

CONFERENCE PROGRAM AND ABSTRACTS

4th

HEALTH SERVICES

&

POLICY RESEARCH

**CONFERENCE
2005**

HEALTH SYSTEMS, SERVICES AND STRIFE

Conference Handbook Sponsors

NSW HEALTH



Australian Government

National Health and Medical Research Council

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WELCOME FROM THE CONFERENCE CONVENOR

On behalf of the Conference Committee you are invited to the 4th Bi-annual Health Services & Policy Research Conference, convened by the Health Services Research Association of Australia and New Zealand.

Health services and health policies are constantly changing. This Conference is your opportunity to hear the latest research from Australia, New Zealand and around the world, in this fast growing research field.

The Conference is bringing together health researchers, policy-makers, clinicians and professionals to share their knowledge and experiences and collaborate on future directions for health services research and policy in Australia, New Zealand and internationally.

Welcome to Canberra and please enjoy the Conference.

Dr Paul Dugdale

Chair, Conference Organising Committee

CONFERENCE ORGANISING COMMITTEE

Paul Dugdale (Chair)

Centre for Health Stewardship
Australian National University

Jim Butler

National Centre for Epidemiology and Population Health, Australian National University

Jackie Cumming

Health Services Research Centre
Victoria University, Wellington, New Zealand

Philip Davies

Australian Department of Health and Ageing

Brendan Gibson

Australian Department of Health and Ageing

Nicholas Glasgow

Australian Primary Health Care Research Institute
Australian National University

Jane Hall

President, HSRAANZ
Director, Centre for Health Economics Research and Evaluation, University of Technology Sydney

Judith Healy

Research School of Social Sciences
Australian National University

Karen Luxford

National Breast Cancer Centre

Suzanne Northcott

National Health and Medical Research Council

Colin Sindall

Australian Department of Health and Ageing

Theo Vos

School of Population Health
University of Queensland

Conference Secretariat

Consec – Conference Management

consec 

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Conference Manager

Pamela Neame, AMM

Conference Coordinator

Melita Agius

INTERNATIONAL KEYNOTE SPEAKERS



Huw Davies



Huw Davies, MA (Cantab), MSc, PhD, Hon MFPHM is Professor Health

Care Policy and Management at the University of St Andrews, UK and a former Harkness Fellow in Health Care Policy when he was based at the Institute for Health Policy Studies at the University of California, San Francisco.



Karen Davis

Karen Davis PhD, is President of The Commonwealth Fund, a national philanthropy engaged in independent research on health and social issues.

Dr Davis, a nationally recognized economist, has had a distinguished career in public policy and research. She holds the distinction of being the first woman to head a US Public Health Service Agency.



Kassem M Kassak



Kassem Kassak, MPH, PhD is the Associate

Professor of the Department of Health Administration, Faculty of Health Sciences, American University of Beirut. This Department is considered the premier training provider for health planning, management and analysis in the Middle East.



Jeanne Lambrew

Dr Jeanne Lambrew, PhD, is an Associate Professor at George Washington University, where she teaches health policy analysis and

conducts policy-relevant research. She has assisted with Medicare prescription drug legislation, various proposals to build on Medicaid and the State Children's Health Insurance Program, and a health reform plan recently announced by the Governor of Maine.

Dr Lambrew worked on health policy at the White House from 1997 through 2000 as the program associate director for health at the Office of Management and Budget and as the senior health analyst at the National Economic Council.



Charles Normand

Charles Normand took up the post of Edward Kennedy Professor of Health Policy and Management in Trinity College, Dublin in January 2004.

Professor Normand was previously Professor of Health Economics at the London School of Hygiene and Tropical Medicine.



Alan Maynard

Alan Maynard is a Professor of Health Economics and Director of the York Health Policy Group at the University of York. He was founding Director of

the Centre of Health Economics at the University of York (1983–95), and founding editor of the specialist journal, Health Economics. He worked as a consultant for WHO, the World Bank, the European Union and UK Government's Department for International Development in countries such as China, Cyprus, Chile, Mexico, Latvia, Brazil, Bolivia and South Africa.



Robin Osborn

Robin Osborn is Vice President and Director of The Commonwealth Fund's International Program in Health Policy and Practice. Prior to joining

the Fund in 1997, she was director of fellowship programs and memberships at the Association for Health Services Research, where she directed the Picker/Commonwealth Scholars Program and served as Deputy Director of the Robert Wood Johnson Foundation Investigator Awards in Health Policy Research Program.



Anna Walker



Anna Walker is Chief Executive of the UK Healthcare Commission, which was created in April 2004.

She has wide ranging experience in regulation and performance improvement in the UK. Anna was Director General, Land Use and Rural Affairs from 2001–2004 and prior to that was Director General,

AUSTRALIAN AND NEW ZEALAND KEYNOTE SPEAKERS



Energy at the Department of Trade and Industry (1998–2001).

John Braithwaite

Professor John Braithwaite is an Australian Research Council Federation Fellow and Founder of the Regulatory Institutions Network (RegNet) at the Australian National University. He has undertaken empirical work on a wide variety of substantive domains of business regulation and is also interested in applying regulatory theory to



crime prevention and peacemaking in international relations.

Jackie Cumming

Dr Jackie Cumming has academic backgrounds in economics and public policy, and 12 years experience in health policy and health services research. She has worked as a policy analyst/ economist in the Treasury, Department of Labour, Department/Ministry of Health and the Public Health Commission.. She is Director of the Health Services Research Centre/Te Hikuwai Rangahau Hauora, a thriving health policy and health services research centre based in the School of Government at Victoria University of Wellington, New Zealand.



Philip Davies

Dr Philip Davies joined the Department of Health & Ageing as Deputy Secretary in 2002. He is responsible for acute care, primary care, health services improvement, medical & pharmaceutical services and e-health.

Prior to joining the Department Mr Davies worked as a Senior Health Economist with WHO in Geneva, Deputy Director-General in the New Zealand Ministry of Health and a Partner in an international management consultancy firm.



Paul Dugdale

Dr Paul Dugdale has been the ACT Chief Health Officer since February 2002. Dr Dugdale is an Adjunct Associate Professor in Public Health, and director of the Centre for Health Stewardship in the ANU Medical School. He is a member of the National Health & Medical Research Council.. He is a principle investigator in the ANU Regulation in Health project (with John Braithwaite and Judith Healy) and associate investigator in the newly formed Centre for Research Excellence in Patient Safety Research (with Monash University).



Nicholas Glasgow

Professor Nicholas Glasgow (MBChB, MD, FRNZGP, FRACGP, FACHPM) is Professor and Director of the Australian Primary Health Care Research Institute at The Australian National University. A general practitioner by clinical discipline, he has held appointments within the University of Auckland, the University of the United Arab Emirates, the University of Sydney and The Australian National University. His interests in this regard include the use of systematic reviews to inform policy and developing the relationships between policy makers, researchers and providers of health services as a platform for shaping policy.



Jane Hall

Professor Jane Hall is the founding Director of the Centre for Health Economics Research and Evaluation and Professor of Health Economics in the Faculty of Business, University of Technology, Sydney. Among her current research are studies of unpaid health care, and developments in the Australian health care system. Professor Hall is involved in health policy and planning issues both in Australia and internationally and has served on numerous advisory committees and working parties.

She is currently President of the Health Services Research Association of Australia and New Zealand, and is the Harkness Fellowship Program Representative in Australia.

AUSTRALIAN AND NEW ZEALAND KEYNOTE SPEAKERS



Shane Houston

Dr Shane Houston is a Gangulu man from central Queensland and is the inaugural Assistant Secretary for the Office of Aboriginal Health, Family and

Social Policy in the Northern Territory Department of Health and Community Services. Shane has over 30 years involvement in Aboriginal affairs particularly in the health and employment fields. He has held numerous positions in both the community and public sectors at local, state and national levels. He has represented Aboriginal health interests in United Nations processes, worked with the World Council of Indigenous Peoples and with development projects in South Africa.



Elizabeth Savage

Associate Professor Elizabeth Savage is an Associate Professor in the Centre for Health Economics Research and Evaluation in the Faculty of Business at

UTS. Her research focuses on modelling individual behaviour, welfare measurement and policy evaluation. She is a Principal Investigator on the NHMRC Program Grant on Individual Decision-Making, Welfare Measurement and Policy Evaluation in the Health Sector. She is a member of the Scientific Committee of the International Health Economics Society and is President of the Economic Society of Australia, NSW Branch.



Jill Sewell

Dr Jill Sewell is President of the Royal Australasian College of Physicians, with responsibilities for training, continuing education, workforce and health policy

areas at state, national and international settings. Dr Jill is a member of the National Health and Medical Research Council (NHMRC) and the Victorian Quality Council (VQC), and immediate past chair of the Board of the National Institute of Clinical Studies (NICS).

A consultant paediatrician, Jill Sewell is Deputy Director and Director of Clinical Services at the Centre for Community Child Health at the Royal Children's Hospital. She runs the Victorian Training Program in Community Child Health for advanced paediatric trainees.

Other Invited Speakers Include:

Dr Malcolm Battersby

Flinders University, SA

Dr John Boffa

Central Australia Aboriginal Congress, NT

Dr Judith Healy

Research School of Social Sciences
Australian National University, ACT

Ms Libby Roughead

School of Pharmacy and Medical Sciences
University of South Australia, SA

Dr Peter Sprivulis

University of Western Australia, WA

Associate Professor Theo Vos

School of Population Health
University of Queensland, QLD

WORKSHOPS

Monday 14 November

Time: 11.00am–12.30pm
 Venue: Sutherland Theatre
 Topic: Indigenous Researchers Forum
 The Nature and Purpose of
 Indigenous Participation in the
 Improvement of Indigenous Health
 Facilitators: **Dr Gordon Briscoe**
 Research School of Social Sciences
 Australian National University
Ms Kerry Arabena
 ACT Health Promotion Board

The Australian and New Zealand Journal of Public Health has cited that Indigenous participation is increasingly recognised as an important element of any research project that aims to improve Indigenous Health.

This session is specifically designed for Indigenous researchers to give some clarity to the meanings we might give Indigenous participation in research, and discuss the implications for how Indigenous participation should be implemented and evaluated. The article 'Moving beyond good intentions: Indigenous participation in Aboriginal and Torres Strait Islander health research' calls for further debate on the meanings and purposes of Indigenous participation in health research.

The outcomes from the discussions in this session will add to our collective refinement and understanding of the nature and purpose of our participation and the relationships of our contributions to improved health outcomes.

Tuesday 15 November

Time: 9.00am–10.30am
 Venue: Sutherland Theatre
 Topic: Rural Obstetrics
 Chair: Dr Sue Page-Mitchell
 Overview by Chair: Dr Sue Page-Mitchell

Current situation in Australia; why we need a national framework; parallel developments: core clinical indicators, QLD review, controversy re midwifery led models; specific rural issues

- International Experiences from Canada and New Zealand
- Work in Progress...
- Are small rural units safe?
- Specialist obstetric locum service
- A National Framework for Maternity Services:
- Essential attributes of a national consensus framework
- Delivering a framework in the rural & remote context
- Developing a National Framework for Rural Maternity Services with input from the floor
- Conclusions & Next Steps

Wednesday 16 November

Time: 11.00am–12.30pm
 Venue: Sutherland Theatre
 Topic: State and Commonwealth
 Research Issues Forum (SCRIF)
 Chair: Dr Paul Dugdale, ACT Health

Please refer to abstract section for papers.

Wednesday 16 November

Time: 10.30am–12.30pm
 Venue: Menzies Theatre
 Topic: Capacity-building in Indigenous
 Policy – Relevant Health Research
 (CIPHER)

Please refer to abstract section for papers

Fledgling Researchers Lunch

Date: Monday 14 November 2005
 Time: 12.30pm–1.30pm
 Location: Derwent Room, 1st Floor,
 National Convention Centre
 Max Nos: 50

Meet the Experts Breakfast

Date: Tuesday 15 November 2005
 Time: 7.00am–8.30am
 Location: Derwent Room, 1st floor
 National Convention Centre
 Max Nos: 50

NHMRC Research Funding Workshop Breakfast

Date: Wednesday 16 November 2005
 Time: 7.00am–8.30am
 Location: Derwent Room, 1st floor
 National Convention Centre
 Max Nos: 50 – tickets can be purchased up until
 10.00am Tuesday 15 November

Harkness Fellowship Lunch

Date: Tuesday 15 November 2005
 Time: 12.30pm–1.30pm
 Presentations
 Time: 12.45pm–1.15pm
 Speakers: Welcome and introductory
 comments from **Robin Osborn**,
 Vice President and Director,
 Commonwealth Fund International
 Program in Health Policy, USA

Harkness Panelists

Marie Bismark, Harkness Fellow, Legal Advisor and
 Researcher, Health and Disability Commissioner, NZ

Libby Roughead, Harkness Fellow, Associate
 Professor, Quality Use of Medicines and Pharmacy
 Research Centre, University of SA, Australia

Peter Sprivulis, Clinical Associate Professor, Director,
 Acute Demand Management, WA Department of
 Health, WA

Location: Bradman Theatre
 National Convention Centre

Lunch

Arrangements: Boxed lunches will be provided
 so you can sit, eat and listen
 at the same time.



ACT Health provides a comprehensive range of health services to the people of the Australian Capital Territory

We aim to deliver the best possible healthcare and health-related services through:

- Calvary Public Hospital
- Community Health
- Health First
- Health Protection Service
- Mental Health ACT
- The Canberra Hospital

health.act.gov.au

Poster and Presentation Competition for Emerging and New Researchers

The HSRAANZ is conducting a competition for the best poster/presentation at the Conference.

The purpose of the competition is to support and recognise emerging and new researchers in the area of health services research.

All current students and researchers who have received their degree within the past 5 years are eligible.

Prizes will be awarded for 1st, 2nd and 3rd place with the overall winner being awarded a prize of \$250 (donated by the University of Auckland).

Judging will be conducted by representatives of the HSRAANZ and winners will be announced at the end of the Conference.

CONFERENCE SPONSORS



Government of South Australia
Department of Health



The Department of Health and Ageing works to ensure better health and healthier ageing for all Australians by supporting a world-class, responsive, affordable and sustainable health system that meets people's needs throughout their life.

As a national leader in health and ageing the department develops policy, manages programs, conducts research, undertakes regulatory activities and provides other services on behalf of the Australian Government. In doing so, it consults and collaborates with consumers, communities, service providers, peak bodies, industry groups, professional organisations, state and territory governments and portfolio agencies.

Through its various activities the department aims to:

- improve the delivery of high quality health services for all Australians where and when they need them;
- encourage healthier living through measures to prevent and reduce the severity of disease and injury and known health risks;

- integrate care for consumers by improving linkages between primary, acute and community care;
- ensure choice and access to appropriate community based and residential aged care services for older Australians, provide support for carers and the aged care industry, and coordinate a whole-of-government approach to the challenges of an ageing Australian population;
- improve choice through promoting strong and viable public and private health sectors in which people have access to affordable private health care; and
- respond to emerging pressures, including from new technology and pharmaceuticals, in ways which improve care but contain costs.

The Australian Government currently spends over \$44 billion dollars annually on health and ageing services, which is about one-fifth of all Australian Government expenditure.

Australian Primary Health Care Research Institute

The Australian Primary Health Care Research Institute (APHCRI) has a unique role to play in promoting primary health care research with a key focus on identifying, generating and synthesising evidence to inform policy and practice.

Established at The Australian National University in 2003 as part of the PHC RED strategy and funded through a grant from the Australian Government Department of Health and Ageing, APHCRI represents a new approach to 'linkage and exchange' activities aimed at bringing the research and health policy communities in Australia closer together thereby broadening the research base for policy. APHCRI operates a 'hub and spoke' model for its research commissioning activities. It has commissioned four streams of research thus far, with research groups (spokes) across Australia.

Streams One and Two have now finished, with Stream One work the subject of a special supplement in the *Medical Journal of Australia* to be published this month.

Stream Three, which was launched in April 2005, will be APHCRI's longest running program of work. These three-year projects cover areas as diverse as the role and use of practice nurses in general practices, the effect of GP interventions on adolescent health outcomes, and how general practice deals with patients who present with depression.

Stream Four focuses on systematically reviewing and synthesising evidence to inform policy regarding chronic disease management, integration, co-ordination and multidisciplinary care, innovative models for comprehensive primary health care delivery, innovative models for the management of mental health in primary health care settings, children and young Australians, health promotion and prevention, and workforce. There are regular meetings bringing researchers and policy makers together to develop, refine and progress the research questions.

In addition to the research activities, APHCRI runs a visiting fellows program. To date, seven international visitors have come to Australia under this program, sharing their expertise on a range of topics relevant to the organisation, financing, delivery and performance of primary health care.

APHCRI also hosts summits and other meetings aimed at stimulating informed national debate on difficult issues confronting primary health care policy and practice.

APHCRI also offers masters and doctoral level research training.

Mission statement:

"Provide national leadership in improving the quality and effectiveness of primary health care through the conduct of high quality priority-driven research and the support and promotion of best practice. It focuses on important sectoral questions relating to the organisation, financing, delivery and performance of primary health care, including its interaction with public health and the secondary and tertiary health care sectors."

Specified aims are to:

1. Strengthen the knowledge base of primary health care to inform policy and practice through the conduct and support of research
2. Facilitate the uptake of evidence in primary health care policy and practice
3. Enhance research capacity in primary health care through strategic partnerships and collaborations with other relevant national and international groups

For more information please see our website at: www.anu.edu.au/aphcri

CONFERENCE SPONSORS




Australian Government
National Health and Medical Research Council

THE NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL

Accelerating the pace of health and medical research

RESEARCH • ETHICS • ADVICE • COMPLIANCE & EVALUATION

INVESTING IN AUSTRALIA'S HEALTH

THE NHMRC IS MAKING SOME SIGNIFICANT AND EXCITING CHANGES WHICH WILL MEAN A BETTER FIT WITH COMMUNITY NEEDS AND NATIONAL HEALTH PRIORITIES.

Processes for allocating research funds will be simpler and more responsive with four main grant types instead of 20, faster funding approvals, improved feedback and less red tape.

Next year is a transition year for the NHMRC which will mean significant changes of particular interest to researchers. For more information on what the changes mean to you and details of the new governance arrangements, visit www.nhmrc.gov.au.

The NHMRC is pleased to support the 2005 Health Services & Policy Research Conference.

SOCIAL PROGRAM

Welcome Reception

Date: Sunday 13 November 2005
 Time: 6.00pm–7.00pm
 Location: Foyer Area of the National Convention Centre
 Dress: Smart casual
 Cost: Included in Full Registration Fee
 Additional tickets can be purchased for \$45.00 per ticket.

An opportunity to catch up with old friends and make new ones, while enjoying a few drinks and wandering through the exhibition and poster display.

All prices include GST

Conference Dinner

Date: Monday 14 November 2005
 Time: 7.00pm–10.30pm
 Location: Members Dining Room 2
 Old Parliament House
 Dress: Smart casual
 Cost: NOT Included in Registration Fee
 Transport: No transport has been organised.
 Please arrange your own way to and from Old Parliament House.

Old Parliament House made headlines for more than sixty years as home to Australia's Federal Parliament from 1927 to 1988. Today, this much-loved heritage building offers the visitor a unique glimpse into Australia's fascinating past.

TRADE EXHIBITION

The trade exhibition will be located in the Foyer Area of the National Convention Centre.

