resilient supply chains; embedding value beyond cost in strategic sourcing decisions; and developing effective partnership models to support the adoption of new technologies. These conversations laid a strong foundation for tackling the complex challenges and emerging trends shaping the future of medtech and healthcare in Australia.

This article captures the key insights, themes, and takeaways that do not represent the AMMA position, but rather what was heard at the Future Solutions Roundtable, which took place on October 16th, 2025.



## WHAT IS THE AMMA MEDTECH SHOWCASE?

The Australian Medtech Manufacturing Alliance (AMMA) is a partnership of peak industry bodies, backed by a network of industry and health champions. Dedicated to creating stronger pathways to market for local manufacturers, the AMMA Medtech Showcase is a cornerstone of this mission.

The Medtech Showcase provided health organisations with the opportunity to engage with local suppliers, get hands-on with new technology, and provide invaluable insights into how manufacturers can engage the health system. Roundtable discussions held throughout encouraged deep discussion among industry peers.

## LEVERAGING LOCAL CAPABILITY TO STRENGTHEN RESILIENT SUPPLY CHAINS

Australia's health system relies heavily on imported health technologies, including consumables and PPE, as well as diagnostics, devices, and components. Despite Victoria having established and emerging medtech manufacturers, regional capabilities, and advanced manufacturing infrastructure, these capabilities are not fully integrated into mainstream procurement pathways. This wide-ranging conversation unearthed some interesting insights and solutions.



### **Establish a Local Supplier Catalogue to Build Visibility of Local Choice**

Connecting with local suppliers is often problematic. Buyers frequently lack awareness of who these suppliers are, and integrating local suppliers isn't standard in their procurement process.

A way forward is to build a governed local supplier product catalogue that incorporates assurance mechanisms to build buyer confidence and improve local firm visibility during category planning and at backorder triggers.

### **Create a Shared Market Data View for Better Planning**

Essential procurement data is trapped in separate silos across HSV, individual health services, and the industry, leaving suppliers confused about where to find relevant data. This lack of a unified, shared view of demand and supply prevents effective prioritisation and risk management.

Introducing a demand-supply intelligence dashboard to share market data and prioritise demand could enhance procurement planning and inform policy development. This would centralise data in a single location.

### **Reduce Contract Rigidity and Long Procurement Cycles**

Current panel structures and long-tenure contracts create narrow entry windows and limited flexibility. This constrains SME access, makes contracts less competitive, and directly slows the adoption and application of better innovation and better local products between cycles.

The Roundtable unearthed a proposed solution to enable rolling refresh and mid-term triggers, and to right-size documentation and insurance requirements for low-risk categories.



### **Diversify The Supply Chain to Ensure Continuity and Reduce Risk**

The fragility of our supply chain is caused by distance, customs, shipping delays, globally stretched supply chains, and upstream component shocks. All of these create recurrent lead-time risks for Victorian health services. When supply is concentrated with a single vendor, outages and recalls cascade faster, and recovery options are limited.

Diversifying the supply chain can help reduce outages and wait times. This could involve identifying and establishing a list of vulnerable products, engaging multiple suppliers, and dual-sourcing to ensure continuity.

### **Track and Highlight Local Content**

Participants also raised the need for stronger support mechanisms to grow domestic supply, including clear targets and transparent measurements, which support local open competition.

A popular suggestion was to publicly report and track local content metrics, alongside an annual summary of outcomes. This summary would highlight categories in which using local capabilities improved continuity and quality, thereby linking targets directly to health-system value.

# EMBEDDING VALUE BEYOND COST IN STRATEGIC SOURCING

Health procurement operates under high scrutiny to maintain service continuity, meet probity requirements, and deliver savings. Price has come to dominate the concept of value, overshadowing existing policy frameworks that advocate for principles such as whole-of-life value, quality, outcomes, risk, and sustainability.

## Shifting Away From Price as a Default Measurement

Price has become the leading indicator of value in health purchasing, a problematic trend. Annual budget cycles, savings-focused KPIs, and reporting requirements reinforce short-term financial decisions over life-cycle and long-term considerations.

The introduction of a best-practice network will encourage the use of different methods for measuring values and KPIs. Defining and using simple value statements alongside price would be helpful. Additionally, creating a method for measuring and making outcomes more visible.

## Clinical Participation Drives Greater Value

Many participants suggested that value improves when clinical and end-user input is taken into account. However, capacity constraints and siloed structures can result in underrepresentation of clinical requirements or in reliance on individual champions in purchasing decisions.

To enhance clinical and user participation, increased patient advisory, early clinical reviews, and input from product evaluation committees is recommended. Additionally, increasing clinical procurement involvement is essential for high-impact categories, supported by appropriate resourcing.





