



5th HEALTH SERVICES & POLICY RESEARCH CONFERENCE 2007

Listening to the Past, Looking to the Future:

How can Health Services Research contribute to assessing fads and fashions in health policy and practice?



CONFERENCE PROGRAMME

02-05 December 2007

Langham Hotel, Auckland, New Zealand

Welcome

welcome

On behalf of the Executive of the Health Services Research Association of Australia and New Zealand, it is my pleasure to welcome all of you to the 2007 Health Services and Policy Research Conference. This is the Conference of the Health Services Research Association of Australia and New Zealand (HSRAANZ). The Association is working for better recognition of health services research and health systems research in both countries – and as the focus on health services research and policy grows on both sides of the Tasman, there is no better time to join if you are not already a member.

This is the fifth Conference – the first was held in Sydney in 1999 and much has happened in the years between. The first Conference came about to provide a forum for researchers who wanted to meet as health services researchers and to promote the dialogue between research and policy. The Association was established following that first Conference, and the Conferences have been continued and are held every two years. But wait, there's more! HSRAANZ is providing more activities to support its members – through early career workshops, special seminars, and its corporate member forums. The Executive is also working behind the scenes to promote health services research to research funding agencies and to policymakers. You will see both Professor Warwick Anderson, CEO of the Australian National Health and Medical Research Council, and Professor Robin Olds, the Chief Executive of the Health Research Council of New Zealand here. Now that HSRAANZ is sufficiently established, it has been able to employ a part-time Executive Director, Sarah Green, and thus engage in a wider range of activities. Please take the opportunity to talk to Sarah while you are here.

This Conference continues the spirit of past Conferences. It is where we come together to share, to discuss and to debate, and through such exchange to improve the quality of research, and increase its policy relevance and impact. This year's theme, *Listening to the Past, Looking to the Future*, aptly captures the goal of health services research: it is not enough to learn from experience, those lessons need to be applied to create a better health system. Terri Green and the Scientific Committee supported by a team of abstract reviewers have put together an interesting and exciting scientific programme which covers many of the issues that are currently challenging health sectors worldwide. The international keynote speakers, Andrew Bindman, Karen Davis, Penny Hawe and Theodore Marmor will cover improving primary health care, moving towards a high performance health system, the use of complex systems thinking, and fads and fallacies in medical care.

Special thanks are due to all of our sponsors, as we could not support the significant local and international speakers without your contributions. Of course, a Conference of this scale and with such a number of submitted abstracts and an array of outstanding speakers, plenary sessions, workshops and panel discussions does not just happen. It takes tireless effort and ongoing commitment. For that, our thanks are due to the Conference Organising Committee under the skilled and efficient leadership of Toni Ashton.

Enjoy all this Conference and Auckland have to offer.

Jane Hall

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Contents

Page

Meeting Venues and Map	4
General Information	5
Speakers	9
Conference Programme	17
Poster sessions	35
Abstracts	39
Programme at a Glance	Back Cover

Organising Committee

Toni Ashton (Chair)

Centre for Health Services Research and Policy,
University of Auckland, Auckland

Paul Brown

Centre for Health Services Research and Policy,
University of Auckland, Auckland

Rob McNeill

Centre for Health Services Research and Policy,
University of Auckland, Auckland

Laura Wilkinson-Meyers

Centre for Health Services Research and Policy,
University of Auckland, Auckland

Rhys Jones

Te Kupenga Hauora Maori, University of Auckland, Auckland

Jackie Cumming

Health Services Research Centre, Victoria University of
Wellington

Terri Green

Department of Management, University of Canterbury,
Christchurch

Sharon Kletchko

Nelson Marlborough District Health Board, Nelson

Stephen Jan

The George Institute for International Health, Sydney

Marion Haas

Centre for Health Economics Research and Evaluation, Sydney

Paul Dugdale

Centre for Health Stewardship, Australian National University,
Canberra

Scientific Committee

Pauline Barnett

Department of Public Health and General Practice, University of
Otago, Christchurch

Jackie Cumming

Health Services Research Centre, Victoria University of
Wellington, Wellington

Geoff Fougere

Department of Sociology, University of Canterbury, Christchurch

Terri Green (Chair)

Department of Management, University of Canterbury,
Christchurch

Stephen Jan

The George Institute for International Health, Sydney

Rhys Jones

Te Kupenga Hauora Maori, University of Auckland, Auckland

Venue Directory

Plenary Sessions – Arawa Room

Concurrent Sessions – Arawa, Westhaven, Akarana, Tamaki, Hauraki, Nikau Rooms

Exhibition and Catering – Tiri/Toroa Rooms

Registration & Information Desk – Pre-Function Area outside Tiri/Toroa and Arawa Rooms.

Function Room Floor Plan





General Information



THE AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

The Australian Primary Health Care Research Institute (APHCRI) takes a unique approach to research. It encourages collaboration not only between research teams, but also with the policy advisers it hopes to influence.

The Institute operates a 'linkage and exchange' model, which brings researchers, policy advisers and stakeholders together to make research relevant. This means research is informed by the needs of policy advisers and policy advisers are aware of the research and able to utilise it from its earliest stages.

Research to date, conducted around Australia, includes work from eight streams of research covering a diverse number of areas ranging from adolescent and child health, Indigenous health through to mental health, chronic disease and workforce.

ENR015 #001200 APHCRI001101

Contact T: +61 2 6125 0766 F: +61 2 6125 2254 E: aphcri@anu.edu.au W: www.anu.edu.au/aphcri

General Information

The following information is offered to make your attendance at the Conference as pleasant and as trouble-free as possible. If you require help, please call at the Registration Desk and we will do everything we can to assist you.

Accommodation

For those registrants who have reserved hotel accommodation at the Langham Hotel, Empire Apartments or O'Rorke Hall of Residence through The Conference Company, please ensure that accounts are settled in full prior to your departure and that the appropriate deposit has been deducted from your account.

Badges

For security reasons, all delegates and exhibitors must wear their name badges at all times during the Conference and Social Functions.

Carparking

Valet carparking is available at the Langham Hotel for NZ\$30 per day. Self parking is available at the multi-storey Tournament Carpark adjoining to the Langham Hotel. The entrance is from Liverpool Street. The costs are:

In-house guests*	Casual parking	Earlybird parking
NZ\$5 per day	NZ\$3 per half hour	NZ\$10 per day

*Contact reception to validate your ticket.

Coat Check / Bag Store

Bags can be left with the staff at the hotel reception desk.

Dress

Dress for all sessions and Social Functions is smart casual.

Facsimiles

If you wish to send a facsimile, please contact the Registration Desk, located in the Pre-Function area of the Langham Hotel.

Evaluation Form

Your thoughts, suggestions and general comments are important to the Organising Committee. They help us to improve future events and their organisation. Please complete the evaluation form enclosed in your satchel, when completed please leave at the Conference Registration Desk or fax to 09 360 1242. The evaluation form will be placed on the Conference website for you to complete online.

Medical Services

Emergency medical services are available on a 24 hour, 7 day basis at the Remuera Accident and Medical Clinic, 122 Remuera Road, Auckland. Telephone: 524 5943.

In an emergency dial 111 for an ambulance, the police or the fire department.

Messages

Messages will be displayed on the message and information board located by the Registration Desk. If you wish to have a message left for you or a facsimile sent to you during the Conference the numbers for those sending the message or the facsimile are:

Telephone:

09 300 2938 (DDI)

Facsimile:

09 300 2919 and mark the facsimile for the attention of the **5th Health Services and Policy Research Conference Registration Desk.**

Pharmacies

Uptown Pharmacy

178 Karangahape Road, Auckland

Telephone: 09 373 3552

Hours:

Monday – Wednesday/Friday 0830-1730hrs

Thursday 0830-1900hrs

Saturday 1000-1400hrs

Refreshments

Lunch, morning coffee and afternoon tea are included in your registration fee and will be served in the exhibition area during the programmed breaks.

Registration and Information Desk

The Registration Desk is located in the Pre-Function Area of the Langham Hotel and is open at the following times:

Sunday 2 December 0800-0900hrs, 1200-1700hrs

Monday 3 December 0730-1800hrs

Tuesday 4 December 0800-1715hrs

Wednesday 5 December 0800-1200hrs

Rental Cars

Avis Rent a Car offers its corporate rates to delegates. Call the Avis office (telephone 525 1982) and quote the booking reference number AWD: Z994400.

Smoking

The Langham Hotel is a smoke-free building.

Special Dietary Requirements

If you have advised any special dietary requirements (other than vegetarian) on your registration form, these will have been forwarded to the hotel to prepare special meals for you. Please ask the catering staff to bring you your special meal. There will be vegetarian options available at the social functions.

Telephone Directory

Registration Desk

Telephone:	09 300 2938
Facsimile	09 300 2919

Airlines	Reservations	Arrivals/Departures
Air New Zealand	0800 737 000	0800 737 000
Emirates	0508 364 728	0508 364 728
Qantas	0800 808 767	0800 808 767

Emergency Services 111 (fire/police/ambulance)

Accommodation

Langham Hotel	09 379 5132
Empire Apartments	09 950 9000
O'Rorke Halls of Residence	09 373 7599

Medical Services

Accident & Medical Clinic	09 524 5943
After Hours Pharmacy	09 373 3552

Telephone Directory Assistance

National	018
International	0172

Taxis

Co-op Taxis	09 300 3000
Regency Cabs	0800 377 8844
Airport Super Shuttle	0800 748 8853
Corporate Cabs	09 377 0773

Time

New Zealand is 13 hours ahead of GMT in December.

Tipping

Tipping is not expected in New Zealand but is appreciated for particularly good service.

Telephones

Public telephones are available in the City Road lower lobby. You will need a credit card or New Zealand coins to make a local or international call.

Social programme

Please wear your name badges to all social functions. Please bring your dinner ticket with you and present it on entry.

Welcome Reception

5.30pm, Sunday 2 December 2007

Langham Hotel

Cost included in full Conference registration fees.

Mix and Mingle Dinners

7.30pm, Sunday 2 December 2007

Various restaurants close to the Langham Hotel.

Groups will depart from the Langham Hotel foyer at 7.15pm.

Please pay the restaurant directly.

Conference Dinner

7.30pm, Monday 3 December 2007

Great Hall, Auckland Town Hall

The Town Hall is a 10 minute walk from the Langham Hotel. Transport will be provided departing at 7.15pm from the Langham Hotel. Return transport will be provided at 10.30pm, 10.45pm, 11.00pm and 11.15pm.

\$80 for full Conference delegates, **\$110** for others.



Speakers



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Action (HEHA) is the
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improving nutrition,
increasing physical
activity and achieving
a healthy weight
for all New Zealanders

www.moh.govt.nz/healthyeatinghealthyaction

Speakers

International Keynote Speakers



Andrew Bindman

Dr. Bindman is Professor of Medicine, Health Policy, Epidemiology & Biostatistics, at the University of California San Francisco (UCSF). He is the Director of the California Medicaid Research Institute and the Chief of the Division of General Internal Medicine at UCSF's affiliated San Francisco General Hospital. Dr. Bindman

has practiced and taught primary care at San Francisco General Hospital and its affiliated clinics for the past 20 years. He has published more than 90 peer-reviewed scientific articles evaluating the impact of health policies on low-income people's access to and quality of care.

Andrew Bindman's attendance at this Conference is sponsored by The Commonwealth Fund.



Karen Davis

Dr. Davis PhD, is President of The Commonwealth Fund, a national philanthropy engaged in independent research on health and social issues. Dr. Davis served as Deputy Assistant Secretary for health policy in the US Department of Health and Human Services from 1977-1980, and holds the distinction of being

the first woman to head a US Public Health Service agency. She is the recipient of the 2000 Baxter-Allegiance Foundation Prize for Health Services Research. She has written extensively on health and social policy issues, and is a former president of Academy Health.

Karen Davis' attendance at this Conference is sponsored by The Commonwealth Fund.



Penny Hawe

Penny Hawe is a professor in the Department of Community Health Sciences at the University of Calgary and she has held the Markin Chair in Health and Society there since 2000. Her interest is in the design and evaluation of population-level interventions to promote health. In 2004 she established the

Population Health Intervention Research Centre at the University of Calgary. She has also established ICCL, the International Collaboration on Complex Interventions, which links 17 investigators in Canada, USA, Australia and the UK in the study of the theory, methods, ethics and economics of complex interventions to promote health.

Penny Hawe's attendance at this Conference is sponsored by the New South Wales Department of Health.



Theodore Marmor

Theodore R. Marmor is Professor at the Yale School of Management, Professor of Political Science, and an adjunct Professor of the Yale Law School and former Director of the Robert Wood Johnson Foundation's post-doctoral program in Health Policy & Social Science from 1993-2003. Professor Marmor is a scholar of

the politics of the contemporary welfare state in the United States, and also comparatively with other OECD nations. He lectures widely on policy and management issues and often appears as a commentator on television and radio networks.

Australian and New Zealand Keynote Speakers



Warwick Anderson

Professor Warwick Anderson was appointed as the Chief Executive Officer of the National Health and Medical Research Council (NHMRC), on 7 June 2006. Professor Anderson has extensive experience in health research leadership and management and has made a strong

contribution to the activities of the NHMRC since 1991, including chairing the NHMRC's Research Committee from 1997 to 2003. Professor Anderson's previous appointments included Head of School of Biomedical Sciences at Monash University (2001-2006); Head of Physiology at Monash University (1996-2000); and Deputy Director of The Baker Institute (1993-1996).



Peter Crampton

Professor Crampton is Head of Department in the Department of Public Health at the University of Otago, Wellington. Peter is a specialist in public health medicine. His research is focused on social indicators and social epidemiology, health care policy, and

primary health care organisation and funding. He has served on numerous advisory panels for the New Zealand Ministry of Health in a variety of policy areas related to public health and health services. He teaches undergraduate and postgraduate courses related to public health, health systems and health services management.



Sue Crengle

Dr. Crengle is from the Waitaha, Kati Mamoe and Ngai Tahu tribes in Aotearoa/New Zealand. A holder of specialty qualifications in general practice and public health medicine, she is currently a Senior Lecturer in Te Kupenga Hauora Māori, and Director of To-maioira Māori

Health Research Centre, University of Auckland. She was a recipient of the Harkness Fellowship in Health Policy 1999-2000, spending time at Johns Hopkins School of Public Health, Baltimore, USA. On her return, she spent a year working as a Senior Advisor in the Ministry of Health.



Stephen Duckett

Dr. Duckett PhD, DSc, FCHSE, FASSA, an economist, heads the Reform Team for Queensland Health. He was Secretary of the Australian Health Department from 1994 - 1996 and has held leadership positions in the Victorian Health Department at La Trobe University, and as

Chair of the Boards governing The Alfred and the Brotherhood of St Laurence. He has published widely on Australian health policy and the economics of hospital care. His research in the latter area has focused on output (casemix) measures to describe and fund hospital services and more latterly, measurement of outcomes of hospital care using routine data sets as part of a policy agenda of improving safety and quality of hospital care.



Sandra Eades

Professor Sandra Eades is a Noongar woman from Western Australia who has studied and worked for extended periods in NSW. Professor Eades currently leads the development of the Aboriginal Health Research program at the Sax Institute, Sydney. She is the only Australian

Indigenous medical graduate with a PhD. In 2006 she was named NSW Woman of the Year in 2006. Professor Eades is a medical epidemiologist with a specific interest in conducting randomized controlled trials to test public health interventions in Aboriginal communities. Her PhD studies investigated the causal pathways and determinants of health among an urban cohort of Aboriginal infants in the first year of life.



Jane Hall

Jane Hall is Professor of Health Economics in the Faculty of Business at the University of Technology, Sydney, and Director of the Centre for Health Economics Research and Evaluation. Recently her significant research contributions have been in the use of discrete choice experiments in

health care applications, including genetic testing, informal care and asthma medication use. Her work also focuses on the assessment of the Australian health care system, and the interface of research and policy decision making. Jane is currently the President of the Health Services Research Association of Australia and New Zealand, as well as President of the International Health Economics Association.

**Robin Olds**

Professor Olds has recently taken up the position of Chief Executive of the Health Research Council of New Zealand. He graduated in medicine from the University of Otago and undertook postgraduate training in Pathology. After completing a PhD at Otago, he undertook research on

the molecular genetics of haemostatic disorders at Oxford University, as a Nuffield Dominions Medical Fellow. In 1994 he returned to the University of Otago and later that year was appointed to the Chair in Pathology at the Dunedin School of Medicine. Recently, his research has focused on molecular aspects of the major mood disorders, particularly manic depression.

**Panel speakers****Philip Davies**

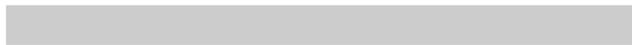
Mr. Davies joined the Australian Government's Department of Health & Ageing as a Deputy Secretary in 2002, and brings to the role almost 30 years international experience in health care policy and management. After graduating in Mathematics, Mr. Davies worked for five

years with the Department of Health & Social Security in London before joining Coopers & Lybrand as a health care management consultant. In 1997 he joined the New Zealand Ministry of Health as a Deputy Director-General. He subsequently spent 18 months as a Senior Health Economist with the World Health Organization (WHO) in Geneva. He has served as an invited speaker at national and international meetings of health sector bodies; led both New Zealand and Australian delegations to numerous global forums; and provided consultancy advice on health policy to the World Bank and WHO.

**Sharon L. Kletchko**

Dr. Sharon Kletchko is currently the General Manager, Planning and Funding, for the Nelson Marlborough District Health Board, New Zealand. She is also a Ministerial appointee on the New Zealand Standards Council and is on the Advisory Board for Public Health Intelligence. Dr. Kletchko has

practiced general and sub-specialty medicine in Canada, Saudi Arabia and New Zealand. She was the Chief Medical Advisor for the NZ Ministry of Health in 1992/93 as well Manager Personal Health Services. She resided in Tauranga from 1993 through to 2006 holding a variety of public health provider roles. As a result, Sharon has wide and varied experience across the entire NZ health sector.

**Stephen McKernan**

Stephen McKernan is the Director-General of Health in the New Zealand Ministry of Health; a role he has held since July 2006. As Director General he is the principal advisor to the Minister of Health and the Associate Ministers of Health on health and disability matters. The Director-

General has the key strategic role in leading the development and performance of the New Zealand health system. Prior to the Director-General position Stephen spent 4 years as a Chief Executive of the Counties Manukau District Health Board which has a reputation of excellence and innovation with a strong focus on integrated care programmes. Stephen also spent 4 years as Chief Executive of Hutt Valley District Health Board.

**Hayden Wano**

Hayden is currently the Chairman of Taranaki District Health Board, New Zealand, a position he has held since 2001. Hayden has over 25 years health sector experience. He has nursing experience in mental health, community and medical services including intensive and coronary

care areas. He also has over 15 years experience in senior health management holding a number of senior management positions in the public health and non-government organisation sectors, including the position of Director of Clinical Services with Taranaki Healthcare Limited. Since 1998 Hayden has held the position of CEO with Tui Ora. He is affiliated to Te Atiawa, Taranaki, Ngati Mutunga and Ngati Awa Iwi.





Mark Wenitong

Dr. Wenitong is the Senior Medical Officer at Wuchopperen Health Service in Cairns North Queensland and holds an adjunct appointment with James Cook University Faculty of Medicine, Health and Molecular Sciences. He is a descendent of the Kabi Kabi Aboriginal people of South East

Queensland. He is also the Senior Medical Advisor for Apunipima Cape York Health Council. He is a founding member of the Australian Indigenous Doctors Association, and is the current President. As a ministerial appointee on NHMRC National Health Committee, he co-chaired the development of the NHMRC Guide to Cardiac Rehabilitation manual for Aboriginal and Torres Strait Islander Peoples. He sits on several other national Indigenous health committees, including the National Aboriginal and Torres Strait Islander Health Council, as well as chairing the Andrology Australia, Aboriginal and Torres Strait Islander Male Health reference committee. He is primarily a clinician, but is also involved in several research projects both in his practice and in the wider Aboriginal community. His main areas of interest are medical education and health workforce, Indigenous men's health and chronic diseases.

Discussants



Dale Bramley

Dr. Dale Bramley is a medical graduate of the University of Auckland and a specialist in Public Health Medicine. Currently he is General Manager of Clinical Support Services for the Waitemata District Health Board, New Zealand. Dale is also an honorary senior lecturer in Public Health

within the School of Population Health, University of Auckland. He is a co-investigator on a number of projects related to his research interest areas which include Māori Health, Inequalities, Cardiovascular Disease, Diabetes and Healthy Lifestyles. In 2003/04 Dale undertook a Harkness Fellowship in Health Policy and was based at the Mount Sinai School of Medicine in New York. Dale has tribal affiliations to Ngati Hine and Nga Puhī.



Jacqueline Cumming

Dr. Jacqueline Cumming is Director of the Health Services Research Centre (HSRC) at Victoria University, New Zealand. She has qualifications in economics and public policy and extensive public policy experience, having previously worked for the New Zealand Treasury, Department of

Labour, Ministry of Health, and the Public Health Commission. She has spent time on secondment to the Royal Commission on Social Policy, the Working Group on Employment Equity, the Health Services Taskforce, and the Core Services Committee. She joined the HSRC in 1993, and since then has built a strong career in health services, health economics and public policy research, and now works with around 20 health services researchers working on a wide range of topics in health and disability services research. Her particular research interests are in health systems performance and reform, health policy evaluation, priority setting and issues relating to access to health services.



Terri Green

Dr. Terri Green has qualifications in Management Science and Economics and is Senior Lecturer, Department of Management, School of Business and Economics, University of Canterbury, New Zealand. Prior to that, she was an independent researcher in health services

research, working on projects for the Ministry of Health and health providers, involving economic evaluation, and service utilisation. She has served on several Ministry of Health advisory groups on population screening programmes and has an interest in the links between evidence, policy and practice. She maintains strong research collaborations with the Christchurch School of Medicine and the Health Services Research Centre, Wellington. Current research interests include colorectal cancer control and access to heart surgery.



Papaarangi Reid

Associate Professor Papaarangi Reid is Tumuaiki and Head of Department of Te Kupenga Hauora Māori at the Faculty of Medical and Health Sciences, University of Auckland, New Zealand. She holds science and medical degrees from the University of Auckland and is a specialist in

public health medicine. She has tribal affiliations to Te Rarawa in the North and her research interests include analysing disparities between indigenous and non-indigenous citizens as a means of monitoring Government commitment to indigenous rights.



Rosalie Viney

Rosalie Viney is an Associate Professor in Health Economics and Deputy Director of CHERE at the University of Technology, Sydney. She has extensive policy and research based experience of health services funding and financing in Australia. Her current research interests include

analysis of the relationship between public and private health insurance and utilisation of health services, valuation of health outcomes, the use of economic evaluation in resource allocation and measurement of individuals' preferences for health care services. Rosalie is the economist member of the Pharmaceutical Benefits Advisory Committee (PBAC).





Conference Programme



THE COMMONWEALTH FUND

2009-10 HARKNESS FELLOWSHIPS IN HEALTH CARE POLICY AND PRACTICE

The Commonwealth Fund invites promising mid-career professionals—academic researchers, clinicians, managers, government policymakers, and journalists—from Australia, Germany, the Netherlands, New Zealand, and the United Kingdom, to apply for a unique opportunity to spend up to 12 months in the United States as a Harkness Fellow in Health Care Policy and Practice. Fellows work with leading U.S. experts to conduct a research study that addresses a critical issue on the health policy agenda in both the U.S. and their home country. A rich program of seminars organized by the Fund throughout the year further enhances the fellowship experience.

All applicants must submit a formal application that includes a research proposal which falls within the scope of The Commonwealth Fund's principal areas of focus: health care system performance, including access to care, insurance coverage, quality improvement, efficiency, and equity; quality of care for children, the elderly, and minorities; and patient-centered primary care. Harkness Fellows have published their findings in leading U.K. and U.S. journals and as reports for Health Ministers and other high-level policy audiences, and have moved into prominent positions within academia, government, and health care organizations. Harkness Fellows become part of a strong international network, with opportunities for future professional development.

Applicants must be citizens of Australia, Germany, the Netherlands, New Zealand, or the United Kingdom (in the U.K., citizens of other countries with permanent residency and five or more years tenure in the U.K. may also apply). Each fellowship provides up to \$107,000 (U.S.) in support, which covers roundtrip airfare to the United States, a living allowance, funds for project-related travel, research and conferences, travel to attend The Commonwealth Fund program of fellowship seminars, health insurance, and U.S. and state taxes. A family supplement—including airfare, living allowance, and health insurance—is also provided to Fellows accompanied by a partner and/or children up to age 18.

The deadline for receipt of applications is September 5, 2008. For more details and an application, please visit www.commonwealthfund.org/fellowships/
For questions, contact Robin Osborn at The Commonwealth Fund
(tel: 001 212 606 3809 or e-mail: ro@cmwf.org).