Exhibition Hours

Sunday 13 November from 6.00pm–7.00pm
Monday 14 November from 8.30am–5.00pm
Tuesday 15 November from 8.30am–5.00pm
Wednesday 16 November from 8.30am–11.30am

List of Exhibitors

Booth 1

Commonwealth Department of Health and Ageing
Mr Peter Brooks

Booth 2

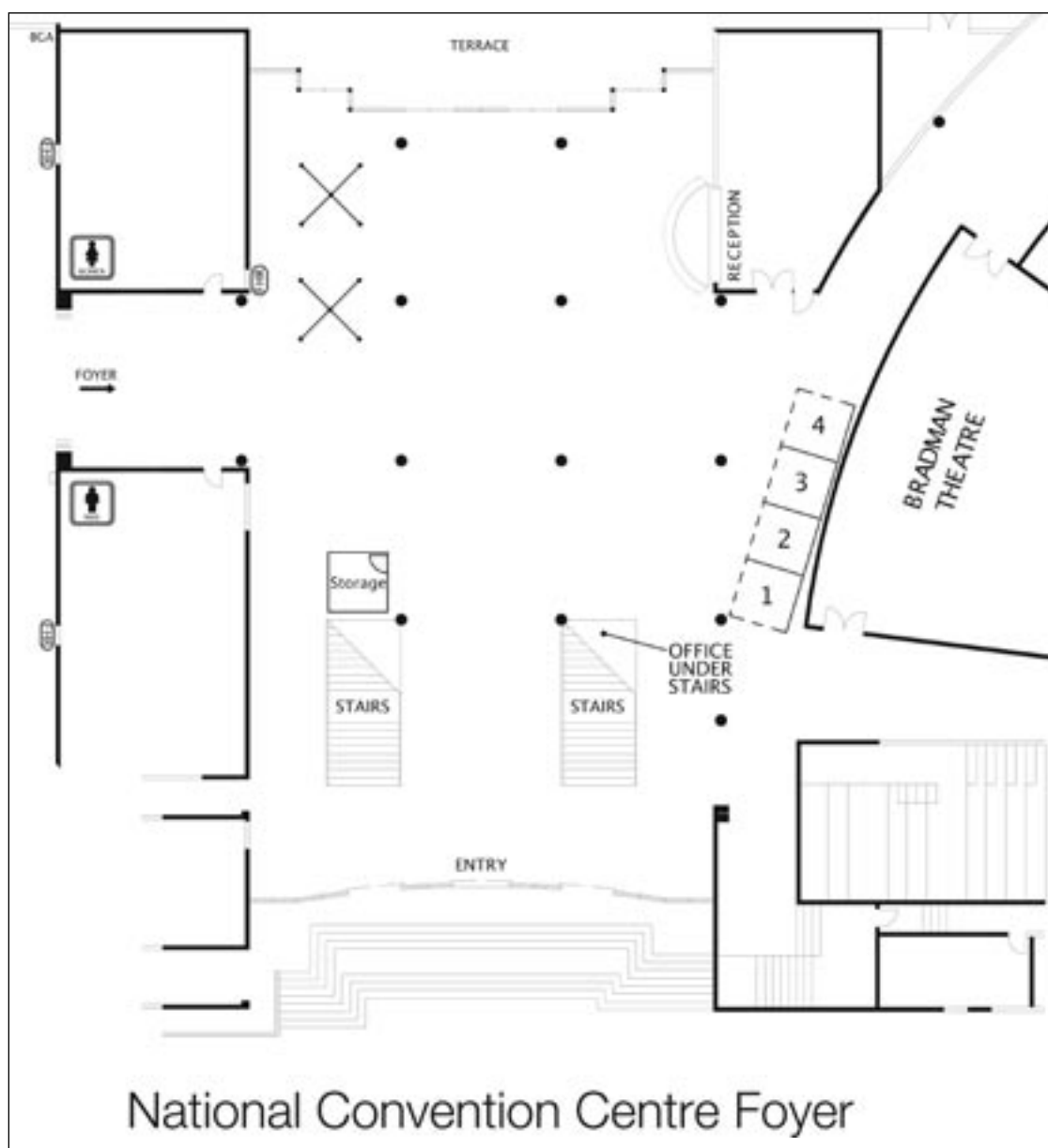
ACT Health
Ms Vicki Crispe

Booth 3

Australian Primary Health Care Research Institute
Australian National University
Professor Nicholas Glasgow

Booth 4

Australian Institute of Health and Welfare
Ms Natalie Sawczak



GENERAL INFORMATION

Welcome to Canberra

Canberra in November is a stunning picture of spring – and there is a decidedly festive feeling in the air. The days are typically clear and sunny with average temperatures in their early twenties.

The venue is only a few minutes walk from the city centre and major attractions, including Parliament House, the National Gallery of Australia and the National Museum of Australia.

Canberra has all the history, political intrigue, sport and culture that you would expect from Australia's capital. It boasts over 350 restaurants and sightseeing to satisfy the most diverse tastes.

Banks

Banking hours may vary but most suburban and city banks are open from 9.30am–4.00pm Monday to Thursday, 9.30am–5.00pm Friday. Most suburban and city banks have after hours autoteller facilities.

Car Parking

Car parking is available at the National Convention Centre, for a flat rate of \$7.70 per day. Additional pay parking is available opposite the National Convention Centre.

Conference Program/Changes

Please check the message board in the registration area each morning for notification of any change to the program. The Chair of each session will also notify delegates of changes to the program.

Conference Secretariat

consec ☆ Consec – Conference Management
 PO Box 3127
 BMDC ACT Australia
 Telephone: +61 2 6251 0675
 Facsimile: +61 2 6251 0672
 Email: hsr05@consec.com.au

Conference Venue

The National Convention Centre, Constitution Avenue, Canberra is conveniently located just 100 metres from the centre of Canberra's business and shopping district and adjacent to the Crowne Plaza

Canberra Hotel. Located nearby are all the major landmarks including New and Old Parliament House, Questacon, the War Memorial and the National Gallery of Australia. The National Convention Centre is located approximately 7km from the Canberra Airport.

Dress

The dress standard for all Conference sessions and social events is smart casual.

Disclaimer

The Conference program and handbook information is correct at the time of printing. However, the organisers reserve the right to change the information where necessary without notice.

Liability Waiver

In the event of industrial disruptions, the Conference and the organisers accept no responsibility.

Messages

Messages can be collected and left at the Registration Desk. All messages will be posted on the message board adjacent to the desk. Please check the board.

Mobile Telephone Policy

Mobile phones are not to be used while sessions are in progress. Please ensure they are turned off during these times.

Name Badges

Your name badge is your entry to the Conference sessions (excluding exhibitors who are not fully registered), morning/afternoon teas and lunches. Please ensure that you wear your name badge at all times and if misplaced, please see the staff at the registration desk as soon as possible for a replacement.

No Smoking Policy

All internal areas of the National Convention Centre are non-smoking.

Personal Insurance

Delegates shall be regarded in every aspect as carrying their own risk for loss or injury to person or property, including baggage during the Conference. We strongly recommend that at the time of booking your travel and tours you take out a travel insurance policy of your choice. The policy taken should include the loss of deposit through cancellation, medical insurance, loss or damage to personal property, financial loss incurred through disruptions to accommodation or travel arrangements due to strikes or other industrial action. The organisers are in no way responsible for any claims concerning insurance.

Personal Mail

All personal mail should be sent to your accommodation address.

Privacy Clause

In registering for this Conference, relevant details will be incorporated into a delegate list for the benefit of all delegates (name and organisation only), and may be made available to parties directly related to the Conference including Consec – Conference Management, the Health Services Research Association of Australia and New Zealand, the Conference Organising Committee, venues and accommodation providers (for the purposes of room bookings and Conference options), key sponsors (subject to strict conditions) and parties associated with related Conferences.

By completing the registration form, you acknowledged that the details supplied by you may be used for the purposes previously described.

Public Telephones/ Rest Rooms

Public telephones are located on the ground floor of the National Convention Centre. Rest rooms are located on the ground and first floor of the National Convention Centre.

Registration Desk

The Conference Registration Desk will be situated on the ground level of the National Convention Centre and will be staffed as follows:

Sunday 13 November	5.00pm–7.00pm
Monday 14 November	7.30am–5.00pm
Tuesday 15 November	7.00am–5.00pm
Wednesday 16 November	7.00am–12 noon

Shopping

Trading hours in the central city are as follows:

Monday–Thursday	9.00am–5.30pm
Friday	9.00am–9.00pm
Saturday	9.00am–4.00pm
Sunday	10.00am–4.00pm

Social Function Tickets

Entry to all social and other events will be by ticket only. Delegates who have not registered for these functions will not be issued with tickets.

If you have nominated to attend a social function and you now won't be attending, please advise the Registration Desk as soon as possible.

Special Needs

We endeavour to ensure delegates with special needs are catered for. Should you require particular assistance, please see the staff at the Registration Desk.

Transport to/from the Airport

The Conference venue is approximately 20 minutes by taxi from the Canberra Airport and the cost will be approximately \$18.00. Telephone Canberra Cabs on 13 2227. Dean's Buslines provide airport transfers from the airport at a cost of \$5 one way.

For timetable information call +61 2 6299 3722.

Useful Telephone Numbers

Crowne Plaza Canberra	02 6247 8999
Rydges Lakeside Canberra	02 6247 6244
Waldorf Apartment Hotel	02 6229 1234
Novotel Canberra	02 6245 5000
Olins Canberra	02 6248 5511
Qantas	13 13 13
Virgin Blue	13 67 89
Canberra Cabs	13 22 27 or 02 6251 8500
ACTION Buses	13 17 10
Registration Desk	6276 5255

Website

The HSR website address is
www.healthservicesconference.com.au



NATIONAL INSTITUTE OF CLINICAL STUDIES

Australian EPOC Satellite Coordinator

The National Institute of Clinical Studies (NICS) is Australia's national agency for improving health care by helping close important gaps between best available evidence and current clinical practice. NICS is funded by the Australian Government.

NICS invites applications for the **Coordinator of the Australian Effective Practice and Organisation of Care Cochrane Review Group (EPOC) Satellite**, which will be established at NICS in early 2006. The Coordinator will work closely with the Australian EPOC editor to help produce and update systematic reviews in Australia.

The successful applicant will ideally have:

- A Masters degree in clinical epidemiology, or other relevant discipline, or Bachelor degree in a relevant discipline and significant critical appraisal or research experience
- Research experience
- Systematic review experience
- Scientific writing experience
- Policy, health or informatics background
- Effective high level communication skills and drive.

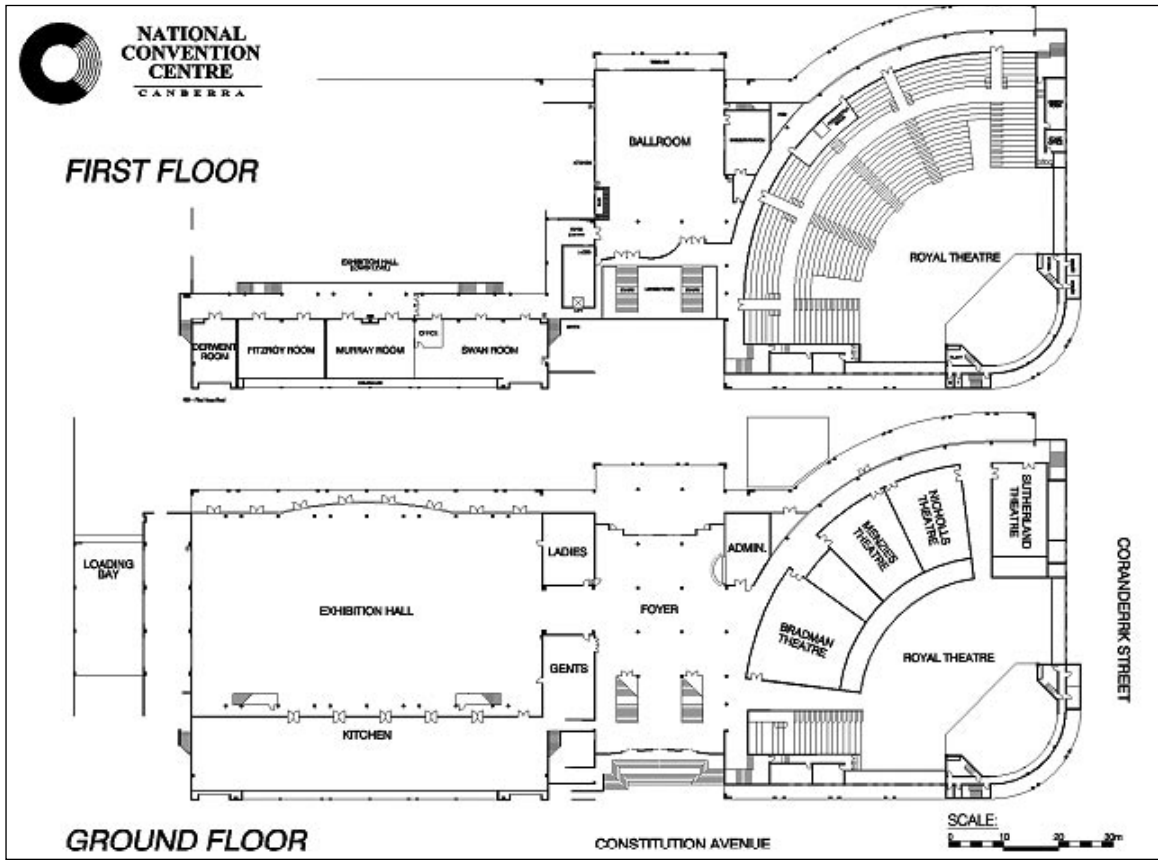
An attractive salary will be offered for this Melbourne based position, which is available for 3 years.

Visit the NICS website at www.nicsl.com.au for a position description.

Applications addressing the selection criteria and including contact details of three referees should be emailed to rbaror@nicsl.com.au by 5pm, Monday, November 21, 2005.

For further information contact Dr Jan Davies on 03 8866 0400

VENUE FLOORPLAN



CONFERENCE PROGRAM

Sunday 13 November

5.00pm–7.00pm **REGISTRATION** *Foyer Area, National Convention Centre*

6.00pm–7.00pm **WELCOME RECEPTION** *Foyer Area, National Convention Centre*

MC: **Dr Paul Dugdale**, Chair, Conference Organising Committee

Mr Phillip Davies, Vice President, HSRANZ, Deputy Secretary, Australian Department of Health and Ageing

Dr Tony Sherbon, Chief Executive, ACT Health

Monday 14 November

7.30pm–5.00pm **REGISTRATION** *Foyer Area, National Convention Centre*

Time **Session** **Bradman Theatre**

9.00am–10.30am **PLENARY I** **HEALTH SYSTEMS, SERVICES & STRIFE**

Chair: **Professor Jane Hall**, Centre for Health Economics Research and Evaluation, University of Technology, NSW

The Hon Christopher Pyne MP, Parliamentary Secretary to the Minister for Health and Ageing

Professor Alan Maynard, Professor of Health Economics/Director of York Health Policy Group, University of York, UK

How Not to Formulate Health Care Policy: A Case Study of the Blair NHS Reforms

Associate Professor Jeanne Lambrew, George Washington University, USA

Health Reform in the US: Its Failure and Its Future

10.30am – 11.00am **MORNING TEA, EXHIBITION & POSTER DISPLAY** *Foyer Area, National Convention Centre*

Time	Session	Bradman Theatre	Menzies Theatre	Nicholls Theatre	Sutherland Theatre
11.00am–12:30pm	CONCURRENT 1	HEALTH SYSTEM COMPARISON 1 Chair: Mr Bob Wells , Australian Primary Health Care Research Institute, Australian National University, ACT Dr Rosalie Boyce <i>A Comparative Study of Allied Health Workforce Issues in Australia and the UK</i> Mr Craig Johnston <i>Lead Them with Love or Drive Them to Market: Reflections on English and NZ Approaches to Influencing General Practice</i> A/Professor Kassem Kassak American University of Beirut, Lebanon <i>Do Payment Mechanisms Affect Primary Care Services?</i>	REGULATION AND RISK 1 Chair: Dr Bev Sibthorpe , Australian Primary Health Care Institute, Australian National University, ACT Dr Rosalie Viney <i>Does the Reason for Buying Health Insurance Influence Behaviour?</i> <i>Analysis of the 2001 National Health Survey</i> Ms Jenny Hawes <i>The New Zealand Human Tissue Review</i> Ms Saskia Patton <i>The Management of Risks to the New Zealand Health Sector Created by Genetic Material Patents: The Genetic Technologies Limited Patents Case Study</i> Mr John Hobbs <i>The Identification and Management of the Health Risks Associated with Assisted Reproductive Technologies</i>	ASSESSING AND IMPROVING VALUE FROM HEALTH SERVICES 1 Chair: Ms Susanne Northcott , National Health and Medical Research Council, ACT Ms Penny Mitchell <i>The Contribution of Intra-organisational and Inter-organisational Capacities to Community-based Primary Care and Services' Involvement in Mental Health Care</i> Mr Ali Mohammad Mosadeqh <i>Evaluation and Accreditation of Healthcare Organisations in Iran</i> A/Professor Jane Pirakis <i>Remunerating Private Psychiatrists for Participating in Case Conferences</i> Dr Glen Randall <i>By Design or Default: The Impact of Health Care Reform on Professional Autonomy</i>	INDIGENOUS RESEARCHERS FORUM <i>The Nature and Purpose of Indigenous Participation in the Improvement of Indigenous Health</i> Co-Facilitators: Dr Gordon Brisbane , Research School of Social Sciences, Australian National University, ACT & Ms Kerry Arabena , ACT Health Promotion Board
12.30pm–1.30pm	FLEDGLING RESEARCHERS LUNCH Conveners: Paul Brown and Rob McNeill	Denwent Room, National Convention Centre			
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Time	Manzies Theatre Nicholls Theatre Sutherland Theatre
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		Chair: Dr Judith Healy , Research School of Social Services, Australian National University, ACT Dr Karen Davis , President of the Commonwealth Fund, USA <i>What Makes a High Performance Health Care System?</i> Professor John Braithwaite , Research School of Social Sciences, Australian National University, ACT <i>Ritualism as a Topic in Health Services Research</i> Professor Charles Normand , Edward Kennedy Professor Health Policy and Management, Trinity College, Ireland TBA		
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		Chair: A/Professor Theo Vos , School of Population Health, University of Queensland Dr Jackie Cumming , Health Services Research Centre, NZ <i>Investing in Primary Health Care: Will New Zealand's Primary Health Care Strategy Provide Value for Money?</i> A/Professor Elizabeth Savage , Centre for Health Economics Research and Evaluation, University of Technology, Sydney <i>Incentives and Health Care Financing</i> Professor Jane Hall , Centre for Health Economics Research and Evaluation, University of Technology, Sydney <i>What is Evidence Based Policy?</i>		
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Time	Session Type	Bradman Theatre	Menzies Theatre	Nicholls Theatre	Sutherland Theatre
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Disclaimer: The Conference Program is correct at the time of printing. However, the organisers reserve the right to change the program where necessary.

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HOW NOT TO FORMULATE HEALTH CARE POLICY: A CASE STUDY OF THE BLAIR NHS REFORMS.

**Alan MAYNARD, University of York
United Kingdom**

The Blair Government has increased investment annually in the UK NHS by about seven per cent in real terms since 2000 and intends to continue this policy until 2008. This policy was articulated as a means of driving NHS spending to the average in the European Union and will double health care expenditure over the eight year period. What can be learnt from this novel social experiment?

The principle driver of the reform process was the reduction in waiting times and the improvement in the quality of care delivered to patients. To achieve these targets, performance management focused on the radical reduction of waiting times and a range of process targets, all of which were actively policed. The Government in exchange for increased funding demanded that providers "act smarter" by becoming more flexible and abandoning restrictive practices.

Is this an efficient way to improve the population health? The risk from the outset was that some inelasticity in the supply of health care, expenditure would be diverted in rents for providers. This is epitomised by poor reforms of labour contracts. Whilst new technologies were to be appraised by the National Institute for Clinical Excellence, a low 4th hurdle has created inflation. Policies to create a national hospital tariff (called Payment by Results) and to reintroduce the "failed" Thatcher policy of GP fund holding (now rebranded as Practice Based Commissioning) have been poorly conceived in a fragmented manner. More recently in effort to get the NHS to act smarter the Government has invested in private sector elective hospitals to create excess capacity, choice and contestability in the NHS, but without as yet articulating a regulatory framework.

These policies of "continuous reorganisation" of structures and policies without clear articulation of policy goals and the alignment of incentives to deliver those goals have wasted considerable resource. Now the unsurprising effect is that deficits are emerging in the system and without further reform inflation may undermine the NHS when funding growth moderates in 2008. What lessons can be learnt from this unique social experiment?

HEALTH REFORM IN THE US: ITS FAILURE AND ITS FUTURE

**Jeanne LAMBREW, George Washington
University, United States of America**

In 1992, Bill Clinton won the Presidency of the United States, in part, due to his promise to reform the American health system. Two years later, he was blamed for losing Democratic control of Congress after a failed attempt to make good on this promise. Numerous historical and political examinations have been published on this dramatic defeat. Less attention has been paid to the role of health policy, analysis, and research in this effort, and subsequent attempts to fix the highly-flawed American system. Dr. Lambrew, who worked on the reform effort and in the Clinton White House, will discuss the impact – positive and negative – of health services research on health reform in the U.S. She will also examine prospects for change in the most expensive health system in the world.

A COMPARATIVE STUDY OF ALLIED HEALTH WORKFORCE ISSUES IN AUSTRALIA AND THE UK

**Rosalie A. BOYCE*, University of Queensland,
Dr Susan NANCARROW, University of Sheffield,
Queensland, Australia**

BACKGROUND

Workforce planning and development typically proceeds at the level of government or its agencies. Recent shifts in workforce planning techniques are stressing a greater focus on integrated inter-professional or service-focused approaches together with attempts to critically appraise the types of roles and expertise needed for the workforce of the future (Davies 2003). Lack of knowledge about the allied health professions has been consistently identified as an impediment to progressing workforce reform in these professions (Boyce 2004). In this paper we outline the main issues identified by senior profession managers and clinicians. By comparing issues identified by professionals in both countries, we are able to evaluate the impacts of allied health policies on the allied health workforce in two different policy contexts.

METHODS

This study involves a survey administered at a multi-disciplinary allied health conference setting in the UK (n=38) and Australia (n=123) in which participants were asked to respond to a series of open questions about key issues and barriers to workforce change.

RESULTS

Data is analysed independently for each country using thematic analysis on NVIVO software before being compared to assess the extent to which identified issues and barriers were rated of similar importance. Australian's rated 'professional tribes' and status and hierarchy highly as key issues. UK respondents rated explicit Department of Health policy initiatives and funding issues highly. Respondents from both countries highlighted several issues as shared concerns in allied health: recruitment and retention issues, changing roles, lack of involvement in policy development and a lack of research capacity.

CONCLUSIONS

Despite differences in organisational, political and policy contexts a significant number of key issues and barriers to workforce management and change were identified as shared concerns.