### **Evidence-based Value Measurement is Key**

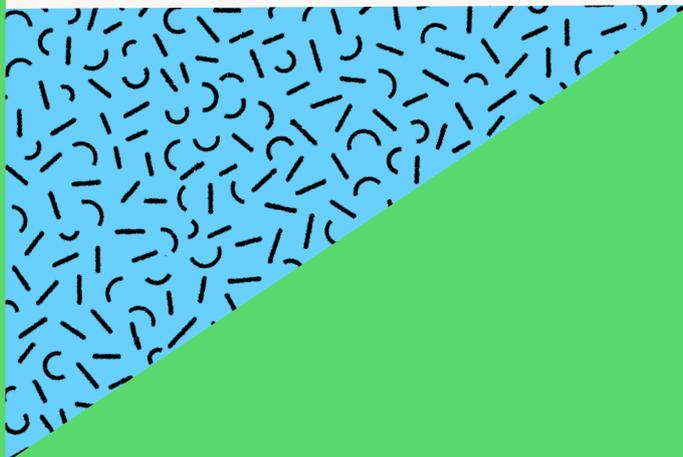
Participants noted that price often dominates as a measure of value because there is no shared, evidence-based approach to measuring value. Current system weaknesses include failure to capture lifecycle costs, siloed outcomes data, and the lack of acceptance of HTA-style methods in medtech. As a result, buyers by default use price as a measure of value.

To better define and measure value, it is recommended that a statewide policy on value-based procurement be implemented. This involves defining a practical value-based assessment framework and establishing a standardised system to record and share validated outcomes for procurement use.

### **Education and Knowledge Reduce Risk Aversion and Encourage Change**

Purchasing decisions are stalled because many groups view value solely through the lens of price. These groups often find themselves stuck in patterns and have limited capacity for change, which hinders their ability to make value-based choices.

The most effective way to encourage the group to adopt a value-based approach is through education. By upskilling the workforce in value-based procurement and conducting pilot programs, its feasibility can be demonstrated and proven.



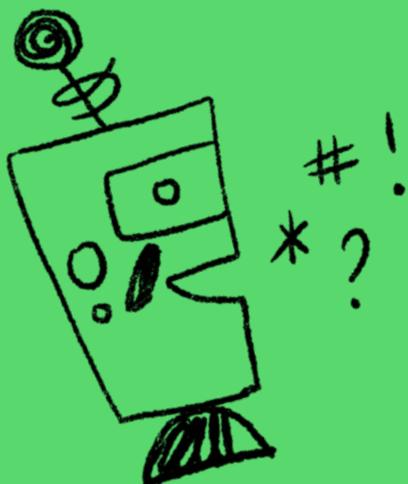
# PARTNERSHIP MODELS FOR ADOPTING NEW TECHNOLOGIES

Adopting new technologies in Victoria's health system is slow, complex, and often unpredictable; even when innovations are clinically sound and aligned with system priorities. Healthcare services juggle safety, probity and budget constraints. Innovators face different challenges, including navigating complex evaluation processes, securing approvals, and dealing with unclear demand.

## Reward Faith In New Technology and Create Clear Pathways Forward

Ad hoc pilots, contract blackout periods, unclear decision-making, and fragmented funding processes are delaying the adoption of new technologies. The path to increased adoption involves creating best-practice networks and integrating value-based procurement practices as drivers for change.

To incentivise adoption, facilities should be rewarded for trialling new technology. Providing a transparent product evaluation pathway and simplifying processes, insurance requirements, and removing red tape will encourage innovation.



## Shared Accessible Data Fosters Transparency and Innovation

Clinical, operational, and economic evidence exists, but it is not easily discoverable across services without shared formats and reporting. There is no central repository to prevent trial duplication, and trial results are often siloed. Normalising a minimum data standard and making de-identified results searchable would remove uncertainty, shorten cycle times and allow value to be chosen over price.

Creating a network to share trial outcomes and evidence would ensure that data is accessible to everyone, supporting equity and fostering better innovation. Additionally, a mandate to report on innovation outcomes will help avoid duplication of results and support innovation.

## Increased and Clear Demand Signalling Would Benefit Suppliers and Buyers

Participants wanted a clear, updated list of unmet needs and challenge briefs so proposals match real clinical or operational gaps, and can move straight to evaluation. Unfocused development wastes time, money and resources.

To solve this problem, the group suggested publishing a list of unmet needs, challenge briefs, ideally using an online portal. Coupled with annual demand signalling, this would create early-stage funding and give buyers a reason to engage with proposed solutions early.

### **Embed Commercialisation units within Health Services**

Limited clinical capacity for intake, triage, pilot implementation, and evidence synthesis slows or prevents the adoption of otherwise viable technologies. Core operations often dominate workers' daily attention, while innovation is neglected.

One solution to improve capacity is to embed small, skilled commercialisation units inside health services, providing a single front door for intake. In addition, standardising pilot design and measurement would ensure projects are presented in a way that procurement and finance can use, to increase the chances of successful uptake.

### **Co-design Can Align Expectations and Reduce Misfires Early**

Co-design can accelerate innovation and reduce misfires. Regular collaboration forums reduce search costs, align expectations early, and surface integration issues before tendering begins.