Conference Programme

Sunday December 2nd	
	Pre-conference workshop
9.00am - 12.30pm	Mixed Methods for Programme Evaluations of Health Services and Interventions
Tamaki Room	Janet Clinton, School of Population Health, Auckland Paul Brown, University of Auckland, Auckland Abstract number 1
	Main Conference Programme
	Listening to the Past, Looking to the Future: How can Health Services Research contribute to assessing fads and fashions in health policy and practice?
2.00pm - 2.30 pm	Powhiri (Maori welcome)
Arawa Room	Opening addresses
2.30 — 3.30pm	Plenary I: Fads and fashions in health services
Arawa Room	Chair: Toni Ashton Fads, fallacies and foolishness in medical care, management and policy Ted Marmor, Yale School of Management, Boston, USA Abstract number 2
3.30pm — 4.00 pm	Afternoon tea
4.00pm - 5.30pm	Plenary I: continued
Arawa Room	Will complex systems thinking take us forward in health research? Penny Hawe, University of Calgary, Alberta, Canada Abstract number 3 Discussant: Papaarangi Reid, Te Kupenga Hauora Māori, University of Auckland, Auckland
5.30pm - 7.00pm	Welcome Reception
7.30pm	Mix and Mingle dinners (Not included in conference registration)

Conference Programme continued

Monday December 3rd

8.45am - 10.30am	Plenary 2: Developments in Health Services Research
Arawa Room	<p>Chair: Nicholas Glasgow</p> <p>Evaluating primary health care and policies to improve it Andrew Bindman, San Francisco General Hospital, San Francisco, USA Abstract number 4</p> <p>Data-driven reform in safety and quality in Queensland Stephen Duckett, Queensland Health, QLD, Australia Abstract number 5 Discussant: Dale Bramley, Waitemata District Health Board</p>
10.30am - 11.00am	Morning tea
11.00am - 12.30pm	Concurrent sessions
Arawa Room	<p>Australian Primary Health Care Research Institute Workshop Abstract number 6 Looking back, planning forward: the APHCRI model — a fad or a foundation for the future?</p>
Akarana Room	<p>Health Sector Reform Chair: Luke Connelly</p> <p>Shaping decision-making in governance in New Zealand public healthcare services Lee Mathias, Auckland University of Technology, Auckland Abstract number 7</p>
	<p>Governance relationships in the changing New Zealand health system Pauline Barnett, University of Otago, Christchurch Abstract number 8</p>
	<p>Are New Zealand's DHBs able to steer towards population health? Tim Tenbenschel, School of Population Health, Auckland Abstract number 9</p>
	<p>The Population Health Approach and Health System Restructuring - New Zealand Nicolette Sheridan, University of Auckland, Auckland Abstract number 10</p>
	<p>A world apart? Purchasing health services in England and New Zealand Toni Ashton, University of Auckland, Auckland Judith Smith, University of Birmingham, UK Abstract number 11</p>
Tamaki Room	<p>Hospital Quality and Clinical Governance Chair: Sharon Kletchko</p> <p>Measuring adverse events in hospitals — comparison of two surveillance systems Sanja Lujic, Sax Institute, Broadway, NSW, Australia Abstract number 12</p>

	<p>The Hospital Mortality Project: a tool for clinical governance S.Aqif Mukhtar, Curtin University of Technology, Perth, Australia Abstract number 13</p>
	<p>Variation in New Zealand public hospital outcomes, 2003-2006 Phil Hider, University of Otago, Christchurch Abstract number 14</p>
	<p>The professional nursing practice environment and patient outcomes Mary Finlayson, University of Auckland, Auckland Abstract number 15</p>
	<p>Hospital quality and safety: linking practices to performance Phil Hider, University of Otago, Christchurch Abstract number 16</p>
Hauraki Room	<p>Organised Session Chair: Russell Gruen</p> <p>Regionalisation of cancer services: in search of evidence-informed policy Russell Gruen, University of Melbourne, VIC, Australia Abstract number 17</p>
	<p>Regionalisation of cancer services: the policy-makers perspective Adam Chapman, Cancer & Palliative Care Unit, Melbourne, VIC, Australia Abstract number 18</p>
	<p>Why high volume surgeons and hospitals should get better outcomes Jonathan Koea, Auckland Hospital, Auckland Abstract number 19</p>
	<p>Case volume and cancer mortality: a systematic review Veronica Pitt, Monash Institute of Health Services Research, VIC, Australia Abstract number 20</p>
	<p>How can health services research inform regionalisation of cancer services? Russell Gruen, University of Melbourne, VIC, Australia Abstract number 21</p>
Westhaven Room	<p>Access and Utilisation Chair: Gillian Durham</p> <p>Inequalities in hospital utilisation in WA by patients with homogenous health status Rachael Moorin, University of Western Australia, WA, Australia Abstract number 22</p>
	<p>Prescribing of psychostimulant medicines for Attention-Deficit Hyperactivity Disorder in Western Australian children David Preen, University of Western Australia, WA, Australia Abstract number 23</p>
	<p>Access to elective surgery in New Zealand - still of concern? Sarah Derrett, University of Otago, Dunedin Abstract number 24</p>
	<p>Causes of different admission rates of high deprivation population in two DHBs Nicola North, University of Auckland, Auckland Abstract number 25</p>
	<p>Hospital and other health service experiences of Indigenous Australians Jill Guthrie, School of Public Health & Community Medicine, UNSW, Canberra, ACT, Australia Abstract number 26</p>

Conference Programme continued

<p>Nikau Room</p>	<p>Workforce Collaboration Chair: Peter Carswell Psychological treatments in primary care: systematic review and policy options Richard Moulding, Department of General Practice, University of Melbourne, Melbourne, VIC, Australia Abstract number 27</p>
	<p>Multidisciplinary Teams working in a Clinical Network An effective platform for the implementation of a multi-faceted program to achieve change in cancer services Sue Sinclair, Cancer Institute NSW, Alexandria, NSW, Australia Abstract number 28</p>
	<p>The test retest reliability of the interprofessional collaboration (IPC) questionnaire Bernadette Stringer, McMaster University, Hamilton, Ontario, Canada Abstract number 29</p>
	<p>Evaluating UK health and social care partnerships: the POET approach Helen Dickinson, Health Services Management Centre, University of Birmingham, Birmingham, UK Abstract number 30</p>
	<p>Multidisciplinary care in cancer services — is it all it s cracked up to be? Karen Luxford, National Breast Cancer Centre, Sydney, NSW, Australia Abstract number 31</p>
<p>12.30pm - 1.30pm</p>	<p>Lunch</p>
<p>Arawa Room</p>	<p>Lunchtime discussion: Pursuing Excellence in Purchasing for Population Health Gain: Lessons from New Zealand Comments from a group of NHS executives visiting from the UK</p>
<p>1.30pm - 3.00pm</p>	<p>Concurrent sessions</p>
<p>Arawa Room</p>	<p>Round Table Chair: Gawaine Powell Davies Building comprehensive primary health care through primary care organisations: a cross country comparative analysis Jacqueline Cumming, Health Services Research Centre, Wellington Abstract number 32</p>
	<p>Reforming primary health care in England: the role of primary care organisations Judith Smith, Health Services Research Centre, Wellington Abstract number 33</p>
	<p>Primary care organisations in New Zealand: a decade of change and challenges for the future Jacqueline Cumming, Health Services Research Centre, Wellington Abstract number 34</p>
	<p>Primary health care (PHC) reform in Australia: The roles and challenges of multiple forms of PCOs Julie McDonald, UNSW Research Centre for Primary Health Care & Equity, NSW, Australia Abstract number 35</p>

Akarana Room	<p>Developing the Health Workforce Chair: Penny Hawe</p> <p>Where are the new Nurse Graduates? A literature review with a view to the future Shayne Rasmussen, AUT University, Auckland</p> <p style="text-align: right;">Abstract number 36</p>
	<p>The development of a workforce tracking tool — gaining insight to influence the future workforce Mark Mackay, Department of Health/University of Adelaide, Novar Gardens, SA, Australia</p> <p style="text-align: right;">Abstract number 37</p>
	<p>Maori health professionals: a framework for assessing benefits James Harris, LECG Ltd, Wellington</p> <p style="text-align: right;">Abstract number 38</p>
	<p>New directions for health workforce policy: a complex systems perspective Catherine Joyce, Monash University, Notting Hill, VIC, Australia</p> <p style="text-align: right;">Abstract number 39</p>
	<p>Skill-mix changes needed to care for community dwelling older Australians Nicholas Zwar, University of New South Wales, Australia, Prairiewood, NSW, Australia</p> <p style="text-align: right;">Abstract number 40</p>
Tamaki Room	<p>Hospital Efficiency, Resources, Outcomes Chair: Mary Finlayson</p> <p>Obesity and the intensity of hospital resource use Katharina Hauck, Monash University, Melbourne, VIC, Australia</p> <p style="text-align: right;">Abstract number 41</p>
	<p>Streaming: fad or fashion in a regional emergency department? Leigh Kinsman, Monash University, Bendigo, VIC, Australia</p> <p style="text-align: right;">Abstract number 42</p>
	<p>Does emergency department length of stay influence patient outcomes? Mary Haines, Sax Institute, Sydney, NSW, Australia</p> <p style="text-align: right;">Abstract number 43</p>
	<p>Use of dynamic modelling in the design of dialysis services David Rees, Synergia Ltd, Auckland</p> <p style="text-align: right;">Abstract number 44</p>
	<p>Evaluation Chair: Gisselle Gallego</p> <p>Innovative ways to measure organisational constructs in the Let's Beat Diabetes programme evaluation Janet Clinton, School of Population Health, Auckland</p> <p style="text-align: right;">Abstract number 45</p>
<p>Evaluating diabetes prevention and care strategies in Australia Agnes Walker, National University, Canberra, ACT, Australia</p> <p style="text-align: right;">Abstract number 46</p>	
<p>Looking to the future: building evaluation capacity in community-based health services Sarah Appleton, University of Auckland, Auckland</p> <p style="text-align: right;">Abstract number 47</p>	

Conference Programme continued

	<p>Evaluating services for the prevention of heart disease in developing countries Masoud Mirzaei, University of Sydney, NSW, Australia</p>	Abstract number 48
	<p>Results of an evaluation of Pacific church-based health promotion programmes Faith Mahony, CHSRP - University of Auckland, Auckland</p>	Abstract number 49
Westhaven Room	<p>Organised Session - Towards More Humanistic Healthcare: Emerging Measures For Palliative Quality Measurement Chair: Karl Lorenz</p> <p>Towards more humanistic healthcare: emerging measures for palliative quality measurement Karl Lorenz, RAND Health, UCLA, Veterans Administration, Lyneham, ACT, Australia</p>	Abstract number 50
	<p>Palliative quality measures and assessing care of vulnerable elders (ACOVE) Karl Lorenz, RAND Health, UCLA, Veterans Administration, Lyneham, ACT, Australia</p>	Abstract number 51
	<p>Addressing symptoms, side effects, and indicators of supportive cancer treatment (ASSIST) Steven Asch, ACOS for Health Services Research, Los Angeles, USA</p>	Abstract number 52
	<p>US end-of-life utilization and place of residence 1989-1999 Sydney Dy, John Hopkins Bloomberg School of Public Health, Baltimore, USA</p>	Abstract number 53
Nikau Room	<p>Linking Policy and Research Chair: Tim Tenbenschel</p> <p>Translating evidence into policy advice - colorectal cancer screening in New Zealand Terri Green, University of Canterbury, Christchurch</p>	Abstract number 54
	<p>Improving the link between policy and research Jane Hall, Centre for Health Economics Research and Evaluation (CHERE), University of Technology Sydney, Broadway, NSW, Australia</p>	Abstract number 55
	<p>Research Translation Projects — evidence for a sustainable health system Naomi Prowse, Department of Health, Western Australia, Perth, WA, Australia</p>	Abstract number 56
	<p>Setting the direction for policy and practice focussed research in Australia Tanja Farmer, National Health and Medical Research Council, Canberra, ACT, Australia</p>	Abstract number 57
	<p>Getting evidence into policy: integrated governance arrangements in healthcare Claire Jackson, University of Qld Discipline of General Practice, Brisbane, QLD, Australia</p>	Abstract number 61

3.00pm - 3.30pm	Afternoon tea
3.30pm - 5.00pm	Concurrent sessions
Akarana Room	<p>Health Services and Indigenous Health Chair: Rhys Jones</p> <p>You Drum, I'll Sing: harmonising indigenous research approaches in community-based health services research Amohia Boulton and Jen Mackie, Massey University, Palmerston North Abstract number 59</p> <hr/> <p>An exploration of whanau ora in the reformed health sector Tai Walker, Victoria University of Wellington, Wellington Abstract number 60</p> <hr/> <p>Health outcomes research on inter-organisational collaboration Amohia Boulton and Jan Lockett-Kay, Massey University, Palmerston North Abstract number 61</p> <hr/> <p>Contract theory and research in Aboriginal and Torres Strait Islander primary health care Kim O'Donnell, Flinders University, Bedford Park, SA, Australia Abstract number 62</p> <hr/> <p>Primary health care reform and Maori: is it working? Lynne Pere, Victoria University of Wellington, Wellington Abstract number 63</p>
Tamaki Room	<p>Funding and Prioritising Health Services Chair: Rosalie Viney</p> <p>Joiners, leavers, stayers: private health insurance choices in Australia Stephanie Knox, Centre for Health Economics Research and Evaluation (CHERE), University of Technology Sydney, Broadway, NSW, Australia Abstract number 64</p> <hr/> <p>Is private health insurance picking up Medicare's surgery slack? David Gibson, University of Western Australia, Crawley, WA, Australia Abstract number 65</p> <hr/> <p>Lifetime fairness? Taxes, subsidies, age-based penalties and the price of private health insurance in Australia Luke Connelly, Australian Centre for Economic Research on Health (ACERH UQ) Centre of National Research on Disability and Rehabilitation Medicine (CONROD), Hereton, QLD, Australia Abstract number 66</p> <hr/> <p>Setting priorities at the local level: criteria, processes and considerations for success Gisselle Gallego, Centre for Health Economics Research & Evaluation (CHERE), University of Technology, Sydney, Broadway, NSW, Australia Abstract number 67</p> <hr/> <p>Exploring policymakers' perspectives on disinvestment from ineffective health care practices Adam Elshaug, Discipline of Public Health, The University of Adelaide, Adelaide, SA, Australia Abstract number 68</p>

Conference Programme continued

Hauraki Room	Rural Health Chair: Robin Gauld Growing pains following the formation of a new rural ambulance service in Australia Peter O'Meara, Charles Sturt University, Bathurst, NSW, Australia Abstract number 69
	No place for children or old people: the impact of changing health policies on small rural communities Julaine Allan, Charles Sturt University, Wagga Wagga, NSW, Australia Abstract number 70
	Autumn or Indian Summer: what services support rural health ageing? Judi Walker, University of Tasmania, Burnie, TAS, Australia Abstract number 71
	Policies to sustain primary health care in rural and remote Australia Robert Wells, Australian National University, Canberra, ACT, Australia Abstract number 72
	Public sector cultural dyslexia: suicide prevention in rural South Australia Jennene Greenhill, Flinders University, Renmark, SA, Australia Abstract number 73
	Identifying Service Needs Chair: Marion Haas Chronic disease self-management programs: policies and evaluation mechanisms Richard Osborne, University of Melbourne, Parkville, VIC, Australia Abstract number 74
Westhaven Room	Support needs of siblings of children with cancer Rebecca Dobson, University of Auckland, Auckland Abstract number 75
	Informal care and home-based palliative: the carers preferences for support Patricia Kenny, University of Technology, Sydney, Broadway, NSW, Australia Abstract number 76
	Identifying the resources and services needed by disabled people to live an ordinary life in the community Laura Wilkinson-Meyers, University of Auckland, Auckland Abstract number 77
	Australasian adolescents transition from paediatric to adult diabetes services: a complex picture of choice and access Kate Gilbert, Type 1 Diabetes Network Inc, Kensington, VIC, Australia Abstract number 78
	Modelling for Service Planning Chair: Stephen Goodall Strategic decision-making — policy implications of bed occupancy modelling: can we do without it? Mark Mackay, Department of Health/University of Adelaide, Novar Gardens, SA, Australia Abstract number 79
Nikau Room	Improving interfaces within the health system using multiscale dynamic simulation models Geoff McDonnell, Adaptive Care Systems, UNSW, Waverley, NSW, Australia Abstract number 80

	<p>System dynamics and agent based modeling of age related changes in people with intellectual disability Geoff McDonnell, Adaptive Care Systems, UNSW, Waverley, NSW, Australia Abstract number 81</p>
	<p>Modelling the future of aged care service provision: a localised system dynamics approach Hamish Robertson, Ageing Research Centre, Prince of Wales Hospital, Randwick, NSW, Australia Abstract number 82</p>
	<p>Forecasting the urban medical insurance system of Kunming City using microsimulation model Linping Xiong, National Centre for Social and Economic Modelling, University of Canberra, Canberra, ACT, Australia Abstract number 83</p>
5.15pm - 6.15pm	Plenary 3: How Will Health Services Research be Funded?
Arawa Room	<p>Chair: Stephen Duckett</p> <p>How will health services research be funded? Robin Olds, Health Research Council of New Zealand, Auckland Abstract number 84</p> <p>National Health and Medical Research Council support for health services research — the past, the future Warwick Anderson, National Health and Medical Research Council, Canberra, ACT, Australia Abstract number 85</p> <p>Discussant: Jacqueline Cumming, Health Services Research Centre, Wellington</p>
7.30pm	Conference Dinner Auckland Town Hall
Tuesday December 4th	
8.45am - 10.30am	Plenary 4: Collaboration In Health Services Research - The Way Forward
Arawa Room	<p>Chair: Jane Pirkis</p> <p>Collaboration in health services research: the way forward Sue Crengle, Te Kupenga Hauora Māori, University of Auckland, Auckland Abstract number 86</p> <p>Aboriginal health research collaborations with primary health care services in Australia — opportunities and challenges Sandra Eades, Sax Institute, Sydney, NSW, Australia Abstract number 87</p> <p>Evaluating primary health care and policies to improve it Peter Crampton, Department of Public Health, University of Otago, Dunedin Abstract number 88</p>
10.30am - 11.00am	Morning tea
11.00am - 12.30pm	Concurrent sessions

Conference Programme continued

Akarana Room	<p>Primary health care services Chair: Stephanie Knox</p> <p>General practice referrals for non-urgent surgical care Antony Raymont, Victoria University of Wellington, Wellington</p> <p style="text-align: right;">Abstract number 89</p>
	<p>General Practitioners knowledge, attitudes and practices regarding cervical cancer screening in Australia Stephen Goodall, Centre for Health Economics Research & Evaluation (CHERE), University of Technology Sydney, Sydney, NSW, Australia</p> <p style="text-align: right;">Abstract number 90</p>
	<p>Do patients use medicines for cardiovascular disease as the doctor intended? Susana Senes, Australian Institute of Health and Welfare, Canberra, ACT, Australia</p> <p style="text-align: right;">Abstract number 91</p>
	<p>Health care and internet use among Australians and New Zealanders: a survey study Robin Gauld, University of Otago, Dunedin</p> <p style="text-align: right;">Abstract number 92</p>
Tamaki Room	<p>Organised Session Chair: Richard Osborne</p> <p>Policy, innovation and reform: the Victorian Orthopaedic Waiting List Programme Richard Osborne, University of Melbourne, Parkville, VIC, Australia</p> <p style="text-align: right;">Abstract number 93</p>
	<p>Organising and managing waiting for hip and knee replacement surgery: getting the chronic care and hospital interface right Lisa Mitchell, Department of Human Services, Melbourne, VIC, Australia</p> <p style="text-align: right;">Abstract number 94</p>
	<p>Generating and implementing healthcare reform to improve quality and equity Richard Osborne, University of Melbourne, Parkville, VIC, Australia</p> <p style="text-align: right;">Abstract number 95</p>
	<p>Evolution of waiting list management of arthroplasty patients at RGH, South Australia Frankie Clarke and Jennifer Monaghan, CNC Ortho, Repatriation General Hospital, Daw Park, SA, Australia</p> <p style="text-align: right;">Abstract number 96</p>
Hauraki Room	<p>Mental Health Chair: Pauline Barnett</p> <p>What is the place of generalism in mental health care - a systematic review David Perkins, UNSW, Wollongong DC, NSW, Australia</p> <p style="text-align: right;">Abstract number 97</p>
	<p>Mental Illness: public program economic impacts on family/friend care costs Linda Cook, Grant MacEwan College, Sherwood Park, Alberta, Canada</p> <p style="text-align: right;">Abstract number 98</p>
	<p>Lost in translation: understanding mental health experience to inform practice Lynne Pere, Victoria University of Wellington, Wellington</p> <p style="text-align: right;">Abstract number 99</p>
	<p>The influence of organisational culture in collaborative healthcare Penny Mitchell, The University of Melbourne, Carlton, VIC, Australia</p> <p style="text-align: right;">Abstract number 100</p>

	<p>Evaluation of an Australian national primary mental health care initiative Jane Pirkis, University of Melbourne, Melbourne, VIC, Australia</p>	Abstract number 101
Westhaven Room	<p>Measurement and Methods for Health Services Chair: Peter Crampton</p> <p>Evaluating functional status management according to best geriatric practice (BGP) Lenore Beddoes, Alfred-Deakin Nursing Research Centre, Melbourne, VIC, Australia</p>	Abstract number 102
	<p>Describing and counting health interventions for good health policy Richard Madden, National Centre for Classification in Health - University of Sydney, Lidcombe, NSW, Australia</p>	Abstract number 103
	<p>Issues in the quantification of health-related quality of life: The EQ-5D Richard Norman, Centre for Health Economics Research & Evaluation (CHERE), University of Technology Sydney, Sydney, NSW, Australia</p>	Abstract number 104
	<p>Application of discrete choice experiments to value multi-attribute health states for use in economic evaluation. Developing and piloting a discrete choice experiment Paula Cronin, Centre for Health Economics Research & Evaluation (CHERE), University of Technology Sydney, Sydney, NSW, Australia</p>	Abstract number 105
	<p>Economic and health costs of smoking in New Zealand Des O'Dea, University of Otago, Wellington</p>	Abstract number 106
Nikau Room	<p>Maternity Services Chair: Terri Green</p> <p>The use of data linkage to examine substance use in pregnancy Lucy Burns, National Drug and Alcohol Research Centre, NSW, Australia</p>	Abstract number 107
	<p>Recurrence of postpartum haemorrhage in consecutive pregnancies, New South Wales Jane Ford, Kolling Institute of Medical Research, University of Sydney, St. Leonards, NSW, Australia</p>	Abstract number 108
	<p>Validation of reporting of maternal medical conditions in hospital discharge data Ruth Hadfield, The Kolling Institute of Medical Research, University of Sydney, Sydney, NSW, Australia</p>	Abstract number 109
	<p>Are babies with antenatally identifiable congenital anomalies born in hospitals with co-located paediatric surgical units? Christine Roberts, Kolling Institute, University of Sydney, St. Leonards, NSW, Australia</p>	Abstract number 110
12.30pm - 1.30pm	Lunch	

Conference Programme continued

<p>Arawa Room</p>	<p>Luncheon Session: The Harkness Fellowship Experience Moderated by Robin Osborn, The Commonwealth Fund Featuring former Harkness fellows, Rhys Jones MChB, MPH, Mark Booth and Jane Burns PhD</p> <p>Proudly sponsored by The Commonwealth Fund</p> 
<p>1.30pm - 3.00pm</p>	<p>Concurrent sessions</p>
<p>Arawa Room</p>	<p>Round Table Chair: Sally Redman Data linkage - a burgeoning resource for health services research Mary Haines, Sax Institute, Sydney, NSW, Australia Abstract number 111</p>
	<p>Population-based evaluation: the use of record linkage for health services research James Semmens, Curtin University of Technology, Perth, WA, Australia Abstract number 112</p>
	<p>Novel approaches to health services research using cross-jurisdictional medical record linkage Rachael Moorin and David Preen, Centre for Health Services Research & Policy, University of WA, Crawley, WA, Australia Abstract number 113</p>
	<p>The Centre for Health Record Linkage: record linkage services for NSW and the ACT Lee Taylor, NSW Department of Health, North Sydney, NSW, Australia Abstract number 114</p>
	<p>Emerging national infrastructure for research using linked health datasets Louisa Jorm, University of Western Sydney, Broadway, NSW, Australia Abstract number 115</p>
<p>Tamaki Room</p>	<p>Purchasing and Payment Systems for Primary Health Care Chair: John Durham Impact of user charges on GP access for injuries Jean-Pierre de Raad, NZIER, Wellington Abstract number 116</p>
	<p>Changes in PCT purchaser activity in the NHS post tariff Stephen Conaty, Islington Primary Care Trust, London, UK Abstract number 117</p>
	<p>National quality and performance system for Australian divisions of general practice: early reflections Karen Gardner, Australian Primary Health Care Research Institute, Canberra, ACT, Australia Abstract number 118</p>
	<p>Pay for performance in general practice - what can we learn from the United Kingdom? Verna Smith, ACC, Wellington Abstract number 119</p>

Hauraki Room	<p>Chronic Care Management Chair: Katherine Nelson</p> <p>Development of a multidisciplinary, community based, integrated primary-tertiary level diabetes service Deborah Askew, Discipline of General Practice, University of Queensland Brisbane, QLD, Australia</p> <p style="text-align: right;">Abstract number 120</p>
	<p>Effects of Chronic Care Model oriented interventions on diabetes care: a systematic review Damin Si, Menzies School of Health Research, Charles Darwin University, Darwin, NT, Australia</p> <p style="text-align: right;">Abstract number 121</p>
	<p>Evaluation of an integrated chronic care management program Peter Carswell, University of Auckland, Auckland</p> <p style="text-align: right;">Abstract number 122</p>
	<p>Chronic disease management: improving general practice performance in five countries James Dunbar, GGT UDRH Flinders & Deakin Universities, Warrnambool, VIC, Australia</p> <p style="text-align: right;">Abstract number 123</p>
Westhaven Room	<p>Round Table Chair: Marion Haas</p> <p>The need for and challenges of developing post-graduate courses in health services research for Australia and New Zealand Marion Haas, Centre for Health Economics Research & Evaluation (CHERE), University of Technology Sydney, Sydney, NSW, Australia</p> <p style="text-align: right;">Abstract number 124</p>
	<p>HSR-specific post-graduate courses: what do they look like? Marion Haas, Centre for Health Economics Research & Evaluation (CHERE), University of Technology Sydney, Sydney, NSW, Australia</p> <p style="text-align: right;">Abstract number 125</p>
	<p>The benefits of specific HSR qualifications Terri Green, University of Canterbury, Christchurch</p> <p style="text-align: right;">Abstract number 126</p>
	<p>Developing capacity and capability in health services research Jacqueline Cumming, Health Services Research Centre, Wellington</p> <p style="text-align: right;">Abstract number 127</p>
	<p>Identifying Service Needs Chair: Nicola North</p> <p>The journey of rehabilitation post discharge for NZ burn patients: exploring psychosocial outcomes and unmet needs Jeanne Reeve, University of Auckland, Auckland</p> <p style="text-align: right;">Abstract number 128</p>
	<p>Support needs and health service use in gynaecologic cancer Lisa Walton, University of Auckland, Auckland</p> <p style="text-align: right;">Abstract number 129</p>
	<p>Economic evaluation of the treatment of obstructive sleep apnoea syndrome Helen Scott, ScottEconomics, Wellington</p> <p style="text-align: right;">Abstract number 130</p>
	<p>Cost of health services for older people: comparing the health services and costs of the MDS-HC and NASC assessment tools Paul Brown, University of Auckland, Auckland</p> <p style="text-align: right;">Abstract number 131</p>

Conference Programme continued

3.00pm - 3.30pm	Afternoon tea
3.30pm - 5.00pm	Plenary 5: Panel Session - What Do Policy-Makers, Funders and Health Providers Want from Health Service Researchers
Arawa Room	<p>Chair: Jane Hall</p> <p>Panel Speakers:</p> <p>Stephen McKernan, Director General of Health, New Zealand</p> <p>Philip Davies, Department of Health and Ageing, Canberra, ACT, Australia</p> <p>Mark Wenitong, Australian Indigenous Doctors Association, Cairns, QLD, Australia</p> <p>Hayden Wano, Chair, Taranaki District Health Board</p> <p>Sharon Kletchko, Nelson Marlborough DHB, Nelson</p> <p>Discussants:</p> <p>Terri Green, University of Canterbury, Christchurch</p> <p>Rosalie Viney, Centre for Health Economics Research & Evaluation (CHERE), Sydney, NSW, Australia</p>
5.15pm - 6.45pm	HSRAANZ Annual General Meeting
Arawa Room	
Wednesday December 5th	
8.30am - 10.00am	Concurrent sessions
Akarana Room	<p>Issues In Primary Health Care</p> <p>Chair: Antony Raymont</p> <p>Primary health care reform in New Zealand: are fees falling and are consultation rates rising?</p> <p>Jacqueline Cumming, Victoria University of Wellington, Wellington Abstract number 132</p>
	<p>The state and primary health care in New Zealand: shifting boundaries</p> <p>Judith Smith, Health Services Research Centre, Wellington Abstract number 133</p>
	<p>Self-Determination and Indigenous primary health care services: a cross-national analysis</p> <p>Josée Lavoie, University of Northern British Columbia, Prince George, Canada Abstract number 134</p>
	<p>PHC care coordination: what is needed?</p> <p>Gawaine Powell Davies, University of New South Wales, NSW, Australia Abstract number 135</p>
Tamaki Room	<p>Public Health</p> <p>Chair: Toni Ashton</p> <p>The impact of celebrity cancer diagnosis on provider referred breast imaging among young women</p> <p>Margaret Kelaher, University of Melbourne, Melbourne, VIC, Australia Abstract number 136</p>

	<p>The impact of the HPV vaccine on women s preferences for cervical screening in Australia</p> <p>Marion Haas, Centre for Health Economics Research & Evaluation (CHERE), University of Technology Sydney, Sydney, NSW, Australia</p> <p style="text-align: right;">Abstract number 137</p>
	<p>The role of income and locality in breast screening participation</p> <p>Minh Vu, Centre for Health Economics Research & Evaluation (CHERE), University of Technology Sydney, Sydney, NSW, Australia</p> <p style="text-align: right;">Abstract number 138</p>
	<p>Cost-effectiveness of folate fortification compared to other alternatives</p> <p>Kim Dalziel, University of South Australia, Adelaide, SA, Australia</p> <p style="text-align: right;">Abstract number 139</p>
	<p>Being 'fat' in today's world: understanding the experiences of people living with obesity in Australia</p> <p>Asuntha Karunaratne, Monash University, Prahran, VIC, Australia</p> <p style="text-align: right;">Abstract number 140</p>
Hauraki Room	<p>Planning and Evaluation of Child Health Services</p> <p>Chair: Jeanne Reeve</p> <p>Responding to the mental health needs of Victorian children: using data to drive policy and service reform</p> <p>Sharon Goldfeld, Office for Children, Department of Human Services, Melbourne, VIC, Australia</p> <p style="text-align: right;">Abstract number 141</p>
	<p>Admissions to hospital of injured children: experiences of whanau / families</p> <p>Brooke Arlidge, University of Auckland, Auckland</p> <p style="text-align: right;">Abstract number 142</p>
	<p>Caring for injured children and their families: perspectives of health service providers</p> <p>Shanthi Ameratunga, School of Population Health, University of Auckland, Auckland</p> <p style="text-align: right;">Abstract number 143</p>
	<p>Evaluating community-based early childhood development initiatives: experience from across the ditch</p> <p>David Dunt, University of Melbourne, Melbourne, VIC, Australia</p> <p style="text-align: right;">Abstract number 144</p>
Westhaven Room	<p>Development of Nursing Services</p> <p>Chair: Rod Perkins</p> <p>Nurse churn and turnover: rates and relationships</p> <p>Nicola North, University of Auckland, Auckland</p> <p style="text-align: right;">Abstract number 145</p>
	<p>A behavioural economics perspective on nurse employment policy</p> <p>Marlene Eggert, Australian National University, Canberra, VIC, Australia</p> <p style="text-align: right;">Abstract number 146</p>
	<p>The development of primary health care nursing in the PHO environment</p> <p>Mary Finlayson, University of Auckland, Auckland</p> <p style="text-align: right;">Abstract number 147</p>
	<p>Establishing and sustaining successful innovation: the primary health care nursing innovations</p> <p>Katherine Nelson, Graduate School of Nursing, Midwifery & Health, Wellington</p> <p style="text-align: right;">Abstract number 148</p>

Conference Programme continued

	<p>Better all round for everybody: community nurses in cancer care Heather McKenzie, University of Sydney, Sydney, NSW, Australia</p> <p style="text-align: right;">Abstract number 149</p>
Nikau Room	<p>Round Table Chair: Ian Anderson</p> <p>Facilitating strong partnerships between researchers and research users for policy relevant research Barbara Beacham, Cooperative Research Centre for Aboriginal Health</p> <p style="text-align: right;">Abstract number 150</p>
	<p>The Cooperative Research Centre for Aboriginal Health's approach to developing research Ian Anderson, ONEMDA VicHealth Koori Health Unit, VIC, Australia</p> <p style="text-align: right;">Abstract number 151</p>
	<p>Managing research partnerships: optimizing links between researchers and research users Barbara Beacham, Cooperative Research Centre for Aboriginal Health, Bedford Park, SA, Australia</p> <p style="text-align: right;">Abstract number 152</p>
	<p>Reflections on the CRCAH approach to research: a researcher's perspective Ross Bailie, Menzies School of Health Research, Casuarina, NT, Australia</p> <p style="text-align: right;">Abstract number 153</p>
	<p>Reflections on the CRCAH approach to research: a policy maker's perspective Mark Thomann, Budget and Planning Branch</p> <p style="text-align: right;">Abstract number 154</p>
	<p>Reflections on the CRCAH approach to research: an Aboriginal community health sector perspective Alwin Chong, Aboriginal Health Council of SA, Norwood, SA, Australia</p> <p style="text-align: right;">Abstract number 155</p>
10.00am - 10.30am	Morning tea
10.30am - 11.45am	Plenary 6: Looking to the Future in Health Services Research
Arawa Room	<p>Chair: Jacqueline Cumming</p> <p>Toward a high performance health system Karen Davis, The Commonwealth Fund, New York, NY, USA</p> <p style="text-align: right;">Abstract number 156</p> <p>Health services research in the age of health care reform Jane Hall, Centre for Health Economics Research & Evaluation (CHERE), University of Technology Sydney, Broadway, NSW, Australia</p> <p style="text-align: right;">Abstract number 157</p>
11.45am - 12.00pm	Prizegiving and Conference Close



Poster Sessions

About the NHMRC

The National Health and Medical Research Council (NHMRC) is Australia's leading funding body for health and medical research. The NHMRC incorporates the National Institute of Clinical Studies, which is charged with closing the gap between best available evidence (what we know) and current clinical practice (what we do).