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LEAD THEM WITH LOVE OR DRIVE THEM TO MARKET: REFLECTIONS ON ENGLISH AND NZ APPROACHES TO INFLUENCING GENERAL PRACTICE

Mr Craig JOHNSTON, HSRC, Victorian University, Wellington, New Zealand

New Zealand began a programme of reform of primary health care in 2001. Key features have included changes to general practice funding streams and the establishment of independent, Primary Health Organisations with responsibility for governing, managing and changing general practice services at the local level. A study trip to England provided an opportunity to learn from more than 15 years of active reform of primary health care in that country. Of particular interest are the new general practice contract and the experience of Primary Care Trusts. The change within general practice is significant but appears to consistently fall short of policy-makers expectations. Now the government is driving PCTs to use markets to achieve change. Based on UK experience, what can we expect in NZ?

DO PAYMENT MECHANISMS AFFECT PRIMARY CARE SERVICES?

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Providing health services at affordable prices while balancing quality with cost has been a major challenge for health managers as well as policy makers in the developing world in an era of major constraints on financial and human resources. This balance has been difficult to sustain especially in the public sector where it is believed to have low levels of efficiency. On the other hand, the private sector has shown strides in their efficient management and cost control. On a different level, health economists often noted that the delivery and consumption of health care is a market in which profit is the powerful motivator of physicians' practices. Recent research has been focusing on financial incentives and its impact on the decision making process of the provider in terms of quantity and quality of services. This study assessed the impact of governance, as measured by ownership, on the practice patterns of providers under different payment modalities. The results support the notion that payment mechanisms and type of ownership affect physicians' behavior. Government health centers had lower mean in duration of visit and less referral patterns. In governmental centers, fee-for-service physicians reported the highest referral rate compared with salaried physicians. A mixed reimbursement mechanism that would provide a prospective payment coupled with some risk adjustment to reward value added services might be a viable alternative to current practices.

DOES THE REASON FOR BUYING HEALTH INSURANCE INFLUENCE BEHAVIOUR? ANALYSIS OF THE 2001 NATIONAL HEALTH SURVEY

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BACKGROUND

Following the implementation of a range of government measures to increase private health insurance coverage in Australia, the 2001 National Health Survey asked respondents not only about their insurance status, but also about their reasons for having or not having health insurance. The most common reason given for having health insurance was 'security/peace of mind' but other reasons included 'choice of

doctor', 'shorter wait for treatment', 'lifetime cover/avoid the surcharge', 'to gain government benefits/avoid the Medicare surcharge'

METHOD

This study uses these data to identify different categories (types) of consumer in terms of their reasons for having health insurance.

RESULTS

Four broad types of consumer are identified: those who purchase health insurance for security reasons, for increased choice, for financial reasons, and for health reasons. We also investigate whether insurance type explains timing of insurance purchase.

CONCLUSIONS

We find that, controlling for risk behaviours, health status and socio-economic status, insurance type is significantly associated with hospital utilization, particularly the probability of being admitted as a public or private patient.

THE NEW ZEALAND HUMAN TISSUE REVIEW

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BACKGROUND

At present, the regulatory framework in New Zealand for human tissue spans a number of acts and regulations. Individually, many of these acts and regulations are considered to be out-of-date and collectively they do not comprise a comprehensive or fully effective framework. Increasingly, issues are raised that either fall outside the scope of the current arrangements or are subject to varying interpretations.

In New Zealand public concern has been expressed in a number of areas associated with the management and regulation of human tissue use including, for example, consent around organ donation and the retention of children's hearts following post-mortem examinations at the Greenlane Hospital Heart Library.

METHODS

In 2004, the Ministry of Health published a Discussion Document on the Human Tissue Review. This Discussion Document formed the basis of public consultation, which was undertaken in April–June 2004. The Ministry received 125 written submissions and held a series of formal public and sector meetings.

RESULTS

Key areas identified in consultation included: the principle of informed consent, consent framework for organ donation (i.e. who can give consent) and the need for mechanisms to enable consideration of emerging technologies which may pose safety and ethical challenges.

CONCLUSIONS

The New Zealand Government has agreed that a new regulatory framework, including new Human Tissue legislation, will be developed to ensure the expectations of New Zealanders are met and that clinicians and researchers have clear frameworks in relation to the collection, use, and storage of human tissue.

THE MANAGEMENT OF RISKS TO THE NEW ZEALAND HEALTH SECTOR CREATED BY GENETIC MATERIAL PATENTS: THE GENETIC TECHNOLOGIES LIMITED PATENTS CASE STUDY.

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Ministry of Health, Wellington, New Zealand

BACKGROUND

There has been increasing concern expressed both in New Zealand and internationally, that patents involving human genetic sequences may have negative implications for research and innovation into diagnostic and treatment methods, health care costs and access to health care.

Genetic material patents have come to the fore in New Zealand recently because the Patents Act 1953 is currently being reviewed. In addition, an Australian company, Genetic Technologies Ltd (GTG), has sought to enforce two New Zealand patents on non-coding DNA analysis and mapping.

METHODS

International reports and studies on patenting of genetic material were reviewed. The GTG patents were used as a case study to examine the practical impacts of genetic material patents on the New Zealand health sector.

RESULTS

The Ministry of Health concluded that the breadth of such patents was an area of concern for the health sector and that therefore the recommended new criteria for patentability (in the proposed Patents Bill) need to be strictly applied. The GTG patents raised

concerns around the patent examination process and highlighted practical difficulties in challenging potentially invalid patents in New Zealand.

CONCLUSIONS

The health sector should become more proactive scrutinising patents when approached by patent holders to ensure that there are no unnecessary risks or costs generated for the health sector. In addition, a robust process should be applied to examination of the patents, including a coordinated approach both within the health sector and with other effected entities.

THE IDENTIFICATION AND MANAGEMENT OF THE HEALTH RISKS ASSOCIATED WITH ASSISTED REPRODUCTIVE TECHNOLOGIES.

Aphra GREEN, John HOBBS*, Pat TUOHY, Wayne GILLET, Ministry of Health, Wellington, New Zealand

BACKGROUND

There is evidence that assisted reproductive technologies (ARTs) are associated with poorer neonatal health outcomes, a higher rate of congenital and chromosomal abnormalities, and poorer maternal health outcomes than natural conception.

The passing of the Human Assisted Reproductive Technology Act in New Zealand in 2004 raised the possibility that government knowledge of these risks could create an opportunity for children born as a result of ARTs to seek legal redress from the government for allowing and funding the use of ARTs.

METHODS

The Ministry of Health established an expert advisory group to assess the risks and their acceptability. The group considered a literature review, a background paper, and two systematic reviews.

The group used a number of methods to assess the acceptability of the risks associated with different ARTs.

RESULTS

There are increased health risks to the mother and child, and subsequent generations, associated with all ART. A combination of risk assessment methods were used to determine the acceptability of the risks associated with particular ARTs.

CONCLUSIONS

The group considered the increased risks to be acceptable as they are not greatly increased above those for the general population and in general the procedures offer benefits to those parents who might

not otherwise conceive children naturally. The group recommended that ARTs continue to be offered, and that the health of children born as a result of ART be monitored on an ongoing basis.

THE CONTRIBUTION OF INTRA-ORGANISATIONAL AND INTER-ORGANISATIONAL CAPACITIES TO COMMUNITY-BASED PRIMARY CARE SERVICES' INVOLVEMENT IN MENTAL HEALTH CARE.

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BACKGROUND

National Mental Health Policy acknowledges community-based primary care services as integral to any comprehensive mental health care system. However, the nature and extent of the mental health care conducted varies substantially across different services; it is often poorly coordinated with medical and specialist care; and there is little research evidence available to inform the design and delivery of effective capacity building initiatives.

METHODS

This research involved interviews with groups of staff from 41 community-based primary care services. A structured interview schedule assessed involvement in a range of mental health care activities, as well as intraorganisational and interorganisational (system-level) capacity factors that may mediate role involvement. Cluster Analysis was used to examine patterns in the responses to reveal the underlying structure of the various roles and capacity factors. General Linear Modelling and Linear Regression analyses were used to examine the relationships between level of role involvement and different capacity factors.

RESULTS

Intraorganisational factors, particularly culture, climate and leadership, were the strongest predictors of current involvement in mental health care. Culture, climate and leadership also mediated the impacts of interorganisational factors upon levels of role involvement. Interorganisational factors that would normally be expected to encourage and support mental health care role involvement did so only when intraorganisational culture, climate and leadership were optimal. When culture, climate and leadership were sub-optimal, these interorganisational factors had a negative impact on role involvement.

CONCLUSIONS

Further research is warranted to explore the importance of organisational culture and climate as possible mediators of the effectiveness of interorganisational capacity building initiatives.

EVALUATION AND ACCREDITATION OF HEALTHCARE ORGANISATIONS IN IRAN

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BACKGROUND

Evaluation and accreditation of Health Care organizations has an important role in increasing the effectiveness and efficiency of these organizations and developing the quality of services provided. The current system of evaluation and accreditation of hospitals in Iran is based on structure only with out considering the context, process and output and this cause many problems for both health care providers and customers. Therefore, there is a pressing need for developing a model for health care systems; evaluation and accreditation, which help these organizations to improve the quality of services.

RESULTS

The aim of this article is therefore: To identify the strengths and weakness of the current system of evaluation and accreditation of hospitals in Iran, determining the ideal system of evaluation and accreditation to develop a model so that health care organizations aiming at achieving effectiveness and efficiency.

A descriptive study using a cross-sectional survey for data collection performed. All of hospital managers and hospital evaluators in Isfahan province were studied via a self-administrated questionnaire (53 managers and 30 evaluators). This questionnaire specifies the respondents' opinions about the current and ideal system of evaluation and accreditation of hospitals. Data was analyzed via SPSS 11 software.

FINDINGS

The mean score of current system of evaluation and accreditation of hospitals was 3.12±0.83 and 4.41±0.34 (in a 5 scale). The mean score of structure, process and outcome were 3.17±0.73, 3.12±0.91 and 3.09±0.1 in the current system of hospital evaluation respectively. From the view points of hospital managers and evaluators the differences between values of current and ideal scores of evaluation and accreditation system

were statistically significant ($p < 0.05$). Therefore, there is a need for developing a model for hospital evaluation and accreditation.

Based on these results an empirical model for Evaluation and Accreditation of Hospitals is developed. In this model the context, structure (input), process and results (out put) were considered comprehensively. In this model items such as customer participation in treatment process, hospital information system, equity of services, employees' participation in evaluation process, increasing employees and managers knowledge and capabilities level, risk and safety management and so on are considered.

DISCUSSION

The evaluation and accreditation system of Hospitals should be a comprehensive system in order to evaluate the whole dimensions of these organizations.

KEY WORDS

Evaluation - Accreditation - Modeling- Hospitals

REMUNERATING PRIVATE PSYCHIATRISTS FOR PARTICIPATING IN CASE CONFERENCES

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BACKGROUND

Sub-optimal collaboration between private psychiatrists and other mental healthcare providers militates against positive consumer outcomes. Case conferences have been proposed as one means of improving collaboration. New item numbers were added to the Medicare Benefits Schedule (MBS) in late-2000 to reimburse psychiatrists for participating in case conferences. An evaluation of these item numbers is described.

METHODS

The evaluation considered the item numbers in terms of their uptake and impact on other services provided by psychiatrists (using MBS data) and the experiences of psychiatrists who had/hadn't used them (via telephone interviews).

RESULTS

After three years, 89 psychiatrists had used the item numbers to participate in 479 case conferences. For consumers who were the focus of case conferences, there was no reduction in the number of face-to-face consultations provided by psychiatrists, although there

was evidence of a reduction in the number of providers involved. Psychiatrists who had used the item numbers noted benefits (e.g., promoting good inter-provider communication), but also some barriers (e.g., the conditions of their use). Psychiatrists who hadn't used the item numbers hadn't done so for various reasons (e.g., lack of awareness), but many indicated an intention to do so.

CONCLUSIONS

Uptake of the item numbers has been moderate but is increasing over time. The item numbers do not seem to be associated with a reduction in other services provided by psychiatrists. Those psychiatrists who have used the item numbers are generally positive; those who haven't cite lack of awareness, rather than opposition, as the reason.

BY DESIGN OR DEFAULT: THE IMPACT OF HEALTH CARE REFORM ON PROFESSIONAL AUTONOMY

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BACKGROUND

In 1995, the Progressive Conservative government in the Canadian province of Ontario introduced a "Managed Competition" model as part of its wide ranging reform of home care. This model assumed that competitive forces can encourage high quality services while driving down service costs. Although health human resources constitute the largest component of such costs, there has been little analysis of the impact of managed competition on rehabilitation professionals, their professional autonomy, or the health care system as a whole.

METHODS

We analyse the results of 36 in-depth interviews with representatives of Ontario's publicly funded Community Care Access Centres (CCACs) as well as for-profit and not-for-profit rehabilitation provider agencies. Professional autonomy has been conceptualized as consisting of the distinct but related dimensions of economic, political and clinical autonomy; measures were created for each of these dimensions.

RESULTS

The findings demonstrate that Ontario's managed competition reform led to an overall reduction in the economic, political and clinical autonomy of rehabilitation professionals. This erosion was experienced equally by individuals working in for-

profit and not-for-profit provider agencies, prompting significant numbers of health professionals to exit home care, thus exacerbating existing health human resources shortages.

CONCLUSIONS

While reducing the autonomy of health professionals may help to control health care costs, it may also have perverse outcomes from a health systems viewpoint. These include difficulties with recruitment and retention of professionals as well as concerns about the quality of health services provided. Findings suggest the need for a more nuanced approach to health care reforms.

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QUALITY IMPROVEMENT AT CENTRAL AUSTRALIAN ABORIGINAL CONGRESS

John BOFFA , Central Australian Aboriginal Congress, Alice Springs, Northern Territory, Australia

DRIVING HEALTH SERVICE CHANGE TO IMPROVE CANCER OUTCOMES

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Research indicates that changes to health service delivery are likely to be at least as important as changes in clinician behaviour to support best practice improvements. However, most research about encouraging evidence-based care and many programs to improve care focus on individual clinician factors.

The National Breast Cancer Centre (NBCC) has taken the lead in Australia in promoting change in service delivery to support multidisciplinary care. Multidisciplinary care (MDC) has been found to improve outcomes for cancer patients. MDC is recognised in clinical practice guidelines as best practice and as a central element of National and State/Territory

frameworks and plans. However, published information about approaches for implementing MDC in the Australian context is limited.

NBCC has undertaken a multifaceted national program to support service change which has included:

- Best practice guidelines (evidence-based recommendations)
- Principles of MDC (flexible, principle-based approach as guidance)
- National Demonstration Project (hospital site implementation - process, impact, cost, acceptability evaluated)
- Observation of meetings (anthropological study of successful elements)
- Sustainability of service change (key elements of sustainability)
- MDC Team meeting guide (practical advice to aid service delivery change)
- National Forum Series (with key stakeholders to discuss strategies to overcome local barriers to service delivery change)
- Cancer Service Standards Framework (MDC promoted as keystone for future cancer service accreditation system)

The national program and associated outcomes will be discussed.

GROWTH IN USE AND COSTS OF PBS MEDICATION FOR NATIONAL HEALTH PRIORITY AREAS (NHPAS)

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BACKGROUND

Future funding of PBS medicines for NHPAs is a major health policy issue. This paper identifies current users, describes trends in PBS script volume, government and consumer costs for NHPA related medications, and explores the possible drivers of growth.

METHODS

Datasets from a microsimulation model of the PBS, "MediSim," provided script and cost data on PBS subsidised medicines over 1992-2004, and data on current users in terms of demographic and socio-economic characteristics. Information from national health surveys, the census and AIHW datasets, was analysed to identify the extent to which the trends could be explained by population growth, growth in disease prevalence or changes in prescribing by doctors.

RESULTS

By 2003-04, scripts for NHPAs constituted 55% (90.9 mil) of prescriptions and 64% (\$3852 mil) of PBS costs. The relative increase in costs of NHPA medications over 1992-2004 is matched by growth in scripts. This varies across different NHPAs with increases in scripts being greatest for angiotensin IIs and cholesterol and triglyceride reducers. Greatest increases in average cost occurred for anti-inflammatories, anti-depressants, anti-psychotics and anti-cancer drugs. Population ageing increases in disease prevalence and doctor prescribing were all significant determinants of script growth. Growth in costs also reflects the entry of newer, more expensive drugs.

CONCLUSION

Growth in the usage and cost of medicines for NHPAs indicates that the way these health conditions are managed affects the cost of the PBS. Nevertheless, policies and measures to contain and treat these conditions, alongside other health measures, should continue to be developed and implemented.

MICROSIMULATION MODEL OF MEDICAL INSURANCE FOR URBAN EMPLOYEES IN CHINA

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Medical insurance reform is a hot topic among ordinary Chinese. Surveys indicate that the medical issue topped the list of most-serious matters among urban residents. The medical insurance system acts an important part in social security system in China. Since 1995, the medical insurance reform for urban employees has been extended to the whole country and has acquired significant achievements. However, the reform still faces several problems, such as the optimization of medical insurance settings, rational deductible, ceiling and co-payment levels, the perfect of supply medical insurance. This paper discussed the construction of microsimulation model for medical insurance system in Zhenjiang, Jiangsu Province by analysing the medical care expenses of urban employees. Using the model, the medical insurance policy was forecasted for different groups of employees for five years.

THE ECONOMIC COSTS OF ROAD TRAFFIC CRASHES: AUSTRALIA, STATES AND TERRITORIES

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Road traffic crashes (RTCs) are known to impose a heavy social burden. The World Health Organisation (2004) estimates that, worldwide, approximately 1.2 million people are killed and more than 50 million people are injured each year in RTCs. RTCs still account for approximately 25% of injury-related mortality in Australia (Australian Institute of Health and Welfare 2004) and worldwide (World Health Organisation 2004). Moreover, non-mortality costs associated with RTCs, in the form of direct medical and other (e.g., police) expenditures, the lost earnings and the pain and suffering of victims and their carers are also substantial sources of social loss. In this paper, we provide estimates of the social costs of RTCs in Australia at the level of each state and territory. The results illuminate the substantial regional variations in the costs of RTCs that have previously been either ignored, or perhaps even shielded from public attention for various (apparently political) reasons.

A COMPARISON OF THE APPROACHES TO BUILDING RESEARCH CAPACITY IN PRIMARY CARE IN AUSTRALIA AND THE UK

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BACKGROUND

The need to develop research capacity in primary care is now recognised internationally as a necessity for the production of high quality, effective services [1, 2, 3]. However, the approaches to developing research capacity vary between countries due to contextual differences such as systems of health care financing and organisation and the geographic dispersion of primary care practitioners.

METHOD

This paper examines the approaches to research capacity building in Australia and the UK by comparing the policy and health care context in each country; the applications of the policy including funding for RCB; mechanisms for allocating RCB funding; and the target practitioners. We provide specific examples of RCB

activity at individual, team, organisational and network levels and where available, discuss the effectiveness of those levels against six principles of RCB.

RESULTS

Both the Australian and UK Governments have made significant investments to develop research capacity. The major areas of focus are:

- Building the research workforce in the form of fellowships and bursaries to facilitate research career progression.
- Building infrastructure and networks. Such as the Federation of Primary Care Networks in the UK
- Investing in research support. In the UK this includes a network of Research and Development Support Units (RDSU) to support practitioners to undertake research
- Responsive funds to support projects. For example in Australia the PHC RED offer grants to primary care practitioners to submit project protocols and link this into support structures to enable capacity building and
- Developing and strengthening academic infrastructure.

CONCLUSION

The evolution of the different approaches to research capacity building (RCB) internationally presents an opportunity for learning and sharing examples of policy development and application.

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TOWARDS STANDARDISING THE BOUNDARY BETWEEN ADMITTED AND NON-ADMITTED CARE IN AUSTRALIAN HOSPITALS

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BACKGROUND

Australia's comprehensive statistics on admitted patient care are used to monitor hospital activity at the national level, and to compare the public and private

sectors, and the states and territories. However, use of the data, for example to monitor effects of policy or funding changes for admitted patient care, could be problematic if the types of hospital activity defined as "admitted patient" care vary over time and/or by hospital. In late 2004, AHMAC's National Health Information Group auspiced work to improve the comparability of the data, following indications that there was variation in criteria used for admission, and in the point at which admissions were recorded as commencing, for example in emergency departments.

METHODS

Comparisons were made of admission policies and practices of the states and territories, and those relating to Commonwealth health insurance arrangements. Recent data on admitted and non-admitted patient hospital activity from the AIHW's national hospital databases were analysed. Relevant National Health Data Dictionary (NHDD) definitions are being reviewed in consultation with stakeholders.

RESULTS

The NHDD definition for admitted patients is relied upon in some states and hospitals, but is supplemented with more detailed clinically based guidelines in others, and with funding-related policies (that some procedures are or are not undertaken on an admitted basis) in others. The national admitted patient data indicated that there is substantial variation in admission practices for same day care such as chemotherapy, rehabilitation and some mental health and cardiovascular treatment.

CONCLUSIONS

Current variations in admission policies and practices affect the comparability of data on admitted and non-admitted patient hospital activity. Progress with national efforts to address this variation will be reported.