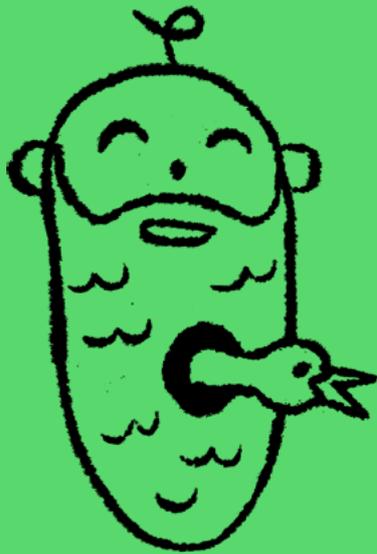
Establishing more opportunities for cross-sector forums and working groups to connect purchasers and innovators would improve collaboration, reduce risk and unearth more opportunities for innovation.

### **Increasing Med Tech Literacy Through Education and Culture Building**

Embedding med tech literacy and sharing real case studies reduces the perceived risk of local technology and accelerates adoption. Building knowledge, a common language, evidence, lifecycle value, and implementation mechanics across clinical, procurement, and finance roles makes change less threatening and more executable.

To improve education and cultural development, we can establish a policy to facilitate communication between the health and industry sectors. Promoting medtech considerations in health strategy and incorporating local medtech into undergraduate and postgraduate education will educate and raise awareness of medical technology.





## CONCLUSION

It's incredible what we can achieve when the health and industry sectors come together. Creating a platform for safe, open discussion to help shape the future of healthcare is exactly what we set out to do. While it was inspiring to see so many participating and making meaningful connections, it's what happens next that really matters. Feedback from the Roundtable has been provided to leaders and incorporated into the Industry Action Plan, due later this year. You are seen and heard.

AMMA is focused on how we can all shape the future of healthcare and deliver lasting, long-term better outcomes for patients - we look forward to providing updates throughout the year.



# ParagonCare launches Baremedical HeartSave AED Range

Take A Look At The New Lightweight Heartsave AED



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## A New Era of Readiness Across Australia and New Zealand

When sudden cardiac arrest strikes, every second counts. With growing regulatory expectations for public access to defibrillation, ParagonCare's introduction of the baremedical Automated External Defibrillator (AED) range—including the HeartSave Y/YA and HeartSave myPAD — marks a significant step forward in emergency preparedness across Australia and New Zealand.

## A Regional Shift Toward Greater AED Accessibility

Regulatory momentum across the region continues to drive wider deployment of AEDs. Workplaces—particularly in higher-risk industries—along with schools, sporting clubs, and public facilities are increasingly expected to maintain accessible and reliable defibrillation equipment. Residential complexes, transport hubs, and large commercial sites are also adopting similar measures.

This emphasis goes beyond accessibility to embrace readiness. Safety authorities and facility managers now seek AEDs that perform daily self-tests, withstand harsh conditions, and guide even untrained responders with clarity and confidence. Features such as universal electrode design, built-in paediatric functionality, multilingual prompts, and extended-life consumables are fast becoming essential.

## **Baremedical HeartSave myPAD: Compact, Durable, and Connected**

At just 15 by 15 centimetres and weighing around one kilogram, the HeartSave myPAD ranks among the smallest AEDs in its class. Compact enough for offices yet rugged enough for outdoor worksites, it carries an IP66 rating—resistant to dust, heavy rain, and water jets.

Its design supports diverse use environments, offering a simple button switch between adult and child modes and clear, multilingual voice instructions. Select models include full-colour displays with CPR rate and depth feedback. Long-life batteries and electrode pads—lasting up to five years—reduce operational costs, while automated daily self-tests ensure reliable readiness. All this is also supported by a 7 year warranty.

For organisations managing multiple locations, the myPAD Connect variant integrates LTE connectivity for remote monitoring and over-the-air updates via the ParagonCare control platform.

## **Baremedical HeartSave Y/YA: Reliable Performance in Every Setting**

The HeartSave Y/YA builds on these same principles of safety, reliability, and simplicity—offering a slightly larger format designed for high-traffic or shared environments. It supports up to four switchable languages, child mode activation at the press of a button, and escalating shock energy up to 360 joules to optimise defibrillation effectiveness.

With an seven-year warranty and components engineered for long service life, the Y/YA range is ideally suited to workplaces, community venues, and first responder fleets that demand enduring operational performance.

## **Engineered for Confidence, Supported Locally**

HeartSave AEDs are built to the highest manufacturing standards, ensuring precision and consistency in every unit. Their IP66 protection, multilingual guidance, and universal electrode compatibility reflect a design approach focused on reliability and ease of use.

Through ParagonCare's local infrastructure, customers gain access to comprehensive technical support and training—delivered through dedicated Australian and New Zealand support teams. This ensures each unit remains compliant, connected, and ready for use whenever it's needed most.

## **Setting a New Benchmark for Community Safety**

As regulations evolve and community expectations rise, the HeartSave AED range delivers meaningful benefits—enhanced accessibility, simplified ownership, and technology built for real-world performance.

In emergencies where every second matters, Baremedical and ParagonCare are helping make immediate, life-saving defibrillation not just accessible, but expected, across every region of Australia and New Zealand.