The NHMRC also provides the government, health professionals and the community with expert and independent advice on a range of issues that directly affect the health and well being of all Australians.

The NHMRC is internationally recognised as an expert body on:

- supporting health and medical research;
- developing health advice for the Australian community, health professionals and government; and
- providing advice on ethical behaviour in health care and in the conduct of health and medical research.

In September 2007 well over half a billion dollars was awarded for NHMRC grants commencing in 2008.



WORKING TO BUILD A HEALTHY AUSTRALIA

Poster Sessions

TITLE	AUTHOR NAME	ORGANISATION	POSTER NUMBER
Prioritising osteoarthritis for chronic disease service development in the Outer Eastern Metropolitan Region of Melbourne	Tamara Adams	Knox Community Health Service Victoria, Australia	1
Developing an instrument to assess local public health capacity	Prue Bagley	La Trobe University, Victoria, Australia	2
Normative ethics: a tool for focusing policy in reproductive medicine	Michael Burns	Oregon Health and Science University, Oregon, USA	3
Evaluating quality of care in oncology settings: symptom management practices	Emma Cohen	Alfred/Deakin Nursing Research Centre, Victoria, Australia	4
Adolescents and young adults with a life threatening illness: preferences for support services	Stephen Goodall	Centre for Health Economics Research & Evaluation (CHERE), University of Technology Sydney, NSW Australia	5
The Cochrane EPOC Group satellite: facilitating evidence-based health policy-making in Australasia	Russell Gruen	Cochrane Effective Practice & Organisation of Care Group, Victoria, Australia	6
Cost-effectiveness analysis of medical intervention in patients with early detection of diabetic foot in a tertiary care hospital in Bangladesh	Samira Humaira Habib	Diabetic Association of Bangladesh, Dhaka, Bangladesh	7
The effects of unemployment on fertility in New Zealand	Andrea Kutinova	University of Canterbury, Christchurch	
A narrative review of primary care management models for mild to moderate chronic lung disease	John Moss	Discipline of Public Health SA, Australia	9
Outcomes for patients waiting for cholecystectomy in Western Australia.	S.Aqif Mukhtar	Curtin University of Technology WA, Australia	10
Nursing handover: can we improve what we are doing?	Bev O'Connell	Deakin University Victoria, Australia	11
A new paramedic model for rural and regional Australia	Peter O'Meara	Charles Sturt University NSW, Australia	12
Comparison of the Australian and New Zealand Joint Replacement Prioritisation tools	Richard Osborne	University of Melbourne Victoria, Australia	13
Do outcomes from chronic disease self-management programs differ across age, gender and education?	Richard Osborne	University of Melbourne Victoria, Australia	14
The validity and usability of the Incident Information Management System	Mary Potter Forbes	Injury Risk Management Research Centre, UNSW, NSW, Australia	15
Development and validation of a maternal morbidity outcome indicator (MMOI)	Christine Roberts	Kolling Institute, University of Sydney NSW, Australia	16
Pregnancy hypertension reporting in population health data is associated with condition severity	Christine Roberts	Kolling Institute, University of Sydney NSW, Australia	17
Sector Wide Approach in India: the advent through RCH	Reetu Sharma	Jawaharlal Nehru University, Faridabad, India	18
Increasing youth access to health services via SMS appointment reminders	Sam Stott	University of Sydney NSW, Australia	19
Patients' perception of weight and primary care weight management	Marlene Tham	University of Melbourne Victoria, Australia	20
Research and reform: the Tasmanian Primary Health Services Plan	Judi Walker	University of Tasmania Tasmania, Australia	21
Hospitalization trends in the last year of life in dementia	Renate Zilkens	Curtin University of Technology WA, Australia	22
Chronic disease management in primary care: what works	Nicholas Zwar	University of New South Wales, NSW, Australia	23



Abstracts

Abstracts

Sunday December 2nd

(9.00am - 12.30pm)

Pre-conference workshop: Mixed Methods for Programme Evaluations of Health Services and Interventions

Abstract Number 1

Mixed methods for programme evaluations of health services and interventions

Janet Clinton¹, Paul Brown²

¹School of Population Health, ²University of Auckland

Abstract:

Evaluations of health services and health interventions often require the use of both qualitative and quantitative research methods. While there is a general acceptance of the merits of using mixed methods in evaluations and research, issues can arise when attempting to integrate and evaluate information from the different approaches. The purpose of this workshop is to provide an understanding of:

- ¹ Appropriate use of qualitative and quantitative methods in programme evaluation and research;
- ¹ Ways to integrate the information from qualitative and quantitative methods when assessing the effectiveness of a health service or interventions;
- ¹ How to reconcile discrepancies that might arise between the qualitative and quantitative information; and
- ¹ How to report the results from mixed methods evaluations.

Sunday December 2nd

(2.30pm - 5.30pm)

Plenary I: Fads and Fashions in Health Services

Abstract Number 2

Fads, Fallacies, and Foolishness in Medical Care, Management, and Policy

Theodore R. Marmor¹

¹Yale School of Management

Abstract:

This presentation reflects my interest in exposing fads, fallacies and foolishness in the health policy and management literature. It

is based on the essays in my new book from World Scientific Publishing 2007. No-one in medical care can miss the onslaught of claims about reforming modern medicine. How doctors should be paid, how hospitals should be governed, organized, and financed, how much patients should pay when sick, how the quality of care could be improved, and how governments and other buyers could better control the costs of care – all find expression in the explosion of medical care conference proceedings, op-eds, news bulletins, journal articles, and books.

My talk takes up a key set of what I regard as particularly misleading fads and fashions. In selecting them, I used as a criterion how much an idea contributed to misunderstandings in contemporary discussions of how to organize, deliver, finance, pay for, and regulate medical care services in modern industrial democracies.

Each of my topics includes major fads in the management and policy literature. In the case of management, the fads include the faith in marketing nostrums, the celebration of integrated delivery systems, and enthusiasm for simple minded clichés like “management by objective” or “primary care led reform”. The topic of “managed care” – the confused and confusing faddish notion of the 1990s – will be given special attention.

My policy topics include: the celebration of explicit rationing as a major cost control instrument, the belief in a “basic package” of health insurance benefits to constrain costs, the faith that contemporary cross-national research can deliver a large number of transferable models, and the belief that broadening the definition of what is meant by health will constitute some sort of useful advance in practice.

Each of these topics constitutes reform ideas that health care managers, policy makers, and students will have read about in the literature of the past decade or more.

Abstract Number 3

Will complex systems thinking take us forward in health research?

Professor Penny Hawe¹

¹University of Calgary

Abstract:

The notion of complexity has crept into health research language in recent years. Bold new ideas are always welcome. But one has to be suspicious when one term has mathematical meaning for some, almost mystical significance for others, sells business books and is also being used as an excuse for why things that should work, don't. Complexity thinking offers great promise. This presentation examines the practical difference this way of thinking has made to the methods within a program of research on preventive interventions in schools and communities.

Specifically we have shifted from “program thinking” to conceive of interventions as events in systems that either leave a lasting footprint or wash out depending on how the dynamic properties of the system are harnessed. The work is set within a six year interdisciplinary collaboration on complex interventions funded by the Canadian Institutes of Health Research and also supported by the Economic and Social Research Council (UK), linking investigators from Canada, Australia, UK and USA.

**Monday December 3rd
(8.45am - 10.30am)**

Plenary 2: Developments in Health Services Research

Abstract Number 4

Evaluating Primary Health Care and Policies to Improve It

Professor Andrew Bindman¹

¹University of California San Francisco

Abstract:

Cross national studies have suggested that the strength of a country's primary care infrastructure is positively associated with health outcomes and negatively associated with healthcare costs. However, the growth over time in the number of people with chronic disease, in the number of preventive care services that are recommended to be provided in primary care settings, and in patients' expectations for rapid responsiveness to their acute care needs is putting enormous pressure on primary care services. It is generally agreed that primary care needs to evolve to meet these challenges. Countries vary in how they are pursuing this re-engineering process and there is a substantial potential benefit in sharing the results of successful innovation strategies. However, the lack of a standard method for describing interventions and for systematically gathering reliable and valid data in an on-going way on the structure, process, and outcomes of primary care practice limits the generalizability of health services research from this setting. Primary care surveys and standardized inpatient datasets offer some valuable lessons for how to successfully address the current shortcomings of data in the primary care setting that are needed to improve services and to evaluate policy.

Abstract Number 5

Data-driven reform in safety and quality in Queensland

Dr. Stephen Duckett¹

¹Queensland Health, Brisbane

Abstract:

A high profile scandal at Bundaberg Hospital transformed the political landscape for safety and quality in Queensland in 2005. The state government responded with a commission of enquiry and a review of the health system, a \$10 Billion five year 'Action Plan', a change of Minister, a change of Director-General and an almost total change of the senior executive team for Queensland Health. Since then, there has been a significant change in clinical governance arrangements in Queensland Health. Key to the reforms has been a strong emphasis on monitoring and measurement. Importantly, the political settings for Queensland Health have been repositioned to emphasise transparency and openness with unprecedented amounts of information being publicly released. This emphasis on transparency and openness helps to create a performance-oriented culture and reinforces the need for continuous improvement.

The data-driven safety and quality agenda is exemplified in two critical areas: the development of a reward structure for safety and quality and improved monitoring processes. In terms of the reward structures, a new clinical practice improvement payment is proposed for introduction in 2008. The Department also has placed significant emphasis on statistical process control techniques to monitor safety of care.

**Monday December 3rd
(11.00am - 12.30pm)**

Concurrent Sessions: Australian Primary Health Care Research Workshop

Abstract Number 6

Looking back, planning forward: the APHCRI model — a fad or a foundation for the future?

Nicholas Glasgow

Abstract:

The Australian Primary Health Care Research Institute (APHCRI) commenced activity in 2003. The model it operates incorporates a number of features that could be fads or perhaps represent important ways of doing policy relevant research. This session will consider four key aspects of the APHCRI model

- 1 a research commissioning and research doing entity;
- 2 priority driven research addressing issues of national policy relevance;
- 3 "linkage and exchange" or "knowledge transfer and exchange"; and
- 4 a virtual institute

and consider whether these aspects are fads to be moved on from, or solid foundations on which to develop the next stage. By briefly surveying the Institute's activities thus far, speakers will consider the extent to which the model has achieved the strategic aims of the Institute of developing the primary health care relevant knowledge base, increasing the uptake of research evidence into policy and building research capacity. The session will include time for audience participation and discussion.

Monday December 3rd (11.00am - 12.30pm)

Concurrent Sessions: Health Sector Reform

Abstract Number 7

Shaping Decision-making in governance in New Zealand public health services

Lee Mathias¹

¹Auckland University of Technology

Abstract:

Objectives

The research study was undertaken in part completion of the requirements for the degree of Doctor of Health Science. Healthcare service reform in New Zealand has been continuous for the past 27 years. One of the aims of the current structure is to include public participation in healthcare service decision-making and the method of achieving this has been through having a proportion of District Health Board (DHB) members elected from the public. This "democratisation" of healthcare services has resulted in conflicts of interest which are not managed by the legislated process.

Methods

Chairs, CEOs and clinicians from three DHBs were purposively invited to participate in individual interviews and focus groups. Each board was observed in formal board meetings. This qualitative study used Pierre Bourdieu's concepts of habitus, field and capital and underpinning frameworks of social, cultural and symbolic capital to analyse the data.

Results

Themes, common to most participants, which were perceived to shape decision-making were: the impact of cultural power; institu-

tional and organisational complexity, impact of healthcare system structure (including organisational structure impeding or facilitating decision-making, co modification and democratisation of health), the impact of context and the influence of time.

Conclusion

Conflicts between fiduciary duty, duties of care and skill, duty of care to patients or communities and the duty of utility arise for all participants in decision-making in governance in NZ public healthcare services. The democratised healthcare service structure has resulted in conflicts of interest, especially but not exclusively with elected board members, and the allocation of funding. These conflicts have not been able to be managed by the legislated process. A recent judgement states that even when there is no actual conflict of interest or any intent to benefit from change, a desire for change by an interested party (board member) amounts to conflict of interest. Democratization at DHB level is a failed experiment. Public inclusion would be better managed through the electoral and select committee processes and programme specific consultation.

Abstract Number 8

Governance relationships in the changing New Zealand health system

Pauline Barnett¹, Jackie Cumming², Clare Clayden³, Toni Ashton⁴, Tim Tenbensen⁴, Meagan Pledger⁴, Mili Burnette²

¹University of Otago, ²University of Wellington, ³Health Research Consultant, ⁴University of Auckland

Abstract:

Objectives

Research into health governance suggests that the increasing complexity of health services leads to 'networks' or 'systems' of governing boards, creating new relationships: between centre and periphery, in inter-board relations, and between boards and stakeholders. In New Zealand, reforms in 2001 instituted a new District Health Board (DHB) model. This research assesses the impact of governance relationships on individual boards and the system overall. Data, for two different time periods, included a national postal survey of board members and interviews with board chairs and chief executives.

Results

Centre-periphery relationships. Results indicate strong central direction, with some dissatisfaction in boards over a perceived lack of local decision-making autonomy. Despite legislative accountability of boards to the Minister of Health, some members saw themselves as accountable to local communities. Reporting arrangements were seen as unnecessarily bureaucratic.

Lateral relationships between boards were not part of the statutory framework, but boards quickly established a national organisation of DHBs and developed local and regional partnerships.

Stakeholder relationships. The requirement for open board meetings and the election of members was expected to enhance community input into decisions. In fact, structured engagement as part of the planning process appeared more useful. However, the more open governance and management style, seemed to have led to improved relationships with the community.

Conclusion

The pattern of vertical, lateral and stakeholder relationships reflect themes from the international literature. Some statutory requirements created unfulfilled expectations, but the desire for stability has led to pragmatic governance and management responses to ensure a workable system.

Abstract Number 9

Are New Zealand's DHBs able to steer towards population health?

Tim Tenbense¹, Jackie Cumming², Toni Ashton¹, Pauline Barnett³

¹University of Auckland, ²Victoria University of Wellington,

³University of Otago

Abstract:

Objectives

Since 2000, the substantive focus of health policy in New Zealand has been closely aligned to the agendas of improving population health and reducing health inequalities. Health system restructuring, through the reinstatement of locally based, partially elected District Health Boards (DHBs), was one of the key mechanisms for steering towards population health. This analysis of the first years of elected District Health Boards (2000-02 to 2004-05) sets out to answer the following broad questions: (i) have DHBs adopted a strategic focus on population health goals?; (ii) to what extent has community input shaped DHB strategic decision-making; and (iii) do DHBs have sufficient autonomy to steer effectively. These questions were explored as part of a larger research project investigating the introduction and implementation of the DHB system. Two rounds of interviews were held with national stakeholders and senior DHB personnel, and other data was collected from surveys of board members, case studies of five districts which included key informant interviews, observation at board meetings and document analysis. Overall, DHBs have demonstrated the 'will' to engage in strategic decision-making processes to enhance population health but have difficulty in finding the 'way'. The priorities and requirements of central government and the weight of institutional history will continue to be the most influential factors on DHB decision-making and practice, with flexibility and innovation exercised at the margins. Opportunities for change have been largely dependent on the availability of new funding from central government.

Abstract Number 10

The Population Health Approach and Health System Restructuring - New Zealand

Dr. Nicolette Sheridan¹

¹The University of Auckland

Abstract:

Objectives

The implementation of the population health approach driving health system restructuring has been variable in developed countries and health outcomes have often been less than maximal. New Zealand Government policies that steer health system restructuring repeatedly advocate a population health approach but are not explicit about how this approach should be implemented. This presentation reports on a study investigating the relationship between a population health approach and health system restructuring in New Zealand between 1999 and 2007. Using a mixed method approach interviews were conducted in 2007 with 15 informants with expertise in policy, health management, research, or clinical practice and documents were reviewed. The investigation focused on how a population health approach was defined and incorporated into recent health policies and health system restructuring, how it was communicated to health providers and community organisations, and the influence this approach had on health system restructuring - including health provider roles and relationships. Key factors in developing a population health approach were found to be only partially implemented. Health care and population health were often understood as competing rather than complementary paradigms. Public engagement in health systems planning has increased but deliberation on issues remains in its infancy. Resources allocated for population health and health promotion programming nationally and locally have increased but remain inadequate and few staff were dedicated to health determinants and tackling inequalities in health. Horizontal links across sectors were patchy and most were short term. New policy development designed to facilitate the integration of the population health approach into the New Zealand health system is advocated.

Abstract Number 11

A world apart? Purchasing health services in England and New Zealand

Dr. Toni Ashton¹, Judith Smith²

¹University of Auckland, ²University of Birmingham

Abstract:

Objectives

In the 1990s, both New Zealand (NZ) and the United Kingdom (UK) developed a market-based health system based on a separation between purchasers and providers. The election of Labour Governments in 1997 (UK) and 1999 (NZ) heralded a

greater focus on collaboration, and the implementation of new structural arrangements concerned with population health improvement and reducing inequalities in health outcomes and access to care. Both countries chose to develop a clear purchasing role at the local level (District Health Board in NZ and Primary Care Trust in England). Over time, however, whilst NZ has focused on an increasingly collaborative and locally governed approach to health planning, the English NHS has embarked on a further series of market reforms that call for a more explicit purchasing function combined with a greater degree of patient choice.

Methods

We compare the two approaches to purchasing using the conceptual framework for effective purchasing developed by Figueras et al (2005). This analysis reveals that key differences in the two approaches to purchasing lie in: the focus on secondary care (NZ) and primary care (England) as the lead agency for planning and funding; the nature of the contracting approaches; the use of targets and performance measures; and in the model of community governance adopted to provide accountability for purchasing and funding decisions. We use our analysis to set out policy options for strengthening the health purchasing function, drawing out how each country could usefully learn from the other.

**Monday December 3rd
(11.00am - 12.30pm)**

Concurrent Sessions: Hospital Quality and Clinical Governance

Abstract Number 12

Measuring adverse events in hospitals — comparison of two surveillance systems

Ms. Sanja Lujic¹, Professor Louisa Jorm¹, Dr. Mary Haines¹

¹The Sax Institute

Abstract:

Objectives

Improving patient safety and quality of care is a major priority for hospitals and health systems. But the measurement of adverse events using routine data remains an important challenge. We compared two methods for identifying adverse events, using data from one hospital.

Methods

We used patient records from a metropolitan large tertiary teaching hospital in Sydney, Australia for the period 1 July 2005-30 June 2006. Hospital separation records (N=64,245) were linked to records from the Incident Information Management System (IIMS), a stand-alone system for recording adverse events. We reviewed IIMS records to select only non-duplicate records where the event was related to inpatient care. We used Mantel-Haenszel methods

to compare rates of adverse event estimated using IIMS and using diagnosis codes (ICD10-AM) in hospital separation records.

Results

The proportion of hospital admissions associated with an adverse event was 3.4% using diagnosis codes, and 1.6% using IIMS. Concordance between the two methods was 95.6% (95% CI 95.4%, 95.7%). However only 17% of IIMS adverse events had an adverse event diagnosis code, and 8% of separations with an adverse event diagnosis code had an IIMS record. There were twice as many in-hospital falls recorded in IIMS than using diagnosis codes.

Conclusion

Diagnosis codes recorded in inpatient records and specialised incident monitoring systems capture different, only slightly overlapping, populations of adverse events. Both need to be used for comprehensive studies of hospital safety and quality.

Abstract Number 13

The Hospital Mortality Project: A Tool for Clinical Governance

Mukhtar S.Aqif¹, Dr. Neville Hoffman², Dr. Gerry MacQuillan², Professor James Semmens¹

¹Curtin University of Technology, Western Australia, ²Sir Charles Gairdner Hospital, Western Australia.

Abstract:

Objectives

The increasing demand for greater clinical accountability requires development of convenient tools to measure healthcare safety and quality, which are able to provide information contemporaneously.

Methods

After an in-hospital multistay patient death (multistay: being any patient who was resident in hospital at 1200hrs midnight, thus excluding day cases) is registered on a hospital patient administrative system, the consultant of record is notified and requested to assign the death to a predefined category. This categorisation leads to further investigation as appropriate.

Hospital administrative data from 01 Jan 1996 to 31 March 2006 was used to define Hospital Mortality Index (HMI). Attribute control chart (p-CHART) was used to express the HMI as a performance indicator for hospital departments and individual clinicians. Summary data is reported to the Clinical Departments and the Hospital Executive via the Quality Improvement Committee on quarterly basis.

Results

The clinical review was complete for 1561 of 1681 (93%) multistay patient deaths, while a further 120 (7%) are still in the process of being reviewed as of 31-August-2006. The median age of all the cases was 78 years (IQR 67-86) of which 825 (53%) were male. The Poisson regression analysis demonstrated that most of the departments showed either non significant change in HMI over time or a slightly significant reduction in HMI over time.

Conclusion

The Hospital Mortality Project provides a simple and efficient tool for analysis of in-hospital deaths. This tool is able to import routine administrative data from any hospital and generate clinical performance analysis.

Abstract Number 14

Variation in New Zealand Public Hospital Outcomes, 2003-2006

Dr. Patrick Graham¹, Dr. Phil Hider¹, Zhaojing Gong², Dr. Jackie Cumming², John Fraser², Dr. Antony Raymont², A/Prof. Mary Finlayson³, Professor Gregor Coster³

¹University of Otago, ²Victoria University of Wellington,

³University of Auckland

Abstract:

Objectives

New Zealand public hospitals account for a substantial proportion of government expenditure on health. Evaluation of hospital performance is therefore an important concern of health services research. Issues of patient safety and health care quality are assuming increasingly high research and policy priority and these issues necessitate evaluation and comparison of health outcomes. Variations in hospital outcome rates suggest areas for quality improvement.

Methods

This study uses administrative data, drawn from the New Zealand National Minimum Dataset for public hospital discharges to compare patient outcomes across the New Zealand public hospital sector. We study variability in a series of mortality and patient safety indicators, developed by the Agency for Health Research and Quality. We use hierarchical Bayesian models to estimate the between-hospital distribution of comorbidity adjusted outcome rates. This approach accounts appropriately for the instability of outcome rates for smaller hospitals.

Results

Preliminary results indicate, that after comorbidity adjustment and proper allowance for statistical uncertainty, there is close to two-fold variation between top and bottom of the hospital outcome distribution, for several outcomes. Despite some consistency in the degree of between-hospital variability for the outcomes studied, individual hospitals often exhibit inconsistent relative performance.

Conclusion

There is considerable variability in New Zealand hospital outcomes. Hospitals appear to exhibit inconsistent relative performance with respect to different outcomes, suggesting that rather than a generic "hospital effect" on patient outcomes, hospital effects may operate at a ward or service level.

Abstract Number 15

The professional nursing practice environment and patient outcomes

Dr. Mary Finlayson¹, Ivana Nakarada-Kordic¹

¹University of Auckland

Abstract:

Objectives

This paper reports a study to determine whether aspects of the professional nursing practice environment in New Zealand public hospitals are associated with patient mortality, readmission rates and length of hospital stay.

Internationally, professional nursing practice environments have been affected by the continual restructuring of the health and hospital systems and there are indications that this may impact on patient outcomes. However there are few empirical studies examining these relationships and the studies have produced mixed findings.

In 2001 and 2004 nurses in the same 19 public hospitals in New Zealand completed a survey on their work environment including the Revised Nursing Work Index (NWI-R) which measures autonomy, control over the practice environment and nurse-doctor relationships. The 2001 and 2004 patient discharge records from the participating hospitals were obtained from the New Zealand Health Information Service and mortality, readmission rates and length of hospital stay were measured and adjusted for risk. Data were aggregated at a hospital level and analysed using hierarchical multiple regression.

The full regression model, including hospital size, year of study, years of nursing experience, nurses' educational qualifications, autonomy, control, and nurse-doctor relations explained 34.6% of the variance in average length of stay, 30.3% of the variance in the in-hospital death rate, and 23.4% of the variance in 30-day post admission death rate. Autonomy and control over practice had no statistically significant individual association with any patient outcome, while a positive nurse-doctor relationship contributed to shorter length of stay. The full model had no statistically significant impact on readmission rates.

Abstract Number 16

Hospital quality and safety: linking practices to performance

Dr. Phil Hider¹, John Fraser², Dr. Patrick Graham¹, Dr. Jackie Cumming², Dr. Antony Raymond², A/Prof. Mary Finlayson³, Professor Gregor Coster³

¹University of Otago, ²Victoria University of Wellington,

³University of Auckland

Abstract:

Objectives

Measuring hospital performance is a complex and multifaceted task. Very many process and outcome-oriented measures have been developed. Establishing where there may be links between patient outcomes and hospital processes is more difficult still, yet crucial in terms of directing investment in hospital quality and safety.