DECISION-MAKING ABOUT NEW HEALTH INTERVENTIONS – A COMPARISON BETWEEN NEW ZEALAND AND AUSTRALIA

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BACKGROUND

The National Health Committee (NHC) provides the New Zealand Minister of Health with independent advice on a range of health and disability issues, including measures to improve the health of the population. The NHC has completed a project, and

made recommendations to the New Zealand Minister of Health, on decision-making about new health interventions in New Zealand.

METHODOLOGY

The NHC's project involved speaking to health sector decision-makers about how decisions about new health interventions are made in New Zealand, and identifying the issues that arise from these processes.

RESULTS

Australia has a central funding agency that reimburses providers for the provision of publicly funded health interventions. This agency acts as a gatekeeper, funding only those new interventions that pass its assessment criteria. In contrast, there is no gatekeeper for new interventions in New Zealand, where funding for, and decision-making about, new publicly funded interventions is dispersed.

CONCLUSIONS

The approaches used to make decisions about new interventions in New Zealand and Australia will be discussed, along with the issues that arise from these. The NHC's recommendations, to the New Zealand Minister of Health, that aim to improve decision-making within the environment of dispersed decision-making and fiscal responsibility in New Zealand will be mentioned briefly.

AUSTRALIAN NEPHROLOGISTS' ATTITUDES TOWARDS LIVING KIDNEY DONATION

Joan CUNNINGHAM*, **Alan CASS**, **Kate ANDERSON**, **Paul SNELLING**, **Jeannie DEVITT**, **Cilla PREECE**, **Josette ERIS**, Menzies School of Health Research, Northern Territory, Australia

BACKGROUND

Little is known about the attitudes and perceptions of Australian nephrologists towards living kidney donation (LKD), specifically regarding donor risk, their willingness to recommend LKD and their own preparedness to act as a live donor.

METHODS

A postal survey of Australian nephrologists was undertaken in 2004. Responses to six multiple-choice questions about LKD were collected as a separate focus of a larger study. Univariate, bivariate and multivariate analyses were performed.

RESULTS

Australian nephrologists and nephrology trainees were generally supportive of LKD. The vast majority of respondents indicated that they would recommend it to a suitable donor (95%) or would themselves donate a kidney to an immediate family member (97%). However, fewer than half (43%) would recommend LKD to a relative of a patient when the patient's end-stage kidney disease (ESKD) had been attributed to diabetes and when there was a strong family history of diabetes. A minority thought that LKD increased the donor's risk of mortality (12%) or of ESKD (25%). Few nephrologists (4%) indicated their preparedness to be an altruistic donor to a recipient unknown to them.

CONCLUSIONS

LKD has the potential to ameliorate the shortage of kidneys available for people with ESKD. However, the increasing incidence of ESKD attributable to diabetes might progressively limit its use. Furthermore, because ethnic minorities, including Indo-Asians and Indigenous peoples, experience a very heavy population burden of diabetes, an increasing shift towards LKD might exacerbate disparities in access to transplantation.

TOWARDS A THEORY OF SERVICE DESIGN

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PURPOSE

In a context in which the researcher was given the practical task of designing Tasmania's first residential service for youth with drug issues, this paper explores what a useful theory of service design might look like, with implications for policy decision-makers, practitioners, and researchers.

BACKGROUND

Research into adolescent substance abuse (at least) takes a strong "intervention" measurement approach, and as such has limited utility for the service designer, though it is ostensibly written as if it can or should inform service delivery.

METHODS

Using a case study of a Tasmanian service design experience as a point of departure, the paper examines key writings in the broader service design theory literature, as well as contemporary western philosophy, helpful to developing a better understanding of the nature and processes of service design.

CONCLUSIONS

Health service design is a multidisciplinary craft that should also be informed by an integrated understanding of service design theory, as well as key philosophical developments, beyond health research. A theory useful to service designers would be one that engaged with the nature of service design blueprints, and the task of systematically translating research evidence and community needs into such blueprints. Such a theory would conceptualise and add meaning to the service blueprint not only in terms of its constituent parts (such as ethos, service delivery activities, architecture and location, staffing, and cost), but also the ways in which these parts must work together to achieve the total client experience.

THE 'INVERSE CARE LAW' REVISITED: SOCIO-ECONOMIC STATUS ARE THE USAGE OF DOCTOR SERVICES

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BACKGROUND

There is a wealth of literature that records the presence of a socio-economic gradient in health that is, increasing socio-economic disadvantage is associated with increased mortality, morbidity and associated risk behaviours. This study investigated current Australian doctor service use and the distribution of benefits provided through the medical benefits scheme (MBS) across income groups.

METHOD

A health micro simulation model of the medical sector, based on the ABS National Health Survey 2001 (NHS01), was used for this investigation. Included in the model were annualised estimates of visits to a doctor, as well as cost data (doctors' charge and MBS benefit received) based on data obtained from the Health Insurance Commission. Age-sex standardised rates and rate ratios were used for comparisons of use of GPs, the GP charges for services and MBS benefits received across income groups.

RESULTS

While our results maybe refined, the preliminary analysis suggests that Australians in the lowest income group are about 25 per cent more likely than the highest income group of Australians to visit a doctor in a year.

CONCLUSIONS

Our study shows that use of doctor services varies with socio-economic status as measured by equivalised income, even after age-sex standardisation. The variation seen does not support the inverse care law assumption that those with higher incomes access services more.

UPTAKE OF HEALTH ASSESSMENT ITEMS FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE: IMPLICATIONS FOR HEALTH POLICY

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BACKGROUND

Health Assessment (HA) items were introduced in 1999 for Aboriginal and Torres Strait Islander people aged at least 55 years and all Australians aged over 75 years. In 2004 a new item was introduced for HAs among adult Aboriginal and Torres Strait Islander people aged 15-54 years. Enthusiasm about the introduction of the new item has been tempered with concern about potential barriers to its uptake. In this study we aim to determine whether there are disparities in uptake of HA items for Aboriginal and Torres Strait Islander people compared to other Australians.

METHOD

The analysis was based on Health Insurance Commission data. Indigenous status was ascertained based on the item number used. Logistic regression was used to compare uptake of HA items for older people among Aboriginal and Torres Strait Islander people compared to other Australians. Adjustments were made for dual eligibility. Uptake of the HA items for older people was compared to the uptake of the new item for Aboriginal and Torres Strait Islander people aged 15-44 years.

RESULTS

Our analyses suggest a significant and persistent disparity in the uptake of items for older patients among Aboriginal and Torres Strait Islander people compared to other Australians. A similar disparity appears to exist in the uptake of the new adult Aboriginal and Torres Strait Islander HA item.

IMPLICATIONS

Further engagement of primary care providers and the community around the uptake of the new HA items may be required to ensure that the anticipated health benefits are eventuate.

THE IMPACT OF ASTHMA: A LONGITUDINAL STUDY OF QUALITY OF LIFE

Patsy KENNY*, Madeleine KING, Jane HALL, Meredyth CHAPLIN, CHERE, University of Technology, Sydney, New South Wales, Australia

BACKGROUND

An individual's experience of a chronic disease such as asthma is often life long and may vary considerably over that time. This paper describes the health related quality of life (HRQOL) of a cohort living with asthma and how this changes over the follow-up period of a three-year longitudinal study. The project was funded by the Cooperative Research Centre for Asthma.

METHODS

The sample comprised 172 randomly selected adults with asthma from throughout NSW and an additional 39 recruited through hospital emergency departments (to ensure sufficient numbers with moderate to severe asthma). HRQOL was measured with the SF-36 Health Survey and the Asthma Quality of Life Questionnaire (AQLQ, Sydney). Participants completed the HRQOL questionnaires at baseline and then at six-monthly intervals for three years. Multilevel models were used to investigate individual variation in HRQOL over time and the relationships between HRQOL and socio-demographic, disease and treatment factors.

RESULTS

Mean scores on all dimensions of the SF-36 were similar to those for the Australian population after standardising for age and sex. While on average there was little change in HRQOL over the follow-up period, some individuals reported considerable variation. Age, sex and asthma control were significant predictors of quality of life.

CONCLUSIONS

An understanding of the HRQOL experienced by people with asthma and the way it changes over time will contribute to future health service planning decisions, which affect this disease group.

THE USE AND ADAPTATION OF CENTRES FOR DISEASE CONTROL & PREVENTION EVALUATION FRAMEWORK FOR THE “LET’S BEAT DIABETES” PROGRAM

Janet CLINTON*, Ingrid McDUFF, Paul BROWN, Chris BULLEN, & Rob McNEILL, School of Population Health, University of Auckland, New Zealand

AIM

While the Centers for Disease Control & Prevention (CDC&P) evaluation framework is accepted as the seminal document to use for large scale community based evaluations, we have found that the framework needed to be adapted for a local New Zealand community programme to take the local culture into account. The aim of this paper is to describe the process of the development of an evaluation model and the adaptation of the CDC&P evaluation framework for the evaluation of the “Let’s Beat Diabetes” program in Counties Mankau, New Zealand. The Let’s Beat Diabetes Program is a large-scale multi-faceted community based initiative designed to reduce the incidence of Type 2 diabetes.

METHOD

The evaluation framework and evaluation plan was developed using the principles of the CDC&P evaluation framework. This paper describes the process used and information gathered. A stakeholder analysis, literature review, multiple focus groups and workshops were undertaken. The framework was developed collaboratively with an identified group of stakeholders.

CONCLUSIONS

The paper concludes that while the CDC&P framework forms the foundation for the evaluation of community based health interventions, it is imperative that the model be adapted to suit the needs of the local community and the indigenous population.

KEY WORDS

Community based health interventions, Evaluation, Centers for Disease Control & Prevention Evaluation Model, Diabetes

REFERENCE

Centers for Disease Control and Prevention. (1999). Framework for program evaluation in public health. MMWR, 48(No. RR-11).

MULTIPLE CHRONIC CONDITIONS: PATIENT CHARACTERISTICS AND IMPACTS ON QUALITY OF LIFE AND HEALTH EXPENDITURES

1 The sub-category is “microeconomics of health”

2 The results mentioned are preliminary, based on ABS National Health Surveys and Disability surveys. The final results will include further analyses, as well as findings from additional data sources.

Agnes WALKER*, NCEPH, Australian National University, Australian Capital Territory, Australia

BACKGROUND

While analyses of health status often focus on a single disease, comprehensive studies of people with multiple chronic conditions, ie comorbidities - are relatively rare. This paper reports on a study of comorbidities carried out under an ARC grant.

METHODS

We used unit record cross sectional and time series data from national surveys to examine patterns associated with comorbidities (demographic/social characteristics; quality of life; risk factors; severity of activity limitation). Methods used included microdata analysis and statistical techniques (survey non-response, age standardisation, statistical significance, regression analyses).

RESULTS

Comorbidities gradually build up as people age. Over 80% of 60+ year old Australians have three or more chronic conditions. Among these, 83% have at least one National Health Priority Area disease; 33% less report being “delighted” with their life and 160% more report feeling “terrible” than other 60+ year olds; a higher proportion suffer from psychological distress (Kessler score) than among other 60+ year olds. Over half of those aged 60+ are overweight - an important risk factor associated with having three or more chronic conditions.

We also found that comorbidities limited everyday activities in terms of ability to work, earning capacity and to live independently. The health care cost of treating people with comorbidities was found by earlier researchers to be five times that of other Australians.

CONCLUSIONS

Improved chronic disease prevention - and treatment that slowed the progression of such diseases - have the potential to reduce the incidence and prevalence of comorbidities and thus lead to better quality of life and to lower health care expenditures.

RECENT RELEVANT PUBLICATIONS

Walker, A. 2004, "Impact of Health on the Ability of Older Australians to Stay in the Workforce - with Possible Contributions to Economic Sustainability", Refereed Proceedings of the Conference: "A Future that Works - Economics, Employment and the Environment", University of Newcastle, 8-10 December.

Thurecht, L., Walker, A., Harding, A and Pearse, J. 2005, "The "Inverse Care Law", Population Ageing and the Hospital System: a Distributional Analysis", Economic Papers, Vol 24 No 1 pp 1-17.

Walker, A. and Becker, N. 2005, "Health Inequalities Across Socioeconomic Groups: Comparing Geographic-Area-Based and Individual-Based Indicators", Public Health (in press)

USE OF MODELLING TOOL TO PREDICT PATIENT FLOW IN A DAY PROCEDURE CENTRE

Chris BAIN*, Kannan SETHURAMAN, Nancy ENG, Kevin RATNAYAKE, Louis IRVING, Susan GARBUTT, Geoff HEBBARD, Caroline BRAND, Departments of Clinical Epidemiology & Health Service Evaluation & Gastroenterology & Respiratory Medicine and Critical Care, RMH; Melbourne Business School Melbourne Health, Victoria Australia

INTRODUCTION

Health Services Systems are often complex and anticipated effects of certain decisions and policies are often hard to predict and costly to demonstrate in the absence of tools.

The study demonstrates the use of simulation modelling to predict patient flow including effects on resource availability in a newly implemented dedicated endoscopic Day Procedure Centre (3WDC) in 2 decision scenarios:

- a) inclusion of Bronchoscopy cases, and
- b) opening a second Procedure room.

METHOD

Effects of change to the patient mix and configuration were measured using:

- Patient Throughput - patients treated over a period of time for 9 patient streams, and
- Resource Usage - usage of the theatre resources eg anaesthetic procedure rooms etc.

It involves:

- Baseline Model Design and Validation - which uses both historical data & expert knowledge to derive the baseline patient flow model, and

- Determine effects on above measures in the 2 decision scenarios.

RESULTS

Base Scenario: Open Single Endoscopy Room, No Bronchoscopy Cases

Model throughput was fairly consistent with actual implying the model assumptions remained fairly consistent in the new 3WDC context.

Scenario 1: Relocate Bronchoscopy Cases to 3WDC
Simulation showed minimal impact (about 6% increase ie. 28 cases over 37 work days) on throughput while potentially increasing usage of the procedure room to almost full capacity.

Scenario 2: Opening a Second Procedure Room
Simulation showed potential benefits (about 45% increase throughput from about 14% increase in session time allocation) with the proposed "Two-room Schedule" and possibility of accommodating more sessions (ie. low utilization numbers of the second Pre-op/& Procedure rooms).

CONCLUSION

The simulation approach though "coarse grained" has shown strength & potential in assisting decision processes.

UNDERSTANDING, INCREASING AND ASSESSING RESEARCH IMPACT

Huw DAVIES, Research Unit for Research Utilisation (RURU), University of St Andrews, Scotland

This presentation will address the key issues of what we mean by "research use", what we mean by "research impact", and how both of these can be facilitated.

While the 'evidence-based everything' agenda can sometimes seem like it is always breaking new ground, it is in fact addressing core concerns of the social sciences: the use of different types of knowledge in motivating socially situated human actions. As such there are many and diverse literatures that we can draw on to help understand (and facilitate) research impact processes. A key aim of this presentation is to map out the ways of thinking (and literatures) that can help extend understanding about research use and impact. It will have a particular emphasis on the use of evidence for organization policy and managerial change.

EVIDENCE IN THE HIERARCHY OF POWER AND ACTION IN HEALTH

Jill SEWELL, President, The Royal Australasian College of Physicians

There are various forms of evidence that some health researchers are not aware of or ignore, but which are used extensively in decision-making, policy development and clinical application within health services. Values and political judgment are increasingly important the higher up the power scale at which decision and policy makers operate. Pragmatism, habits and traditions are important the more one is involved with action and implementation.

At these levels, "pure" scientific research and the traditional RCT outcomes are less likely to have an impact because their relevance "on the ground" may not be well understood. To overcome this imbalance, when considering research and its funding, it becomes increasingly important to have all levels of the power and action hierarchy represented at the one table.

As the policy challenges become more urgent, our research efforts need to become more broadly focused, with research organizations building a more sophisticated understanding of the interactions of these hierarchies.

EVIDENCE INTO AUSTRALIAN PRIMARY HEALTH CARE POLICY AND PRACTICE – A NEW INITIATIVE

Nicholas J GLASGOW, Director, Australian Primary Health Care Research Institute, Canberra, Australian Capital Territory, Australia

The Australian Primary Health Care Research Institute (APHCRI) was established in 2003. This presentation will briefly background the Institute and its mission and goals. It is unusual in that it has both 'research doing' and 'research commissioning' roles. The notion of 'contestable collaboration' as it applies to the Institute's research commissioning role will be described.

Australia faces a number of important challenges in its health system. APHCRI has identified key priorities for its activities which will be outlined.

There is an increasing literature on both 'linkage and exchange' and the use of systematic review and synthesis as mechanisms to bring evidence to bear on policy formation. The Institute has used this literature to shape and drive its early activities. These will be summarised.

AGEING AND HEALTH CARE EXPENDITURES: IS AGEING A "RED HERRING"

Luke CONNELLY BA(Econ) MEconSt PhD, Associate Professor Director, UQ Node, Australian Centre for Economic Research on Health and Associate Director, Centre of National Research on Disability and Rehabilitation Medicine (CONROD) and The University of Queensland, Mayne Medical School, Herston, Queensland

Longer life expectancy and declining fertility rates in the developed world have resulted in important demographic changes over the past three decades and will continue to do so. These changes – summarily referred to as the "ageing of the population" – have potentially important fiscal consequences. The conventional wisdom is that the ageing of the population will, in the decades to come, increase health expenditures dramatically.

A large body of the literature in health economics, however, now challenges this conventional wisdom and suggests that ageing is really just a "red herring". Specifically, it has been hypothesised that it is the proximity to death, rather than ageing itself that drives health care expenditures up. The empirical evidence tends to support this hypothesis and, in fact, some authors go so far as to suggest that health expenditures are actually "age-neutral". Although the proximity to death and age are obviously positively correlated, this age-neutrality hypothesis has very important fiscal consequences. To the extent that the hypothesis is correct, predictions of huge increases in health expenditures appear more likely to represent "doomsday" scenarios rather than credible predictions of the impact of ageing on health care expenditures. This presentation will consist of a non-technical overview of the debate on ageing and health expenditures and its policy implications.

PROVIDING EVIDENCE FOR POLICY MAKERS: A REFLECTION ON EIGHT YEARS OF BURDEN OF DISEASE AND ECONOMIC EVALUATIONS

Theo VOS, University of Queensland, Queensland, Australia

The growth in health expenditure is outpacing that of other sectors of the economy. The first Intergenerational Report raised concern about the affordability of continuing to provide health care to an ageing population. In such an environment, pressure is increasing on governments to justify their expenditure on health. The term evidence-based policy is frequently

invoked in this debate but less often it is understood what evidence can help policymaking under what circumstances.

As health is the main outcome of a health system, one of the types of evidence of importance is detailed knowledge of the level and distribution of disease in the population and the underlying modifiable risk factors. The purpose of a burden of disease assessment is to quantify the amount of fatal and non-fatal disease in a population. Such a comprehensive study was carried out in the late nineties with results for the Australian population and, in greater detail, for the state of Victoria. A new study by the University of Queensland and the AIHW is in its final stages to update the Australian figures to the year 2003. Apart from improvements in the methods of modelling disease, the added features of the new study include: a) a more comprehensive approach to correcting for co-morbidity; b) estimates for the Indigenous population; c) small area estimates; d) greatly improved methods of attributing disease to underlying risk factors; e) new risk factor assessments of air pollution and intimate partner violence; and f) projections of disease, mortality and health care costs.

Priority setting is further informed by economic evaluations. While traditionally cost-effectiveness studies have been conducted alongside clinical trials comparing two or a limited number of interventions for the same health problem, the type of evidence policymakers need for priority setting needs to cover a multitude of intervention options for a large range of health problems. This can only be done by modelling existing data from different sources as primary data collection would be prohibitively expensive and time consuming. Over the last five years a number of economic evaluation studies have been carried out in the areas of cancer, cardiovascular disease and mental disorders that have been dubbed the Assessing Cost-Effectiveness (ACE) studies. Currently, there are two further ACE studies underway: ACE-Obesity and ACE-Prevention. The latter study is funded for the coming five years under NHMRC's Health Services Research Grant scheme and aims to comprehensively evaluate the cost-effectiveness of prevention for non-communicable disease in Australia. A similar project, Setting Priorities based on Information on Cost-Effectiveness (SPICE), is also being undertaken in Thailand. While a few other economic evaluation studies have been conducted in Australia in specific disease areas, the ACE studies distinguish themselves by a more rigorous assessment of intervention impact measures from meta-analysis of systematic reviews and greater sophistication of modelling health outcomes and the cost-effectiveness of combinations of interventions addressing the same health problem.

The talk will give examples from the burden of disease and ACE studies and discuss the interaction between policymakers and the researchers in these studies.

THE COST OF ASTHMA TO INDIVIDUALS AND THE HEALTH SERVICE: IT MAY LEAVE YOU BREATHLESS

*Meredyth CHAPLIN, Patsy KENNY, Jane HALL, Madeleine KING, Emily LANCSAR, CHERE, University of Technology, New South Wales, Australia

BACKGROUND

Asthma places an economic burden on individuals and the health care system. Understanding the services used and consequent costs of asthma has important policy implications for improving access to services and providing an efficient mix of services.

METHODS

A cohort of 245 people with asthma, aged between 5 and 75 years, was recruited from NSW between October 2001 and October 2002. Data sources covered a one-year period for each individual, including two six-monthly self-completed surveys, hospital data from NSW Health, and pharmaceutical benefits and Medicare data. The use and cost of health care services and products, including alternative therapies and home modifications, were measured. Costs to both the health care system and individuals were estimated. Multiple regression was used to assess predictors of health service utilisation and costs.