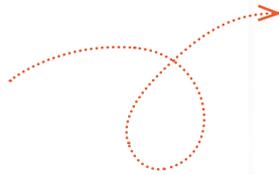


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# What's The "Value" In Healthcare Procurement?

Learn about Brian's journey within the NHS and the benefits of value-based procurement in healthcare.

WORDS BY BRIAN MANGAN



## My Journey into Procurement

My working life started back in 1981, when “wireless” was an old-fashioned word for a radio, and as I sat behind a post office counter selling stamps and paying pensions; visions of 2026 peppered with flying cars and life on the moon didn't turn out quite as planned! Twenty years or so later, via a period as a Logistics Manager in Royal Mail, I found myself in procurement... a perfect job for me, my family said, as I'm tight with money and like arguing!

In 2004 I left the enthralling business of procuring rubber bands used by postmen and joined the English National Health Service, where I served as a Head of Procurement at two hospitals over a 10-year period. During this time, it's fair to say my default position was that suppliers were the enemy and I was there to make sure I could screw them down on price as much as possible — and like most procurement professionals, I believed it was something I was fairly good at.

# Realising the Limits of Traditional Procurement

In 2014 I started a regional role focused on looking at ways to develop procurement in the NHS. Reflecting on my time in operational procurement and the constant cycle — the procurement cycle of doom, where we get allocated a savings target, produce work plans of savings schemes and then challenge suppliers using tactics of aggregation, standardisation and supplier switching — it became apparent that each year it was becoming more and more difficult to keep getting the same level of savings. After all, if you've done a good job with your tender/negotiations in the first place, then you'd have done something wrong if the supplier or the market came back with a radically reduced offer the next time you went out to tender.

This got me thinking that maybe, as a profession, we needed to start looking wider than just product price and more at how we could create value across a patient pathway and generate greater savings related to the total costs of care. To support this idea, I engaged with the University of Liverpool to explore the notion of "value based procurement" (VBP) — a phrase we adopted for the report published in 2015. We found that across the NHS we were focused on short-term price reductions, we had poor relations with suppliers and we need to become more strategic.

Over the next few years I engaged with the NHS, the Medical Technology industry and health systems in the UK, Europe and Canada, and it became apparent that there was a need and an appetite to change — and that doing so could enable healthcare organisations to improve outcomes and lower costs: the formula for Value Based Healthcare developed by Michael Porter in 2006<sup>1</sup>. A methodology and strategy that is a focus of healthcare systems around the world, including Australia and many others.



## Developing and Proving the Case for Value Based Procurement

Applying theory into practice, in 2019 I was engaged as a consultant to design and lead a Value Based Procurement proof-of-concept project for the NHS Supply Chain organisation, which is the national procurement organisation for the NHS with an annual spend of £4.5bn.

Engaging with a multidisciplinary team of clinicians, finance, procurement and nursing staff, we approached a selection of suppliers (large and small) and asked them to submit what they perceived to be solutions that could create value to the NHS. The result was a number of schemes were taken through to a pilot phase with hospitals from around the country. We found that benefits created ranged from the basic — where you may pay slightly more for a product but use less (reduction in consumption) — to innovative technologies that enabled patients to be treated as a day case rather than having to spend time in hospital, products and solutions that enabled patients to be treated at home or in a less complex setting in a hospital (theatres to day ward), with some projects having a direct impact on reducing infections.



▼  
The projects were written up as case studies<sup>2</sup> and shared across the NHS as examples of how the approach could help improve patient experience and outcomes, increase efficiency, reduce total cost of care and also create environmental benefits.

The projects were written up as case studies<sup>2</sup> and shared across the NHS as examples of how the approach could help improve patient experience and outcomes, increase efficiency, reduce total cost of care and also create environmental benefits. Creating, in effect, stories that people could relate to, elevated value based procurement from theory to an approach that has the potential to support the transformation of the NHS, and has been supported and integrated into the 10-year plan for the English NHS<sup>3</sup>.

At present there is a national project underway that involves active stakeholder engagement from across the NHS, including clinicians, finance and procurement leads and the medical technology industry, to establish a system-wide approach to integrate value into tendering procedures — a significant sign of progress and commitment to the adoption of VBP.

## The Future: Transforming Procurement Through Value

Procurement as a profession has been good to me. It's a job — particularly in the health service — where I've felt that, along with my peers, we have made a difference to people's lives by making savings which you hope are re-invested in patient care. The challenge is that the "savings well is running dry," and if all we as a profession are recognised for is product price reductions, then to maximise our contribution to the institutions we serve, we need to do things differently — "Adapt or AI" is a phrase that springs to mind.

We need to broaden our horizons to consider how we can use our unique position as conduits between healthcare organisations to tap into the collective intelligence of industry and, instead of viewing them as the cause of the problem, see them as the source of the solution — ask a better question, get a better answer.