Methods

A study is being conducted to describe patient outcomes in New Zealand hospitals using the Agency for Healthcare Research and Quality's (AHRQ) Patient Safety Indicators and Inpatient Quality Indicators. The study will also seek to identify potential linkages between several patient outcomes measured by the indicators and hospital safety and quality practices employed at clinical and organisational levels.

Results

A conceptual framework and method are presented for developing a census of hospital adoption of well-founded quality and safety practices, with reference to (i) the construct validity established in the literature for each AHRQ outcome measure, and; (ii) national statements of best practice promulgated under policy.

Conclusion

In addition to describing the adoption or not of these practices across New Zealand, the census results may, in conjunction with the AHRQ indicator results, allow cross-sectional analysis for plausible associations between practices and patient outcomes.

**Monday December 3rd
(11.00am - 12.30pm)**

Concurrent Sessions: Organised Session

Abstract Numbers 17 — 21: Organised Session

Abstract Number 17

Regionalisation of Cancer Services: In search of evidence-informed policy

A/Prof. Russell Gruen¹

¹University of Melbourne

There is an international trend for cancer services to be concentrated in centres that treat high volumes of cancer patients and offer a full range of cancer services. The UK NHS has largely adopted this as policy. Several Australian states and much of the United States, for example, are currently examining related policy options.

It makes sense that comprehensive services with vast experience often provide improved clinical outcomes for some patients when compared with centres that do not have the same level of experience or cannot provide the same services. The same may be said for high volume surgeons compared to low-volume surgeons. However, confining cancer services to specialist centres in Australia may adversely affect access to those services for people in outer metropolitan and rural areas, and may have other unintended consequences.

An objective assessment of the pros and cons of regionalisation is required. In this presentation we focus on this major policy dilemma and try to distinguish 'facts' from 'fads' and 'evidence' from 'politics', through a policy-maker's perspective of the different stakeholder interests; consideration of what high volume providers might do differently that gives better results; a systematic review that highlights the strengths and weaknesses of the research evidence; and an explicit focus on what health services research has to offer in informing related health policy.

Abstract Number 18

Regionalisation of Cancer Services: the policy makers perspective

Adam Chapman¹

¹Cancer & Palliative Care Unit, Melbourne, Australia

Abstract:

Objectives

In 2002 the Victorian Government committed to a wide-ranging reform of cancer services, based on a report done for the Victoria Government, A Cancer Services Framework for Victoria. A major structural element for reform was the establishment of eight integrated cancer services (ICS) across Victoria, to coordinate cancer care and services for the population within their catchments. Five of the ICS cover regional Victoria.

The development of models of care across the Integrated Cancer Services requires a sound basis in quality of care and outcome. The Framework noted the issue of many practitioners undertaking small numbers of operations in numerous health services, and discussed the need for a formalised accreditation and role designation system for tumour streams at each health service, and across ICS. Assessing the level of evidence for a volume/specialization - outcome association across tumour streams was important in understanding this.

The role for policy makers in assessing this sort of evidence is to understand the possible implications for service delivery. Factors that require consideration include the need to improve access to cancer services, and the impact that confining particular procedures to high volume services could have for regional patients, and the need to support regional centres in providing for their populations. Framing policy in terms of risks and benefits is important in clarifying recommendations to Government.

Abstract Number 19

Why high volume surgeons and hospitals should get better outcomes

A/Prof. Jonathan Koea¹

¹Auckland Hospital

Abstract:

Objectives

The relationship between surgical volume and outcome is more complex than immediately apparent. While it seems reasonable that surgeons, who perform certain procedures with high frequency, should achieve high quality outcomes in terms of surgical morbidity, mortality and patient hospital stay, defining the contribution of institution and sub-specialisation to this process is more difficult. High volume surgeons are usually highly specialized surgeons and most frequently work in tertiary referral centres in major metropolitan cities. The development of a high volume surgical practice implies sub-specialisation in conditions affecting a particular

region or organ system. Such practices are usually driven by individual enthusiasm and dedication and permit the surgeon to hone clinical and operative skills, assemble and develop specialized operating and support teams of medical and paramedical personnel.

There is also the opportunity for leading edge research, teaching, and surgical audit. High volume focused surgical practice may also result in shorter waiting times for patient assessment and treatment and also encourages the development of specialized prevention programs for at risk populations and rehabilitation services following treatment.

Abstract Number 20

Case volume and cancer mortality: a systematic review

Veronica Pitt¹, Sally Green¹, Russell Gruen², Silva Zavarsek¹, Damien Jolley¹, Donald Campbell¹

¹Monash Institute of Health Services Research, ²University of Melbourne

Abstract:

Objectives

This paper will provide a comprehensive and evidence based literature review examining the relationship between surgeon volume, hospital volume and patient outcomes of cancer treatment. Approximately 150 publications across 10 tumour streams are reviewed. The strengths, weaknesses and applicability of the evidence will be discussed, including: the issue of clinician versus hospital volume; limitations of the evidence and whether conclusions are generalisable; the types of cancer treatment for which there is evidence and those for which the evidence is lacking (e.g. does the evidence focus solely on surgery, or is there evidence for a volume outcome effect for other oncology treatments?); the outcome measures used (e.g. are outcomes measured over the short, medium or long term? How appropriate are the outcome measures for the condition and treatment examined?); as well as a discussion of the applicability of evidence from overseas studies to the Australian health care context.

Abstract Number 21

How can health services research inform regionalisation of cancer services?

A/Prof. Russell Gruen¹

¹Cochrane Effective Practice & Organisation of Care Group

Abstract:

Objectives

As illustrated in the preceding papers, regionalization of services raises issues of quality, accessibility, cost-effectiveness and politics.

This paper will discuss how health services research can inform all aspects of this complex policy issue, and how the lessons learned in other jurisdictions, plus a critical examination of the effects of new policy initiatives can result in a more transparent and reasoned debate. I will comment on the role of systematic reviews, and touch on related issues such as how big is the effect on quality, what thresholds are required for large volume centers, and whether high volume centers need to focus on only a small number of conditions or procedures. Finally the importance of engaging health services researchers early in the policy-making process will be underscored.

**Monday December 3rd
(11.00am - 12.30pm)**

Concurrent Sessions: Access and Utilisation

Abstract Number 22

Inequalities in hospital utilisation in WA by patients with homogenous health status

Rachael E Moorin¹, C. D'Arcy J Holman¹

¹The University of Western Australia.

Abstract:

Background:

This study investigated patients with homogenous health status to evaluate the degree to which use of the Australian hospital system is affected by socio-economic status, locational accessibility to services and patient payment classification.

Method:

Records of all deaths occurring in Western Australia from 1997 to 2000 inclusive were extracted from the WA mortality register and linked to hospital morbidity data system (HMDS) records via the WA Data Linkage System. Adjusted incidence rate ratios of hospitalisation in the last, second and third years prior to death were modelled for five underlying causes of death.

Results:

The independent effects of socio-economic status on hospital utilisation differed markedly across cause of death. Accessibility was generally not an independent predictor of utilisation while private patient status was only influential three years prior to death.

Conclusion:

It appears that the Australian hospital system may not be equitable since equal need did not equate to equal utilisation. Further it would appear that horizontal equity, as measured by equal utilisation for equal need, varies by disease. This implies that a 'one-size-fits-all' approach to further improvements in equity may be over simplistic. Thus initiatives beyond Medicare should be devised and evaluated in relation to specific areas of service provision.

Abstract Number 23

Prescribing of Psychostimulant Medicines for Attention-Deficit Hyperactivity Disorder (ADHD) in Western Australian Children

David B. Preen¹, Janine Calver¹, Frank M. Sanfilippo¹, Max Bulsara¹, C. D'Arcy J. Holman¹

¹The University of Western Australia

Abstract:

Objectives

To examine psychostimulant prescribing for the treatment of ADHD in Western Australian (WA) children by age, sex, prescriber specialty, geographical remoteness and socioeconomic status.

Methods

Using whole-population, geocoded, linked administrative prescribing and pharmacy data from 2003-2004, age and sex specific prevalence of children (3-17 years) treated with psychostimulants, and dose prescribed, were determined. Logistic and linear regressions were used to model the number of patients treated and daily dose of stimulants prescribed by prescriber specialty. Variations in prescribing by geographical remoteness and socioeconomic status were determined using the Accessibility/Remoteness Index of Australia (ARIA+) and Index of Relative Socio-Economic Disadvantage (IRSD) for WA.

Results

23.5 children per 1,000 child-population were prescribed psychostimulants for ADHD in WA during 2004, with a peak-prevalence of 5.5% in 14 year-old males. The mean number of children treated (per prescriber) was 159.8 (range: 1-1,977) and 34.3 (range: 1-166) for paediatricians and psychiatrists respectively. Males were 32% ($p=0.002$) more likely to be prescribed stimulants by paediatricians. Psychiatrists were 2.9-times (95%CI: 2.4-3.4, $p<0.001$) more likely to prescribe multiple psychotropic medications and prescribed higher stimulant doses (4.5mg/day greater; 95%CI: 2.0-7.0, $p<0.001$) than paediatricians. Rate of prescription was 2.3-5.3 times greater in cities compared with remote localities. Children with greater socioeconomic disadvantage were more likely to receive stimulants than their advantaged counterparts.

Conclusion

The overall prevalence of psychostimulant use for the treatment of ADHD in WA children is 2.4%, but as high as 5.5% for some ages. Paediatricians treat more patients and a greater proportion of males, but rely less on combined pharmacotherapy and prescribe lower stimulant doses than psychiatrists. Geographical remoteness and socioeconomic disadvantage are associated with rate of stimulant prescription for ADHD in WA children.

Abstract Number 24

Access to elective surgery in New Zealand — still of concern?

Dr. Sarah Derrett¹, Tui H Bevin¹, A/Prof. Peter Herbison¹, Professor Charlotte Paul¹

¹University of Otago

Abstract:

Objectives

In New Zealand, there is a two-tier health system with elective surgery provided by the publicly funded state system and by private hospitals. Clearly issues of equity should be considered across such parallel systems – where wealthy can pay for surgery regardless of their relative clinical need. We examined commonly-provided surgical procedures to: 1) identify changes in rates of surgery over 5 years; 2) examine geographical variation, 3) explore the contribution of publicly and privately funded surgery to equity, and 4) explore access according to socio-economic status.

Methods

Data for people receiving publicly funded elective total joint replacement (hip and knee joint combined), prostatectomy and/or cataract surgery between 1 July 2000 and 30 June 2005 were obtained, and most recent data for people receiving privately funded surgery (2001-2002). Direct age-standardisation was carried out using the 2001 Census population as the standard. NZDep2001 was used to select people in three deciles (8, 9 & 10) to determine the numerator and denominator to calculate their age-standardised rates of surgery.

Results

There were 74,836 eligible elective surgery reports. Large variations in access to publicly funded elective surgery existed for all groups according to where people lived, and low public provision was significantly correlated with high private provision for joint replacement and prostatectomy. A greater proportion of people living in the lowest decile areas had surgery in the publicly funded sector. However, the lowest NZDep groups' rates of publicly-funded surgery were not higher in areas with high private provision.

Conclusion

Despite the introduction of a booking system aimed at increased equity and fairness, provision of elective surgery remains inequitable based on where people live. The wider implication of this research is that an unregulated private sector does not appear to have a positive effect on the equity of elective surgery provision.

Abstract Number 25

Causes of different admission rates of high deprivation population in two DHBs

Dr. Nicola North¹, Jagpal Benipal¹

¹The University of Auckland

Abstract:

Objectives

A number of NZ reports carried out by the Ministry of Health and individual researchers have highlighted that Maori, Pacific Islanders, and people in lower socioeconomic groups, have a poorer health status and a higher incidence of disability and higher utilisation of health services. The aim of this study was to compare whether high deprivation people living in different DHB regions had similar or differing acute medical admission rates to hospitals.

This mixed methodology research was conducted in two phases, which analysed retrospective hospital inpatient medical data (1997-2004) obtained from Middlemore and Auckland Hospitals to identify trends in acute medical admissions. These identified trends were further explored and explained through the involvement of key expert panellists invited to comment on these results.

One of the unexpected findings related to the comparison of the age-standardised admission rates (ASRs) of two hospitals indicated that each of the MMH high deprivation ethnic groups had significantly higher ASRs to the equivalent high deprivation ethnic group at APH. Overall, the high deprivation domicile findings indicated that the MMH Maori groups had the highest, Pacific Islander group the 2nd highest and the European/Other groups the lowest admission rates. In contrast at APH all three high deprivation domicile groups had significantly lower ASRs, than their counterparts at MMH, but higher than low deprivation counterparts at APH. According to the expert panel findings, the explanation for this variation was likely to be related to the availability of primary care and the hospital admitting practices.

Therefore, it is concluded that the reasons for significant differences in the admission rates of the two hospitals and their ethnic groups were also related to the availability and access to primary care services in community and hospital admitting practices, rather than purely because of the poor socioeconomic status and ethnic predisposition to disease of the Maori and Pacific Islander groups.

Abstract Number 26

Hospital and other health service experiences of Australian Indigenous families in the Australian Capital Territory

Ms. Jill Guthrie¹,

¹School of Public Health & Community Medicine, University of New South Wales

Abstract:

Objectives

Focusing on the Australian Capital Territory, the study has two perspectives: families and health professionals. Factors associated with avoidable hospitalisation include poor healthcare access, lower educational attainment, poverty, lack of a primary health care physician – factors often characteristic of the lives of many Indigenous people. Most research has been quantitative, usually highlighting under-reporting of Indigenous identification. Considerably lesser research explores interactions between Indigenous Australians and hospital systems. This study explores the hospital experiences of families of Indigenous children.

Methods

To date I have analysed ACT Health data, showing, in summary, numbers of hospitalised Indigenous children (≤ 5 years) from 2000-2005, and primary diagnoses, and interviewed 16 families of 22 hospitalised Indigenous children, and 10 health professionals, and examined hospital records of 34 children. Family case studies describing admission and discharge processes, socio-demographics, family and community circumstances, and access to and use of health care services will provide insights into how some Indigenous families experience the hospital system. In line with the grounded theory approach, emergent themes will underpin new areas for exploration and analysis. Integral to the methodology is a Research Reference Group comprising key health providers and policy-makers in relevant ACT and NSW jurisdictions.

Conclusion

The study will continue for 12-15 months. Guided by the Research Reference Group, emergent themes will underpin recommendations to relevant ACT and NSW policymakers. Expected recommendations include: discharge planning, cultural appropriateness of hospital services, health workforce, (consumer) health education, medical education and data collection.

**Monday December 3rd
(11.00am - 12.30pm)**

Concurrent Sessions: Workforce Collaboration

Abstract Number 27

Psychological Treatments in Primary Care: Systematic Review and Policy Options

Dr. Richard Moulding¹, Dr. Grant Blashki¹,
Professor Jane Gunn¹, Cathy Mihalopoulos²,
A/Prof. Jane Pirkis¹, Dr. Lucio Naccarella¹, Dr.
Lynette Joubert¹

¹University of Melbourne, ²Deakin University

Abstract:

Objectives

Over the last decade, there have been a number of policy reforms to improve primary mental health care around the world. In Australia, the recent mental-health programs by the Federal government have incrementally opened up consumer access to psychological treatments from allied health providers. Such initiatives need to be tied to current evidence from the literature in relation to local health systems.

Methods

We performed a systematic review of the literature regarding the effectiveness and cost-effectiveness of psychological treatments in primary care, using Medline, Cochrane, Web of Science, PsycINFO, PubMed and Scopus. The literature search identified 4520 abstracts, which were scanned for relevance.

Results

We reviewed 40 studies of generalist and specialist provision of psychological treatments, 10 studies of collaborative models and 21 studies relevant to cost-effectiveness. The results supported the effectiveness and cost-effectiveness of psychologist provided treatments. The use of collaborative models of health-care was particularly effective.

Conclusions

Our review supports the use of collaborative models of health-care incorporating specialist provision of psychological treatment, and we discuss ways to encourage this within the Australian system. We hope to encourage practitioners and policy makers to consider how to use such evidence to continue to build world-leading models of primary mental health care.

Abstract Number 28

Multidisciplinary Teams in Clinical Networks Implementing Change in Cancer Services

Sue Sinclair¹, Dr. Cynthia Lean¹, Robyn Thomas¹, Bronwen Conn¹, Penny Adams¹, Professor James Bishop¹

¹Cancer Institute NSW

Abstract:

Objectives

Under Program 3.1 of the NSW Cancer Care Program I the development of a co-ordinated approach to patient care is pivotal to achieving better outcomes for cancer patients in NSW. A patient centred approach via multidisciplinary teams (MDTs) within a clinical network has been shown to provide an effective platform to deliver coordinated patient care across multifaceted treatment programs. A survey of MDTs within NSW completed in May 2007 showed that 152 MDTs are currently active in cancer care in NSW. The study provides qualitative and quantitative analysis of MDT membership and activities and provides an estimate that 66% of newly diagnosed cancer patients receive the benefits of care coordination by these teams. The information from this survey provides an opportunity to engage MDTs within a clinical network. As a pilot project developed by the Cancer Institute NSW for Cancer Australia, the CanNET program strategically aligns MDTs with other key programs within the Cancer Plan 2007-2010 under a managed clinical network model. The other network elements under this pilot program include a specialist services directory, evidence based standard treatment protocols (CI-SCaT), a cancer services accreditation framework, innovative roles for the cancer workforce, a professional development program, telehealth communication and a clinical cancer registry. The pilot is funded for two years and is supported by an evaluation framework to explore the contribution of MDTs in managed clinical networks along with the other key elements.

Abstract Number 29

The test re-test reliability of the Interprofessional Collaboration (IPC) questionnaire

Dr. Bernadette Stringer¹, Dr. Ted Haines¹

¹McMaster University, Canada

Abstract:

Objectives

Poor nurse-physician collaboration is a risk factor for adverse events in patients, and an important reason why nurses stop practicing. Yet there are few instruments to measure collaboration. Those that are available focus primarily on the specialty care context, rather than inpatient medical and surgical wards. To

fill this gap, after conducting focus groups and a systematic literature review, we developed a 39-item questionnaire with nine dimensions in English, that was translated into French, and back translated into English.

Methods

A test re-test reliability study of the IPC questionnaire measuring collaboration between nurses and physicians on medical-surgical wards was conducted in Ontario and Québec nurses; questionnaires were self-administered twice, separated by a minimum of 2 weeks.

Results

40 Ontario and 80 Québec nurses completed both questionnaires. Over 90% were female and over 50% more than 40 years old; 63% and 37% worked in surgery and medicine, respectively. The intra-class correlation coefficients (ICC) for 8 dimensions ranged from 0.51 (95% CI 0.30-0.66) to 0.83 (0.75-0.88), falling within the 'good' to 'excellent' range. However, for one dimension, consisting of 3 items on perceptions regarding the link between collaboration and patient wellbeing, the ICC was 'poor' (0.35), partly related to the fact that fewer than 10% of nurses disagreed about its importance (that is, nurses' responses were not distributed evenly over the response options).

Conclusion

Medical-surgical nurses reproducibly described nurse-physician collaboration. This provides a sound basis for using the IPC questionnaire in future intervention studies on nurse-physician collaboration on medical and surgical wards.

Abstract Number 30

Evaluating UK Health and Social Care Partnerships: the POET approach

Helen Dickinson¹

¹University of Birmingham, UK

Abstract:

Objectives

Health and social care partnerships have formed a central tenet of New Labour policy in the UK, but have also become a core feature of most developed countries. Yet despite this, there is little conclusive evidence that partnerships improve outcomes for service users. Although implicitly partnerships seem like a 'good thing' there is little evidence which has unequivocally demonstrated this in practice. Therefore, this project sought to test the notion of whether partnerships improve outcomes for services users, and if so, for whom, when and how?

Methods

The Partnership Outcomes Evaluation Toolkit (POET) is a generic evaluation toolkit which was designed specifically for this project and was applied in four case study areas to see what specific partnerships were able to deliver in terms of outcomes for those who use their services. The toolkit draws on Theories

of Change and is set within a critical realist framework in order to search for the mechanisms underpinning changes in outcomes and draw generalisable lessons.

Results/Conclusion

Conceptualising the outcomes of partnerships is a fundamentally difficult task, and a number of the outcomes identified pertained more to organisational and structural factors than user outcomes per se. The presentation will discuss the ways in which different types of partnerships are able to offer different service user outcomes and the particular tensions and difficulties that are inherently associated with these working arrangements. In this way, the findings from this project assist in establishing an evidence-base of 'what works' in terms of health and social care partnerships.

Abstract Number 31

Multidisciplinary care in cancer services — Is it all it s cracked up to be?

Dr. Karen Luxford¹, Dr. Helen Zorbas¹, Dr. Alison Evans¹, Heidi Wilcoxon¹, Holly Goodwin¹, Janice O'Brien¹

¹National Breast Cancer Centre

Abstract:

Objectives

Multidisciplinary care (MDC) is promoted as the gold standard for service delivery for cancer patients in many developed countries including Australia, USA and England. Is MDC really the panacea for improving outcomes? Are the efforts of protagonists supported by evidence? Which outcomes are improved? What are the service level implications? What are the implications for individual clinicians?

This paper will present a summary of the current evidence relating to this form of patient management, focussing on treatment planning for cancer patients. Evidence relating to outcomes for patients, clinicians and managers will be discussed.

Evidence about current levels of uptake of MDC in cancer services and the role of re-imburement in promoting service level change will be reviewed. Commencement of the Australian Medicare Benefits Schedule items 871 and 872 (Nov 06), which provided rebates for specialist participation in multidisciplinary treatment planning meetings, will be considered.

Medico-legal implications, such as professional liability for health professionals involved in collective planning processes, will be reviewed as a perceived barrier to service change.

**Monday December 3rd
(1.30pm - 3.00pm)**

Concurrent Sessions: Round Table

Abstract Numbers 32 — 35: Round Table

Abstract Number 32

Building comprehensive primary health care through primary care organisations: a cross country comparative analysis

Dr. Jacqueline Cumming¹

¹Health Services Research Centre

Abstract:

Primary health care systems in many countries are undergoing reform, as governments seek to strengthen the contribution that primary health care can make to improving health, reducing inequalities and better managing health care expenditures. A number of common themes and developments are being pursued to reconfigure primary health care internationally, including the development of primary care organisations (PCOs) as organisations responsible for steering primary health care in the future.

Recent research has focused on bringing together the findings from New Zealand, Australia and the United Kingdom, in order to identify what we know about the development of PCOs and what we can learn about the role of PCOs in primary health care in different contexts and at different stages of development (McDonald et al, 2006).

In this organised session, we bring together researchers in primary health care from New Zealand, Australia and the United Kingdom to share the findings from this research about the development of PCOs in each of these countries, to provide an update of experiences with PCOs since the research was completed, and to discuss the key implications for future primary health care development.

Abstract Number 33

Reforming primary health care in England: the role of primary care organisations

Judith Smith¹

¹Health Services Research Centre

Abstract:

Objectives

Primary health care in England is provided through general practices that are contracted by primary care trusts (PCTs) to deliver services for their enrolled population. PCTs have a statutory responsibility for improving the health of their local population, carrying out needs assessments, working to reduce inequalities, and seeking to better integrate local care services. PCTs are responsible for purchasing all local health services, contracting with GPs, and directly managing local community health service provision.

This joint responsibility was intended to facilitate integrated local care. However, policy now expects PCTs to focus on purchasing services from a diverse range of providers, and to move away from direct service provision.

Whilst PCTs originally evolved from general practice-led bodies in the 1990s, they have in effect been 'taken over' by the government as they have assumed a wider role. Arguably, this has compromised the attention that is able to be paid to the actual development and strengthening of primary care.

Abstract Number 34

Primary care organisations in New Zealand: A decade of change and challenges for the future

Dr. Jacqueline Cumming¹

¹Health Services Research Centre

Abstract:

Objectives

The organisation and funding of primary health care in New Zealand has changed significantly over the past twenty years. The development of networks of general practices – a form of PCO – during the 1990s set the scene for the implementation of the Primary Health Care Strategy from 2001 onwards, which is aimed at strengthening New Zealand's primary health care system and at improving access to and use of primary health care services, in order to improve health and to reduce inequalities in health.

In this presentation, the presenter will draw on the New Zealand findings from the systematic review about the development of PCOs in New Zealand over the past twenty years, to identify what we know about the implementation and effectiveness of

such organisations. She will also present additional findings from more recent New Zealand research about the specific development of Primary Health Organisations associated with the Primary Health Care Strategy.

Abstract Number 35

Primary health care (PHC) reform in Australia: the roles and challenges of multiple forms of PCOs

Julie McDonald¹

¹UNSW Research Centre for Primary Health Care & Equity

Abstract:

Objectives

The PHC system is characterised by a mixture of private and public provision, a range of blended funding mechanisms and two levels of government responsibility. Both levels have established PCOs as vehicles for reform to improve access, coordination and quality.

Lack of patient enrollment and split responsibility for PHC presents challenges for the role of PCOs in planning and coordinating PHC services across the range of providers and that meet local population needs.

Member support has influenced the activities of Divisions of General Practice and has led to a somewhat uneven performance across Divisions. They have been effective in supporting general practice through specific Commonwealth-government funded initiatives, with less engagement in broader PHC reform.

State-government level Networks have been effective in improving service coordination, but engagement with general practice remains variable.

Despite the not inconsiderable challenges, there are indications that a focus on integrated PHC planning, service development and delivery is emerging.

**Monday December 3rd
(1.30pm - 3.00pm)**

Concurrent Sessions: Developing the Health Workforce

Abstract Number 36

**Where are the new Nurse Graduates?
A literature review with a view to the future**

Shayne Rasmussen¹

¹AUT University

Abstract:

Objectives

The negative impact of the professional healthcare workforce shortage frequently makes front page news. Understanding how the socio-political factors and individual contexts influence the ability to recruit and retain new Nurse Graduates is essential to inform future workforce policy and planning.

Methods

A Literature review exploring factors influencing new Nurse Graduates' employment as an RN was conducted. New Zealand and International qualitative and quantitative research was examined for relevance to the current and emerging socio-political context.

Results

The entry of students into study, together with their developing perceptions and experience of the healthcare system influence future career choices. Studies suggest these influences are dynamic and multidimensional.

Conclusion

Meeting the current and future workforce requirements of the healthcare service will require collaborative and creative interventions. If the health of the New Zealand people is to be maintained, improved and sustained, then consultation, collaboration and effective action across key health care stakeholders must begin.

Abstract Number 37

The development of a workforce tracking tool — gaining insight to influence the future workforce

Dr. Mark Mackay¹, Pam Castle

¹University of Adelaide

Abstract:

Objectives

A range of issues has been identified as having a significant effect on the Australian health sector: Workforce shortages have been forecast to be a major issue as increased pressure on the health

sector is expected. This increase in pressure is expected at the very time when many of the current workforce are expected to retire. Workforce redesign and the creation of new health sector worker roles are strategies that are being suggested as a means of ameliorating workforce pressures.

In order to redesign roles, and also identify the potential of new worker roles, it is necessary to have detailed information about what workers do. Such information is not routinely available. A new electronic workforce tracking tool has been developed to facilitate the capture of data that will result in the provision of much of this information. When combined with other data capture strategies, the ability to gain additional new information about health workers is significant. Also, the approach has wider uses, such as the evaluation of the introduction of workforce change and capturing information relevant to quality and safety issues.

The development of the tool will be discussed and the range of potential uses will be identified. Examples of information gained using the tool will be presented.

Abstract Number 38

Maori health professionals: a framework for assessing benefits

James Harris¹

¹LECG Ltd

Abstract:

Objectives

We put forward an analytical framework for assessing the effects that increasing the number and proportion of Maori in the professional health workforce may have on Maori health. A common response to health disparities is to call for the training and employment of more Maori health professionals. As with any health sector investment, converting this call into action requires quantification, prediction and evaluation of the benefits.

In turn, evaluation requires us to identify the mechanisms that could translate investment in Maori health provision or capability development into improved Maori health outcomes.

Our framework is based on a population health model of the causes of poor health and early death. It also draws from Sen's capability theory and from new institutional economics.