RESULTS

General practitioner visits and asthma medications were the most commonly used items of health care. Medications contributed most to individual costs for health care in terms of the average payment and the number of people facing an out-of-pocket cost. Home equipment and modifications, while not common, were the most expensive per-individual items. Costs to the health sector were significantly higher for people living in Sydney than those living in Regional NSW, due to greater use of medical care.

CONCLUSIONS

The results are consistent with previous studies identifying an association between supply and utilisation of medical care. Improving access to medical care in regional areas may be one factor in reducing the burden from asthma.

MODELLING MACROECONOMIC COSTS OF PANDEMIC INFLUENZA: METHODOLOGY AND APPROACHES

Alexandra SIDORENKO, NCEPH (ANU), CAMA (ANU) and ACERH, Australian Capital Territory, Australia

The conventional approach by health economists to measuring the economic burden of disease is to estimate the direct and indirect costs of illness for those who have the disease. It is becoming increasingly evident that this conventional approach is inappropriate for infectious diseases of epidemic proportions, highly transmissible and for which there is no vaccine. Examples include HIV/AIDS, SARS, Avian Flu and influenza pandemics.

Epidemics can have devastating effects on economies through large reductions in consumption of various goods and services, increase in business operating costs, and re-evaluation of country risks reflected in increased risk premiums. Shocks to other economies are transmitted according to the degree of the countries' exposure, or susceptibility, to the disease. Lessons from the SARS epidemic in 2003 demonstrate that despite a relatively small number of cases and deaths, the global costs are significant and not limited to the directly affected countries. The presentation provides an overview of the existing literature on the subject and discusses the methodology for modelling macroeconomic impact of a potential influenza epidemic.

DISTRICT VARIATIONS IN RATES OF GENERAL SURGERY IN NEW ZEALAND

Antony RAYMONT*, Health Services Research Centre, Wellington, New Zealand

BACKGROUND

The existence of marked variation in rates of surgery is well established. Higher levels of intervention do not produce better outcomes and lower levels may result in unnecessary suffering and disability. Both are wasteful of resources. There are advantages to considering this phenomenon in New Zealand because the association between sub-populations and particular surgical services is clear. Patterns of variation may be affected, however, by the control of public surgical volumes by District Health Boards and by the relatively low level of surgery in New Zealand.

METHODS

General surgery discharges from public hospitals for 2001-2004, and from private hospitals for 2001, were analyzed. Discharges were attributed to one of 23 districts based on the address of the patient; they were allocated to a specialty on the basis of the "diagnosis related group." Rates of surgery were expressed as a proportion of the national rate and were adjusted for population variables.

RESULTS

Modest variation (0.88 - 1.20) in rates of general surgery at public hospitals was demonstrated. The components of general surgery with greatest variability were operations for varicose veins and hernia repair. When private surgery was included in the analysis there was a small reduction in variability although for one component variability actually increased.

CONCLUSIONS

Variation in general surgical rates across districts in New Zealand is less than that reported elsewhere. However, the variation in rates of hernia repair, which is not undertaken in the absence of complications in some hospitals, is unexpectedly high. Surgical rates in New Zealand reflect contractual arrangements to a greater extent than elsewhere.

MORAL HAZARD AND CASH BENEFITS IN LONG-TERM HOME CARE

Bernard VAN DEN BERG (*), Wolter H.J. HASSINK, University of Technology, Sydney, New South Wales, Australia

This paper tests empirically for ex-post moral hazard in a system based on demand-side subsidies. In the Netherlands, demand-side subsidies were introduced in 1996. Clients receive a cash benefit to purchase the type of home care (housework, personal care, support with mobility, organisational tasks or social support) they need from the care supplier of their choice (private care provider, regular care agency, commercial care agency or paid informal care provider). Furthermore, they negotiate with the care supplier about price and quantity. Our main findings are the following. 1) The component of the cash benefit a client has no residual claimant on, has a positive impact on the price of care. 2) In contrast, the components of the cash benefit a client has residual claimant on, have no or a negative impact on the price of care. Both results point at the existence of ex-post moral hazard in a system of demand-side subsidies. We will explore the implications of our findings for the Australian health care system.

VARIATIONS IN HOSPITAL ADMISSION RATES AND PATIENT STATUS IN AUSTRALIA

Denise DOIRON, Glenn JONES* and Elizabeth SAVAGE, CHERE, University of Technology, Sydney, New South Wales, Australia

BACKGROUND

Hospital separation rates vary significantly across and within countries. Australian rates are substantially higher than the US and Canada but lower than most European countries. Within Australia, in 2002 the lowest rate per 1,000 population was 277 in the ACT and the highest 368 in SA. An interesting question is whether state variation remains after controlling for patient characteristics and allowing the impact of patient characteristics to vary across states.

METHODS

We use AIHW Hospital Statistics to investigate how Australian separation rates vary over time and across states. We then use unit record data from the 2001 National Health Survey to estimate models of the probability of hospital admission and number of admissions in the last 12 months controlling for detailed patient demographics, income, insurance and health status. Using demographic/state interactions we also investigate the degree to which these state differences are associated with patient types.

RESULTS

The aggregate data shows private hospital admission rates differ dramatically with the highest rates in coastal Queensland and in capital cities. In most states there has been significant growth in private separations, with the largest growth in Queensland and WA. In Queensland, the private-patient-private-hospital rate increased from up from 7 to 12 per 1,000 with no corresponding fall in the public rate. Using the NHS individual data and controlling for patient characteristics, the only independent state effect is for WA. However there are significant differences between states in the admission rates for individuals with particular conditions.

CONCLUSIONS

One hypothesis for persistent differences between states is differential treatment of otherwise similar patients in the state hospital systems, whether public or private. This could arise from different state priorities to do with the supply of hospital places for specific conditions or to the admission behaviour of doctors of different specialties.

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FACTORS THAT INFLUENCE THE RELATIONSHIP BETWEEN CARE TYPES AND LOS IN CEREBRAL INFARCTIONS EPISODES

*Shyamala NADATHUR and Barry MCGRATH, Monash University, Victoria, Australia

INTRODUCTION

A review of current practices and construction of predictive models for a commonly collected outcome measure, Length Of Stay (LOS) of various care types, can help to create an outcome-oriented process of care. The purpose of this study was to gain a better understanding of how key collected variables in a state hospital-admission dataset impacted on the relationship between care types and LOS of the episode. Stroke is a common problem for acute hospitals and cerebral infarction (CI), the most common stroke, was chosen as the medical condition for this study.

METHOD

All public acute-hospital episodes with principle single diagnosis of CI were selected from 3 consecutive years' de-identified Victorian Admitted Episode Dataset. Episodes excluded were maternity & newborn admissions, deceased and those who left-against-advice. The data was cleaned and transformed prior to analysis. Comparisons were made using Chi-square. In General Linear Model analysis all of the selected variables were used as covariant in assessing the relationship between the main predictor care types and the outcome, the natural log of LOS.

RESULTS

The cohort consisted of 4030 males and 3744 females (n = 7774) with a mean age of 75 years (+/-13.4, range=0-103) with the distribution skewed towards older age group. There were significant relationships between LOS and the care types, admission source, admission types, hospital categories, separation types, age and gender. There were also significant relationships between care types and all of the selected covariance factors.

The average LOS of care types "Elderly" care and "Rehabilitation" were 2.9 (range 2.5-3.4) and 3.0 (range 2.3-4.1) times that of "Acute" care. The former can be explained as the elderly can often present with more complex and/or multiple diagnoses. The most significant factor which impacted on the relationship between care type and LOS was separation type. The average LOS before separations to "Elderly" care (n=488) was 209% greater than "Formal" separations. Separations to "Rehabilitation" (24%, n=498) and "Transfers" (43%, n=3,348) were also greater than "Formal" separations.

CONCLUSION

It is essential that stroke patients receive timely and appropriate care to enhance their recovery and minimize disability. In light of the above results it would be of interest to further characterise the process of care of patients undergoing "Rehabilitation" care and those who are assigned to "Elderly" care. Studies such as these are useful both as an aid to clinical decision-making, and also in providing important information on hospital resource utilisation.

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WHEN CLINICAL PRACTICES VARY, BEST PRACTICE IS ONLY ONE OF MULTIPLE VARIATIONS: NEED FOR A FORMAL MECHANISM TO MONITOR EFFECTIVENESS

Adam G ELSHAUG* (1,2), Janet E HILLER (1) & John R MOSS (1) (1) Department of Public Health, The University of Adelaide, (2) Respiratory Medicine Unit, The Queen Elizabeth Hospital, The University of Adelaide, South Australia, Australia

Recent issues of the MJA and BMJ have re-visited in detail the interesting and often controversial question: "how much mainstream medical care is based on the best available scientific knowledge about what does or doesn't work?" In Australia, questions arise as to what formal mechanisms exist to ensure consumers receive "effective" Care? And importantly, what occurs if it is demonstrated they are not? Using the example of

Obstructive Sleep Apnoea (OSA), there are currently 19 surgical interventions listed on the MBS. This is despite a recent Cochrane review (1) concluding: "Clinicians should consider restricting surgery for OSA to that carried out as part of clinical trials... Patients should be told that there is a lack of good trial based evidence of the efficacy... a course of action that may restrict the use of these operations". A multi-centre project is underway to examine the effectiveness of surgery as a treatment for OSA. Interim results demonstrate that significant limitations exist in the effectiveness of these procedures, particularly when compared to an alternate, non-surgical therapy. This demonstration of limited effectiveness has significant implications for the health outcomes of OSA positive individuals. Questions arise regarding the ability of the modern health care system to ensure currently implemented interventions produce outcomes of effectiveness (as may have been demonstrated in trials leading up to their approval and wide-spread implementation). The focus of this discussion will include aspects of clinical autonomy and the need for a consumer voice, as well as equipoise, outcome transparency, supplier-induced demand and opportunity cost. Moreover, it reinforces the need to establish a framework to formally monitor the effectiveness of commonly used interventions in health care.

(1) Bridgman S, Dunn K, Ducharme F. Surgery for obstructive sleep apnoea (Cochrane Review). In: The Cochrane Library. Chichester, UK: John Wiley & Sons, Ltd; 2004.

FACTORS INFLUENCING THE INCIDENCE OF ADVERSE EVENTS IN VICTORIAN HOSPITALS

SJ DUCKETT, TJ JACKSON*, School of Public Health, LaTrobe University, Victoria, Australia

OBJECTIVE

To estimate the incidence of and risk factors for adverse events using hospital morbidity data.

SETTING

Overnight patients treated in public and private hospitals in the financial year 2000-01 in one Australian state, Victoria.

DESIGN

Secondary analysis of data collected by the Victorian Department of Human Services (VAED).

MAIN OUTCOME MEASURES

Incidence rate and odds ratios of adverse events, length of stay, likelihood of death in hospital.

RESULTS

13.5% of overnight stay patients had an adverse event recorded in their patient record. Patients with an adverse event had a longer length of stay than patients without. Patients in older age groups had a significantly higher risk of an adverse event: patients over 85 for example, had a ten-fold higher risk than patients in the 0-4 age group. Patients with adverse events stayed more than five days longer than patients in the same DRG who did not have an adverse event.

CONCLUSION

Routine datasets can and should be used to measure the incidence of and risk factors for adverse events.

REGULATING THE NHS AND INDEPENDENT SECTORS IN ENGLAND – IMPACT AND EFFECTIVENESS

Anna WALKER, UK Health Care Commission, United Kingdom

The environment of health and healthcare is ever changing and often complex. The Healthcare Commission was established in April 2004 to promote improvement in healthcare and public health. It does this by inspecting the quality and value for money of healthcare (both in the private and public sectors) in England. National reviews also cover Wales. In carrying out its statutory functions, the Commission seeks to equip patients and the public with the best possible information about the provision of healthcare.

This presentation will describe the statutory functions of the Commission; its guiding principles; and its strategic goals. It will set out the way the Commission works, together with some concrete examples of the Commission in practice. The presentation will put the work of the Commission in the wider context of national healthcare reforms, trends in UK public policy, and the international debate on regulation. I will then proceed to discuss some of the ways we develop and use our evidence base and research to evaluate our own impact and value for money. The presentation concludes by identifying some of the challenges for the future.

HEALTH SYSTEMS IN DEVELOPMENT: THE EASTERN MEDITERRANEAN REGION

Kassem KASSAK, Dept of Health Administration, Faculty of Health Sciences, American University of Beirut, Lebanon

The Mediterranean region comprises of an intriguing array of countries which though share a lot in terms of cultural and ethnic homogeneity, nevertheless, have quite a distinct variability in the provision and the delivery of its health services. This can be attributed largely to the level of development, economy and governance in these countries. This presentation will shed some light on these similarities and differences with some parallels to international findings.

A CROSS-NATIONAL COMPARISON OF HEALTH SYSTEM PERFORMANCE: FROM THE PATIENTS' PERSPECTIVE

Robin OSBORN, Commonwealth Fund, United States of America

Findings from The Commonwealth Fund's 2005 International Health Policy Survey on Sicker Adults in Six Countries will be presented. The 2005 survey, the eighth in this series, solicits the views of 700 people in Australia, Canada, and New Zealand, and an expanded sample of 1,500 in Germany, the United States and United Kingdom, respectively, on their health care systems and their experiences with access to care, prescription drugs, medical errors, doctor-patient communication, coordination of care, preventive and emergency care, and management of chronic diseases. The survey provides a unique cross-national perspective on health care system performance and highlights opportunities for learning from other countries.

AN ANALYSIS OF THE NEW SAUDI HEALTH SYSTEM

Liza HESLOP, Omar ALSHARQI*, Monash University, Victoria, Australia

BACKGROUND

As a result of increasing costs and the growing demands of health services, the Saudi government recently reviewed its health care system. A new health care system was developed by the Ministry of Health and was approved by the Saudi Cabinet in 1999. During the first stage of implementation, all residents require

compulsory health insurance and services are delivered privately to those insured. Whether the new system is efficient and effective in delivering the first stage of health services in Saudi Arabia has not been evaluated. The aim of the study presented is to explore ideas, beliefs, and the experiences of senior policy officials about access to, and the quality of, the new system during the implementation phase.

METHODOLOGY

The study employed a qualitative research approach and semi-structured interviews were conducted with 15 key informants between December 2004 and January 2005 (Minichiello et al 2004; Rice and Ezzy 1999:4). The informants were senior policy officials from Saudi health insurance board, health insurance companies, and private hospitals in Riyadh and Jeddah. Data were analysed through QRS NVivo software program (Williamson 2002).

RESULTS

Themes arising from the analysis will be presented to describe:

- the situation of the NSHS especially with regard to access and quality
- the advantages and disadvantages of first stage of the NSHS implementation, and
- the future of the NSHS and its health insurance plan.

CONCLUSION

The study suggested the need for an ongoing evaluation of the NSHS. Access to health services was made available to all residents and Saudi citizens with both acute and chronic diseases. However, rural and remote areas were not covered by private providers. The quality of the NSHS needs improvement to reach Saudi National Standards.

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RESEARCHING HEALTH CARE REGULATION: WHO IS WATCHING THE DOCTORS?

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BACKGROUND

Research studies and "medical scandals" show that health care is a "risky business"; for example, around 10% of patients experience an adverse event in hospital (Runciman et al. 2000). Public inquiries on hospital performance, such as Campden & Campbelltown, and Bundaberg, typically find regulatory failings among managers and professional bodies. Thus the health sector in many countries, which had relied upon self-regulation by the professions, is under pressure to implement external regulation (McKee and Healy 2002). Who are the regulatory actors in Australia concerned to produce safer and better health care, and what is the evidence on the success or otherwise of their activities?

METHODS

This three-year study is funded by an ARC Linkage Grant and by industry partners: Australian Council for Safety and Quality in Health Care, ACT Health, and the Australian National University. Regulation is broadly defined as covering strategies ranging upwards in a pyramid from persuasion to enforcement. The "mapping" stage during 2005 involves literature and website reviews and interviews with key informants.

RESULTS

The complex Australian health sector exhibits "de-centred" regulation, since no one regulatory body acting alone has sufficient power or knowledge to bring about change. The proliferation of regulatory actors, however, results in an array of strategies that lack complementarity. Reliance upon "soft" regulatory strategies is giving way to "harder" forms of regulation, such as monitoring and mandatory standards.

CONCLUSIONS

Professional autonomy has to be weighed against other principles, such as accountability and transparency, in the ongoing debate on the need for meta-regulation (Braithwaite et al. 2005).

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IS COMPLEMENTARY MEDICINE OF SUFFICIENT RISK TO WARRANT GOVERNMENT REGULATION?

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In 2000, the Victorian Government in Australia passed legislation to register practitioners of acupuncture and Chinese herbal medicine as a measure for protecting public health and safety. In 2003, following a series of high profile mishaps involving naturopathy and western herbal medicine, policy research was commissioned to assess whether there were sufficient risks to warrant government intervention, and if so, what regulatory measures were appropriate. The research involves assessment of risks and benefits, profiling of the workforce and the clients, determining the degree to which comparable education standards exist across institutions and the extent to which the profession and the has been recognized in the mainstream health system, ascertaining current arrangements for self-regulation via the professional associations, and reviewing relevance of other health workforce regulatory practices. This paper will review the methodology used as well as the findings, and the policy recommendations, which will be made in mid-2005.

HOSPITAL OVER CROWDING: AN INCREASING THREAT TO PATIENT SAFETY

Peter SPRIVULIS, University of Western Australia

Australian hospitals are experiencing increasing levels of emergency department overcrowding, caused by poor access to inpatient beds for patient requiring emergency admission to hospital. The principal reason for poor access to beds is high hospital occupancy rates (>90%); which are largely the result of the use of hospital bed closures as a short term tool to reduce demand for hospital beds and hospital running costs.

OBJECTIVE

This study examines the relationship between hospital occupancy and emergency department occupancy, as indicators of hospital overcrowding, and emergency admission mortality.

DESIGN

Retrospective analysis of 62,495 probabilistically linked emergency hospital admission and death records.

SETTING

Three tertiary metropolitan hospitals between July-2000 and June-2003.

PATIENTS, PARTICIPANTS

All emergency attendance records of patients 18 years or older resulting in hospital admission.

MAIN OUTCOME MEASURES

Two, seven and 30 day mortality were evaluated against an Overcrowding Hazard Scale (OZS) based upon hospital and emergency department admitted patient occupancy, after adjustment for age, diagnosis, referral source, urgency and mode of transport to hospital.

RESULTS

A linear relationship between the OZS and 7-day mortality was demonstrated ($r = 0.98$, 95%CI 0.79-1.00). An OZS>2 was associated with an increased Day-2, Day-7 and Day-30 death hazard of 1.3 (95%CI 1.1-1.6), 1.3 (95%CI 1.2-1.5) and 1.2 (95%CI 1.1-1.3) respectively. Thirty day deaths associated with an OZS>2 compared to OZS<3 were undifferentiated with respect to age, diagnosis, urgency, transport mode, referral source or hospital length of stay but had longer emergency department durations of stay (RR per hour of ED stay, 1.1, 95%CI 1.1-1.1, $P < 0.001$) and longer physician waiting times (RR per hour of ED wait, 1.2, 95%CI 1.1-1.3, $P = 0.01$). These measured delays may be proxies for delays in receiving time-critical care in some patients.

CONCLUSIONS

Hospital and emergency department overcrowding is associated with increased mortality. Delay in receiving time-critical care may be a mediator of this relationship. The Overcrowding Hazard Scale may be used to assess the risk to patients posed by hospital and emergency department overcrowding. Reducing overcrowding may improve outcomes for patients requiring emergency hospital admission.

USING HEALTH DATA SETS TO IMPROVE AND EVALUATE MEDICINE AND HEALTH SERVICES USE: VETERANS' MATES PROJECT

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BACKGROUND

The Veterans' Medication Advice and Therapeutics Education Services (MATES) project aims to improve medicine use in the veteran population. Pharmacy claims data are used to provide direct patient-based feedback to medical practitioners regarding medications dispensed to their veteran patients. Veterans who meet the target criteria are also mailed an educational brochure. Three modules have been implemented to date, focusing on home medicine review (HMR), use of beta-blockers for congestive heart failure and use of adjunctive medicines in diabetes.

METHOD

Material was mailed to 11,384 GPs and 38,570 veterans for module one. Reply paid response forms evaluated the usefulness of the material and the likelihood of taking action on the information. Changes in home medication review rates and medication usage were traced using the pharmacy and Medicare claims data. Results

Response forms were received from 1,085 (10.6%) GPs and 11,150 (29%) veterans. 68% of GPs and 86% of veterans who responded reported the information provided to be good or very good. 79% of GPs, but only 21% of veterans, who responded indicated they were aware of the HMR service prior to the mailing. Only 304 (29%) of responding GPs had participated in a HMR, while 1763 (16%) of veterans had participated in a HMR in the past. 66% of veterans indicated they would speak to their doctor about a HMR at their next visit.

CONCLUSIONS

Changes in home medicine review rates will be presented at the meeting as will a discussion of the strengths and limitations of using claims data for improving health service delivery.