Industry too needs to change. Trust — or lack of it — between healthcare buyers and suppliers, created by a lack of transparency (the "you're my special customer" pricing tactic), is a fundamental area that needs to be addressed. When I work with industry I insist that they don't look to market value out of products/solutions that don't exist; that for value based procurement to be credible, they must be able to deliver tangible and measurable benefits that relate directly to the adoption of their technology or solution, and they need to provide contractual assurance of delivery.

Value Based Procurement creates opportunity for patients as it aims to improve patient experience, outcomes and access to care; for clinicians, where we use the process of procurement to support them to improve patient care, reduce cognitive strain, address challenges in current processes and promote innovation; for Finance Directors — VBP offers system-wide, long-term benefits and helps release capacity to improve patient flow; for Procurement — it enriches the role as a strategic function rather than a tactical one, supporting and improving healthcare delivery; for payers — it reduces procedure costs, offers options to increase profit, gain share with providers and reduce customer fees; and for providers, it ensures survival and mitigates the challenges mounting on health systems to deliver more with fewer resources.

My advice for both healthcare and industry is to start small. Identify a range of projects that can be assessed as delivering value — I've created a tick list based on the word TRIAGE to help: is the solution Tangible (will it make a difference?); what is the Return on investment; is the solution Integral to creating the value; what Assurance can the supplier offer that it will be delivered; is there Granular data available to baseline and measure success; and is there sufficient Evidence to show that it works.

Use the information generated to create case studies: highlight the challenge, the process, the outputs and the lessons learned — the more we do, the more we share, the more we achieve.

"To change is difficult; not to change is fatal."<sup>4</sup>  
A bit dramatic, but I really believe that healthcare procurement and healthcare systems are at a precipice where we need to act now. Value Based Procurement is one vehicle I believe is worthy of exploration.

**BRIAN MANGAN**  
FCIPS MSc  
CEO Luach Consulting Group



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1. Porter, M. E., & Teisberg, E. O. (2006). Redefining Health Care: Creating Value-Based Competition on Results. Harvard Business School Press.
2. Value Based Procurement For Healthcare - NHS Supply Chain
3. Fit for the future: 10 Year Health Plan for England - executive summary (accessible version) - GOV.UK
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# Education Update



Mentoring younger talent is a powerful tool for strengthening the workforce, creating benefits for both the individuals and the organisation.



WORDS BY DEBRA BIRZNIK

## Introduction: Building Bridges in a Field of Change

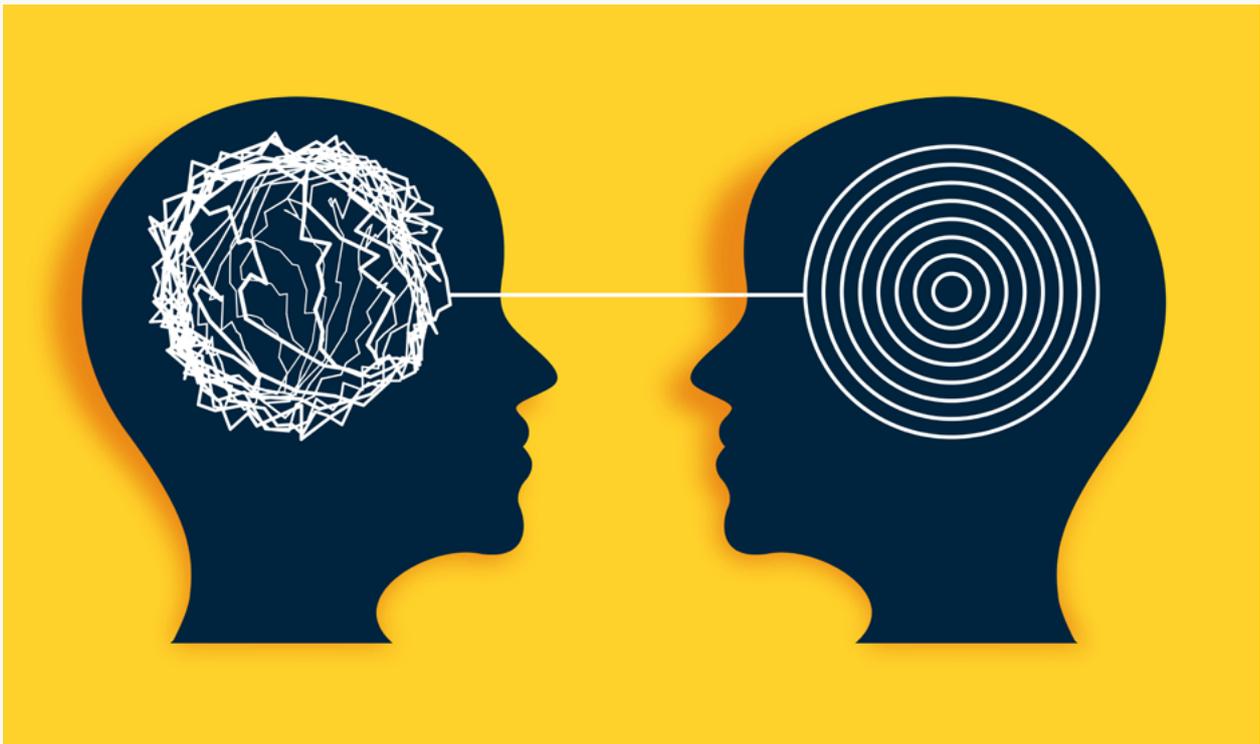
As the AHSP0 Education Officer, my mission has always been clear: to ensure that no matter where you started your journey, you have a clear pathway to where you want to go. In the world of healthcare procurement and supply chain, we are a unique cohort.