The framework can identify where increasing the proportion of Maori health professionals available for both "by-Maori-for-Maori" health services and mainstream health services might yield the greatest benefits.

This framework has immediate implications. Priority should be given to developing Maori health professionals in the primary and community health workforce, and in the areas of acute care that have similar characteristics. Development of senior clinicians and managers should be encouraged because they are able to lead

entire institutions to more equitable and culturally effective health care. The framework also enables quantification of at least some of the benefits of developing the Maori health workforce.

Abstract Number 39

New directions for health workforce policy: a complex systems perspective

Dr. Catherine Joyce¹, Professor Just Stoelwinder¹

¹Monash University

Abstract:

Health workforce planning aims to avert under or over-supply in the workforce, but planning efforts are often unsuccessful in achieving this. Planning has traditionally utilised simple linear models that do not adequately capture the inherent uncertainties and complexity of health workforce systems. We have previously developed a stochastic simulation model to project future workforce supply, as part of a move toward conceptualising the health workforce as a complex system.

In this paper we explore the application of a complex systems framework to health workforce policy and planning. This offers new insights health workforce supply dynamics, and points to new directions for policy development. Key implications of this approach for health workforce policy include: relinquishing the goal of equilibrium between supply and demand; ensuring continued monitoring and iterative planning of health workforce supply; adopting strategies based on emergence as well as those based on control; and adopting a transdisciplinary perspective.

A complex systems perspective implies that global equilibrium is neither desirable nor even possible. A process of continued small, adjustments is required, underpinned by continued monitoring and iterative planning, and therefore resulting in small, more frequent adjustments rather than large and infrequent ones. There is much discussion about innovation to address current workforce shortages. Innovation can be fostered by strategies based on emergence, which accept variation with the system as inherent and as potential catalysts for innovation. Similarly, a transdisciplinary approach aims to foster innovation by drawing together those from a range of relevant perspectives.

Abstract Number 40

Skill-mix changes needed to care for community dwelling older Australians

Professor Nicholas Zwar¹, Dr. Sarah Dennis¹, Professor Rhonda Griffiths³, Dr. David Perkins¹, Dr. Jenny May², Iqbal Hasan¹, Dr. Gideon Caplan¹, Professor Mark Harris¹

¹University of New South Wales, Australia, ²University of Newcastle, Australia, ³University of Western Sydney, Australia

Abstract:

Objectives

To identify the health care needs of older Australians who live in the community that could be addressed through skill-mix changes in the primary care workforce.

Methods

A systematic review of the literature is being conducted to identify reports of skill mix interventions among the health professionals in primary health care designed to address the health care needs of the community dwelling older Australians. We have searched Cochrane Library, DARE, Joanna Briggs, Medline, Embase, Cinahl and reference lists of included papers. The key skill-mix changes that we are focussing on are doctor substitution by other health professionals, particularly by nurses and pharmacists; enhancement and delegation among the health care professionals in the nursing spectrum; and creating new type of workers (innovation) to replace/supplement the traditional primary care workforce.

Results

The initial search of the databases resulted in 15,148 papers being identified for the review. After a vigorous screening process 133 relevant primary research papers were identified. Currently data being extracted from those papers. This will be followed by data synthesis and formulating the results. The review will be completed by the end of November 2007 and detailed results will be presented at the conference.

Conclusion

In Australia, skill-mix changes are occurring informally in rural and remote areas because of workforce shortage. Skill mix innovation is less developed in metropolitan areas because the workforce shortages are less acute and the current payment systems may be a barrier.

**Monday December 3rd
(1.30pm - 3.00pm)
Concurrent Sessions: Hospital
Efficiencies Resources Outcomes**

Abstract Number 41

**Obesity and the intensity of hospital
resource use**

Dr. Katharina Hauck¹, A/Prof. Bruce
Hollingsworth¹

¹Monash University, Melbourne, Australia

Abstract:

Increasing obesity rates and associated risks of developing serious illnesses costs Australia an estimated \$3.7 billion (2005), including \$870 million in direct health care costs. However, this figure may underestimate the economic costs of treating illnesses aggravated by obesity. Obesity may not only directly cause illnesses, it may influence progression or severity of illnesses, including ones which are not traditionally thought of as obesity related. This would imply that for a large variety of conditions, obese patients are more expensive to treat than non obese patients. Using quantile regression methods we estimate the differences in length of stay of obese versus non-obese inpatients at different levels of medical complexity for various hospital specialties. Data used are all inpatient episodes in public hospitals in Victoria in 2005/6. The dataset includes detailed individual patient and hospital characteristics. In some specialties including 'General Surgery', 'Neurology' and 'Neurosurgery', obese patients do not stay significantly longer than non-obese patients in hospital. In other specialties including 'General Medicine', 'Orthopaedics', and 'Obstetrics', obese patients stay up to 3.5 days longer in hospital than non-obese patients, especially at higher levels of medical complexity. In a number of specialties including 'Cardiology', 'Vascular' and 'Rheumatology', obese patients stay shorter than non-obese patients, in particular at higher levels of complexity. We hypothesize that this surprising result may be explained by different treatment patterns in these specialties, for example, transfers to other hospitals or use of medical rather than surgical interventions.

Abstract Number 42

**Streaming: Fad or fashion in a
regional emergency department?**

Leigh Kinsman¹, Dr. Robert Champion²,
Geraldine Lee², Mary Martin², Kevin Masman³,
Elizabeth May, Professor Terry Mills², Dr.
Michael D Taylor³, Paulett Thomas³, Dr. Salomon
Zalstein³

¹Monash University, ²La Trobe University, ³Bendigo Health

Abstract:

Objective

To evaluate the impact of a streaming model, previously validated in metropolitan emergency departments, on patient flow in a regional emergency department (ED).

Method

Multiple linear regression models were applied to monthly time series data from 43 months prior to the intervention and 15 months following the intervention to measure the impact of streaming on: The proportion of patients who were admitted to hospital, who spent less than eight hours in the ED; The proportion of patients who were discharged, who spent less than four hours in the ED; The proportion of those patients who presented for treatment at the ED, who left without being seen by a doctor or nurse practitioner.

Results

There was a significant reversal of a downward trend in the proportion of admitted patients who spent less than eight hours in the ED ($p = 0.007$) and the proportion of discharged patients who spent less than four hours in the ED ($p = 0.002$). There was no statistically significant change in the proportion of patients who left without being seen ($p = 0.904$).

Conclusion

Streaming significantly improved patient flow through this regional ED but did not affect the proportion of patients who did not wait to be seen. This model may improve patient flow in other regional EDs. The analysis of time series enabled the identification of trends in patient flow before and after streaming that would not have been identified by a two-sample before and after comparison.

Abstract Number 43

Does emergency department length of stay influence patient outcomes?

Dr. Mary Haines¹, Marilyn Cruickshank¹, Sanja Lujic¹, Anna Holdgate², Teresa Anderson³, Louisa Jorm¹, Anne Krickler⁴, Jane Young⁴, Judy Simpson⁴, Sally Redman¹

¹The Sax Institute, ²Liverpool Hospital, ³Sydney South West Area Health Service, ⁴University of Sydney

Abstract:

Objectives

Increasing the speed at which patients are admitted to wards through Emergency Departments has been a major focus of hospital improvement programs in the UK, USA and Australia. No previous study has examined whether processing patients more quickly through the Emergency Department (ED) has an impact on patient outcomes. This study addresses the question: What is the relationship between patient outcomes and Emergency Department length of stay?

Methods

A retrospective analysis was undertaken of linked routine data related to 17,072 admissions to a large tertiary hospital in metropolitan Sydney from 1 July 2004 to 30 June 2006. Using univariate and multivariate analysis, we examined the relationship between ED length of stay and four main outcome measures: hospital readmission within 28 days of discharge, representation to the emergency department within 7 days of discharge, in-hospital adverse events and in-hospital mortality.

Results

51% of ED patients were admitted to a ward within 8 hours, the readmission rate was 9%, the re-presentation rate was 6%, the adverse event rate was 4% and the mortality rate was 4%. The length of time patients spent in the ED had no demonstrated association with the four patient outcomes, after adjustment for sex, age, admitting specialty, triage score, co-morbidity and time of arrival in the ED.

Conclusion:

The results suggest that the processes concerning hospital admission did not adversely affect patient outcomes. This study provides a baseline from which to assess the outcomes of recent initiatives to speed patient flow through EDs.

Abstract Number 44

Use of Dynamic Modelling in the Design of Dialysis Services

David Rees¹, Dr. Ray Naden^{2/3}, Dr. Adrian Field¹

¹Synergia Ltd, ²Auckland City Hospital, ³Ministry of Health

Abstract:

Objectives

The demand for renal dialysis services has been growing at a significant rate over the last decade. Driven by rises in the prevalence of chronic conditions, especially over the last 5 years by diabetes, renal dialysis services are finding it difficult to cope and District Health Boards are faced with increasing demands for additional investment in facilities.

A commonly held view is that this rise in prevalence combined with the ageing population will require more in-centre facilities to be built to meet this demand. However, little is known about the drivers of demand for specific renal modalities in hospitals or the extent to which developing new facilities will improve patient outcomes. The purpose of this research is to use primary source data and System Dynamics modelling techniques to model renal flows within a medium-sized District Health Board in order to identify the drivers of demand, the nature of patient flows and the leverage points that were available to respond to that demand.

The results suggest that whilst the total demand volumes would be very difficult to change in the medium term, changing the practices of the renal service within the hospital and their relationships with the primary sector could have a significant impact upon the level of dependence exhibited by patients and consequently the modality choices available to them. The results explore a number of scenarios based upon different practice options and highlight a range of plausible futures that different practices could deliver. These scenarios showed considerable variation in patient outcomes and costs.

**Monday December 3rd
(1.30pm - 3.00pm)
Concurrent Sessions: Evaluation**

Abstract Number 45

Innovative ways to measure organizational constructs in the Let's Beat Diabetes programme evaluation

Dr. Janet Clinton¹, Sarah Appleton¹

¹University of Auckland

Abstract:

Objectives

This paper describes the measurement techniques used in the Let's Beat Diabetes (LBD) programme evaluation. LBD is a five year, life course community based program in, Counties Manukau New Zealand at long-term changes to prevent and/or delay the onset of Type II Diabetes. The programme evaluation is underpinned by the Centres for Diseases Control programme evaluation framework for public health initiatives. A number of organisational constructs are measured within the course of the evaluation. First, the degree of implementation, which asks how much of the program participants received. Second, program adherence and or adaptation, which is defined as the extent to which implementation of a particular activity and method is consistent with program plans. Third, organizational management, this includes areas such as organizational structures, collaboration, sustainability, and evaluation readiness. These variables are correlated to illustrate their inter-connectedness and their relationship with overall program progress. This paper demonstrated the worth of measuring organizational variables when evaluating health initiatives. Further, it highlights innovative ways of bridging the quantitative and qualitative divide in the measurement of health initiatives.

Abstract Number 46

Evaluating Diabetes Prevention and Care Strategies in Australia

Dr. Agnes Walker¹, Professor Stephen Colagiuri²

¹Australian National University, ²University of Sydney

Abstract:

Objectives

Type 2 diabetes is of particular concern worldwide because: many people who have it are undiagnosed; with early treatment its often debilitating complications can be delayed or avoided; and with early detection of those at 'high risk' the development of the disease itself can be avoided. We estimate the health benefits and costs of a national diabetes screening and prevention scenario, similar to the successful trials carried out in Finland and the US.

Methods

Use the Australian Diabetes Cost-Benefit Model to compare Baseline and Scenario outcomes. Carry out sensitivity tests in search of the most appropriate Scenario settings for Australia. Screen Australians aged 45-74 years. Offer intensive care for people newly diagnosed with diabetes – expected to lower complication rates. For those 'at high risk' offer a lifestyle intervention program – expected to reduce the numbers developing diabetes.

Results

115,000 persons became 'newly diagnosed'. Among those 'at high risk' 53,000 avoided developing diabetes by 2010. Average yearly intervention and incremental treatment cost was A\$179 million, with a cost per DALY of A\$50,000.

Discussion

Diabetes is among the major chronic diseases which people tend to acquire as they age. Several of these share common lifestyle risk factors, such as obesity, poor diet and insufficient exercise. A chronic disease model-system is currently being built under a 5-year ARC grant which will be able to analyse and rank intervention scenarios that target several chronic diseases simultaneously (e.g. diabetes and cardiovascular disease).

Abstract Number 47

Looking to the Future: Building evaluation capacity in community-based health interventions

Sarah Appleton¹, Dr. Martha Silva¹, Dr. Janet Clinton¹, Mr. Daniel McConnell¹

¹University of Auckland

Abstract:

Objectives

With increasing demands for monitoring and evaluation of health programmes, there is a need to develop decentralized models of cyclical data collection that allow programme providers at different levels to assess and use the data they are collecting. The aim of this paper is to demonstrate a process for building evaluation capacity in community based health interventions to support programme development.

Methods

Software was used to create a database to monitor a Diabetes Self-Management Education programme. The programme is designed to provide Type II Diabetes Mellitus patients with the knowledge and skills to make informed and sustainable changes to their current health behaviours and lifestyle, through group education sessions. The database was designed to store data on attendance, changes in patients' knowledge and attitudes to their diabetes care, as well as markers of patients' physical health. The programme facilitators were trained to use the database and steps were taken to ensure data security. Additional support for using the database was available on request and all facilitators were provided with a user

manual. To build evaluation capacity, the database was also designed to produce a descriptive summary of the data.

Results

A Microsoft Access database provided a consistent means of recording patient and programme data. The facilitators also used the summary reports to provide feedback to the programme coordinator, as well as to develop the programme and monitor their own progress.

Conclusion

Providing the programme facilitators' with control over their dataset, increased their understanding of evaluation and using reports to facilitate feedback also supports the notion of programme development.

Abstract Number 48

Evaluating services for the prevention of heart disease in developing countries

Dr. Masoud Mirzaei¹, Stephen R. Leeder¹

¹The University of Sydney

Abstract:

Objectives

There is growing recognition of the huge personal, social and economic cost of coronary heart disease (CHD) in developing nations. CHD is the third biggest cause of burden of illness in the world. In developing nations, where preventive and treatment services are limited and primary care is under-developed, the strategic response has been slow. In particular, efforts to control the upstream factors that predispose to CHD has been remarkably tardy, given that one third of deaths are among people aged less than 65. This study aims to classify the patterns of the epidemic and prioritise interventions on major risk factors of the disease across various developing countries.

Methods

We examined the epidemic curves of 70 countries to understand what services should be developed in these nations. Mortality trends in CHD using routine statistics were used to assess the natural history of CHD. Population attributable fractions were calculated to prioritize interventions on the four major risk factors of the disease including high blood pressure, tobacco smoking, high serum cholesterol and diabetes mellitus.

Results

Classical WHO regions were not useful in determining national strategic launch pads for individual nations, because the natural history and location of the constituent countries varied widely. Instead we propose that, as a basis for planning health services, the epidemiological data allow a different (non-regional) grouping of countries into (rise and fall, rise only and flat). Also the

population attributable fraction of CHD in different nations suggests that, for example, tobacco control will have radically different impacts in different countries.

Conclusion

This research base is critical for planning appropriately responsive and economical health services to address CHD epidemic in developing countries.

Abstract Number 49

Results of an evaluation of Pacific church-based health promotion programmes

Faith Mahony¹, Iutita Rusk¹, Dr. Janet Clinton¹

¹University of Auckland

Abstract:

Objectives

Pacific peoples living in New Zealand experience high rates mortality and morbidity as a result of cardiovascular disease (CVD). There are modifiable CVD risk factors such as obesity, exercise, diabetes, tobacco smoking, high serum cholesterol, high blood pressure and dietary fat that can be addressed by healthy lifestyle initiatives. Pacific Islands Heartbeat works with Pacific peoples in New Zealand to improve heart health. This paper presents an overview of the evaluation of two church based healthy lifestyle initiatives in Auckland, New Zealand. Health Promoting Churches is a programme that provides training and support to 30 Pacific churches in the Auckland and Wellington regions and the Auckland Pacific Community Project is a pilot programme where CVD risk screening and a twelve week healthy lifestyles course is provided to the members of two Pacific churches.

Methods

Using the Centres for Disease Control and Prevention framework for evaluation of public health interventions data was gathered from a variety of sources including, workshops, focus groups, survey, biomedical results and demographic details. The perspectives of programme providers, church ministers, health komiti members and church members were sought to identify examples of success, enablers and challenges to programme success.

Results

A variety of examples of success will be presented including changes in eating behaviours, activity, smoking environments, and health. Likewise enablers for programme success will be described including the key role of the minister; Pacific friendly material and whole family approach. Challenges to the implementation and uptake of healthy lifestyles will also be presented.

**Monday December 3rd
(1.30pm - 3.00pm)
Concurrent Sessions: Organised
Session**

**Abstract Numbers 50 — 53:
Organised Session**

Abstract Number 50

**Towards More Humanistic
Healthcare: Emerging Measures for
Evaluating Palliative Care Quality**

Karl Lorenz¹, MD MSHS

¹VA Greater Los Angeles

Abstract:

We will review findings from 3 major recent projects to determine and evaluate quality measures for palliative care practice. The Assisting Care of the Vulnerable Elders (ACOVE) Project as well as Cancer Quality ASSIST (Addressing Symptoms, Side Effects, and Indicators of Supportive Treatment) are two recent projects that developed process-based measurement sets based on extensive systematic reviews (over 30,000 citations total) of the published literature, clinical practice guidelines, and a review of other quality measures, guided by advisory panels, and evaluated by formal group judgement using the RAND appropriateness method. The workshop will describe the need for and principles of palliative care quality measurement, and describe the methods of ACOVE and ASSIST as well as the resources that are being developed, focusing on measures and supporting evidence in several key areas for palliative care: pain and other symptoms, information and care planning needs, and complications (of cancer). We will provide an overview of these measurement sets and pilot efforts to implement them in order to characterize the quality of palliative care delivery in patients with cancer and non-cancer conditions. Utilization-based quality measures have been proposed as an alternative to process-based measures. We will describe an effort to characterize utilization in US Medicare patients and its implications for utilization based quality measurement.

Abstract Number 51

**Palliative Quality Measures and
Assessing Care of Vulnerable Elders
(ACOVE)**

Karl Lorenz¹, Neil Wenger¹

¹UCLA

Abstract:

Background

We set out to systematically identify quality measures and the evidence for them to support the palliative care of elders with serious, chronic eventually fatal conditions (metastatic cancer, advanced heart failure and chronic obstructive pulmonary disease, dementia).

Methods

We built on a systematic review of the literature (English only, Medline 1995-2006) we previously conducted for the United States National Institute of Health using terms for palliative or end-of-life care to identify citations and guidelines relevant to effective interventions to ameliorate symptoms (pain, dyspnea, depression) and caregiving, and improve advance care planning and continuity. Potential quality measures were subjected to expert panellist review using the RAND appropriateness method, rating each measure from 1-9 on validity. Measures accorded a median validity rating of > 7 on which experts also agreed were deemed valid.

Results

21 / 24 proposed indicators addressed aspects of palliative and end-of-life care for the four serious chronic conditions targeted. Panelists endorsed the ideas of comprehensive palliative assessment, advance care planning, dyspnea assessment and management, and addressing caregiver burden including bereavement.

Conclusion

A wide variety of tools that apply across generalist, specialist, and palliative care settings are available for process-based evaluation of palliative care management in serious chronic conditions.

Abstract Number 52

**Addressing symptoms, side effects
and indicators of supportive cancer
treatment (ASSIST)**

Steven Asch¹

¹ACOS for Health Services Research, USA

Abstract:

Objectives

Our recent systematic review of cancer supportive quality measurement for the US National Quality Forum demonstrated extensive deficits in evidence-based measures in the areas of pain, dyspnea, depression, and advance care planning.

Methods

Following expert rating of areas for potential quality measure development, we focused on measure development for symptoms related to cancer and its treatment as well as complications (organized by pain, dyspnea, depression, nausea/vomiting, fatigue, and other treatment-related toxicities), and information and care planning needs. We conducted systematic reviews of the published literature for each domain (Medline, PsychInfo) and Internet-based sources including guidelines and professional recommendations. Potential quality measures were subjected to expert panellist review using the RAND appropriateness method, rating each measure from 1-9 on validity. Measures accorded a median validity rating of > 7 on which experts also agreed were deemed valid. Measures accorded a median feasibility rating for chart-based abstraction of > 4 on which experts also agreed were deemed feasible.

Results

A series of 7 expert panels addressed potential measures and endorsed 92/122 proposed measures as valid and feasible. Indicators addressed all stages of cancer (e.g., diagnosis, active management, palliation). 50-80% of potential indicators in each domain were endorsed (50% in fatigue including anemia - 80% in information needs and depression). Panelists endorsed indicators addressing a comprehensive spectrum of supportive care domains and panellist comments stressed the principles of risk assessment (e.g., narrowing indicators to highest risk patients) and certainty of evidence to guide indicator application.

Conclusion

Future panels may need to address fatigue and anemia based on developments in the published literature. A wide variety of valid tools are available to assess care in primary care and oncology settings for chart-based evaluation of supportive and end-of-life cancer quality of care.

Abstract Number 53

US end-of-life utilisation and place of residence 1989-1999

Sydney Dy¹

¹John Hopkins Bloomberg School of Public Health

Abstract:

Objectives

To evaluate the association of institutional residence and chronic disability with end-of-life Medicare utilization from 1989-1999. Research design: Retrospective study of nationally representative survey data linked to Medicare claims. Subjects: Medicare beneficiaries who completed the National Long-Term Care Survey in 1989 or 1999 who died within 1 year. Measures: Medicare utilization (hospital, hospice, and skilled nursing facility) in the last year of life and at the time of death among the nondisabled, chronically disabled, and institutionalized.

Results

Medicare utilization over the last year of life was relatively stable from 1989 to 1999 for the proportion hospitalized (e.g, 76% vs. 73% among the nondisabled), although there were significant increases in skilled nursing facility use. Trends in utilization at the time of death were somewhat different, with significant increases in hospice use among all groups, and a significant decrease in the proportion dying in the hospital in the nondisabled group (53% vs. 40%). Utilization was relatively similar for the nondisabled and chronically disabled, but was dramatically lower in the institutionalized population over almost all outcomes; for example, the proportion hospitalized in the last year of life was 51% compared to 73% in the nondisabled population and 77% in the disabled population in 1999.

Conclusions

Despite dramatic growth in hospice use, health care utilization in other areas generally did not decline. Factors, such as institutional residence, not included in Medicare claims data are strongly associated with Medicare utilization, which may affect the usefulness of efficiency indicators based on claims.

Monday December 3rd (1.30pm - 3.00pm)

Concurrent Sessions: Linking Policy and Research

Abstract Number 54

Translating evidence into policy advice - colorectal cancer screening in New Zealand

Dr. Terri Green¹, Dr. Susan Parry², Professor Ann Richardson³

¹University of Canterbury, ²Middlemore Hospital, ³University of Otago Christchurch

Abstract:

Objectives

A multidisciplinary advisory group was appointed in 2005 by the New Zealand Ministry of Health to review the evidence and provide recommendations for population screening for colorectal cancer. The process involved an evidence-based review of the literature, reviews of commissioned studies on test acceptability and resource capacity, and an assessment of colorectal cancer screening using the New Zealand Screening criteria. This presentation reflects on the results of this process and the rationale for the recommendations.

Results

There is evidence of benefit from overseas' randomised controlled trials, for CRC screening using guaiac based faecal occult blood testing. The benefit is however modest and it is unclear whether the level of benefit can be maintained over time. The level of benefit for New Zealand is not known and could differ from the

trials due to the higher incidence of the disease and possibly a different level of participation in screening. Difficulties of test interpretation and quality control limit the support of pathologists for the guaiac FOBT. Colonoscopy capacity in public hospitals is insufficient to provide timely diagnostic, or surveillance, procedures for those with symptoms, or at increased risk, of CRC.

Introducing screening without addressing colonoscopy capacity could increase delays in procedures for these patient groups.

The advisory group recommended a feasibility study of CRC screening using faecal occult blood testing to provide information on acceptability and participation in screening, demand for colonoscopy, pathology and other services on the screening pathway, and costs. This would help determine whether New Zealand could support a screening programme and provide a basis for planning a full pilot study and a national programme. Further recommendations to improve the diagnosis and treatment of colorectal cancer; include expansion of colonoscopy capacity, and monitoring to ensure that treatment for CRC throughout NZ meets international standards.

Conclusion

This study illustrates how, even when there is RCT evidence of benefit of a health programme, many other factors need to be taken into account before a new programme can be introduced. The value of systematically applying screening criteria is affirmed.

Abstract Number 55

Improving the link between policy and research

Professor Jane Hall¹, A/Prof. Marion Haas¹

¹University of Technology Sydney

Abstract:

Objectives

Research impact is of increasing concern to those who fund research, while ensuring an evidence base for policy is becoming more valued by decision makers. Most advocates for research knowledge transfer criticise reliance on the academic literature for dissemination, and encourage the involvement of policymakers in developing and implementing the research.

Methods

This paper uses two model case studies which demonstrate an alternative and collaborative approach to forming a partnership between researchers and policymakers. One works from an identified need for policy to be better informed by economic analysis. Through the use of a facilitating agency and a knowledge broker, a formal partnership is formed with the policy agencies and a research group. The partnership agrees an annual workplan in response to the agency priorities; the policy agencies act as clients for the research. The second works as direct collaboration between clinicians and the research group with the aim of informing clinical practice and clinical decision making.

Substantial development work is required to understand current decision making mechanisms and identify where and how research might influence practice; and to ensure broad clinician involvement in further research and implementation. The resulting research program was funded through competitive peer review, with both clinicians and researchers as chief investigators.

Results

There are similarities and contrasts between the two approaches. Both can be successful in developing a joint research program. Both require substantial upfront time in developing relationships and identifying needs.

Abstract Number 56

Research Translation Projects — Evidence for a Sustainable Health System

Naomi Prowse¹, Babu Simon¹, Dr. Neil Lynch¹

¹Research Development Unit, Department of Health, Western Australia

Abstract:

Research is integral to high quality health care, and the translation of research findings into effective health policy and practice is increasingly important. Western Australia has engaged in strategic planning for health and medical research under the leadership of the State Health Research Advisory Council. Research translation is a key element of the future vision, which complements the major health reform process underway in the State.

The WA Department of Health established a program of short-term research translation grants with the priority to investigate and evaluate efficiencies and cost savings that research can deliver to WA Health.

This program generated enormous interest across the entire spectrum of the WA health sector; and it has revealed some significant insights with respect to health services research and research translation.

Key findings include:

The WA health system has an enormous wealth of high quality ideas around research and its translation. This is often at the "grass roots" level, and is not necessarily being captured by existing research funding mechanisms.

New awareness and collaborations have been forged between clinicians, researchers and policy makers, with issues not restricted to single areas or disciplines.

There is untapped health economics and health services research expertise in non-traditional areas, such as health service costing branches. The program has encouraged the incorporation of skill and data sets not generally utilised in health services research.

Abstract Number 57

Shaping the direction of policy and practice activity in Australia

Tanja Farmer¹

¹INHMRC

Abstract:

Objectives

The NHMRC is one of the main funders of health and medical research in Australia. In order to enhance and accelerate the translation of research evidence into the formulation of health policy and clinical practice, it has established a Policy and Practice Program (the Program).

Methods

In establishing this Program, the NHMRC has undertaken a scoping and analysis process to identify the current investment and level of activity in policy and practice focused research in Australia and the elements underpinning this activity. This process will compare NHMRC activities to that of other similar organisations involved in policy and practice focused research at the international level. In addition, it will identify the key partners for future NHMRC work under this programme.

Results

Capacity of the Australian research workforce to contribute to policy and practice, as well as any areas for improvement, will be examined and the findings will inform any further activities of the Programme in this respect.

Conclusion

Preliminary results indicate areas where the NHMRC could enhance linkages between research, policy and clinical practice in Australia. This will enable the NHMRC to capitalise on its unique position and ability to influence researchers, policy makers and health professionals through effective partnerships, funding of research and the development of health advice.