THE DIVISIONS OF GENERAL PRACTICE NETWORK: WHO'S DOING WHAT, HOW MUCH OF IT AND WITH WHAT EFFECT?

Elizabeth KALUCY* and Carmen NAVARRO-SANCHEZ, Primary Health Care Research and Information Service, South Australia

BACKGROUND

Over the last decade, the Divisions of General Practice program has become a significant national network in terms of members, programs, and integration between general practice and other health services. The progress of the network has been documented thoroughly through an annual survey as well as collection of plans and reports by the Primary Health Care Research and Information Service (PHCRIS). Following a review of the role of Divisions in 2003 a National Quality and Performance System is being implemented, which will provide information on outcomes. This paper will use the example of GP-hospital integration to illustrate the information available in the past, and that, which should be available in 2006 under the new system.

METHODS

Data sources used are the Annual Survey of Divisions for 2003-4, the Activities of Divisions database on www.phcris.org.au, and the new performance indicators for GP-hospital integration.

RESULTS

Successive Annual Surveys of Divisions provide trend information on collaborative programs with hospitals, involvement of consumers, formal reciprocal agreements, and representation on external committees, answering "who's doing what?" To find out "how much of it?" requires more detailed study of Divisions plans and reports on the on-line database. The new performance indicators involve descriptions of major achievements for GP-hospital integration.

CONCLUSIONS

The new performance system should be able to provide some answers to the question "with what effect?" for this and other national priority areas, to supplement information from the existing system on "who's doing what?" in relation to GP-hospital integration.

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RELATIONSHIPS BETWEEN SOCIOECONOMIC STATUS, INCOME INEQUALITY, HEALTH SERVICE USAGE AND SURVIVAL FROM STROKE

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BACKGROUND

Previous studies have identified socio-economic status (SES) as being associated with increased risk of mortality. However, there is continued debate regarding the importance of societal-level factors (such as income inequality) in predicting mortality rates. This study examines whether SES and income inequality predict survival from stroke. The study then examines whether the associations are explained by differences in health services usage.

METHODS

Data comes from an incidence study of stroke (n = 1438) in Auckland, New Zealand. Two aspects of mortality are examined: Short term mortality rates (survival after stroke of less than 30 days) and long-term mortality (survival more than 30 days but less than one year). Survival analysis is used to examine whether SES, income inequality and health service usage predict short and long term risk of mortality.

RESULTS

The results suggest that both SES and income inequality are significantly associated with increased short term and long term risk of mortality. The analysis examines the extent to which SES and income inequality are proxies for known risk factors (e.g., severity of stroke and time to receiving medical attention) of mortality. The results suggest that SES

and income inequality remain significant predictors of short-term mortality, but only SES is associated with long-term mortality. Regression analysis is used to identify the pathway by which SES and income inequality are associated with health service usage.

CONCLUSION

The paper adds to our understanding of the mechanisms by which SES and income inequality are associated with increased risk of mortality and the association with health service usage.

THE COSTS AND POTENTIAL SAVINGS OF A NOVEL TELEPAEDIATRIC SERVICE IN QUEENSLAND

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In November 2000, we established a novel telepaediatric service for selected regional hospitals in Queensland. Instead of sending patients to Brisbane, the majority of referrals to specialists in Brisbane have been dealt with via videoconference. Since the service began, over 2500 consultations have been conducted for a broad range of paediatric sub-specialities including burns, cardiology, child development, dermatology, diabetes, endocrinology, gastroenterology, nephrology, neurology, oncology, orthopaedics, paediatric surgery and psychiatry.

The total cost of providing 975 patient consultations through the telepaediatric service was \$740,248. The estimated potential cost of providing an outpatient service to the same number of patients at the Royal Children's Hospital (RCH) in Brisbane was \$1,060,231. Telepaediatrics was a less costly method for the delivery of outpatient services when the workload exceeded 597 patient consultations and resulted in a net saving of about \$320,000 to the health service provider at the actual workload encountered. A sensitivity analysis showed that the threshold point was most sensitive to changes related to videoconference equipment costs, staff salaries and patient travel costs.

USING DIARIES TO MEASURE UTILISATION OF PRIMARY CARE BY INDIVIDUAL PATIENTS

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BACKGROUND

Information on utilisation of general practitioner and other primary care services by individual patients is often required in studies of access to care by gender, age, socio-economic status or chronic disease status. A further use is in estimating the public or personal costs of care.

Health information systems cannot always provide information on utilisation of general practitioner services by individual patients. Researchers are not always granted access to medical records to compile this information. In such cases, patient-completed diaries are often used.

METHODS

This paper compares the measurement of the utilisation of primary care services using monthly diaries, with information from a practice database for a sample of families with and without a member with asthma. Medical records were also accessed for those with asthma.

The results of the comparisons are presented by patient characteristics including gender, age, income, and asthma status. Performance measures include the proportion of all general practitioner visits captured and the proportion of visits for asthma captured.

RESULTS

The results show serious under-reporting of GP visits in the diaries of the general group, with 54 per cent of visits recorded. For the group with asthma, diary reporting for their asthma-related visits was much higher (82 per cent) but only 53 per cent of non-asthma consultations were recorded.

CONCLUSIONS

These results are encouraging for studies of targeted groups with specific conditions, but show that caution is required in interpreting diary reported GP utilisation for the general population.

IMPACT OF TWO AFTER-HOURS MODELS OF GP SERVICES ON PATIENT SATISFACTION AND ACCESS TO CARE AT A WHOLE POPULATION LEVEL

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BACKGROUND

The delivery of GP after hours (AH) medical care in Australia and other countries has been affected by the decline in own-practice care. This study focuses on three after hours (AH) trials, initiated by the Australian government aimed at increasing consumer access.

OBJECTIVE

To study the impact of two models of after hours (AH) primary medical care - telephone triage and advice and GP cooperative - on perceptions of access to services at a whole-population level.

METHODS

Local trials were offered on a whole-population basis and a monitoring strategy was used to evaluate their impact. Trial effects are considered in terms of changes in availability, accessibility, affordability, acceptability and responsiveness of care plus unmet need. Changes in levels for each of these variables across the trial period were compared with changes in a national sample. Pre-trial and post-trial telephone surveys of two separate random samples of approximately 350 households using AH services in each of five regional areas plus nationally were conducted.

RESULTS

Reduction in unmet need approached but did not achieve statistical significance in most but not all individual trial areas. Increases in access variables only occurred in the multi-service GP cooperative, this being for affordability and acceptability. Significant change in levels in call centre areas, considered together, could not be detected for any of the access dimensions.

DISCUSSION

Findings in regard to both the triage model and the GP cooperative are discussed.

CONCLUSIONS

Results are more supportive of further development of the cooperative than the triage model.

MEASURING THE VALUE OF A NATIONAL PROGRAM FOR QUALITY USE OF MEDICINES: INFORMING ACCOUNTABILITY AND SERVICE IMPROVEMENT THROUGH MULTI-FACETED EVALUATION

Sonia WUTZKE*, Nicole COCKAYNE, Linda KEHOE, John MANDRYK, Fiona HORN, Emma SLAYTOR, National Prescribing Service, New South Wales Australia

BACKGROUND

The National Prescribing Service (NPS) is an independent public company that targets health professionals and consumers, with the aim of promoting Quality Use of Medicines (QUM). At establishment, evaluation was recognised as a critical component to support both the strategic direction and accountability of the organisation.

METHODS

The approach taken to measuring the value of NPS is broad ranging and comprehensive. Measures include: the process, scope and reach of activities; perceptions about the usefulness and trustworthiness of information; changes in awareness, skills and behaviour; and changes in health and economic outcomes resulting from programs. Value is measured from the perspective of a range of internal and external audiences. A range of existing and purpose-designed datasets are used.

RESULTS

Evaluation of NPS services to date show impressive achievements: high awareness of the organisation (GPs 98%, pharmacists 99%); widespread uptake of educational activities and resources across a broad range of therapeutic topics (over 85% of GPs actively participating in activities at least once); high level of respect and trust in NPS as a reliable and independent source medicines information (84 and 97% of GPs and pharmacists rating NPS to be of either great or moderate value); changes in consumer and health professional knowledge, attitudes and behaviour consistent with program key messages (including changes in antibiotic use, NSAIDs and low-dose thiazides); and PBS savings >\$235 million over the seven years of operation.

CONCLUSIONS

Measuring and reporting the value of NPS is essential for sustainability. Continued refinement of existing evaluation methods and further exploration of new techniques remains a priority for the organisation.

REFORM HEALTH BY FOCUSING ON SELF-MANAGEMENT

Malcolm BATTERSBY PhD, FRANZCP, FACHAM, Flinders University, South Australia

The term 'self-management', whilst inducing a warm inner glow in those who espouse it, has no formal place in the current Australian health care system. There is now a considerable body of evidence that a wide range of self-management interventions improve health outcomes for a number of chronic conditions, yet clinicians and managers are yet to be convinced that it is worth including a self-management focus in routine primary care let alone acute care systems. The National Sharing Health Care demonstration projects national evaluation has shown that self-management interventions are effective and that self-management support needs to be targeted to the individual through assessment, planning and follow-up. This will require a minor revolution in the current care delivery system yet by focusing on the relationship between patient and clinician may provide a means to address systemic issues at the clinician, patient and system level.

INVESTIGATING THE SUSTAINABILITY OF OUTCOMES IN A CHRONIC DISEASE TREATMENT PROGRAM

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AIM

To determine sustainability of primary care service and outcome measures for chronic disease following withdrawal of a specialised chronic disease treatment program.

METHODS

Review of clinical records of 98 participants with confirmed renal disease or hypertension in a remote Indigenous community health centre in Northern Australia. The review period spanned an initial three years for each participant in a specialised cardiovascular and renal disease treatment program and a subsequent three years following withdrawal of the treatment program. The time series analysis included at least six measures prior to and six following intervention. Main outcome measures were trends in BP control, and systolic and diastolic BP.

RESULTS

Following initial improvement in BP control, there was a steady declining trend in BP control. There was no significant difference in this trend between the pre- compared to the post-program withdrawal period. This finding was consistent for control at levels below 130/80 and 140/90, and for trends in mean systolic and diastolic BP.

CONCLUSIONS

The findings indicate a failure to sustain the initial success achieved under the specialised treatment program, both during the operation of the program and following program withdrawal. Investigating the sustainability of program outcomes presents major challenges for research design. Sustained success in the management of chronic disease through primary care services requires better understanding of the causal mechanisms related to clinical intervention, the basis upon which they can be "institutionalised" in a given context, and the extent to which they require regular revitalisation to maintain their effect.

VALIDITY, RELIABILITY AND RESPONSIVENESS OF THE QLQ-C30 & LC-13 AS MEASURES OF HEALTH-RELATED QUALITY OF LIFE IN AUSTRALIANS WITH LUNG CANCER

Madeleine KING*, Julie WINSTANLEY, Patsy KENNY, Rosalie VINEY, Michael BOYER, CHERE, University of Technology, Sydney, New South Wales, Australia

BACKGROUND

The QLQ-C30 and LC-13 are complementary components of the European Organisation for Research and Treatment of Cancer's modular approach to measuring health-related quality of life (HRQOL): QLQ-C30 contains 30 items relevant to all cancers; QLQ-LC13 contains 13 lung cancer specific items. Their validity, reliability and responsiveness have not yet been assessed in Australians with lung cancer.

METHODS

We used data from the longitudinal follow-up of 173 participants in a randomised study of the use of Positron Emission Tomography in the management of early stage lung cancer. Participants completed HRQOL questionnaires at recruitment, before and after surgery, and then four monthly for two years. Construct validity was tested with confirmatory factor analysis.

Reliability was characterized by internal consistency and test-retest reliability. Responsiveness was assessed by estimating standardized response means for patients who underwent surgery and those for whom disease recurred.

RESULTS

The factor structure reported previously was replicated in this sample, confirming construct validity. Most scales demonstrated excellent internal consistency (Cronbach's alpha range: 0.86 - 0.94); the exceptions were the cognitive functioning and nausea/vomiting scales (Cronbach's alpha: 0.67). Test-retest reliability was generally good (intraclass correlation (ICC) range: 0.70 - 0.81); the exceptions were the pain and nausea/vomiting scales (ICC 0.56 and 0.42). Most scales were responsive to the large expected effects of surgery and disease progression (standardized response mean range: 0.77 - 1.37).

CONCLUSIONS

The QLQ-C30 and QLQ-LC13, when used together, provide a valid, reliable and responsive measure of HRQOL in Australians with lung cancer.

HOME BASED PALLIATIVE CARE: THE CONTRIBUTION OF INFORMAL CARERS AND THE IMPACT IT HAS ON THEIR LIVES

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BACKGROUND

Palliative care services are increasing the provision of care in the community, resulting in a greater demand for informal care, the provision of unpaid care at home by relatives and friends. Home-based care requires a substantial contribution from these informal carers. This study describes this contribution and the impact it has on those providing care.

METHODS

Eighty-two carers, of patients registered with two community palliative care services in Sydney, were interviewed to assess patient care needs, care provided by informal carers and the health status of the carer (using the SF36 questionnaire). A number of open-ended questions asked about the impact of caring and the type of support carers would find helpful.

RESULTS

Most carers reported that patients required help with household tasks and many needed assistance with personal activities of daily living (PADL), taking medications and organizational tasks. Although on average the physical health of carers was similar to that of the general population, their mental health scores were lower. Many carers reported effects on social and family relationships, restricted work and leisure activities, and negative emotional effects including: feeling depressed, emotional exhaustion, and frustration. Some carers reported positive emotional effects such as a sense of achievement, and happiness at being able to give something back. The support carers said they would like included information and advice, in-home respite, household assistance, and financial support.

CONCLUSIONS

An understanding of the demands on informal carers, and their preferences for support can assist planners and palliative care providers to develop a range of services that best meet the needs of carers.

WHAT MAKES A HIGH PERFORMANCE HEALTH CARE SYSTEM?

Karen DAVIS, Commonwealth Fund, United States of America

Based on survey results, policy research, and the promising approaches of innovators, The Commonwealth Fund has identified ten core values that define high performance health systems. The priority areas are: long, healthy, and productive lives; the right care; coordinated care over time; safe care; service excellence; efficient, high value care; universal participation; affordable care; equitable care; and knowledge and capacity to improve performance. Assessing health system performance on these dimensions, identifying best practices, and evaluating country policies using these criteria would make a real difference to patients, payers, and the future of health care systems themselves. The goals should be simultaneous attainment of better access, higher quality, and greater efficiency, especially for the most vulnerable members of society.

RITUALISM AS A TOPIC IN HEALTH SERVICES RESEARCH

John BRAITHWAITE, Research School of Social Sciences, Australian National University, Australian Capital Territory, Australia

Robert Merton developed a typology of modes of adaptation to a normative order: conformity, innovation, ritualism, retreatism and rebellion. Empirical research on nursing home regulation since 1987 reveals that ritualism is the most difficult problem to deal with. Ritualism means committing to institutional means for achieving a goal while losing sight of goals or outcomes themselves. Unfortunately, quality improvement strategies in health services that are designed to be outcome-oriented are prone to go the way of ritualism. Implementation of the Minimum Data Set with US nursing home regulation will be used to illustrate the problem and the need for observational research methods that study ritualism. Unless we understand how ritualism works, we may settle for strategies for the governance of health services that do as much harm as good, as US nursing home regulation illustrates

TOWARDS HIGH IMPACT HEALTH SYSTEMS RESEARCH

Charles NORMAND, University of Dublin, Ireland

INVESTING IN PRIMARY HEALTH CARE: WILL NEW ZEALAND'S PRIMARY HEALTH CARE STRATEGY PROVIDE VALUE FOR MONEY?

Jackie CUMMING, Health Services Research Centre, Victoria University, New Zealand

New Zealand's Primary Health Care Strategy is aimed at improving health status and reducing inequalities in health. Implementation has involved new funding, the development of Primary Health Organisations (PHOs) to provide care to enrolled populations, and a move to capitation funding.

This presentation reports on an evaluation funded by the Ministry of Health, ACC and the Health Research Council of New Zealand. The presentation will note that much has been achieved with the Primary Health Care Strategy and there is strong support for its goals. Key issues for the future include the need to ensure that: small PHOs achieve financial stability; meaningful community engagement is achieved; service

delivery is reviewed and services delivered in the most cost-effective setting; issues relating to fees charged by practices are resolved; and workforce issues are addressed. The presentation will conclude with an overview of the next stages of the evaluation.

INCENTIVES AND HEALTH CARE FINANCING

Elizabeth SAVAGE, CHERE, University of Technology, New South Wales, Australia

Because of the unpredictable nature of medical expenditures and the potential for extremely high costs, insurance is an inevitable feature of health care financing. The design of a financing system that promotes efficiency while addressing distributional concerns is a difficult task. Even minor reforms can result in unexpected and large increases in health care costs. The aim of this paper is to outline the nature of the incentive problems facing health policymakers in a range of institutional settings and to explore financing methods that can be used to align incentives and health goals. I explore examples of policy reforms both in Australia and overseas and link outcomes to the underlying incentives on the behaviour of patients, providers and insurers that drive health care costs.

WHAT IS EVIDENCE BASED POLICY?

Jane HALL, CHERE, University of Technology, New South Wales, Australia

PATTERNS AND COSTS OF TREATMENT FOR HEROIN DEPENDENCE: FINDINGS FROM THE AUSTRALIAN TREATMENT OUTCOME STUDY

Marian SHANAHAN*, Alys Havard, Maree Teeson Jo Ross, Shane Darke, Katherine Mills, Anna Williamson, National Drug & Alcohol Research Centre, University of New South Wales, New South Wales, Australia

BACKGROUND

Dependence on illicit drugs comes at a significant economic burden to the drug user, their family and society at large. Treatment for substance misuse has been demonstrated to be cost-beneficial in that it provides positive economic returns to society when

short-term treatment costs are compared to a range of societal benefits. However, the actual cost of treatment for patients that drop out and re-enter treatment remains uncertain in the Australian context. The aim of this paper was to assess the patterns and costs of treatment for heroin dependence over a 12-month period.

METHODS

The study design is a longitudinal cohort study conducted. Participants were 596 heroin users interviewed for ATOS upon entrance into methadone maintenance, residential rehabilitation or detoxification, and reinterviewed at 12-month follow-up.

RESULTS

Participants spent an average of 188 days in treatment over 2.7 episodes. There was a noticeable trend for subjects who received maintenance or residential rehabilitation as their first treatment to return to the same form of treatment for subsequent episodes. In contrast, those who received detoxification as their first treatment tended to access a wider variety of treatments. The cost of treatment over the 12-month follow-up period averaged \$6,546 per person. Differences in costs were a function of days in treatment and average cost per day of treatment types.

CONCLUSIONS

There was extensive treatment exposure throughout the follow-up period. While the mean cost for was greater than average annual healthcare expenditure, at \$6,546 per person it is not an excessive amount for treatment of a chronic disease, which has a significant societal burden.

IMPLEMENTATION AND ASSESSMENT OF AN EFFICIENCY PROTOCOL IN SLEEP MEDICINE: RESOURCE NEUTRAL IMPROVEMENTS IN PATIENT CARE

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BACKGROUND

Increasing recognition of Obstructive Sleep Apnoea Syndrome (OSA) has led to a marked rise in the provision of hospital-based sleep studies in Australia, from 14,308 in 1994 to 61,240 in 2004. Despite this, there continues to be unmet demand. One proposed solution is the split-night protocol, whereby the

diagnosis and treatment components are condensed into a single night as opposed to the traditional two. This practice is resource neutral, has the potential to increase patient throughput and expedite treatment. The American Academy of Sleep Medicine (AASM) released a protocol recommendation for conducting split-night studies (1) yet Australia has no formal policy and the practice is not widely adopted.

AIM

To quantify technical efficiency (improved throughput, treatment turnaround) achievable by implementing a split-night protocol.

METHODS

A split-night sleep study protocol was implemented at Adelaide's Queen Elizabeth Hospital (TQEH) in accordance with AASM criteria (1). Resulting efficiency gains were measured by reviewing the clinical data of 944 sleep studies collected over a twelve-month period (2002-2003).

RESULTS

The adoption of split-night sleep study protocols improved technical efficiency by at least 15%. TQEH conducted 142 additional sleep studies in the twelve-month period than would otherwise have occurred, if no split-night protocol were in place. Treatment time was expedited by up to 7 months for the most severe sufferers.

CONCLUSIONS

If applied to the total of 61,240 sleep studies conducted in Australia during 2004, an efficiency gain of 15% would allow 9,186 additional studies to be carried out annually within existing resources. We argue the need for greater consensus regarding the policy and widespread implementation of this evidence-based technique.

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CHOOSING PAP TESTS: WHAT FACTORS DO WOMEN AND GP'S TAKE INTO ACCOUNT?

Marion HAAS*, Denzil FIEBIG, Rosalie VINEY, CHERE, University of Technology, New South Wales, Australia

BACKGROUND

Economic evaluations of population-based screening programs often use decision analytic modeling to estimate the costs and consequences of factors such as screening interval or target age ranges. Whilst such changes have an impact on compliance, there is little information about how the behaviour of women and providers will be influenced. We investigated the interaction of consumers' preferences and providers' recommendations in the context of cervical screening decisions.

METHODS

Separate discrete choice experiments were conducted with women and GPs.