Many of us didn't set out with a degree in procurement, contract management, or logistics; instead, we transitioned from clinical floors, administrative hubs, or entirely different industries - often landing in complex roles without a roadmap. While formal qualifications are vital, there is a nuance to what we do that can't always be explained in a textbook. It is found in the lived experience of our peers.

This is why I am so passionate about the power of mentoring. It is more than just a professional "buddy system"; it is t bridges the gap between raw talent and specialised healthcare expertise. Whether you are an executive looking to leave a lasting legacy or a newcomer navigating your first contract, mentoring creates a culture of continuous uplift. By sharing our collective "intellectual capital," we don't just improve our individual capabilities - we strengthen the entire healthcare supply chain for the benefit of the patients we ultimately serve.

## For the Mentee: Accelerating Growth

- **Contextual Knowledge Transfer:** Healthcare procurement is uniquely complex (clinical governance, patient safety, and sterile supply chains). Mentoring helps newcomers understand the why behind the what far faster than any manual.
- **Navigating the "Shadow" Organisation:** A mentor helps junior or transitioning staff understand the unspoken cultural nuances and stakeholder management required to influence clinicians and executives.
- **Confidence in Decision-Making:** Having a sounding board reduces the "imposter syndrome" often felt by those moving from different sectors into specialised healthcare procurement roles
- **Career Pathway Clarity:** Mentors provide a roadmap for professional development, identifying the specific certifications and experiences most valued in the Australian healthcare landscape.



## For the Mentor: Elevating Leadership

- **Refining Leadership & Coaching Skills:** Acting as a mentor forces senior leaders to practice active listening and constructive feedback - essential traits for any Executive role.
- **Gaining "Reverse Mentoring" Insights:** Engaging with entry-level or transitioning staff gives mentors fresh perspectives on new technologies, ground-level bottlenecks, and the challenges facing the current workforce.
- **Legacy and Talent Pipeline:** By investing in others, you directly strengthen the AHSPo community and ensure the future resilience of the Australian healthcare supply chain.
- **Intrinsic Professional Fulfilment:** You can experience a profound sense of "giving back" to your industry, which can reinvigorate your passion for your career.

## Taking the First Step: A Guide to Getting Started

Mentorship doesn't need to be a daunting or overly formal arrangement. It is simply a commitment to a professional conversation with a purpose. Whether you are looking to guide or to be mentored, here is how you can kickstart the process today:

### For the Aspiring Mentee

- **Identify Your 'Gap':** Before reaching out, ask yourself: What is the one area I want to grow in? Is it clinical stakeholder management, navigating the tender process, or developing executive presence?
- **Be Proactive:** Don't wait to be "discovered." Simply reach out to someone whose career path you admire within the AHSPo community. A message like "I've followed your work and would love to grab a 15-minute coffee to ask a few questions" is often all it takes.
- **Set the Agenda:** Value your mentor's time. Come to sessions with specific questions or a real-world challenge you are currently facing.



## Your Call to Action: Let's Elevate Together

As your Education Officer, I am challenging every member of the AHSP0 community to take one action this month. If you are an experienced leader, identify one high-potential individual in your network, perhaps someone who has recently transitioned into the field and offer them a "mentoring moment." If you are new to the sector or stepping into a more senior role, be brave and ask for guidance.

We have an incredible wealth of knowledge within our Association. Let's not keep it in silos. By engaging in mentorship, we aren't just improving our individual resumes; we are building a more resilient, capable, and connected healthcare supply chain for all of Australia.

## For the Potential Mentor

- **Open the Door:** Make it known that you are available for mentourship. A small note in your email signature or a mention during a regional meeting can signal your willingness to support the next generation.
- **Listen More, Talk Less:** You don't need to have all the answers. Often, the most valuable thing you can provide is a safe space for a peer to vent, ask for support, brainstorm, and find their own solutions.
- **Commit to Consistency:** Even one 30-minute check-in per month can make a monumental difference in someone else's career trajectory.



**Are you ready to start the conversation? Reach out to me directly or connect with your fellow members via our AHSP0 LinkedIn group to find your match**

# Pass the Torch: Lead the Future of Healthcare Supply Chain Education

Debra Birznieks, the AHSP0 Education Officer, will soon be concluding her tenure. We are currently seeking a successor to take on this important role.



## ARE YOU AHSP0'S NEXT EDUCATION OFFICER?

After three incredibly rewarding terms serving as your Education Officer, my current tenure will conclude in August 2026. This role has been one of the many highlights of my professional journey, but as the saying goes, "Leadership is about the next generation."