Abstract Number 58

Getting evidence into policy: Integrated Governance arrangements in healthcare

Professor Claire Jackson¹, A/Prof. Jenny Doust¹,
Caroline Nicholson², Dr. John O'Donnell², Lily Cheung¹,

¹University of Queensland, ²Mater Health Services, Brisbane

Abstract:

Objectives

Traditional fragmented multi-sector approaches to health care delivery are struggling to deliver appropriate integrated health care services to communities internationally. Our study sought to identify evidence-based models of integrated governance, which could allow appropriate sharing of control and funding across jurisdictions in the Australian health care context.

Methods

We conducted a systematic review and key stakeholder interviews using an integrative process. The review identified and described models of integrated governance evaluated in the health care literature. The key informant interviews with prominent national and state stakeholders allowed us to contextualize this to the Australian setting.

Results

Three models for integrated health care governance, with a demonstrated ability to be sustained effectively in the medium term, were identified. These included: the creation of an incorporated body, with governance responsibility shared across integrating organisations, and with resource allocation capability for a given population or region; an incorporated body established by integrating organisations, with its own funding pool, and with responsibility for defined areas of common business overlap; and formal and agreed governance arrangements between organisations to 'share' resources in delivering services across a finite geographical area. A common set of enablers and barriers to all models was identified from both the literature and key informant interviews.

Conclusion

This research has been utilized to date by state and commonwealth governments, NGOs, Divisions of General Practice, and commonwealth agencies. It demonstrates the opportunity for high quality research to play a central role in informing health care policy.

**Monday December 3rd
(3.30pm - 5.00pm)
Concurrent Sessions: Health Services
and Indigenous Health**

Abstract Number 59

**You Drum, I'll Sing : Harmonising
Indigenous Research Approaches in
Community-Based Health Services
Research**

Dr. Amohia Boulton¹, Jen Mackie²

¹Massey University, ²University of Northern British Columbia,
Canada

Abstract:

Objectives

Increasingly Maori health researchers in New Zealand are aligning themselves with their indigenous counterparts in other nation states to address the disparities which persist between the health of indigenous peoples and the health of the general populations in those countries. Health research funding bodies in New Zealand, Canada and Australia have supported moves towards greater collaboration between indigenous peoples. These countries established a trilateral partnership agreement in 2002 to support research in the area of indigenous peoples' health with the goal of improving the health of indigenous peoples in their respective countries.

For indigenous researchers the ability to navigate different languages, customs, protocols and processes, in addition to different stakeholders and health structures is essential if collaborative research programmes are to successfully benefit indigenous communities.

In this presentation two emerging indigenous health researchers will outline the research protocols demanded by, and developed for, their respective indigenous communities. These protocols intend to ensure the conduct of respectful and mutually beneficial research; research which is transformative; which emphasises knowledge synthesis, translation and exchange; and which places the indigenous experience at the centre of the research activity. We offer an analysis of these protocols to demonstrate that despite the great range and diversity of indigenous communities and experiences, common principles may form the foundation of ethical health services research with indigenous communities. The researchers conclude that valuing different knowledges and respecting indigenous ethical frameworks is crucial to ensure that international research collaborations are conducted successfully.

Abstract Number 60

**An Exploration of Whanau Ora in the
Reformed Health Sector**

Tai Walker¹, Dr. Amohia Boulton²

¹Victoria University of Wellington, ²Massey University

Abstract:

Objectives

In 2001 the Ministry of Health, through the Maori Health Strategy He Korowai Oranga, introduced the notion of whanau ora. The Health Reforms Research project 2001 decided to explore with informants the notion of whanau ora. This was a large longitudinal study over four years.

Methods

The data presented come from three case study sites: one small rural District Health Board (DHB) and two large urban DHBs. Two were in the North Island. This was a qualitative study with over 100 participants, both Maori and Pakeha. Participants included senior and middle management of DHBs, general practitioners within Independent Practitioner Associations, Primary Health Organisations and Maori providers.

Results

Whanau ora has been described as 'the most challenging' aspect of the Maori Health Strategy. The data represent two distinct worldviews: one Maori, with notions of connections to whanau, hapu, iwi and community and cultural understandings or tikanga. The other worldview is western where Pakeha participants discussed frameworks, contracts and measurements. At the interface of these differing views, there are tensions between implementing a Maori concept within strong western clinical models of service delivery, accountability and contracting. The way in which whanau ora was articulated depended on the context and the site.

Conclusion

This presentation will extrapolate on the issues above and highlight the policy implications for service delivery to Maori.

Abstract Number 61

Health outcomes research on inter-organisational collaboration

Dr. Amohia Boulton¹, Dr. Manuhia Barcham¹,
Dr. Jan Lockett-Kay¹, Tracie Mafile'o¹

¹Massey University

Abstract:

In this presentation we discuss some ongoing research looking at the transition from an output/input model of policy to an outcomes-based approach. A key aspect of the research programme will be identifying the levers which facilitate and enable the transition from an inputs/outputs model to an outcomes model.

Initial research and discussions with stakeholders has pointed to inter-organisational collaboration as a possible lever in the shift towards an outcomes based policy framework in the health sector. Focusing on this particular lever we will discuss the project we have just initiated looking at the reasons behind successful inter-organisational collaboration in the New Zealand health sector. With the key research question being: how can organisations involved in the New Zealand health system optimise their collaboration for improved health outcomes? The research project will utilise action research and case study methodologies in order to investigate inter-organisational collaboration in the New Zealand health sector at two levels: the national level and regional and/or local health initiatives addressing locally-identified health needs. The rationale behind the programme is that by identifying the critical success factors that promote successful inter-organisational collaboration in the New Zealand health sector we will be able to provide opportunities for the replication of successful initiatives across a range of health-related services in the pursuit of improved population health outcomes, reduced inequalities and improved chronic disease outcomes.

Abstract Number 62

Contract theory and research in Aboriginal and Torres Strait Islander Primary Health Care

Kim O'Donnell¹, Professor Judith Dwyer¹, Dr. Patrick Sullivan², Dr. Josée Lavoie³

¹Flinders University, ²Australian Institute for Aboriginal and Torres Strait Islander Studies, ³University of Northern British Columbia

Abstract:

Objectives

Australian Aboriginal Primary Health Care (PHC) providers receive funding in more complex ways, many of them short-term, and for a broader variety of activities, dollar for dollar, than mainstream agencies. This pattern creates an administrative overburden, compromises the effectiveness of service delivery and weakens the capacity of the agencies to attract and retain a skilled workforce. The structures and processes of the funding relationship (i.e. between funders and providers of health care) are compromised, with mistrust and tension about goals and values between the parties.

Sources of these difficulties include the complexity of allocation and administration by multiple funding sources (typically national and state/territory, and often, allocations from multiple funding program) and the associated contractual environment which is based on classical contracting theory made popular in public administration over the last 20 years. Although there has been significant innovation by the Office of Aboriginal/Torres Strait Islander Health (OATSIH) and others in recent years, the way that Aboriginal-specific PHC is funded and regulated across jurisdictions has not been systematically investigated from the perspective of the receivers of funding and regulation (the providers of health care). This paper presents a theoretical framework for such an investigation, developed as part of a larger project.

The major findings from review of relevant literature are presented. The potential for moving from a classical contracting model to a relational contracting model is explored. Our aim in presenting this paper is to engage in discussion about the implications of this theoretical base for the methods we propose to use in the major study.

Abstract Number 63

Primary health care reform and Maori: Is it working?

Dr. Lynne Pere¹,

¹Victoria University of Wellington

Abstract:

Objectives

In 2001 the government introduced the Primary Health Care Strategy, aimed at improving health and reducing inequalities. By late 2006, it had allocated billions of dollars to primary health care reform, 81 Primary Health Organisations (PHOs) had been established, and 3.9 million people were enrolled. A formal evaluation of the Strategy has been undertaken by the Health Services Research Centre, Victoria University of Wellington and CBG Health Research, Auckland, for the Health Research Council of New Zealand, the Ministry of Health and ACC.

Methods

The evaluation involves three-phases over three time periods (2004, 2006, 2008). In the first phase qualitative interviews were undertaken with doctors, nurses and managers from a sample of PHOs and practices. The second phase involved both: a postal survey of all PHO Board members and staff, practice managers, GPs, and nurses working in general practices; and a second set of qualitative interviews with a range of national stakeholders, PHO Board members and staff, and staff in general practices. And the third phase will use computerised data sets to measure changes in the rates of primary care activities (visits, prescriptions, tests etc) and changes in "ambulatory sensitive" admissions.

Results

This paper discusses how the Strategy is working or not working for Maori, based on findings from the first and second phases of the evaluation. Preliminary results were presented at the Social Policy, Research & Evaluation conference in April 2007.

Conclusion

This presentation will update findings, focusing on: the goals of the Strategy that are specific to Maori; general perceptions from Maori of the Strategy and its implementation; what PHOs are doing to improve Maori health and reduce inequalities between Maori and non-Maori; and challenges and issues for Maori identified in the evaluation.

Monday December 3rd (3.30pm - 5.00pm)

Concurrent Sessions: Funding and Prioritising Healthcare

Abstract Number 64

Joiners, leavers, stayers: Private Health Insurance choices in Australia

**Stephanie Knox¹, A/Prof. Elizabeth Savage¹,
Professor Denzil Fiebig^{1,2}, Vineta Salale¹**

¹The University of Technology, Sydney, ²The University of New South Wales

Abstract:

Objectives

To arrest the decline in private health insurance rates, the Australian Government introduced a suite of policies, between 1997 and 2000, to create incentives for Australians to purchase private health insurance (PHI). These policies include an increased Medicare levy for those without PHI on high incomes, a 30% rebate for private hospital cover and the Lifetime Health Cover (LHC) policy where PHI premiums are set at age of entry, increasing for each year older than 30 years (introduced 2000).

In 2004 the longitudinal study on Household Income and Labour Dynamics in Australia (HILDA), included a series of questions on private health insurance and hospital use. We used the HILDA study panel to investigate the demographic, health and income factors related to PHI decisions, especially around the introduction of the Lifetime Health Cover policy.

The outcome was self-report of PHI choices at interview in 2004. Predictors were responses in 2001 interviews. We used the balanced panel of respondents who had complete data for the relevant variables in 2001 and 2004 (n = 9,204). We modelled the PHI outcome using multinomial probit to allow for heterogeneity of choice and correlation across alternatives.

After controlling for other factors, we found that LHC prompted working age adults (30-55 yrs) to purchase before the 2000 deadline. Young singles or couples with no children, and the overseas born were more likely to purchase since 2000. Declining financial circumstances remains the main factor motivating those who dropped PHI since the introduction of the policy incentives.

Abstract Number 65

Is Private Health Insurance picking up Medicare's surgery slack?

David Gibson¹, Dr. Rachael Moorin¹

¹University of Western Australia

Abstract:

Objectives

The Federal Government implemented several policies between 1998 and 2001 to improve uptake and utilisation of Private Health Insurance (PHI) to relieve the pressure on Australia's public hospitals.

Aim

To investigate patterns of utilisation of PHI for surgery over the period 1981 to 2005 in Western Australia (WA).

Methods

The WA Data Linkage System was utilised to extract all hospital morbidity records in WA from 2002 to 2005, this was combined with a previous extraction for 1981 to 2001. Annual changes in the age standardised admission rate for surgery in WA were compared for the period of 1981 to 2005. The comparison was further divided by surgical group based on International Classification of Diseases surgical coding.

Results

Overall, PHI funded surgical admissions increased congruently with increased PHI membership. Medicare funded surgical admissions continued to increase despite increases in PHI membership levels. Three broad trends in the relative levels of admission rates were observed in surgical groups; (i) similar rates between public and private throughout study period (7 surgical groups), (ii) higher private admission rates for the majority of the period (2 surgical groups) and (iii) higher public rates for the majority of the period (4 surgical groups).

Conclusion

PHI membership increases after 1998 increased private surgical admissions but did not provide a reduction of Medicare funded surgical admissions.

Abstract Number 66

Lifetime Fairness? Taxes, Subsidies, Age-Based Penalties and the Price of Private Health Insurance in Australia

Luke B. Connelly¹, H. Shelton Brown III²

¹The University of Queensland, ²University of Texas School of Public Health

Abstract:

Australia has voluntary private health insurance (PHI) markets in which open enrolment and community rated premiums are mandated by government. Historically, adverse selection in these

markets led to a substantial decline in coverage, giving voice to fears about the viability of PHI markets in the longer-run. In order to preserve community rating but improve the PHI pool, the Australian Government instituted a novel scheme of age-based penalties (ABPs) for individuals who join a PHI fund later in life.

This paper computes the price of health insurance under the so-called "Lifetime Cover" (LC) scheme and shows that the LC scheme per se is not appropriately calibrated to prevent another adverse selection "death spiral" (Butler 2002).

Based on our results, we recompute age-based penalties that would result in a fair price of PHI for all age groups. The premium multipliers we derive suggest a premium ratio of 10:1 for the oldest and youngest joiners. Our premium multiplier sequence is well-approximated by a linear ABP scheme that is approximately three times that of the present LC scheme for older joiners.

Abstract Number 67

Setting priorities at the local level: criteria, processes and considerations for success

Dr. Gisselle Gallego¹, Kees van Gool¹, Dr. Jane Hall¹

¹University of Technology, Sydney, Australia

Abstract:

Objectives

There has been a recent recognition that Australia has a fragmented and ad hoc system for the rational introduction of health technologies in public hospitals. This study describes the efforts of one NSW Area Health Service (AHS) to redress this situation by improving local decision-makers' capacity to make efficient and transparent resource allocation choices and concurrently engage clinicians and health services managers to ensure good compliance with the developed processes.

Aim

This study describes the development of a process for evaluation, approval and implementation of new health technologies (and discontinuation of existing less effective technologies).

Methods

A one day workshop was convened with health service managers and clinical specialist in the AHS. Two independent observers identified and summarised the findings.

Results

Participants identified principles and key features to guide the development of the processes. Participants considered that in order for the process to be successful, stakeholders need to not only to understand it but also feel engaged. The process should also be administratively simple and adhere to principles of procedural justice. Decisions must be transparent and based on

clearly articulated criteria which are well communicated. The evaluation of technologies and the decisions must be complementary, and not duplicative, to already existing national and state processes. Decisions cannot be independent from funding.

Conclusion

The premise for the workshop was that if stakeholders feel engaged with the new decision-making process they are more likely to accept limits imposed by it. To this end the workshop may provide an important source of information in the development of a new process and may also have been initial step to create trust and buy-in from clinicians as well as health services managers.

Abstract Number 68

Exploring Policymakers Perspectives on Disinvestment from Ineffective Health Care Practices

Adam G. Elshaug¹, Professor Janet E. Hiller^{1,2},
A/Prof. John R. Moss¹

¹Discipline of Public Health, ²The University of Adelaide, South Australia, ²Hanson Institute, South Australia

Abstract:

Objectives

Many existing health care interventions diffused prior to modern evidence based standards of clinical and cost-effectiveness. Disinvestment from ineffective or inappropriately applied practices is growing as a priority for international health policy, both for improved quality of care and sustainability of resource allocation. Australian policy stakeholders were canvassed to assess their perspectives on the challenges, and the nature, of disinvestment.

Methods

Senior health policy stakeholders from Australia were criterion and snow-ball sampled (to identify opinion leaders). Participants were primed with a potential disinvestment case study and took part in individual semi-structured interviews which focused on mechanisms and challenges within health policy to support disinvestment. Interviews were taped and transcribed for thematic analysis. Participant comments were de-identified.

Results

Ten stakeholders were interviewed before saturation was reached. Three primary themes were identified: 1) The current focus on assessment of new and emerging health technologies/practices and lack of attention toward existing practices is due to resource limitations and methodological complexity. Participants considered a parallel model to that of Australia's current assessment process for new medical technologies is best-positioned to facilitate disinvestment 2) To advance the disinvestment; agenda requires an explicit focus on the potential for cost-savings coupled with

improved quality of care; 3) Support (financial and collaborative) is needed for research advancement in the methodological underpinnings associated with health technology assessment and for disinvestment specifically.

Conclusion

In this exploratory study, stakeholders support the notion that systematic policy approaches to disinvestment will improve equity, efficiency, quality and safety of health care, as well as sustainability of resource allocation.

Monday December 3rd (3.30pm - 5.00pm)

Concurrent Sessions: Rural Health

Abstract Number 69

Growing pains following the formation of a new rural ambulance service in Australia.

Dr. Peter O'Meara¹

¹Charles Sturt University

Abstract:

Objectives

Rural Ambulance Victoria was established in 1999 as an amalgamation of five regional ambulance services in the Australian state of Victoria. Its State-wide rural focus makes it a unique amongst ambulance services and it is recognized as a modern and highly performing ambulance service. In spite these accolades it has been plunged into a politicized crisis that has thrown its management into turmoil and its very existence questioned.

The objectives of this study were to understand whether the issues of concern were foreseeable at the genesis of Rural Ambulance Victoria and to identify any lessons that may inform the management of similar ambulance services in the future. This was undertaken through access to publicly available documents and re-analysis of the data from previously completed research that had been undertaken during the process of organisational amalgamation and development. These data provided information on recent events as well as the cultural and historical context of delivery of rural ambulance services in Victoria.

Soft systems methodology was used to analyze the history, culture and structure of Rural Ambulance from its formation in 1999 until 2007. This allowed the historical and emerging models of governance and service delivery to be untangled to identify issues and problem situations, their activities, elements and relationships to better understand recent circumstances and provide suggestions for the future.

Abstract Number 70

No place for children or old people: The impact of changing health policies on small rural communities

Dr. Julaine Allan¹, Professor Patrick Ball¹, Professor Margaret Alston¹

¹Charles Sturt University

Abstract:

Objectives

Health services in rural and remote Australia have been steadily shrinking. They are beset by crumbling infrastructure, workforce shortages and funding crises. Simultaneously, and nationally, health policy is created to improve health status, to recognise and provide for an aging population with chronic illnesses and to be equitable for all citizens. To develop sustainable and equitable models of rural health service provision, local conditions affecting health status and service use need to be identified.

Methods

The project used a community development approach to identify the impact of national and state health policy on two small rural towns in central NSW. The case study project applied policy analysis, statistical and Global Information System data, document analysis and focus groups to compare local conditions and local needs with services provided. The analysis identified service gaps and overlaps and service delivery problems. Specifically highlighted were the significant difficulties in turning health policy intentions into technical and administrative detail required for service delivery within a neo-liberal funding agenda. The serious consequences of ineffective health policy for small communities with limited healthcare are outlined with examples.

Results

Health care policy is better able to identify health needs and health status of rural populations than in the past. However we have not learned how to implement health policy effectively including costing and evaluation of its impact.

Conclusion

Models of health care delivery need to identify and incorporate local conditions to effectively evaluate and adapt health care policy.

Abstract Number 71

Autumn or Indian Summer: what services support rural healthy ageing?

Professor Judi Walker¹, Dr. Peter Orpin¹, Kim Boyer¹

¹University of Tasmania

Abstract:

Objectives

The capacity of health and community services to meet the needs of rurally-based older people is restricted by the lack of in-depth understanding of the ageing experience in the diverse and changing

environments that make up rural and regional communities.

Historical patterns of service delivery, with their focus on frailty and illness, and based on static populations, are no longer relevant.

Methods

A multidisciplinary team of UTas-based researchers have undertaken three research projects over the past two years specifically aimed to identify current patterns of service useage, and projected needs of rurally based older Tasmanians in order to maintain their health and wellbeing. These are: (1) a two stage (baseline and 18 month follow-up) study by face-to face interviews of approx 200 rural older people to determine existing and projected future service/support needs; (2) a study of three funded services to promote healthy eating for healthy ageing; (3) a questionnaire based study looking at the nature and effect of changes in patterns of social engagement among older people.

Results/Conclusion

All three studies highlighted the central importance of social engagement in supporting healthy ageing and the need to rethink the type of services most needed to support rural people to remain engaged and active within their communities. The team is working closely with funders and providers in planning for the sustainable delivery of such services.

Abstract Number 72

Policies to sustain primary health care in rural and remote Australia

R Wells¹, Professor John Humphreys², Professor John Wakerman³, Dr. Pim Kuipers³, Dr. Philip Entwistle³, Dr. Judith Jones²

¹Australian National University, ²Monash University, ³Flinders & Charles Darwin University

Abstract:

Objective

One of the most pressing problems confronting Australian health policy is how best to deliver sustainable primary health care to small, widely dispersed rural and remote communities any pilots and trials have been conducted. What do they tell us and how might we shape future policy?

Methods

We recently undertook a rigorous, systematic review of more than 5000 articles on innovative rural and remote models of primary health care in Australia published since the 1993 National Rural Health Strategy.

Results

Despite the significant number of publications espousing 'sustainable models' of health care, most only describe case-studies or pilots, reiterate the nature of the existing problems, or at best speculate on possible solutions. A handful of studies provide detailed empirical investigations of what is required to

underpin sustainable rural and remote health services or are comprehensive evaluations demonstrating what aspects of existing models worked well where and why.

Conclusion

Funding of more 'pilot' studies targeting local solutions and the continual call for 'innovative' solutions to a problem that has long been recognised and is well-understood are not likely to be helpful. Whilst the existing evidence base upon which to develop sustainable service models is less than extensive, three key messages emerge. First, the need for strong community support and leadership; second, funding models that allow flexibility and resource adequate infrastructure and workforce; and thirdly a responsibility for researchers to undertake sustained and comprehensive investigations of what works well where and why and assist in translation of findings. Principles to guide policy makers have been developed.

Abstract Number 73

Public Sector Cultural Dyslexia: Suicide Prevention in Rural South Australia

Dr. Jennene Greenhill¹, Kerry Dix¹

¹Flinders University

Abstract:

Objectives

Are public sector health services best positioned to deal with suicide prevention? Most research on suicide prevention is quantitative, epidemiological studies concerned with "evidence" such as suicide rates, mortality ratios and risk factors. Whilst these studies provide some useful information on suicide by identifying and highlighting some social risk factors, they tell us little about why suicide prevention is difficult, particularly in Australian Aboriginal communities.

This paper tells a story about seven rural and remote communities as they develop and implement local strategies to prevent suicide. It follows our journey in search of ways to collect meaningful data and reveals the difficulty navigating through cultural differences in bureaucracies, rural communities and Aboriginal cultures. We identified this as cultural dyslexia.

Cultural dyslexia is defined as "a failure to 'read' other cultures and come to terms with the difference" and emphasises the repeated failure of groups in the same society to understand each other (Palsson, 1999). We found that bureaucratic systems are grounded in institutional racism and hindered connections. Given the history of research being 'done to' Aboriginal people the importance of building relationships, showing respect and a willingness to learn was foremost in our minds. Our challenge was to find ways to achieve a degree of trust and rapport with the communities, elders, individuals, their families and service providers in short time frames. Cultural dyslexia continues to go

largely un-actioned. The thought of perpetuating this tragic parody with yet another short term project was agonising.

The ability to be open to new approaches with the aim of community inclusion confronts the traditional exclusivity of bureaucratic structures and the academic culture of research expertise. We seek to undertake meaningful research to inform public policy, share experiences and collaborate with communities to learn without perpetuating public sector performativity?

Monday December 3rd (3.30pm - 5.00pm)

Concurrent Sessions: Identifying Service Needs

Abstract Number 74

Chronic disease self-management programs: Policies and evaluation mechanisms

A/Prof. Richard H Osborne¹, Joanne Jordan¹

¹The University of Melbourne

Abstract:

Objectives

Recent government initiatives, such as the Australian Better Health Initiative, have prioritised patient self-management education as a key component in the prevention and management of chronic disease. However it is important to consider the factors required for successful implementation of such interventions, particularly within the primary healthcare setting. This study reviewed self-management policy and program trends at the international and national levels and developed a framework which identifies the key issues to be addressed for these interventions to be effectively implemented within the healthcare system.

Methods

Prominent self-management education policies and programs were identified through a comprehensive and purposeful literature search which included journal articles, grey literature (policy documents) and websites. Interviews with national policy stakeholders were also conducted (n=21).

Results

Engagement with primary healthcare professionals (PHP) is critical to the viability and sustainability of programs. Endorsement of programs is dependent on key infrastructure to facilitate a systematic approach including a suite of self-management education interventions that are flexible and meet the diverse needs of populations, targeted training and education strategies for PHP and raising the profile of self-management within the healthcare sector.

Conclusion

A framework was developed with actionable items from policy through to community levels that need to be considered for implementation of self-management programs into the healthcare system. In light of new government initiatives, taking heed of experiences at the international and local levels is vital in future planning for the implementation of self-management education programs into the Australian healthcare sector to ensure that improvements in the quality of chronic disease care are truly realised.

Abstract Number 75

Support needs of siblings of children with cancer

Rebecca L. Dobson¹, Professor R. Glynn Owens¹, A/Prof. Linda D. Cameron¹

¹University of Auckland

Abstract:

Objectives

This study aims to identify the psychosocial needs of siblings of children with cancer as well as looking at how these needs are addressed and what improvements can be made to the services provided to this population. The diagnosis of cancer in a child and subsequent journey through treatment may significantly impact siblings and it has been shown that siblings experience similar levels of distress from the experience as other family members.

Methods

This study which utilised both quantitative and qualitative methods included 37 siblings of children diagnosed with cancer within the past 18 months. An interview was conducted with each sibling during which they responded to open-ended questions and completed quantitative measures.

Results

The results of this study identified both negative and positive effects of the experience for siblings. Further this study illustrates that the psychosocial needs of the participants were commonly being met by family although those who had had the opportunity to make use of services recommended that these be made available to others. Ninety-seven percent of the siblings indicated that they would have liked specific information on what it is like to have a brother or sister with cancer.

Conclusion

As well as identifying psychosocial effects of childhood cancer on siblings, this study highlights the ways in which the needs of this population can be met. Currently family are a key provider of support to this population. Health services for this population should be expanded to ensure all siblings have the opportunity to utilise them.

Abstract Number 76

Informal care and home-based palliative: the carers preferences for support

Patricia Kenny¹, Professor Jane Hall¹, Siggi Zapart¹, Pauline Davis¹, Dr. Ishrat Hossain¹

¹University of Technology, Sydney

Abstract:

Objectives

As the provision of palliative care services in the community increases, so does the requirement for family and friends to provide unpaid care (informal care). This study investigates the informal carers' preferences for different types of services to support their care-giving role.

Methods

A discrete choice experiment was conducted with 168 informal carers, recruited through two palliative care services in Sydney. Data were collected in face-to-face interviews where carers were asked to choose between two service plans, and then to choose between their preferred plan or their current services. Data analysis used multinomial mixed logit models.

Results

The probability of choosing a service plan increased if it included home visits from palliative care and community nurses, and 24 hour access to phone advice from a palliative care nurse. Carers providing high levels of care also wanted help with personal care and home respite (daytime and overnight). Where the care-giving need was relatively low, carers wanted help with household tasks, transport to medical appointments and a case co-ordinator. Carers generally had a high propensity to choose their current support but this differed among carers and was associated with characteristics of the carer and the care-giving situation.

Conclusion

While all carers valued nursing services, preferences for other services varied over the palliative process. Domestic help, transport and coordination of treatment and information sharing were important at the earlier phase, while personal care and respite became the priority as the care recipient's condition deteriorated. Preference for the status quo suggests satisfaction with current support.

Abstract Number 77

Identifying the resources and services needed by disabled people to live an ordinary life in the community

Laura Wilkinson-Meyers¹

¹University of Auckland

Abstract:

Objectives

Disabled people have long advocated for sufficient resources to allow them to live an ordinary life. However, previous attempts to identify the resource requirements of people living in the community have tended to rely up surveys of current resource use rather than focusing upon the resources that would be required to achieve an ordinary life. The purpose of this project was to integrate a social model of disability with a robust economic approach in identifying the resources required by people with physical, vision, hearing, intellectual and mental health impairments living in the community. The research was a collaborative effort between a disability advocacy/provider organisation, members of the disabled community and academic researchers. A budget standards methodology was used to identify the additional resources (goods, services and activities) identified by people with impairments compared with the non-disabled. Thirteen focus groups were held to negotiate and validate budgets for people with physical, intellectual, mental health, hearing and vision impairments. The results suggest that resource needs are dependent upon numerous factors aside from the type and level of impairment, with transportation, access to information and home modifications being identified as key areas of need. However, the discussions also highlighted the importance of intangibles (such as discrimination) as barriers to achieving an ordinary life. The implications of these results for health and social policy are discussed.