RESULTS

Women tended to choose to have a Pap test when the doctor was female, she/he was their regular GP, they were due or overdue for a test and when the GP recommended they have a test. They were discouraged by cost and any decreases in the accuracy of the test but were not influenced by the recommended screening interval or whether the GP received an incentive payment. In making a recommendation to have a Pap test, GPs took into account whether the patient was due or overdue for testing and any cost to the patient. They were less likely to recommend a Pap test if the patient had come to them with a serious health problem or was aged 70 or over.

CONCLUSIONS

The results of DCEs enable us to predict the uptake of new technologies and provide a better understanding of how prices, recommended screening interval and levels of accuracy affect screening uptake. How women and GPs differ in their preferences also provides information about the agency relationship in this context.

'WILLINGNESS-TO-PAY' FOR THE FINANCIAL, COMFORT AND HEALTH BENEFITS

Des O'DEA*, Ralph CHAPMAN, Philippa HOWDEN-CHAPMAN, Wellington School of Medicine, University of Otago, Wellington, New Zealand

BACKGROUND

"Willingness-to-Pay" can be a valuable technique for estimating the worth of public sector investments. New Zealand houses have traditionally not been well insulated and this remains true for many lower income households, with adverse effects on occupants' health. In a recent large-scale experiment insulation was retro-fitted to 1400 dwellings in seven localities, half being insulated in 2001, and the other half (the control group) in 2002. Extensive data were collected on dwelling and household characteristics, energy consumption, and use of health-care services. (Howden-Chapman et al; 2005) This included participants' expected and actual trade-offs between financial savings from lowered energy consumption, and increased warmth; and also their "willingness-to-pay" for the insulation in advance, and "willingness-to-accept" payment for it afterwards.

METHODS

Data were analysed "before" and "after", as influenced by locality, health-care subsidies, etc. Results were also compared with a standard cost-benefit analysis, valuing energy savings and reduced use of health-care services.

RESULTS

Participants in the experiment on average gave estimates of the value of insulation reasonably consistent with actual cost. Their predicted \$/warmth trade-offs beforehand were also consistent with actual trade-offs.

CONCLUSIONS

Willingness-to-Pay techniques proved workable in this application. They are a useful alternative for valuing "benefit" in both housing and health economics.

INDIGENOUS HEALTH IN A FRAGMENTED POLICY ENVIRONMENT: THE VICTORIAN

Juan BAEZA*, Dr Jenny LEWIS, University of Melbourne, Victoria, Australia

BACKGROUND

The Australian health system is characterised by fragmentation in terms of policy, delivery and finance. Although mainstream health services suffer from this structural fragmentation the context for community controlled Indigenous health services is even more fraught. This paper reports on the findings of an organisational study that maps the Victorian health system and the association between mainstream health related organisations and those linked to Indigenous populations.

METHODS

A qualitative interview study of 22 health related organisations in Victoria was conducted in early 2005. The nominated spokesperson (usually the chief executive or their equivalent) from each organisation was asked what they perceived as the strengths and weaknesses of the Victorian health system, what they considered the main strains in the system and their organisation's perspective upon Indigenous health. The informants were also asked about their organisations relationships with other bodies in order to establish a map of the health sector in Victoria and the relationships within this system in general and between mainstream and Indigenous health organisations in particular.

RESULTS

This study provides qualitative and social network data of a highly fragmented health system that makes planning and partnerships difficult to develop and sustain. There is evidence that the Indigenous health sector is particularly vulnerable within this fragmented arena.

CONCLUSIONS

The results from this study will be used to examine what these connections and disconnections mean in terms of getting Indigenous health onto the policy agenda, and in terms of effecting change in Indigenous health policy.

INDIGENOUS FAMILY VIOLENCE: NEW INSIGHTS & PATHWAYS IN POLICY & PROGRAM PROVISION.

Kyllie CRIPPS, Onemda VicHealth Koori Health Unit, Victoria, Australia

BACKGROUND

The incidence of family violence in Indigenous communities in Australia has become so commonplace in some communities that Indigenous leaders state that "no Indigenous family is ever free from it" "violence is a part of everyday life and none of us escapes it" (Dodson 2003: 2). Yet few quantitative studies exist to support such statements or explain why this is. This is largely due to small sample sizes in violence specific surveys and problematic administrative data that are only able to capture in a limited way the incidence of violence (Lievore 2003).

The 1994 and 2002 National Aboriginal & Torres Strait Islander Social Survey are the noted exceptions. These surveys with samples of 15,700 and 9,400 Indigenous people provided information across key areas of social concern including socio-economics, cultural factors, family context and networks, substance use and of particular interest to this research - violence.

METHODS

Using the NATSISS datasets this research explored the association of variables across the key areas of social concern with those survey respondents who reported to be victims of violence.

RESULTS

Initial analysis of this data has shown a significant jump in the number of people reporting to be victims of violence - 13% in 1994, 24.3% in 2002, and highlighted that associations exist based on one's locality, age, employment status, income level, and past contact with police.

CONCLUSIONS

This paper will discuss the results of this research and the significant implications they have for those designing family violence intervention and prevention policy and programs.

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CANCER DIAGNOSIS AND TREATMENT IN THE NORTHERN TERRITORY – ASSESSING HEALTH SERVICE PERFORMANCE FOR INDIGENOUS AUSTRALIANS

John R CONDON*, Joan CUNNINGHAM, Tony BARNES, Bruce ARMSTRONG, Sid SELVA-NAYAGAM, Menzies School of Health Research, Northern Territory, Australia

BACKGROUND

A retrospective cohort study investigated why Indigenous Australians with cancer are diagnosed with more advanced disease and have lower survival than other Australians.

METHODS

Stage at diagnosis and relative risk of cancer death were compared for 242 Indigenous and 955 non-Indigenous residents of the Northern Territory diagnosed with cancers of the colon and rectum, lung, breast, cervix and non-Hodgkin lymphoma in 1991 - 2000. Data was collected from medical records on features of the person and of cancer diagnosis and treatment.

RESULTS

No explanation was found for later cancer diagnosis in Indigenous people. Lower Indigenous cancer survival was partly due to late diagnosis, partly to deficiencies in cancer treatment, and partly to other unidentified factors. Cancer survival was better for Indigenous people whose first language was English than for those with an Indigenous first language. For English-language speakers, cancer survival was similar to that of non-Indigenous people after adjusting for site, age and stage at diagnosis. For Indigenous-language speakers, treatment and other factors were also involved.

CONCLUSIONS

Cancer diagnosis needs to improve for all Indigenous people in the NT, but once diagnosed, cancer treatment services appear to be as effective for English-language speakers as for non-Indigenous people. For Indigenous-language speakers, both diagnosis and treatment outcomes need to improve, but other factors (eg, knowledge of and attitudes to cancer symptoms and treatment, communication difficulties, social, environmental, economic and educational disadvantage) that are distinctive to these Indigenous people need to be further investigated before their disadvantage in cancer survival can be eliminated.

INDIVIDUAL AND AREA LEVEL EFFECTS ON ABORIGINAL BIRTH OUTCOMES IN COMMUNITIES IN THE NORTHERN TERRITORY

Matthew STEVENS* and Stephen HALPIN, Menzies School of Health Research, Northern Territory, Australia

Aboriginal families and communities suffer considerably higher levels of perinatal mortality and low birth weight babies compared to non-Indigenous Australians. The majority of Aboriginal people in the Northern Territory live in communities of varying size scattered across remote and very remote regions. However the relative importance of access to antenatal care compared to individual level risk factors and other community level risk factors is currently unknown. This study aimed to investigate this using multilevel modeling.

Birth outcomes and individual level factors were derived from the 2000-2002 Northern Territory Midwives Collection. Area (or community) level risk factors were derived from the 2001 Community Housing and Infrastructure Needs Survey and 2001 Census of Population and Housing. The data sets were linked using a concordance between the Department of Infrastructure, Planning and Environment Aboriginal Community number; Australian Bureau of Statistics Aboriginal community number and 2001 census Collection Districts.

Expected individual level factors (mother's age, parity, smoking and drinking status, and length of gestation) remained in final models. Additionally, a number of area based measures (access to services and area level socioeconomic status) showed significant effects on birth outcomes after controlling for individual level factors.

Many of these communities have poor housing, poor socioeconomic outcomes and a wide range of health problems generally. In addition to this many pregnant Aboriginal women do not have easy access to antenatal care. This is an important consideration in health care given that limited access to antenatal care has been shown to be associated with higher rates of pre-term births and low birth weight babies.

CHANGING HEALTH CENTRE SYSTEMS FOR BETTER DIABETES CARE IN ABORIGINAL COMMUNITIES IN THE NORTHERN TERRITORY

DAMIN SI*, Ross BAILIE, Christine CONNORS, Michelle DOWDEN, Lynette O'DONOGHUE, Tarun WEERAMANTHRI, Joan CUNNINGHAM, Menzies School of Health Research, Charles Darwin University, Northern Territory, Australia

AIM

To evaluate the impact of an intervention to improve diabetes care in Aboriginal community health centres.

METHODS

A prospective before-after study was conducted in 12 Aboriginal community health centres with a random sample of 295 patients with type 2 diabetes. The intervention consisted of a cycle featuring audit and feedback, organisational learning, goal setting for system changes, and implementation of changes in practices. The Assessment of Chronic Illness Care scale was adapted to measure system development in health centres, and administered by interview with health centre staff. Data on care provided were extracted from medical records. Main processes of care measures were annual testing of HbA1c, blood pressure, total cholesterol, creatinine, fundi examination and influenza vaccination. Main outcomes measures were HbA1c, blood pressure and total cholesterol levels. Multilevel analysis was used to account for repeated observations and clustering.

RESULTS

Health centre systems improved across all areas of the scale, with significant improvement in areas of delivery, system design and clinical information systems. Annual total cholesterol testing showed significant improvement (from 56% to 70%), while other process measures showed a trend to improvement. Average HbA1c level reduced significantly from 9.3% to 8.8% (adjusted mean difference 0.45%, 95%CI 0.01-0.90%). No improvement was found in blood pressure and total cholesterol control.

CONCLUSIONS

This multifaceted intervention achieved favourable changes in health centre systems, and in some process and outcome measures of diabetes care in a short period. Longer follow-up and comparison with non-intervention communities will provide a stronger basis for assessment of impact.

ABORIGINAL AND TORRES STRAIT ISLANDER USE OF EMERGENCY DEPARTMENTS

David PTHOMAS*, Ian ANDERSON, Margaret KELAHER, University of Melbourne, Victoria, Australia

BACKGROUND

Most Indigenous health care policy, debate and research has concentrated on primary health care services (especially Aboriginal community controlled health services). Most research of hospital services has only focussed on admitted patients. There has been little attention to how Indigenous people use emergency departments.

METHODS

This literature review used a formal search strategy of two online databases, four electronic databases on CD, and manual searches of Emergency Medicine journal, publication sections of ABS and AIHW websites, selected bibliographies and informal networks.

RESULTS

Aboriginal and Torres Strait Islander peoples attend emergency departments (EDs) about twice as often as other Australians. The waiting times of Indigenous patients are similar to or slightly shorter than those of non-Indigenous patients. But more Indigenous than other patients choose to walk out before being seen, indicating possibly greater Indigenous dissatisfaction with ED care. Further conclusions of this literature review are limited by contradictory results in the few studies of reasonable quality and by general concerns about data quality, especially the poor (but slowly improving) identification of Indigenous people in routine ED datasets.

CONCLUSIONS

There are new possibilities, albeit with considerable constraints, for better monitoring and researching of Indigenous use of EDs using existing datasets. In particular, all jurisdictions are now required report annually on all items (including an Indigenous identifier) in the Non-admitted patient emergency department care National Minimum Data Set.

PET: COSTS AND TREATMENT OUTCOMES FOR PATIENTS WITH STAGE I AND II NON-SMALL CELL LUNG CANCER.

Rosalie VINEY* PhD, Patsy KENNY MPH, Madeleine KING PhD, Kees VAN GOOL* MEd, Christine POLLICINO M Med Stat, Emma WARREN, MSc, Brian MCCAUGHAN FRACS, Michael FULHAM FRACP, Jocelyn MCLEAN MN, Michael J BOYER PhD, CHERE, University of Technology, Sydney, New South Wales, Australia

BACKGROUND

Positron Emission Tomography (PET) has been heralded by some as an essential part of cancer diagnosis and treatment. Despite its gradual introduction into health care practice, little Australian evidence has been reported on the cost and consequences of PET. This paper reports on a randomised controlled trial to investigate the impact of PET on costs and outcomes for patients with Stage I-II NSCLC.

METHODS

An economic evaluation was undertaken to measure the impact of PET in terms of cost per thoracotomy avoided, disease recurrence and survival over a two year follow-up period, as well as detailing clinical management, resource use and surgical outcomes. Patients presenting to surgeons with a diagnosis of Stage I-II NSCLC were randomised to receive PET (n=91) or conventional staging (n=92) prior to the final decision about surgical management.

RESULTS

Compared with conventional staging, PET assigned 22 patients to a higher stage, confirmed staging in 61 and staged two patients as benign. PET detected Stage IIIA disease in 11 patients. Thoracotomy was performed in 96% and 98% of the PET and conventional staging arms respectively (p=0.2). The cost per thoracotomy avoided was \$A120,681.

CONCLUSION

The study demonstrates that the value of PET for management of patients with clinical stage I-II NSCLC depends on the management strategy for Stage IIIA disease. There were no significant differences between the trial arms in terms of adjuvant radiotherapy, disease recurrence, palliative chemotherapy after recurrence and survival at two years.

CONSTRUCTION OF A MODEL FOR MEASURING HOSPITAL EFFICIENCY; THE APPLICATION OF A BROADER SET OF VARIABLES IN HOSPITAL EFFICIENCY MEASUREMENT

Hossein HAJIALIAFZALI*, John R. Moss, Afzal Mahmood, The University of Adelaide, South Australia

Over the past few decades, there has been an increasing interest in the measurement of hospital efficiency. Whilst the choice of measurement methods has been widely argued, few authors have offered a model to specify variables that reflect health promoting activities, the quality of the process of care, and the effectiveness of hospital services. Indeed, the variables employed in the majority of studies have predominantly been based on the quantity and/or cost of services (service oriented approach), with little attention to the quality of care provided and other hospital functions including preventive care, cooperation with community-based services, and human resource development. However, without knowledge of hospital objectives and all relevant functions, efficiency studies run the risk of making biased comparisons, particularly against hospitals which provide higher quality services requiring the use of more resources. This study aims to rectify that apparent conceptual gap in the literature by moving from a service-oriented to a health-centred approach.

By undertaking an in-depth investigation regarding the multi-product nature of hospitals, and using a welfare-based definition of efficiency (allocative efficiency), the various hospital functions mentioned above, and the values of various stakeholders (patient, staff, and community), this study has developed a new system-based model to select the most appropriate variables for measuring hospital efficiency.

It is worth noting that employing an economic framework to measure hospital efficiency, without knowledge of its mission, objectives, and functions will not necessarily lead to a sufficiently deep analysis and hence to a real improvement in efficiency. This study by incorporating a broader set of variables, which are linked to all essential functions and through them to the hospital's final goal, seeks to increase the validity of hospital efficiency studies in terms of achieving the greatest possible health outcomes with the minimum feasible use of scarce resources.

CONTRACTING FOR OUTCOMES IN MAORI MENTAL HEALTH SERVICE PROVISION: THE EXPERIENCE OF MAORI PROVIDERS

Amohia BOULTON* Te Pumanawa Hauroa, New Zealand

BACKGROUND

New Zealand's mental health performance measurement framework comprises a complex set of policies, guidelines, standards, service specifications, input, output and contracting data. The framework was not designed in a systematic fashion from "blank canvas" but, as in other health care systems, grew over time into its current state (Anderson, Moran et al. 1998). This presentation notes that a weakness of New Zealand's framework is its current inability to recognise the outcomes Maori mental health providers are achieving.

METHODS

The research collected three types of qualitative data: semi-structured interviews with 20 key informants and 15 staff from 7 community-based Maori mental health providers; contracting and performance measurement documentary material; and observations noted in a field journal. Content analysis of each individual type of data, and of the whole, was undertaken.

RESULTS

In contracting for mental health services the Government is concerned that products and services bought at a particular price represent value for money and the efficient and effective use of tax dollars. By comparison performance measurement for Maori occurs at, and is viewed on, a very personal and intimate level. Performance measurement is viewed in terms of relationships, experiences and interactions with consumers and communities.

CONCLUSIONS

The findings from this research indicate that Maori mental health providers tend to focus on, and put their energies into, changes in the lives of consumers, rather than on the indicators contained in contracts. In essence it would appear that providers are using proxy outcome measures to gauge their own performance (Boulton 2005).

REFERENCES

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SCRIF WORKSHOP

The AHMAC Priority Driven Research Funding Program was a strategic, shared investment in research priorities across the jurisdictions. Grants totalling \$7,563,751.00 have been awarded in two funding rounds. The PDR Program was managed by the State/Commonwealth Research Issues Forum.

This workshop will include presentations by five researchers who received funding under the PDR Program (see below). This session is intended to provide attendees with an indication of the projects funded under this program. Each presenter will outline their project and describe their key findings to date.

The expectation of AHMAC in providing funding under the PDR Program is that the results from the research projects will provide important information for policy and planning purposes and provide a solid evidence base in the area of health systems research.

COMMUNITY HEALTH CARE CENTRE ORGANISATION AND QUALITY OF CARE FOR THE PREVENTION AND MANAGEMENT OF CHRONIC DISEASE

Ross BAILIE, Menzies School of Health Research

INTELLIGENT TELEDERMATOLOGY: ENHANCING DIAGNOSIS FOR RURAL AND REMOTE COMMUNITIES USING MULTIMEDIA DATA AND INTELLIGENT DECISION SUPPORT

Geoff WEST, Curtin University of Technology

A STUDY OF THE RELATIONSHIP BETWEEN THE USAGE OF EMERGENCY DEPARTMENT SERVICES AND THE AVAILABILITY OF COMMUNITY-BASED PRIMARY CARE

Kathy EAGAR, University of Wollongong

PSYCHOSOCIAL IMPACT INDICATOR AS EFFECT MODIFIERS OF BEHAVIOURAL AND BIOCHEMICAL OUTCOMES IN ABORIGINAL DIABETES PREVENTION PROGRAMS

Margaret CARGO, McGill University

RANDOMISED CONTROLLED TRIAL OF A BRIEF GP INTERVENTION TO REDUCE OVERWEIGHT IN VICTORIAN PRIMARY SCHOOL CHILDREN

Sharon GOLDFIELD, University of Melbourne

ASSESSING AND IMPROVING VALUE FROM HEALTH SERVICES

COST EFFECTIVENESS OF TREATMENTS FOR ADOLESCENT SEXUAL OFFENDERS: EVIDENCE FROM NEW ZEALAND

Paul BROWN*, and Jane WILLINGALE, CHFRP, New Zealand

BACKGROUND

Sexual abuse by adolescents has become a recognised public health issue. Sexual abuse associated with significant reduction in quality of life for victims. It is also associated with lower quality of life and increased use of health and social services by perpetrators. New Zealand's community based cognitive behavioural therapy programmes are recognised as being innovative within Australasia, however no study has assessed the cost effectiveness of these programmes.

METHODS

Data from an ongoing study of three treatment centres in New Zealand and international studies are used to develop an economic model of the treatment outcomes. Primary source data includes the treatments, costs and outcomes for 699 youths in New Zealand from 1995 to 2004. International evidence is used to project long term costs associated with recidivism. The number of months till recidivism is used as the primary outcome variable. Costs include direct programme and treatment costs and the costs associated with re-offending to the victim, perpetrator and society.

RESULTS

The study compares the cost and effectiveness of treatments between facilities and against international standards. In addition, the analysis examines differences in rates of recidivism as a function of the amount the treatment received, ethnicity, severity of offence and previous sexual offending.

CONCLUSIONS

This paper examines the cost effectiveness of treatment programmes aimed at reducing rates of recidivism by adolescent sexual offenders. The conclusions highlight the importance of economic modelling for understanding the cost effectiveness of interventions aimed at increasing the health and welfare of offenders and reducing rates of recidivism.

IMPROVING ACCESS TO MEDICINES AMONG CLIENTS OF REMOTE AREA ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH SERVICES

Margaret KELAHER,* Debbie TAYLOR-THOMSON, Nea HARRISON, Lynette O'DONOGHUE, David DUNT, Tony BARNES, Ian ANDERSON, School of Population Health, University of Melbourne, Victoria, Australia

BACKGROUND

Despite unequivocally worse health, expenditure on indigenous people through the Pharmaceutical Benefits Scheme (PBS) is considerably less than for other Australians. We report on the effectiveness of a program to supply PBS medicines to remote Aboriginal and Torres Strait Islander Health Services (ATSIHSs) under Section 100 (S100) of the National Health Act of 1953. Under the special PBS arrangements (SPBSA), approved ATSIHSs are able to order PBS medicine in bulk through local pharmacies, and supply them as needed to patients on-site. The usual co-payment associated with PBS medicine is not charged and the pharmacist remuneration structure is different.

METHODS

The project involved consultation with the evaluation reference group and other stakeholders at all stages. There were six main data collection components: Public submissions; Interviews with Government and other key stakeholders; Pharmacist survey; Medicine utilisation and expenditure data; National ATSIHS minimum data set; Case studies of ATSIHSs.