Now, AHSP0 is looking for a passionate leader from within our membership to step forward, bring fresh perspectives, and take our educational offering to the next level.

### Is This Your Next Move?

Do you believe that a stronger, more educated workforce leads to better patient outcomes? Are you passionate about helping your peers navigate the complexities of healthcare procurement?

The Education Officer plays a pivotal role on the Executive Committee. It's not just about "training", it's about being a navigator for our cohort. You will be the primary advocate and guide for our members' professional growth, helping them find their unique path in a field that is constantly evolving.

### Your Impact in This Role:

- **Professional Mentorship Opportunity:** You will guide members from all backgrounds: clinical, admin, or corporate, as they build their "healthcare-specific" supply chain expertise.
- **Strategic Support:** You will oversee and advise on member sponsorships, ensuring financial support reaches those who most need it and are committed to elevating their educational and professional standards.
- **Capability Champion:** You'll work at a leadership level to identify skill gaps in the Australian market and source the pathways to fill them.
- **Conference Visionary:** As a key member of the organising team for the AHSP0 Annual Conference, you will help curate the educational program, help select speakers, and ensure the content delivers high-value learning that resonates with our members' real-world challenges.
- **Voice of the Executive:** As a member of the Executive Committee, you will help shape AHSP0's strategic direction, ensuring education remains at the heart of our mission.



### Why Nominate?

If you have benefited from the AHSP0 community, this is your chance to give back. You will expand your own professional network

at the highest levels of the industry. You will also develop your governance experience and directly influence the capability of the Australian healthcare supply chain.

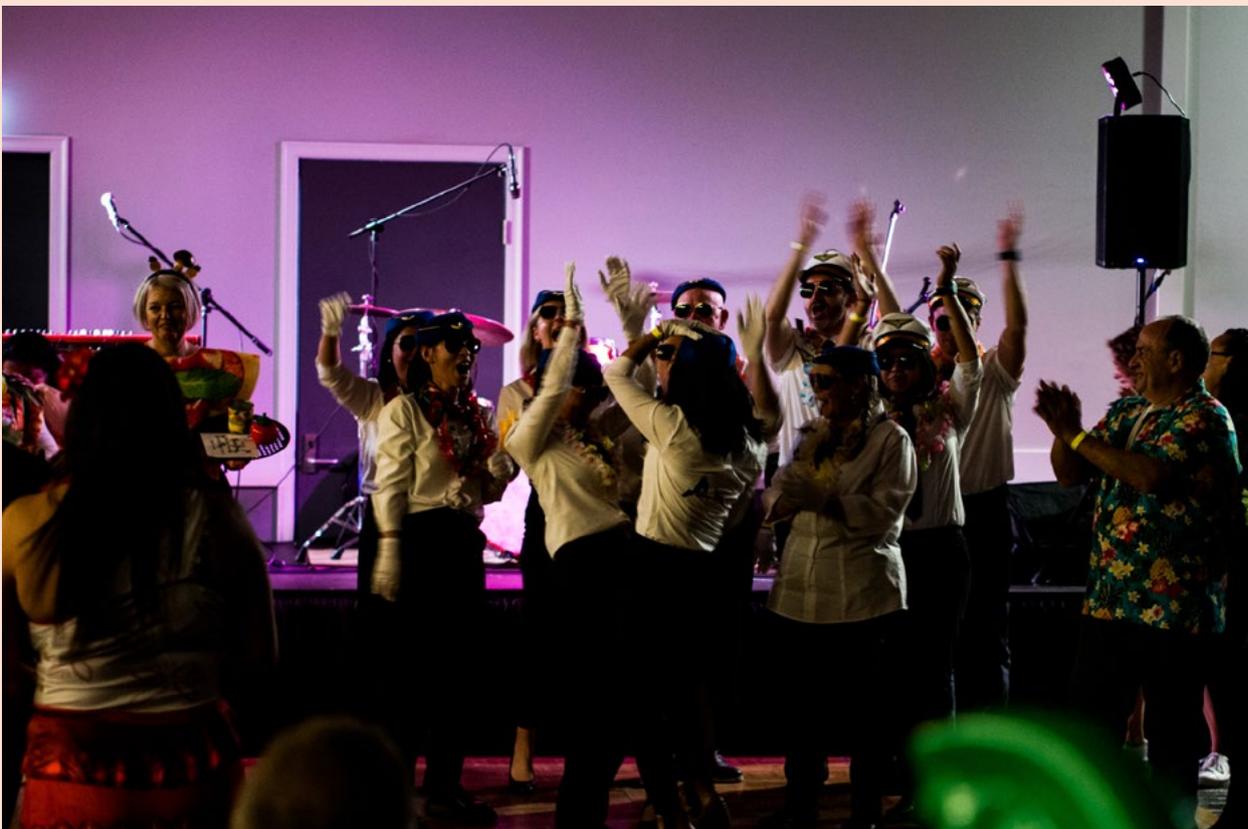
# Social Pages

Subheading here



Here are some of our favourite shots from Conference 2025. We can't wait to see more of our members at this years conference!