Abstract Number 78

Australasian adolescents transition from paediatric to adult diabetes services: a complex picture of choice and access

Kate Gilbert¹, **Melinda Seed**¹

¹The Type 1 Diabetes Network Inc.

Abstract:

Transition from paediatric to adult care is recognised as a major problem in type 1 diabetes care with many patients 'falling through the cracks' at this time. The Type 1 Diabetes Network investigated young adults' experiences of 'transition'.

168 people (24% male) living in Australia or New Zealand during their transition period responded to an email invitation and completed an online survey.

33 (20%) were newly-diagnosed during this period. The remaining 135 were diagnosed before 16 years of which 51% attended a children's hospital, 50% private endocrinologist, 18% adult hospital and 3% only a GP.

Of those attending a children's hospital (n=69), transition involved: children's hospital made appointment in adult system (22%), given details of adult hospital (26%), 'I looked into options myself' (6%), 'I stayed away from hospitals and doctors after I was too old for children's care' (22%).

First contact with the adult system was reported as private endocrinologist (49%), public 'transition' clinic (16%), other diabetes clinic (28%), diabetes nurse (11%) or GP (8%).

The literature describes optimal transition as supported transfer from paediatric diabetes services to adolescent-focused services in the adult system: 4% of respondents reported this as their experience.

Literature on transition almost exclusively draws target populations from public hospital clinics. This study suggests that significant proportion of adolescents may have been overlooked. Information and support outside of traditional health services, such as websites and peer networks, may be important for supporting adolescents with diabetes through transition. In addition to disease-specific education, information may be required about available services and how to navigate the health system.

Monday December 3rd (3.30pm - 5.00pm)

Concurrent Sessions: Modelling for Service Planning

Abstract Number 79

Strategic Decision-making — policy implications of bed occupancy modelling: can we do without it?

Dr. Mark Mackay¹

¹University of Adelaide

Abstract:

Objectives

Bed crises have become more frequent in recent years in Australia and elsewhere. Occupancy levels have been increased in an attempt to meet the pressure of rising demand. Various strategies have been enacted concomitantly in attempts to reduce the likelihood of crisis, reduce risks to patients and improve outcomes in Australia. The crises, however, have not abated. The role of modelling does not seem to have focussed greatly in the debates about decisions relating to hospital bed, or for that matter issues relating to the forecasting of the use of resources in the health sector. It is not clear whether this has been due to the paucity of

funding for health services research in Australia or issues regarding the usefulness of modelling in the health sector:

There is little doubt that the wave of ageing baby boomers will see further pressures exerted on the health sector. Thus, the need to improve decision-making exists. Attempts at modelling bed issues to date have spanned the tactical to strategic, and have involved simplistic through to complex models. To date there has been little traction in any one modelling approach relating to decisions affecting beds. The compartmental flow model of bed occupancy will be presented as a modelling approach that offers improved information for strategic decision-making and represents a significant leap forward from many of the simplistic approaches currently used.

Abstract Number 80

Improving interfaces within the health system using multiscale dynamic simulation models

Dr. Geoff McDonnell¹, Mark Heffernan², Victor Vickland³

¹Adaptive Care Systems, ²Evans & Peck, ³UNSW

Abstract:

Objectives

There is increasing interest in applying complex systems approaches to healthcare, fuelled by advances in computer simulation software and hardware, and the prominence of systems modelling in climate change and systems biology. Combined use of pattern oriented system dynamics and agent based variance methods with zoomable interactive visualisations is now available.

We have modelled the following interfaces: between acute hospital and aged care in the community and in residential aged care facilities between the national ehealth program and healthcare system quality between medicines and medical services use and the workforce supply between clinical practice and policy in dementia and intellectual disability. This has involved the integration of national and regional datasets at the individual and the aggregate level, with the simulation modelling providing a logical consistent framework for dynamic data integration. This has the advantage of enabling a variety of "what-if" virtual experiments that may be impossible or too expensive to perform in the real world. Structural and parameter sensitivity analysis allows more robust policy and practice recommendations under a range of possible scenarios. A key advantage is the use of compelling and engaging animations to build policy consensus among a wide range of stakeholders and experts from different disciplines. We will demonstrate models from the above projects, play out policy options and the lessons learnt from

these projects. We will also discuss how these methods can become more useful for health services researchers and the capabilities required for successful applications.

Abstract Number 81

System dynamics and agent based modeling of age related changes in people with Intellectual Disability

Lynette Lee¹, Geoff McDonnell², Victor Vickland³, Mark Heffernan⁴

¹Concord Hospital and Sydney University, ²Adaptive Care Systems, ³UNSW, ⁴Evans & Peck

Abstract:

Objectives

Planning to address the health service and general support needs of people with Intellectual Disability as they age is a complex task. Available data is incomplete and sometimes confusing. There are biological, lifestyle and funding dimensions to be considered and it is sometimes difficult to understand the interactions amongst these issues.

The incorporation of engineering principles in desktop software using System Dynamics tools and methods has reduced the time needed for the development of computer simulations to weeks. Virtual experiments of interactions between disability support and aged care accommodation, and 'what if' scenarios, can now be run in seconds, allowing visualization of outcomes of age related illness deterioration, workforce changes or policy developments for this group of people. We can then also 'zoom in' with agent based modeling to microscopically visualize the movement of individuals and gain an understanding of the impact of interventions on them.

This paper will present research in progress in the Ageing and Behaviour Changes in Developmental Disability (ABCD) Clinic at Concord Hospital in Sydney.

It will begin with computer simulation of the changes that might occur in the personal care and nurse dependency profile of people over 40yrs with Intellectual Disability, living in the Concord Aged Care Assessment Team 'catchment' (approximately 175,000 people) and continue with a demonstration of the depiction of movement of the individuals as they age.

Abstract Number 82

Modelling the future of aged care service provision: a localised System Dynamics approach

Hamish Robertson¹, Professor Tony Broe^{1,2}, Nick Nicholas¹

¹Prince of Wales Medical Research Institute, ²University of NSW, Australia

Abstract:

Objectives

Population ageing is considered to be one of the greatest challenges facing developed and developing country health systems. Growth in the very old, those aged 85+, is likely to precipitate systemic redesign across the public health system from acute hospitals to residential and primary care. Population ageing reinforces the need to address chronic and complex illnesses across the life-cycle and engage with the processes of ageing in a multidisciplinary fashion.

Methods

The development of this project involved key elements including: the development of a conceptual model of how aged care operates at the local government area; the design of a system dynamics (SD) model showing those relationships; the collection of data to populate the model; and interviewing key health managers to ensure the model reflected their understanding of how the system works and the key data elements to include.

Results

This project illustrates how the effective design, development and implementation of careful, scale-specific models of health systems can help health planners and managers plan more effectively and appropriately for complex, population change scenarios. It also shows how modelling can support health care decision making by developing key "what if" scenarios to show how flow-on effects of policy and planning changes are likely to impact on service provision across complex environments of care.

Conclusion

Innovation is not the same as novelty. This paper shows how careful innovation in thinking and modelling can be used to address complex issues in health care in a more practical, rational, timely and cost-effective manner.

Abstract Number 83

Forecasting the Urban Medical Insurance System of Kunming City Using Microsimulation Model

Xiong Linping¹, Jia Jianhai², Gong Mingxing², Ms. Liu Hong³, Hu Kejian²

¹University of Canberra, Australia, ²Bureau of Labour and Social Security of Kunming, China, ³No. 43 Hospital of Kunming, China.

Abstract:

Objectives

Commenced in 1995 with two cities of Zhenjiang and Jiujiang, through several rounds of pilot programs and experimental implementation, a new medical insurance system in China has been established. This system covers all employers and employees in urban areas and has had a profound impact on the funding, management and provision of health services. However, as the ageing of the population quickens in China, the large number of elderly people impose a heavy burden on medical insurance. The reform of China's medical insurance system faces many challenges. This paper aims to assess the distributional impacts of medical insurance policies and to predict the medical expenses of urban employees and employers using microsimulation techniques. Cooperated with the Bureau of Labour and Social Security of Kunming, capital city of Yunnan Province, this paper created a static microsimulation model to simulate the implementation of the medical insurance policy for the insured urban employees in Kunming. The main data used in this thesis are administrative medical care records of the basic medical insurance scheme participants, which represent 1.08 million insured urban employees. The simulation commences in 2006 and forecasts over five years until 2010. The model built in this paper is able to simulate the usage of medical resources by different types of urban employees. In addition to the base case forecasting the current policy setting, this paper also modelled two other policy settings to investigate what happens to key output variables if the policy settings are changed.

**Monday December 3rd
(5.15pm - 6.15pm)**

Plenary 3: How will Health Services Research be Funded?

Abstract Number 84

How will health services research be funded?

Dr. Robin Olds¹

¹Health Research Council of New Zealand

Abstract

The HRC has identified health services research as a priority and has put in place processes to allocate research funding. In the presentation, the success, or otherwise, of this will be considered. Health services research has been funded through three mechanisms. As part of the annual contestable funding round, investigator initiated proposals can be supported through one of the nine research portfolios (Health and Disability Sector Management and Services). This portfolio was recently revised, after broad stakeholder consultation, and has several explicit priorities, details of which will be presented. In 2005, the HRC established a small strategic fund, Targeted Research for Health (TRH), to address gaps identified in the HRC's investment in areas of critical importance. Health services research is one of the identified priority areas in the TRH output, hence providing a mechanism for the preferential funding of health services research proposals submitted to the annual contestable round. The Partnership Programme (PP) provides a third avenue for funding, via requests for proposals. Through the PP, the HRC establishes Joint Research Portfolios with government and non-government stakeholders to address specific needs or achieve broad stakeholder involvement in cross-sectoral health issues. The District Health Board Research Fund represents a special type of Partnership Programme, which has successfully sought and supported several pieces of research through a process that involves strong stakeholder involvement in the design of the request for proposal and the ongoing engagement with the research team, with the purpose of maximizing the uptake of findings by the stakeholders. Details of the level of investment in health services research through each of these mechanisms will be presented and the challenges that lie ahead in sustaining, or growing, the investment will be considered.

Abstract Number 85

National Health & Medical Research Council support for health services research — the past, the future.

Professor Warwick Anderson¹

¹National Health and Medical Research Council, Canberra

Abstract:

NHMRC has developed a wider range of support mechanisms for the four "pillars" of health and medical research, biomedical, clinical, public health and health services research, over the last decade. In addition to its traditional project grants scheme, the Council has introduced new support mechanisms for early and mid career research, for building research capacity, for the support of specific calls for research proposals in targeted areas. Despite this, support for health services research remains low in comparison to the other three "pillars". NHMRC is investigating whether there are unintended barriers within its schemes through its Research Committee. We will also subject all its schemes to international scrutiny through the next 6 months.

A particular initiative of most relevance to health services research will also be announced shortly and outlined at the meeting. Objective 2 of NHMRC's Strategic Plan 2006-2009 focuses on increasing evidence base to improve the delivery of health care and to inform the development of health policy by health authorities. NHMRC has allocated substantial financial resources to a range of funding schemes to support this objective.

**Tuesday December 4th
(8.45am - 10.30am)**

Plenary 4: Collaboration in Health Services Research - The Way Forward

Abstract Number 86

Collaboration in health services research: the way forward

Sue Crengle¹

¹Auckland University

Abstract:

Collaborative research can be a rewarding experience but may also pose a unique set of challenges.

In this presentation I will discuss some of the rewards and challenges using examples from my own experience.

The presentation will include information about collaborative research in general, as well as discussion from my perspective as a Maori health researcher.

Abstract Number 87

Aboriginal Health Research Collaborations with Primary Health Care Services in Australia — Opportunities and Challenges

Dr. Sandra Eades¹

¹The Sax Institute, Sydney.

Abstract:

In Australia, National Health and Medical Research Council funding directed towards improving the health of Aboriginal and Torres Strait Islander people has increased significantly in recent years. In addition despite many reservations about the value of past health research to communities, Aboriginal people through Community Controlled Primary Health Care Services across Australia have a substantial record of collaborating in research programs to explore the causes and solutions to a range of health problems. Aboriginal community controlled primary health care services were first established in the early 1970s and today operate throughout a range of urban, rural and remote settings in Australia. The governance and service delivery models ensure these services are responsive to community identified health needs and to broad National and State programs in areas of health priority. Aboriginal controlled primary health care services that engage in health research collaborations present a number of unique opportunities for research and innovation. These opportunities must be balanced against the organisational and community needs for research collaborators to recognize their right to self determination, to maintain appropriate ethical standards in the conduct of research and to develop appropriate business systems and contractual agreements with services in relation to the research. Researchers must also maintain the highest possible scientific standards of the research and take time to explore potential opportunities for research outcomes to be translated into policy and practice. This paper will explore these issues using specific research case studies.

Abstract Number 88

Evaluating Primary Health Care and Policies to Improve It

Peter Crampton¹

¹University of Otago

Abstract:

Health services research frequently attempts to illuminate and solve complex and important problems, such as the disparate treatment and adverse event outcomes for Maori and European populations in New Zealand. Researchers have a tendency to define themselves and their work according to the contents of their disciplinary toolbox (for example, health economics, sociology, epidemiology); however, all toolboxes are limited in

terms of their capacity to contribute to our understanding of complex problems. Researchers (and policy makers) similarly tend to define problems, and solutions, in terms of the tools we feel comfortable with. For example, depending on the disciplinary viewpoint, disparate health outcomes for Maori may be viewed as primarily a problem related to financial barriers to access to health services, or to ineffective cross-cultural communication, or to the mismatch between the health workforce and the population, or to colonisation and resultant socioeconomic disparities. In order to understand and contribute to solving complex, multifaceted problems, collaboration is required where researchers use the combined strengths of their respective methodologies. This point applies equally to different types of collaboration: interdisciplinary, cross-work boundaries (for example, policy-research), cross-country, methodological (within a discipline, or across disciplines), cross-cultural...etc. Unless we collaborate we risk failing both to engage with the complexity of problems and to identify the most effective solutions.

Magic does sometimes result from effective collaborations.

Tuesday December 4th (11.00am - 12.30pm)

Concurrent Sessions: Primary Health Care Services

Abstract Number 89

General practice referrals for non-urgent surgical care

Dr. Antony Raymont¹, **Sonya Morgan**², **Deborah McLeod**², **Tony Dowell**², **Jacqueline Cumming**¹

¹Victoria University of Wellington, ²University of Otago, Wellington

Abstract:

Objectives

The Pathways study recruited and followed a cohort of patients, referred for non-urgent surgical care, to map their progression through the system.

Methods

Six districts representing varied rates of surgical care and ethnic mix were chosen. All general practitioners (GPs) in each were invited to enroll patients referred for surgical care over a month in 2004. Consenting patients were followed by the research team. This presentation describes their characteristics and needs.

Results

42% (N=345) of eligible GPs agreed to participate and data on 1324 referrals were analysed. GPs made 2.4 non-urgent surgical referrals per week. 41% of those referred were male and 70% were European New Zealanders; their mean age was 56 years. The modal level of urgency was "routine" and in 24% of cases

cancer was a possibility. The GP sought surgery in 47% of cases and advice in 73%. One third of the patients were referred to the private sector. Private referral was associated with the ability to afford care but non-European ethnicity was associated with lower private referral rates after controlling for other factors including insurance status.

Conclusion

Elective surgical referral makes up a significant proportion of GP workload. In more than half of cases advice, rather than surgery, was sought, and in nearly two thirds of cases the patient was aged less than 65 years. The very small number of cases where a desired referral was not made suggests that GP and patient expectations are adjusted to service capacity.

Abstract Number 90

General Practitioners knowledge, attitudes and practices regarding cervical cancer screening in Australia

Dr. Stephen Goodall¹, A/Prof. Marion Haas¹, A/Prof. Rosalie Viney¹, A/Prof. Jeanette Ward², Professor Denzil Fiebig^{1,3}

¹University of Technology Sydney, Australia, ²University of Ottawa, ³The University of New South Wales

Abstract:

Objectives

In Australia, the National Cervical Screening Program (NCSP) has been an important public health achievement. General practitioners (GPs) are the main providers and have been crucial to this success. This study assesses the views of GPs about the value of the Pap smear tests, their knowledge of the current screening policy, awareness of new technologies and concerns of litigation.

Methods

A postal survey was conducted on a random sample of GPs in New South Wales, Australia.

Results

Completed questionnaires were returned from 452 GPs. GPs are generally supportive of the NCSP guidelines; 88.5% agree with the 2 yearly screening interval. However, half believe the age range should be increased to include older and younger patients. Factors most important in recommending a Pap test were time since last test and false negative rate. Least important factors were; patient age, socio-economic status and cost. There are notable differences between male and female GPs. Female GPs were more likely to: support the 2 yearly screening interval; advocate expansion of the age range to include younger and older patients; be familiar with new technologies; offer opportunistic screening; and be at ease with patients from different cultural/religious backgrounds. Male GPs were more concerned about legal implications of over and under-screening.

Conclusion

While the NCSP is generally well supported by GPs there are differences in the knowledge and views of male and female GPs. This information is essential if we are to optimise the effectiveness of GPs as providers of cervical screening, improve the rate of appropriate utilisation and successfully implement future changes to the national screening guidelines.

Abstract Number 91

Do patients use medicines for cardiovascular disease as the doctor intended?

Susana Senes¹, Elizabeth Penm¹

¹Australian Institute of Health and Welfare

Abstract:

Objectives

Cardiovascular disease (CVD) affects nearly one in five Australians and an estimated 65% (2.3 million people) use medicines for CVD. Government expenditure on medicines for CVD amounted to \$2 billion in 2006, 35% of the total spent on all subsidised medicines. Concordance with medicines (patients using medicines as prescribed) greatly affects outcomes. We studied concordance with common medicines usually indicated for lifelong use to prevent or treat CVD. We analysed persistence (taking medicines for the specified treatment period) and compliance (taking medicines at the prescribed interval and dose) with medicines in newly prescribed patients studied over 2003-06 using individual patient records from the Pharmaceutical Benefits Data System, supplied by the Australian Government Department of Health and Ageing. Medicines studied included cholesterol-lowering agents (statins), blood-pressure-lowering agents (angiotensin II antagonists, ACE inhibitors, beta-blockers), and clot-preventing agents (warfarin and other). We found that, depending on the medicine type considered, 10-25% of patients had stopped taking their medicines at 6 months from the start of therapy, rising to 21-47% at 24 months. Furthermore, 14-27% of patients were only ever dispensed one script. The average duration of persistence ranged from 288 days to 432 days. Compliance levels were 77-90% in the first year of therapy. Our study shows a high level of discontinuation of medicines that are generally intended to be taken long term. This represents a significant waste of resources and a lost opportunity to prevent CVD, or delay its progression and complications.

Abstract Number 92

Health care and internet use among Australians and New Zealanders: a survey study

A/Prof. Robin Gauld¹

¹University of Otago

Abstract:

Objectives

How many people use the internet for health information and what kind of information to they seek? Do they check the validity of internet health information sources? Do people want email contact with their doctors and have they taken information from the internet to their doctor? This paper provides insights into such questions.

Methods

A 30-item telephone survey of randomly-selected Australian (n=250) and New Zealand (n=250) respondents was conducted in December 2006-March 2007.

Results

Surprisingly few respondents from either country used the internet for health information. Around half of New Zealanders who did felt that doctors should provide online health information and be available for email consultations. Almost three-quarters of Australians felt this way. A third of Australians felt internet information was more useful than medical advice, compared with almost half of New Zealanders. Almost 90 percent of all respondents felt internet information was reliable, but only a third checked the credentials of websites. Around half of respondents who had taken internet information to their GP felt this had improved their relationship.

Conclusion

If the internet is changing the way people access health information, education about internet use for health information is needed – for both patients and doctors.

**Tuesday December 4th
(11.00am - 12.30pm)**

Concurrent Sessions: Organised Session

Abstract Numbers 93 — 96: Organised Session

Abstract Number 93

Policy, innovation and reform: the Victorian Orthopaedic Waiting List Program

A/Prof. Richard H Osborne¹

¹The University of Melbourne Parkville, Melbourne, Australia

Abstract:

Objectives

The generation and implementation of significant healthcare reform is not for the lighthearted as it requires substantial cooperation across numerous sectors. This symposium describes a program of work where an idea generated from within academia (a public health research team) led to dynamic and sustained partnerships with government agencies, clinical and academic groups. With four years of consultation, relationship building, policy strategy and clinical pathway generation, piloting and evidence generation a new system of care and prioritisation of people requiring hip and knee replacement surgery was generated. Three perspectives on the successful and challenging processes are offered – policymaker, health service researcher and “coal face” clinicians.

Abstract Number 94

Organising and Managing Waiting for Hip and Knee Replacement Surgery: Getting the Chronic Care And Hospital Interface Right

Lisa Mitchell¹, Maree Roberts¹, Kaye Brown¹

¹Department of Human Services, Victoria

Abstract:

Objectives

Whether measured by GP referrals, outpatient attendances, admissions or operations the demand for orthopaedic treatment has grown steadily over the past decade. Historically, orthopaedics has offered patients slower access to surgery compared with other specialties. This applies particularly to joint arthroplasty. The challenges of managing waiting times are compounded where patients have a chronic disease in part

because the hospital system is designed largely to meet the needs of those requiring acute care services. Thresholds for hip and knee replacements are variable. There is a spectrum of disease severity and patients experience different rates of disease progression. Need and time waited on a waiting list are not always closely correlated. Fairness requires serving patients in order of need. Victoria has begun to introduce a new service delivery mode for the care of osteoarthritis patients which involves early comprehensive assessment with referrals to appropriate services for conservative management, prioritisation for surgery, and on-going monitoring of patients waiting for surgery. There is resistance to spending health care dollars on administration, information systems, and analysis rather than on service delivery. Nevertheless, standardised assessment tools can aid clinicians' decisions and provide assurance to patients that their wait is being actively managed and is equitable compared to the needs of others.

Abstract Number 95

Generating and implementing healthcare reform to improve quality and equity

A/Prof. Richard H Osborne¹, Caroline Brand¹, Melanie Hawkins¹, Fiona Landgren¹, Richard de Steiger², Stephen Graves³

¹The University of Melbourne, ²The Royal Melbourne Hospital, ³Flinders Medical Centre, Adelaide, SA

Abstract:

Improving quality of care and rational, equitable allocation of resources is central to healthcare reform in local and international settings. The Victorian Department of Human Services funded a University of Melbourne/Melbourne Health partnership to develop a new service delivery model and system of prioritisation for people with hip and knee osteoarthritis (OA), which might also provide a blueprint for elective surgery reform in Victorian public hospitals.

The model included redesign of workforce roles, initial triage, early assessment and referral, optimisation of conservative management, monitoring, and prioritisation for surgery.

Central to the program was a Multi-attribute Prioritisation Tool (MAPT) with domains derived through 8 workshops and extensive clinical consultation. Domains were pain, activity limitations, psychosocial wellbeing, economic impact and deterioration. Rigorous clinimetric and psychometric evaluation were undertaken. Items (n=11) were weighted by orthopaedic surgeons (N=96) using Discrete Choice Experiments. Validation in 960 patients involved co-administration with standardised questionnaires and verification of MAPT scores through clinical interview. The MAPT finely ranks patients requiring JRS on a 100 point scale, clearly differentiating levels of severity even at the severe to very severe end of the scale.

The system was generated and tested in 5 hospitals over one year; then piloted in 4 hospitals through an open tender process to develop specifications of a state-wide rollout plan. To facilitate effective implementation, sites were supported by a technical support team including training on 'introduction of innovations' into the healthcare setting. A comprehensive Program Evaluation was undertaken and will be reported.

Abstract Number 96

Evolution of Waiting List Management of Arthroplasty Patients at RGH, South Australia

Frankie Clarke¹, Jennifer Monaghan¹, Graham Mercer¹

¹CNC Ortho

Abstract:

Objectives

Hip and Knee replacement surgery (arthroplasty) for end-stage arthritis is a common elective surgical procedure where 65,000+ procedures are undertaken across Australia annually. The number of these procedures has doubled over the past 10 years and is linked to protracted waiting times for an outpatient appointment for an appointment to see an orthopaedic surgeon and waiting to have surgery once clinical need has been established. The reasons for waiting lists are complex and involve mismatch between recourses and services and the 'competition' for operating theatre time by trauma services. The recognition of the need for a campus separated from trauma for the development of a dedicated Arthroplasty Service was followed by a Pilot Study using the Hip and Knee Questionnaire Multi-attribute Prioritisation Tool (MAPT) to prioritize and manage patients on the waiting list for joint replacement surgery. The campus was Repatriation General Hospital Adelaide which undertakes about 40% of the State's Public Hospital hip and knee arthroplasty procedures. This paper reports the barriers and enablers encountered in establishing the Service following the pilot study. A parallel program for patients with arthritis, but not on the waiting list was also implemented. Patients completed the 11-item Hip and Knee questionnaire. The service involved comprehensive assessment and provision and/or referral (to) for conservative management. Patients were monitored at 3-monthly intervals, and specific triage, prioritisation and reprioritisation (were) was undertaken where necessary. This paper covers the first year of the Service, with over 3,500 MAPT scores recorded, discussion of impact and effectiveness, audit feedback and rationales for ongoing modification (to) of the model.

**Tuesday December 4th
(11.00am - 12.30pm)
Concurrent Sessions: Mental Health**

Abstract Number 97

What is the place of generalism in mental health care - a systematic review?

David Perkins¹, Karen Larsen¹, Julie McDonald¹, Anna Williams¹, Gawaine Powell Davies¹, Mark Harris¹, Helen Lester²

¹University of New South Wales, Sydney, ²University of Manchester, UK

Abstract:

Objectives

Mental health disorders are the leading cause of the disability burden in Australia, they affect one in five adults during their lifetime. In the last 20 years there has been a major focus on community settings and mental health conditions account for a large proportion of presentations to primary health care services. Shortages of specialist mental health staff in regional and rural areas amplify the impact on primary care services. The Mental Health Council of Australia has stated that further research is required to understand the current capacity of the various professions and workers to expand their roles to relieve key pressure points such as those faced by psychiatrists, mental health nurses and general practitioners.

Methods

The paper will present the key results from an APHCRI funded international narrative review addressing the following questions: what elements of care do generalist primary health care providers currently provide to people with mental health problems in Australia and what supports do they have in doing this? What elements of mental health care can be effectively undertaken by generalist primary health care providers, taking into account the range of patients and mental health problems and health service context? What are the implications for workforce arrangements?

The paper will discuss the implications for mental health manpower policy and service development in Australia.

Abstract Number 98

Mental illness: Public programme economic impacts on family/friend care costs

Dr. Linda Cook¹, Dr. Norah Keating²

¹Grant MacEwan College, ²University of Alberta

Abstract:

Objectives

Over the last several decades, the worldwide move toward deinstitutionalising persons with mental illness has changed the face of health care. However, the gains in quality of life that could be achieved may be more evident on paper than in reality. A recent study of public program policy impacts on the economic costs of family/friend carers for persons with mental illness in Canada revealed that public program policy often fails to fit either the carers or the mental health care consumers well. Quantitative analysis of national telephone survey data provided description of care dyads that experienced high costs related to care in the community. Documentation for programs that could potentially reduce care costs was examined to determine economic impacts on those example carers. Program policy statements showed much evidence that we have a long way to go to avoid discrimination against those whose illnesses are mental and against their carers. Some programs militate against regaining health because the recipient must remain disabled to obtain necessary health benefits such as medication. The relationship of the carer to the person with mental illness can determine which benefits are available and which costs are involved. In some instances, entire families can be trapped in poverty in order to obtain needed treatment. Recommendations for policy changes that would encourage as high a level of function in these families as possible will be presented.

Abstract Number 99

Lost in translation: Understanding mental health experience to inform practice

Dr. Lynne Pere¹

¹Victoria University of Wellington

Abstract:

Objectives

Many factors contribute to the disparity in mental health status between Maori and non-Maori in Aotearoa/New Zealand – including cultural identity. Indigenous people the world over have considered the relationship between identity and wellbeing, generally maintaining that identity is a necessary pre-requisite for mental health and wellbeing.