RESULTS

These SPBSA potentially benefit 36% of the Aboriginal and Torres Strait Islander population. They have resulted in improved access to much needed medicines representing an increase of \$36.5 million in expenditure on Aboriginal and Torres Strait Islander people through the PBS between 2000/01 and 2002/03. They have further ensured that \$8.3 million of State and Territory expenditure formerly directed at medicine can be spent on prevention and primary care.

CONCLUSION

Overall the SPBSA have been very successful and demonstrates an effective model for the development of indigenous health policy.

A SURVEY OF TOTAL QUALITY MANAGEMENT IN IRAN: BARRIERS TO SUCCESSFUL IMPLEMENTATION IN HEALTH CARE ORGANISATIONS

Ali Mohammad MOSADEGH RAD, University of London, United Kingdom

INTRODUCTION

Total quality management (TQM) is a managerial practice to improve the effectiveness, efficiency, flexibility, and competitiveness of a business as a whole. However, if some important principles are not considered before its implementation, the overall strategy of a TQM initiative may fail.

PURPOSE

The objective of this research is to investigate the success of TQM and barriers to its successful implementation in health care services organizations in Isfahan province, Iran, 2004.

DESIGN

This descriptive and cross-sectional research was done via two questionnaires (TQM success and its barriers questionnaires). The statistical population of this research consists of all managers of health care services organizations who implemented TQM in their organizations (90 managers).

FINDINGS

TQM success in Isfahan health care organizations was high. In correlation analyses between the success of TQM and its principles' success, process management and focus on employees had a positive and the most effect and focus on material resources and focus on suppliers had less effect. In correlation analysis between the barriers to TQM and the problem dimensions, human resource problems, strategic problems and structural problems were the most important obstacles and barriers of TQM successful implementation respectively. Research Limitations

Although conducted in Iran, it is anticipated that the findings may well have relevance on a broader scale. Value: By replicating this study in different countries and contexts the results of could be very fruitful for developing a model of TQM that can be implemented easily, effectively, efficiently and successfully in a cross cultural context. Key words: Total Quality Management- success- barriers - health care services organizations

DEVELOPING A TOTAL QUALITY MANAGEMENT MODEL FOR HEALTH CARE SYSTEMS

Ali Mohammad MOSADEGH RAD, Maryam ANSARIAN, University of London, United Kingdom

BACKGROUND

Total quality management (TQM) is a managerial practice to improve the effectiveness, efficiency, flexibility, and competitiveness of a business as a whole. However, in practice, these TQM benefits are not easy to achieve. Despite its theoretical promise and the enthusiastic response to TQM, recent evidence suggests that attempts to implement it are often unsuccessful. Many of these TQM programmes have been cancelled, or are in the process of being cancelled, as a result of the negative impact on profits. Therefore, there is a pressing need for a clinical approach to establishing TQM.

METHOD

The aim of this article is therefore: "To identify the strengths and weakness of TQM, the logical steps towards TQM, and to develop a model so that health care organizations aiming at using TQM to achieve excellence can follow through easily". Based on the research questions proposed in this study, the research strategies of a literature review, a questionnaire survey, semi structured interviews, and a participatory action research were adopted in this study. For determining the success and barriers of TQM in health care organizations, a questionnaire survey has done in 90 health care organizations in Isfahan Province which implement TQM. The results of this survey were used for introducing a new model of TQM. This model will be developed via a semi structured interview with at minimum 10 health care and quality managers. Then, through a participatory action research, this model will be implemented in 3 sites. At this time the questionnaire survey has done and the model is introduced. Therefore, developing the model and its implementation will be done later.

RESULTS

In this survey, The mean score of TQM success was 3.48 (plusmn) 0.68 (medium) from 5 credits. Implementation of TQM was very low, low, medium, high and very high successful respectively in 3.6, 10.9, 21.8, 56.4 and 7.3 percent of health care organizations. TQM had the most effect on process management and focus on employees and the less effect on focus on material resources, customers, and suppliers. The mean score of TQM implementation problems was 3.01 (plusmn) 0.83 (medium) on a 5 scale. TQM

Barriers in health care organizations were strategic problems, performance appraisal problems, human resource problems, structural problems, process problems respectively. Based on these results a Model with 10 enablers and 3 results' indicators is introduced. Enablers are factors that enable organization to reach excellent and results are the out comes of organization which can be achieved through implementation of enablers. This model will be developed through semi structure interviews and implemented in 3 health care organizations for determining the efficacy and efficiency (this two phases has not done).

DISCUSSION

Total quality management is a good strategy for improving the productivity of organizations. However, if some important principles are not considered in TQM models before its implementation, the overall strategy of a TQM initiative may fail. Key words: Total Quality Management- Modeling- Health care services organizations

THE CAPACITY OF THE HEALTH SERVICES RESEARCH COMMUNITY IN AUSTRALIA AND NEW ZEALAND

Jane PIRKIS*, Sharon GOLDFELD, Stuart PEACOCK, Sarity DODSON, Marion HAAS, Jackie CUMMING, Jane HALL, Amohia BOULTON, University of Melbourne, Victoria, Australia

BACKGROUND

As the quest for value for money in healthcare increases, evidence from health services research becomes more crucial. Despite this, the health services research community is relatively poorly supported. To date, there have been few attempts to quantify the capacity of the health services research community. This paper reports on the findings of a web-based survey that attempted to address this gap, in the local context.

METHODS

Members of the Health Services Health Services Research Association of Australia and New Zealand (HSRAANZ) and delegates of the HSRAANZ's Third Health Services Research and Policy Conference were invited to complete the survey.

RESULTS

191 (68%) individuals responded, 165 (86%) of whom conducted or managed health services research. Of these, the majority were female, aged 35-54, and highly qualified. Most were at a mid-career level or above. Most were employed in full-time positions

(predominantly in universities), but could devote only part of their time to health services research. They relied heavily on external funding – only half had core funding from their institution and around one third had employment contracts of one year or less. Many expressed concerns about the lack of security for individuals and groups, limited career pathways and paucity of directly-relevant training opportunities.

CONCLUSIONS

If health services research is to achieve its potential in Australia and New Zealand, policy-makers and funders must take the concerns of the health services research community seriously, foster its development, and contribute to maximising its capacity through a sustainable approach to funding.

CONCEPTUAL MAPPING OF PRIMARY HEALTH CARE RATIONALISATION

Antony RAYMONT, HSRC, Victoria University, Wellington, New Zealand

BACKGROUND

The reforms of the New Zealand health care system are a manifestation of the worldwide need to rationalise health care delivery as resource constraints clash with increasing demand. Rationalisation needs an appropriate model of health care that connects resources, through health care activities, to outcomes. Only with such a model can key relationships can be tested and appropriate measures of success chosen. This paper will present an analysis of the model implied by the New Zealand primary health care reforms and compare it with a theoretical model developed in Canada.

METHODS

An analysis of the key New Zealand documents was undertaken. These included the Health Care and Primary Health Care Strategies, the related documents concerning the health of Maori and Pacific peoples, and the Disability Strategy. This was compared with the "Results-Based Logic Model for Primary Health Care," developed at the University of British Columbia.

RESULTS

On careful examination, the model of primary health care implied by the New Zealand documents was remarkably similar to the theoretical Canadian one. However, those whose reading was confined to summary statements might have felt that the New Zealand documents omitted concern for certain issues – particularly the welfare of the existing medical workforce and the distribution of that workforce

CONCLUSIONS

The New Zealand government documents imply a sophisticated model of primary care. However, the needs of the medical primary health care workforce and the distribution of that workforce were under-emphasised, perhaps perpetuating a history of conflict.

ASSESSING THE COST OF DISABILITY: A BUDGET STANDARDS APPROACH

Laura WILKINSON-MEYERS and Rob MCNEILL,
University of Auckland, New Zealand

BACKGROUND

The New Zealand government is currently undergoing a review of the support payments for individuals with disabilities. This paper develops a budget standards approach to estimate the cost of disability using a model that incorporates various dimensions of disability. The budget standards approach identifies, describes, and costs the "basket of goods and services" required to meet the needs of a person with a disability.

METHODS

International literature, economic theory and consultation with representatives of the disabled community was undertaken to develop the model of disability. The resulting model integrates a social model of disability with a budget standards approach to aid in the determination of the level of support required for people with different needs or levels of impairment. Case studies or 'personal stories' for hypothetical individuals with different degrees of need were developed, resource requirements were identified, and market prices applied.

RESULTS

The results report the resources and costs (NZ\$) associated with the various dimensions of disability. Three different levels of resource use are identified, representing basic to generous levels of access to services. The analysis compares resource allocation between various levels of impairment and degrees of need.

CONCLUSION

This study provides a framework for assessing the needs of the disabled community that integrates the social model of disability with an economic approach to health and social service utilisation. The analysis highlights the difference between current, expenditure

based models of reimbursement and those based upon the budget standard approach. The implications for government policy are discussed.

HEALTH OUTCOMES FROM HEALTH SERVICES AND SYSTEMS

PLANNING FOR AND DELIVERING PUBLIC HEALTH PROGRAMS IN AN UNCERTAIN ENVIRONMENT

Prue BAGLEY* and Vivian LIN, LaTrobe
University, Victoria, Australia

BACKGROUND

The health system is often subject to governments impulse to reform. The New South Wales government intends to restructure Area Health Services. In contrast, Victoria is now in a period of relative stability following restructuring experienced during the 1990s. Given that these cycles of calm and flux are likely to remain, the question is how are systems for planning and delivering public health programs effected during periods of uncertainty?

METHODS

Semi structured in-depth interviews were conducted with 22 people in Victoria and New South Wales. These included senior people at the local level and others in state based organisations, including state health departments.

RESULTS

Analysis of the interviews suggest that health system restructuring creates an uncertain environment that has a negative impact on the ability of organisations, and individuals and units within them, to plan for and deliver public health programs. In some instances, activity appears to be paralysed as organisations await the outcome of reforms. This effect is not uniform and some individuals, units and organisations are more vulnerable to the negative impact of change than others. Interviews also suggest that some types of activity are more susceptible than others.

CONCLUSION

To what extent change is problematic either because of its content or simply because of the process itself is unclear. However, better recognition of this effect and increased attention to improving the ability of the workforce to deal with change may help diminish its negative consequences.

SHOULD PLANNING BE MANDATED?

Prue BAGLEY* and Vivian LIN,
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BACKGROUND

In Australia the configuration of the delivery system for public health varies from state to state. In Victoria many public health programs are delivered by local government. In 1988 the State government made it mandatory for each local government to develop a municipal public health plan (MPHP). More than a decade after the introduction of MPHPs, the question is what has been the impact of this mandatory system on planning for public health?

METHODS

Semi structured in-depth interviews were conducted with 10 people in local government plus five additional interviews with state-wide agencies, including the State health department.

RESULTS

Four significant themes emerge from the interviews. Firstly, there is general agreement that the legislation has improved systems for planning, although there is debate about the degree of that improvement. Secondly, there is concern that the focus is primarily on the process itself (producing a plan), rather than on outcomes (implementing the plan). Thirdly, there is significant variation in the ways in which councils approach planning and the level of priority they attach to the process. Finally, there is evidence of tension over priorities.

CONCLUSION

A system of mandatory planning has led to some improvements in the planning processes within local government. It has not eliminated the significant variations between local governments in their approaches to planning. Some of the issues identified are specific to this particular system of planning. Other concerns raised are likely to be problems irrespective of the planning system in place

A MODIFIED SUCCESS CASE METHOD FOR EVALUATING COMPLEX COMMUNITY BASED HEALTH PROGRAMS

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AIM

The aim of this paper is to describe the use and worth of an adapted Success Case Method for evaluating the outcomes of the "Healthy Housing" program. The Healthy Housing program is designed to reduce housing related illnesses as well as supporting vulnerable families socially. This paper describes the adaptation of the Success Case Method to suit the context and philosophy of the program

METHOD

The Success Case Method (SCM, Brinkerhoff, 2003) is an innovative approach in evaluation which combines the ancient craft of story telling with the contemporary evaluation approaches used in case study methodology. SCM has four basic components: developing a model of success; using that model to develop a survey to identify a purposive sample; conducting in-depth studies of the identified success cases; and reporting and analyzing all the findings. Thirty families were selected to take part in the case studies aimed to describe their perceptions of success and failure. Three separate two hour interviews were conducted with each family over a four week period.

CONCLUSIONS

It is argued that the SCM is a defensible approach for conducting outcomes based evaluation in the health sector. This method is not only a useful methodology but also is a preferable approach for determining outcome measures when a program produces a complex range of outcomes.

KEY WORDS

Community based health interventions, Evaluation, Success Case Method, Healthy Housing

Reference Brinkerhoff RO. (2003) The Success Case Method. Berrett-Koehler, San Francisco CA.

OUTCOME MEASURES FOR ASSESSING PRACTICE CHANGE IN HEALTH CARE PROFESSIONALS

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BACKGROUND

There is an increasing body of research of the efficacy of interventions designed to change in clinical practice. Knowledge of the outcomes measured by these trials is vital for the interpretation and application of the work done to date, and to inform future research.

OBJECTIVE

To identify methods used to measure change in clinical practice following an intervention aimed at increasing the uptake of evidence into practice.

Methods All published trials included in a Health Technology Assessment of interventions to change clinical practice (n = 215) formed the sample. We extracted the following information from the retrieved papers: measure(s) of practice change used; details of how the outcome measure was developed; timing of outcome measurement.

Outcome measures were categorized into five distinct categories: A. Patient level A1: Measures of actual change in health status of the patient A2: Surrogate measures of A1 B. Health practitioner B1: Measurements of actual change in practice B2: Surrogate measures of B1 C. Organizational Measurements of change in the health system e.g. waiting lists, change in policy.

RESULTS

88.8% of studies used a B1 outcome measure. A1 and A2 measures were used in 28.8% and 36.7% of studies (respectively). Health practitioners' knowledge and attitudes (B2) were assessed in 22.8% of the studies and changes at an organizational level (C) were assessed in 17.6%.

CONCLUSION

Most trials of interventions aimed at changing practice measure the effect of the intervention at the level of the practitioner. Less than half of the trials measured whether or not any change in practice resulted in a change in the ultimate end point of patient health status.

DEVELOPMENT OF A MANAGEMENT AND PRIORITISATION TOOL (MAPT) FOR ORTHOPAEDIC WAITING LISTS: A MODEL FOR HEALTHCARE REFORM IN VICTORIA

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BACKGROUND

There are long waits for joint replacement surgery (JRS) in public hospitals but prioritisation is not coordinated and little active patient management occurs. The aim is to develop a Management and Prioritisation Tool (MAPT) that equitably prioritises people with hip or knee joint disease and ensures that active conservative management occurs.

METHODS

The project, funded by the Victorian Department of Human Services, is being undertaken at one rural and three metropolitan public hospitals. Eight concept mapping workshops were held with 24 orthopaedic surgeons and 35 patients. Participants identified the most important factors to be considered in determining priority for JRS. Thirty key stakeholder interviews across the healthcare sector were conducted to determine current management and prioritisation activities and to obtain insights for improvements.

RESULTS

The key clinical domains for prioritisation, derived from surgeon workshops were pain, limitations to activities of daily living, psychological effects, social effects, economic effects, and indicators of rapid decline. High concordance was observed between patient and surgeon indicators for priority. The MAPT was based on these key indicators for prioritisation and will be validated through approximately 1000 patient and clinical assessments. Key stakeholder interviews have informed the development of patient care models. Musculoskeletal coordinators have been employed at each site to undertake patient assessment and monitoring.

CONCLUSIONS

The development and implementation of a MAPT requires careful mapping of objective clinical and patient-reported priorities. Key informant interviews and documentation of healthcare system structures

and mechanisms provide information that assist implementation of this new evidence-based and equitable system.

THE LONGITUDINAL EVALUATION OF THE BUSH BURSARY SCHEME

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BACKGROUND

The shortage of medical practitioners in rural Australia has been well documented. The NSW Rural Doctors Network is working to decrease this shortage. One initiative is the Bush Bursary/Country Women's Association Scholarship Scheme which began in 1997. The scheme enables medical students to spend time in a rural community, experiencing both medical practice and lifestyle. Students are hosted by a sponsoring shire council. A longitudinal evaluation is being undertaken to track the long term career paths of recipients. Past evaluations of the placements have been very positive and indicate that after the experience, students are highly motivated to pursue further opportunities in rural medicine.

METHOD

The longitudinal evaluation is being carried out in two phases. The first phase involves compiling quantitative data, including data on where participants grew up, what other scholarships they have held and their career path to date. Phase two will involve collating and collecting qualitative data to inform both RDN, who administers the scheme and the shire councils who sponsor recipients and fund the placements.

RESULTS

Over 120 students have been Bush Bursary/CWA Scholarship recipients since 1997. RDN is now collecting data and tracking information about all recipients. The analysis and reporting of results will be completed by the end of August.

CONCLUSIONS

Anecdotal reporting from scholarship holders, shire council staff and placement evaluations indicate that the scheme's strengths lie in encouraging students to consider a career in rural medicine. The longitudinal evaluation will inform both the administration of the scheme and examine the benefits for future medical workforce planning. I. Health Workforce Australia. 2004 'National Health Workforce Strategic Framework' http://www.health.nsw.gov.au/amwac/pdf/NHW_stratfwork_AHMC_2004.pdf

REDUCING, MINIMISING AND/OR PREVENTING FRAILTY THROUGH QUALITY HEALTHCARE SERVICES – INSIGHT FROM A STUDY OF COMMUNITY DWELLING OLDER PEOPLE

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BACKGROUND

Because of the older demographic profile of our district, in 2002 the BOPDHB created a Programme of Care for Older People with an initial focus on their 'functional needs'. We were particularly interested in why older people became frail and the experience of older people who live with frailty.

METHODS

The BOPDHB, collaborating with the University of Waikato, developed a definition of frailty using the data set from a New Zealand Ministry of Social Development's Survey of Older People 2000 (quantitative); and, examined the lived experiences of frailty among community dwelling older people (qualitative).

RESULTS

This research catalogued and traced events experienced by older people in the community who are frail including: the role of major medical events; complications of medical care; other trigger events such as falls and loss of eyesight and hearing (usually considered minor from a health care perspective); important accompanying life changes in mobility and social connectedness; and the role of environmental factors such as housing, social networks and supports and home care services in facilitating community living. Information was collected on a variety of themes to inform the recommendations to the DHB.

CONCLUSIONS

This study has provided greater understanding of the experience of the transition into frailty among community dwelling older people; knowledge of the impact of different types of support networks on the frailty process; an appreciation of the preferred configuration of informal and formal services; and, health services delivery/care practices to meet the needs of older people who are vulnerable to frailty.

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QALYS BEWARE: DO EXISTING APPROACHES ENHANCE INFORMED DECISION MAKING?

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BACKGROUND

Economic evaluation is used increasingly to answer questions about which health services should be provided by government on a subsidised basis, for example through the Australian Pharmaceutical Benefits Scheme. This has led to an increased requirement for comparability across interventions and diseases, and the emergence of cost-utility analysis (CUA) as the dominant evaluation tool, in which interventions are compared in terms of cost per quality adjusted life year (QALY).

METHODS

In this paper we critique commonly used approaches to generate QALYs from clinical trial data. We present simulation results to show the potential distortions that result from using the QALY approach if the restrictions on individual preferences are not valid

RESULTS

QALYs are frequently generated by ad hoc methods, including: transformation of clinical data and or quality of life data into descriptive scenarios, which are then evaluated using a range of different methods, which often have a limited theoretical basis; or transformations of clinical data into multi-attribute utility space allowing the application of published utility weights (or QALY weights). Even where multi-attribute utility instruments are used to directly measure quality of life in trials, there are problems with the interpretation of the results in terms of QALYs, because of the need to extrapolate beyond the trial period. Further the underpinnings of QALYs in economic theory require acceptance of unrealistic restrictions on individual preferences

CONCLUSIONS

There remains considerable debate over the methods of generating QALY estimates, particularly given that most clinical trials measure intermediate endpoints.

REGULATION AND RISK

EVALUATING CLINICAL PERFORMANCE: A CROSS DISCIPLINARY STUDY OF PSYCHIATRY PSYCHOLOGY AND SOCIAL WORK

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The aim of the study was to examine the formal and informal processes used to evaluate clinical performance, in order to identify the skills, qualities and structures that generate and sustain clinical performance. Most of what takes place in clinical intervention is unobserved in the seclusion of the consulting room. This is reinforced by the privacy afforded by confidentiality essential for intervention. The inviolable clinical environment appears only accessible in extreme cases. Where there are observers, they are not usually extraneous to the clinical process except perhaps in the case of students and these are not usually in the position of being able to critically engage the clinician. The clinician is uniquely placed in this circumstance to be a primary source of performance evaluation as: the capacity of the clinician may only be known to themselves; the process by which the clinician evaluates that capacity is unknown; the way in which the evaluation process is acquired and developed is unknown; and finally, the factors that influence capacity from this perspective are also unknown.

The findings of the study identify skills, qualities and structures, especially the quality of resilience in clinicians, which have implications for the development of theory by contributing to the existing body of knowledge, the systems of training and accreditation, and the recruitment and retention of practitioners.