//AHSPO

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# Secret Wine Business



In this edition, Peter Lack takes a trip back in time with a Tyrrell's Rufus Stone Heathcote Shiraz.



## Welcome to my Autumn Secret Wine Business Article for 2026.

The Tyrrell's Rufus Stone Heathcote Shiraz 2024 is more than just a bottle of wine for me — it's a gateway to memories of long dinners, shared laughter, and friendships forged through AHSP0 Conferences, Strategic Alliance Study Tour, good food, good wine, and the legendary hospitality of Michael Clarke, Sue McCallum and their partners. We were first introduced to this wine back in the 1990s, it quickly became a staple at our rotating dinner gatherings, and opening a new vintage today still brings a warm sense of nostalgia.

## A Little History

The Rufus Stone name carries a medieval backstory: King William II ("William Rufus") was allegedly killed by an arrow fired by Sir Walter Tyrrell, an ancestor of the modern Tyrrell family. The site of the incident is still marked in England today by the Rufus Stone, and since 1997 the Rufus Stone label has represented Tyrrell's top non-Hunter Valley red wines, sourced from premium regions such as Heathcote and McLaren Vale.

Heathcote, of course, needs little introduction. As most of you reading this article know, I am a very big lover of most wines that come from Heathcote. What is there not to love about one of Australia's most exciting red wine regions, its ancient Cambrian soils, temperate climate, and physical features of the area, consistently produce some of Australia's most distinctive Shiraz.



## Tasting Notes

Revisiting this wine after several years was like stepping back in time — and its 2024 Vintage didn't disappoint. The full-bodied flavour of plum and dark cherry, with spice and slight chocolate tones were there, BUT it was the memories that made it so enjoyable.

As always, I am not an expert, so what do people who are say about this wine:

"Tyrrell's Rufus Stone Shiraz 2024 is a powerful and expressive Shiraz from Heathcote, showcasing the region's renowned ability to produce bold, structured reds with elegance and finesse."

"Tyrrell's Rufus Stone Heathcote Shiraz is one of the most awarded wines in the Tyrrell's portfolio and continues to deliver on quality. With its deep ruby-red with vibrant purple hues appearance, this Shiraz presents an impressive depth of colour in the glass, signalling its concentrated fruit character and youthful vigour. It has an intensely aromatic bouquet, revealing concentrated black plum and ripe mulberry aromas, complemented by hints of white pepper and subtle spice. Notes of dark chocolate and toasted oak from careful French oak maturation add complexity and depth, whilst a whisper of vanilla provides a sophisticated aromatic lift."

"On the Palate, it is full-bodied and richly textured, with the finish is lively, clean, and refined, with excellent persistence that showcases the quality of Heathcote Shiraz."

## Accompany

Again, the wine makers say this wine shines with hearty, flavour-driven dishes such as:

- Grilled steak or lamb shanks
- Venison, kangaroo, or duck
- Beef ribs or braised short ribs
- Aged cheddar, gruyère, or mature gouda
- Bolognese or rich ragù

We enjoyed ours with lamb backstraps, mashed mint peas, roasted root vegetables — and a generous serving of cherished memories.

## Final Thoughts

The Tyrrell's Rufus Stone 2024 is a big yet elegant Shiraz that delivers on heritage, regional character, and value for money. But for me, its greatest quality is its ability to transport me back to wonderful times shared with dear friends.

We miss you, Michael. RIP — and here's to all the great bottles and great stories still to come in your memory.

Good quaffing,  
Peter Lack (Life Member)



### AVAILABILITY

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# Who Am I?



Can you guess the identity of this respected doctor,  
or will you skip directly to the hidden answer?



I was born on December 4, 1856, in Hobart, Tasmania. In 1872, I moved to Melbourne. Moved by the poverty in my parish, I decided to study medicine, which was uncommon for women at that time. I was forced to leave Australia because no universities would admit women to medical courses. I studied abroad, graduated from the Women's Medical College of Pennsylvania, and earned my MD from Trinity College, Toronto, in 1888.

After that, I moved to London, where I worked at the New Hospital for Women and qualified as a licentiate of the Worshipful Society of Apothecaries in 1889. My time at the New Hospital inspired me to one day establish a hospital run "by women, for women."

I then returned to Australia in 1890 and became the first woman to be registered with the Medical Board of Victoria. My sister Grace followed in my footsteps, and we went into private practice together, both working at the outpatients' dispensary in La Trobe Street.

In 1895, I hosted the inaugural meeting of the Victorian Medical Women's Society in my home, where I assumed the presidency. In September 1896, eleven female doctors from Melbourne decided to establish the Queen Victoria Hospital for Women. The hospital was funded through a Jubilee Shilling Fund appeal and officially opened in July 1899.

I passed away in 1902, and a lane in the Queen Victoria Village in Melbourne (known as QV) is named after me. I was posthumously inducted into the Victorian Honour Roll of Women in 2001.

Who Am I?

**CHECK THE ANSWER HIDDEN ON THE CONTENTS PAGE.**

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