Methods

This paper is based on my doctorate research which sought to understand the experience of mental illness from the perspective of those it affects most – the consumers. By examining the worldviews of Tangata Whai Ora (Maori with experience of mental illness) it explored the importance of cultural identity for their wellbeing, in order to answer the research question: “Does a secure cultural identity lead to improved wellbeing for Tangata Whai Ora?” A methodological approach that was cognisant of Maori knowledge and understandings was key to the research and a Kaupapa Maori research paradigm was employed alongside other relevant qualitative methodologies.

Results

Four major findings emerged from the research: understandings of cultural measures vary; cultural identity and cultural affiliation change; Maori cultural identity is valued and regarded as a positive factor in mental health recovery; and understanding the experience and its meaning is extremely important.

Conclusion

Two sets of conclusions were drawn from the research. Firstly, cultural identity is an important factor in the mental health recovery process, and the recovery process itself can contribute to a secure cultural identity. And secondly, understanding mental illness has two dimensions: clinical; and personal. The clinical dimension is not necessarily perceived by Tangata Whai Ora as the most significant aid in a recovery journey, and personal understandings may be more significant. This paper will focus on the importance for practice, of understanding the experience of mental illness and its meaning for Tangata Whai Ora.

Abstract Number 100

The influence of organisational culture in collaborative health care

Penny Mitchell¹

¹The University of Melbourne

Abstract:

Intersectoral collaboration across health and social care is central to systemic reform efforts in several key areas including health promotion, prevention, and continuing care for individuals with complex and chronic conditions. Organisational factors are widely recognised as critical to the success of such reforms, yet little health services research has met the challenge of measuring proposed organisational constructs and testing their importance empirically. Research in the private sector has found organisational culture and climate to be important determinants of valued behaviours such as the adoption of innovation, quality, and safety measures. Several recent studies in the health sector found that organisational culture predicts providers' attitudes towards the uptake of evidence-based practice. Organisational

culture may also influence engagement in activity modifications involving intersectoral collaboration.

The particular values comprising a positive organisational culture are likely to vary across sectors, making valid measurement difficult in studies of intersectoral issues. This paper describes a study that examined the influence of organisational culture on collaboration around mental health care among a wide range of primary health and social care services. A novel method was employed whereby respondents worked as a group to complete a structured survey that collected quantitative and qualitative data simultaneously. Evidence from principal components analysis of quantitative data, and content analysis of qualitative data, combined to support the construct validity of the organisational culture measure across the diverse services involved. Organisational culture was directly related to organisational involvement in mental health care and moderated the effects of inter-organisational factors upon role involvement.

Abstract Number 101

Evaluation of an Australian national primary mental health care initiative

A/Prof. Jane Pirkis¹, **Bridget Bassilios**¹, **Justine Fletcher**¹, **Fay Kohn**¹, **Grant Blashki**¹, **Philip Burgess**²

¹University of Melbourne, ²University of Queensland

Abstract:

Objectives

Australia's primary care sector is a lynchpin in the delivery of mental health care. The Better Outcomes in Mental Health Care (BOiMHC) program is a national initiative that began in 2001 and is designed to better equip the primary care sector for this role. The Access to Allied Psychological Services (ATAPS) component of the BOiMHC program enables GPs to refer patients to allied health professionals (predominantly psychologists) for evidence-based care, via I I I projects being run by Divisions of General Practice. This presentation aims to report on some of the key findings from the ongoing evaluation of the ATAPS projects.

Methods

The evaluation has run in parallel to the ATAPS projects since they began. It has drawn on information from a number of data sources, including projects' local evaluation reports, a minimum dataset, several purpose-designed surveys, interviews and focus groups, and case studies.

Results

The ATAPS projects have been extremely well received by GPs and allied health professionals. The projects have delivered high quality care to a significant numbers of patients with depression and anxiety, many of whom may not previously have been able

to access such care for geographical or financial reasons. The projects are achieving positive outcomes for these patients in terms of reduced symptomatology, increased levels of functioning and improved quality of life.

Conclusion

The ATAPS projects are having a positive impact on a range of levels, and may provide some useful lessons for primary mental health care delivery in other countries.

**Tuesday December 4th
(11.00am - 12.30pm)**

Concurrent Sessions: Measurement and Methods for Health Services

Abstract Number 102

Evaluating functional status management according to best geriatric practice (BGP)

Lenore Beddoes¹, Professor Mari Botti¹, Professor Maxine Duke¹

¹Deakin University, Australia

Abstract:

Objectives

Hospitalisation, with or without surgery, can impact the health and functioning of older people. Over one-third of people aged 65+ years experience functional decline during episodes of acute care. Evidence suggests functional decline can be prevented using principles of BGP. Best geriatric practice involves consultation by a specialist geriatric team, early detection and prevention of complications, and promotion of independent functioning in activities of daily living. For BGP to be effective, these principles must be applied across the 24 hour acute care continuum.

The aim of this research program is to develop a model to evaluate and enhance functional status management for older patients admitted for acute medical conditions. The specific aim of this paper is to describe the process used to develop a framework of quality indicators to evaluate 24 hour care delivered to older acutely ill medical patients.

A literature search identified current BGP recommendations for the prevention of functional decline in older hospitalised patients. Identified recommendations were operationalised as quality indicators to evaluate care across the 24 hour continuum within this context to form a preliminary framework. This framework will be refined using case study design and a multimethod approach in a clinical setting in order to develop a model for evaluating current functional status management of older people in acute care. Additionally, barriers and facilitators of

independent functioning of older hospitalised patients will be identified. Measurement of these quality indicators will enable continuous practice improvement to promote independent functioning of older adults in acute care.

Abstract Number 103

Describing and Counting Health Interventions for Good Health Policy

Richard Madden¹, Albrecht Zaiss², Glen Thorsen³, Pierre Lewalle⁴, Birgit Krause², Susanne Hanser²

¹University of Sydney, ²University Hospital, Freiburg, ³Norwegian Centre for Health Informatics, ⁴World Health Organisation

Abstract:

Objectives

Health data is built on good health classifications. The International Classification of Diseases (ICD) has a 110 year history spanning 10 editions, and is modified to better reflect morbidity in national health systems. The International Classification of Functioning, Disability and Health (ICF) provides a framework for describing the several impacts of health conditions on body functioning and structures, and activities and participation, in the context of personal and environmental factors.

But there is no international classification of interventions. The result is multiple, inconsistent national classifications, with limited scope, which are expensive to maintain and do not allow international comparisons. Countries which cannot afford their own classification must adopt one from somewhere else, with no opportunity for local input. A focus on surgical interventions can lead to a devaluing of other interventions as data systems overlook them.

The WHO Network on Health Classifications (WHO-FIC) has initiated work on development of an international classification. The proposed structure will be presented. The scope covers all health interventions: surgical, medical, diagnostic, allied health, provision of assistance and public health. Options for coding systems will also be presented, building on best practice in national classifications, designed for stability over time while recognizing the rapid rate at which health interventions are developed and implemented. Capacity for international comparisons will be discussed.

Abstract Number 104

Issues in the quantification of health-related quality of life: The EQ-5D

Richard Norman¹, Paula Cronin¹, Rosalie Viney¹, Madeleine King¹, Deborah Street¹, Julie Ratcliffe², John Brazier²

¹University of Technology Sydney, Australia, ²University of Sheffield, Sheffield UK

Abstract:

Objectives

Generic multi-attribute utility tools such as the EQ-5D, SF-6D, HUI and AQoL attempt to value profiles of health, which can be used in economic evaluation. The advantage of these tools over disease-specific measures is that they allow comparison between interventions in different areas of health. The features of how these tools are constructed, and how information is gathered from the general population regarding the appraisal of health states is likely to affect the value we place on improvements in quality of life. The EQ-5D is a prominent example of these tools and, in investigating how different studies have valued the 243 health states described within it, it is possible to illustrate general points about quality of life valuation which may apply across all of these types of tools.

Methods

We searched the published and grey literature for existing studies valuing the EQ-5D states. We then undertook a structured review of the literature identifying issues in two areas: These were methodological differences between papers (and the likely implication of these on health state valuations) and methodological issues applicable across the school of studies.

Results

Ten articles were identified. Three key methodological issues between studies require consideration. These are the number of states that are directly valued by respondents (rather than estimated using an algorithm), the approach to valuing states considered to be worse than immediate death, and the variables considered within an algorithm. In addition to this, the use of time trade-off needs to be questioned as it artificially deflates health state valuations. Finally, potential alternative approaches to the TTO are discussed, in particular the use of discrete choice experiments.

Abstract Number 105

Application of discrete choice experiments to value multi-attribute health states for use in economic evaluation: Developing and piloting a discrete choice experiment

Paula Cronin¹, Richard Norman¹, A/Prof. Rosalie Viney¹, Dr. Madeleine King¹, A/Prof. Deborah Street¹, A/Prof. Julie Ratcliffe², A/Prof. John Brazier²

¹University of Technology Sydney, Australia, ²University of Sheffield, Sheffield UK

Abstract:

Objective

Health care resource allocation decisions are increasingly made on the basis of assessment or incremental cost-effectiveness ratios measured in terms of cost per additional quality adjusted life year (QALYs). QALYs adjust survival duration by a QALY weight that reflects the trade-off between quality of life and survival. As QALYs become more commonly used, there has been growing interest in the development of generic quality of life instruments known as multi-attribute utility instruments (MAUI), which allow QALY weights to be estimated for any health state that can be described by the MAUI. To date QALY weights have most commonly been obtained through rating scales, standard gamble and time trade-off experiments. These approaches impose a considerable data collection burden and require strong restrictions on individual preferences. Discrete choice experiments (DCEs) offer a potentially more flexible approach to do estimation of preferences for health outcomes and the trade-off between quality of life and survival for use in cost-utility analysis.

In this paper we review MAUI instruments (the EQ-5D and the SF-6D) and the methods that have been used to derive QALY weight for these instruments. We propose a new approach for estimation of QALY weights for the instruments based on use of DCEs that provide greater flexibility in testing the underlying model of preferences and reduce respondent burden. The paper describes the design and pilot study of a DCE to value multi-attribute health states for use in economic evaluation.

Methods

A questionnaire was designed to elicit preferences for hypothetical scenarios in which respondents were offered the choice between alternative health profiles each described as an EQ-5D health state and a survival duration. The pilot study was conducted using an online panel (n=200). In this paper we focus on issue related to the choice of health states to be included in the discrete choice experiment, in particular the trade-off between statistical efficiency and respondent burden.

Results and Conclusion

The results from the pilot study will be presented and the implications for the main study will be discussed. This research demonstrates that use of a DCE to obtain QALY weights is feasible and provides a potentially more flexible approach that allows for greater coverage of the response surface, more flexible functional forms and reduces respondent burden.

Abstract Number 106

Economic and Health Costs of Smoking in New Zealand

Des O'Dea¹

¹University of Otago Wellington

Abstract:

Objectives

This paper presents new estimates of the cost of smoking, from a recent report on tobacco taxation for the NZ Smokefree Coalition. The estimated 'economic' cost, for New Zealand in 2005 dollars, amounts to NZ\$1.7 billion. The 'health' cost is of the order of 82,000 QALYs, with total population 1.5 percent less than it would otherwise be because of smoking-caused premature mortality. The ways such information can be used are discussed, and the results compared with Australian estimates. Some of the technical issues involved in the estimation are also discussed. For instance whether a 'production loss' should be assigned to years of life lost for persons who would not be in paid employment, and whether a \$ value can usefully be placed on QALYs. The author's answer to both is negative.

**Tuesday December 4th
(11.00am - 12.30pm)**

Concurrent Sessions: Maternity Services

Abstract Number 107

The use of data linkage to examine substance use in pregnancy

Lucy Burns¹, Richard P. Mattick

¹National Drug and Alcohol Research Centre

Abstract:

Objectives

Linked population data is a method that addresses questions around substance use in pregnancy that cannot be answered by smaller scale clinical samples. This presentation will demonstrate this by examining three questions: (1) what are the neonatal impacts of substance use in pregnancy, (2) is long term

methadone maintenance beneficial to the neonate and (3) what are the common reasons for hospitalization by women who use methadone during pregnancy.

Methods

Antenatal and birth admissions from hospital data were linked to midwives information and the NSW Pharmaceutical Drugs of Addiction System.

Results

(1) Women who used substances during pregnancy presented later in their pregnancy to antenatal services and were more likely to arrive at hospital unbooked. Neonates born to these women were more likely to be premature, and were admitted to neonatal intensive care and special care nursery more often. (2) Compared to mothers who were maintained continuously on methadone throughout pregnancy, those who entered methadone treatment late also presented later to antenatal services and were more likely to arrive at hospital for delivery unbooked. A higher proportion of neonates born to late entrants were premature and admitted to care more often. (3) Women on methadone during pregnancy showed increased rates of hospital admissions for trauma, poisonings, skin and respiratory conditions, relative to the non-drug using population.

Conclusions

Linked population level administrative data is a powerful method of examining policy questions around the prevalence and impact of drug use in pregnancy.

Abstract Number 108

Recurrence of postpartum haemorrhage in consecutive pregnancies, New South Wales

Dr. Jane Ford¹, Dr. Christine Roberts¹, Jane Bell¹, Charles Algert¹, Professor Jonathan Morris¹

¹University of Sydney

Abstract:

Objectives

Postpartum haemorrhage (excessive bleeding post-childbirth) is one of the leading causes of maternal mortality. Postpartum haemorrhage (PPH) may arise de novo in any pregnancy and may recur in a subsequent pregnancy. Previous studies have reported an increased risk of PPH with a previous occurrence, however these studies relied on self-report of previous PPH status, were hospital based, involved small numbers and ignored parity.

Aim

Determine population-based rates of occurrence and recurrence of postpartum haemorrhage.

Methods

Data were from linked birth and hospital separation datasets and included 125,925 women having at least two consecutive singleton pregnancies in New South Wales, Australia over the period 1994 to 2002. PPH included any blood loss of ≥ 500 mls after vaginal delivery or ≥ 750 mls after caesarean delivery as identified by a clinician and reported in the hospital data.

Results

Six percent of women had a PPH in their first pregnancy, 4.5% had a first PPH in their subsequent pregnancy. Among those women that had three pregnancies in the study period, 4.4% (908/20839) had a first PPH in their 3rd pregnancy. The rate of recurrence in a second consecutive pregnancy was 14.8%, in a third consecutive pregnancy (after two previous PPHs) was 21.7% (43/198) and even with an intervening non-PPH pregnancy was 10.2% (111/1085).

Conclusion

These consistently elevated recurrence rates highlight the need for women with a history of PPH to have an active management of the third stage of labour and give birth in a hospital that has on-site cross-match facilities.

Abstract Number 109

Validation of reporting of maternal medical conditions in hospital discharge data

Dr. Ruth M. Hadfield¹, Samantha Lain¹, Carolyn Cameron¹, Jane Bell¹, Dr. Christine L. Roberts¹

¹Perinatal Research, The Kolling Institute of Medical Research, University of Sydney

Abstract:

Objectives

Linked population health data sets are a valuable source of data for studying health outcomes however their validity has not been thoroughly examined. The coding of maternal medical conditions is of particular interest for monitoring the health of mothers and assessing the quality of maternity care. In this study, we aimed to determine the accuracy and reliability of reporting of pre-existing maternal medical conditions affecting pregnancy.

Methods

We identified 2229 women from the 2002 linked NSW birth-hospital discharge data with a major morbidity during childbirth. A random sample of hospital records from 400 of these patients was compared to a random sample of 800 patients without a recorded severe morbidity. The hospital records for these women were reviewed for any evidence of pre-existing medical conditions and used as a 'gold standard' for comparison to the hospital discharge data. Values from the sample were extrapolated to the entire population to estimate the sensitivity (Sn) and specificity (Sp) of identification in the linked data.

Results

Maternal conditions affecting the delivery hospital admission included: chronic or pre-existing hypertension (Sn 45.6; Sp 99.5), pre-existing diabetes (Sn 100; Sp 100), thyroid disease (Sn 96.6; Sp 99.7), renal conditions (Sn 47.0; Sp 100.0), cardiac conditions (Sn 22.9; Sp 100) and lung diseases (excluding chronic asthma) (Sn 7.2; Sp 99.1).

Conclusion

There is a tendency towards under-reporting of maternal medical conditions in NSW hospital discharge data. Although sensitivity is quite variable, specificity is uniformly high for all conditions investigated, indicating that false positives in the linked data are rare.

Abstract Number 110

Are babies with antenatally identifiable congenital anomalies born in hospitals with co-located paediatric surgical units?

Charles Algert¹, Christine Roberts¹, Jennifer Bowen², Ruth Hadfield¹, Emily Olive³, Jonathan Morris¹

¹University of Sydney, ²Royal North Shore Hospital, Sydney, ³Royal Women's Hospital, Melbourne

Abstract:

Objectives

Health policy dictates that infants diagnosed antenatally with severe but potentially correctable anomalies, such as spina bifida, should be delivered at a hospital with a co-located paediatric surgical unit. The aim of this study was to determine what proportion of livebirths with selected, potentially-correctable anomalies were delivered at obstetric hospitals with co-located surgical units, and how many got a repair procedure.

Methods

The linked NSW Admitted Patient Data Collection provided records on 250,000 births for the years 2001-2003. Live-born infants with selected anomalies were included if they underwent a repair procedure or died during the twelve months after birth. Infants with multiple severe anomalies were excluded from the analysis.

Results

Anomalies with the highest proportions delivered at a co-located hospital were gastroschisis (85%) and exomphalos (73%), diaphragmatic hernia (66%), spina bifida (65%), tracheo-oesophageal atresia (47%) and transposition of the great arteries (44%). The rates were similar for urban and rural women. There were 296 liveborn infants in the analysis, of whom 90% got a repair procedure, and 91% of these were alive at 6 months. Infants with diaphragmatic hernias born at a co-located hospital had a survival rate of only 47% compared to those born elsewhere.

Conclusion

The proportions delivered at co-located hospitals probably reflect the rates of antenatal diagnosis for these conditions and indicate a high level of compliance with the health policy. Survival rates were generally high among the liveborn infants selected for repair surgery. Antenatal diagnosis of diaphragmatic hernia may be an indicator of severity and poor prognosis.

**Tuesday December 4th
(1.30pm - 3.00pm)**

Concurrent Sessions: Round Table

**Abstract Numbers III — III5:
Round Table**

Abstract Number III

**Data Linkage - a burgeoning resource
for health services research**

**Dr. Mary Haines¹, Professor Sally Redman¹,
Professor Louisa Jorm¹**

¹The Sax Institute

Abstract:

Objectives

Australia is well placed to be a world leader in health services research using linked data because of the availability of population-based databases that cover most elements of the health system, its favourable policy and legislative environment, and its existing foci of research excellence. Research using linked data is cost-effective compared with performing de novo longitudinal studies and other more traditional approaches; it generates a research return on the substantial existing investment in health information systems.

The aim of this session is to explore the emerging opportunities for using linked routine databases for health services research, and to encourage researchers and policy makers to exploit these burgeoning resources for research.

The session will commence with presentations outlining how the Western Australian Data Linkage System has supported internationally acclaimed health services research and new research that has been made possible through linkage with the Pharmaceutical Benefits Scheme and Medical Benefits Scheme databases. These will be followed by presentations describing emerging possibilities for research through the new Centre for Health Record Linkage, which provides data linkage services for NSW and the ACT, and developments at the Australian national level through the National Collaborative Research Infrastructure Strategy. A panel discussion, focusing on key opportunities for health services research, will conclude the session.

Results

A greater understanding of the most recent developments in data linkage, the potential for using linked routine databases to generate world class health services research, and of possibilities for forming new research collaborations.

Abstract Number III2

**Population-based evaluation: the use
of record linkage for health services
research**

Professor James B Semmens¹

¹Curtin University of Technology Western Australia

Abstract:

Objectives

Record linkage of health service data to allow the development of models to evaluate health service outcomes, particularly at the population level, is a priority in Australia and internationally. The Western Australian Data Linkage System (WADLS) is unique in Australia and brings together around 20 million records from more than 30 population-based state and national health datasets. Record linkage is performed using probabilistic matching and is continuously updated as new data becomes available. It has been used to support public health surveillance, aetiological and primary prevention research, studies of the utilisation, adverse effects and patient outcomes of health and mental health care services.

Methods

The WADLS has now been used in over 350 distinct health related studies including the assessment of trends and outcomes of patients receiving surgical care; a study of travellers' thrombosis in passengers arriving on international flights; the physical status of mental health patients; and long-term health outcomes for prisoners after their release.

Results

The benefits of data linkage have included cost-efficiency of research; adding value to existing information assets; conservation of patient privacy; healthcare utilisation for chronic disease management; established benchmark standards for surgical care in a variety of specialties; and improvements in patient safety and population-health.

Conclusion

Dissemination of outcomes have translated to changes in clinical care, improvements in patient outcomes and influenced health policy. Concerns regarding governance, ethics, patient privacy have been addressed. It is contributing to the national strategy to promote record linkage nationally and internationally.

Abstract Number 113

Novel approaches to health services research using cross-jurisdictional medical record linkage

Dr. Rachael Moorin¹, Dr. David Preen¹

¹The University of Western Australia

Abstract:

Objectives

The WA Data Linkage System, established in 1995, provides a powerful resource for whole-population health services research within an Australian setting. It combines seven core State health datasets linkable to >30 external databases. Links have also been established with Commonwealth Medicare, PBS and aged-care data.

The UWA School of Population Health is currently utilising cross-jurisdictional (i.e. Commonwealth and State) health record linkage to study issues of national priority using unique epidemiological and biostatistical methodology. Areas of focus include: i) medication safety and adverse drug reactions, ii) primary care management of chronic disease, iii) assisted reproductive technology, iv) health effects of social inequality, v) economic burden of illness and injury, and v) national policy evaluation. Projects are large in scope, requiring extraction of linked Medicare, PBS, inpatient and death data (combined with other external linkages) for samples of 100,000 – 500,000 patients (150-300 million records) over 15-20 years of observation.

This presentation will outline currently ongoing work, in addition to future plans to investigate areas of public health significance using cross-jurisdictional record linkage.

Abstract Number 114

The Centre for Health Record Linkage: record linkage services for NSW and the ACT

Dr. Lee Taylor¹

¹NSW Department of Health

Abstract:

Background

The NSW Department of Health has carried out linkage of health-related databases since 1994 for health and health services research.

Perspective

There are substantial benefits in record linkage for health services research. Record linkage supports population-based studies; a range of study designs; is cost-effective; can be used to test and develop hypotheses for future studies; and boosts research productivity. The Centre for Health Record Linkage (CHeReL) was established in 2006 as a joint initiative of: ACT Health, the Cancer Institute NSW, the Clinical Excellence Commission, NSW Department of Health,

the Sax Institute, the University of Newcastle, the University of NSW and the University of Sydney. The Cancer Institute NSW is the host organisation for the CHeReL.

Viewpoint

The benefits of health record linkage are currently available through the Western Australian Data Linkage Unit and the CHeReL, which in combination cover 45% of the Australian population.

Abstract Number 115

Emerging national infrastructure for research using linked health datasets

Louisa Jorm^{1,2}

¹University of Western Sydney, ²The Sax Institute

Abstract:

Objectives

The Australian National Collaborative Research Infrastructure Strategy (NCRIS) is supporting the development of research infrastructure in selected priority areas, including population health and clinical data linkage. Over the past year, NCRIS has overseen the development of an investment plan for this capability.

This presentation will describe the current status of the NCRIS data linkage capability, and the opportunities that it presents for health services research.

Building a national capability for research using linked health data requires investment in structures and frameworks for governance, privacy, ethics and community involvement; information technology and information management; data sets and metadata; methods and tools for data linkage and analysis of linked datasets; and, perhaps most critically, human capacity to use these datasets for research. Health services research is a key application for the large, national, population-based datasets that will become more readily available as a result of the investment by NCRIS.

**Tuesday December 4th
(1.30pm - 3.00pm)**

Concurrent Sessions: Purchasing and Payment Systems for Primary Health Care

Abstract Number 116

Impact of user charges on GP access for injuries

Jean-Pierre de Raad¹, John Stephenson¹

¹NZIER

Abstract:

Objectives

During 2005/2006 ACC paid GPs in six pilot sites \$10 more per GP consultation than GPs in other parts of the country. We assessed whether the increase in subsidy reduced user charges, and whether that led people with injuries to use GPs more.

We used data from regular nationwide co-payment surveys conducted for ACC to test for statistically significant changes in user charges. We used ACC claims data to test whether GP visits for injuries increased in pilot sites, using econometric time-series methods.

We found evidence of a 41% decrease in user charges in the pilot sites. We also found evidence of a 3% increase in GP visits in pilot sites that can be attributed to the reduced user charges.

We conclude that people's use of GP services is not very price responsive. Our estimate (0.07) is at the lower end of those reported in the literature. Responsiveness is greater for Maori, for Pacific people, and low socio-economic groups. The evidence for the latter two groups is weaker. We also find some evidence of substitution between services. The main effect of raising the subsidy payment is to transfer money from taxpayers to claimants, with little impact on the objective of raising utilisation of vulnerable groups. The scale and design of this study make these findings important to health researchers and health policy makers in New Zealand and abroad.

Abstract Number 117

Changes in a PCTs purchasing activity in the NHS post tariff

Dr. Stephen Conaty¹, Dr. Nkechi Agbala², Dr. Eva Carneiro¹

¹Islington Primary Care Trust, ²Royal Free Hospital

Abstract:

Objectives

Since April 2005, faced with fixed unit activity costs in the hospital sector (tariffs), Primary Care Trusts in England have moved rapidly to saving through controlling demand or shifting

provision to primary care and community care. Growth of multiple small schemes is changing the relationship between primary and secondary care. Here we outline two examples with evaluation data from an inner-London Primary Care Trust (Islington): a redirection scheme from a local emergency department for minor ailments, and a paper-based referral triage system for musculoskeletal conditions. Both were high priority schemes commenced in the 2006-7 financial year and featured in the Trust's operating plans. We will also mention other examples.

Methods

We collected descriptive and routine activity and process data and assembled patient and practitioner views through a mix of questionnaires and interviews (May to July 2007).

Results

The redirection scheme relied on a PCT funded nurse redirecting ambulatory patients presenting with pre-defined minor conditions to self, primary or community care. Approximately 3-5% of attendances were redirected instead of the planned 20%, mainly due to restrictive protocol, operational problems and some staff resistance; some patients viewed the experience negatively. The paper-based musculoskeletal triage scheme was highly successful in redirecting referrals to physiotherapy and podiatry rather than secondary care with a 7-9% fall in outpatient activity in local Trusts in relevant specialties. However, it was viewed with hostility by some general practitioners.

Conclusion

Both these schemes delivered smaller changes in activity than were anticipated. Practitioner resistance raised questions of sustainability.

Abstract Number 118

National Quality and Performance System for Australian Divisions of General Practice: Early Reflections

Karen Gardner¹, Dr. Beverly Sibthorpe¹

¹Australian Primary Health Care Research Institute

Abstract:

Objectives

Two approaches to performance management in health care have been described – assurance systems that use summative information for external accountability and internally driven systems that use formative information for continuous quality improvement (CQI). Australia recently introduced a National Quality and Performance System for Divisions of General Practice (NQPS) with the dual purposes of increasing accountability and improving performance, the latter explicitly based on CQI. The system is examined in terms of four factors known to affect quality improvement – 1. Having clear objectives; 2. Stakeholder engagement in development; 3. Type of data collected and approach to analysis; 4. Feedback.

Methods

Involvement in the development of the NQPS and interviews with Chief Executive Officers (CEOs) of Divisions.

Results

1. Performance information is collected against objectives defined during system development.
2. A consultative process greatly influenced system development but could be further utilised.
3. Data includes a mix of qualitative and quantitative indicators fitted to a coherent conceptual framework. Approach – including use of points – has not yet been fully decided but capture of contextual information could aid interpretation.
4. Feedback system has not yet been fully developed – either at the individual Division or sector levels. Whether a more qualitative approach or more points based system linked to rewards and sanction is used is yet to be determined.

Conclusion

The system shows promise because of 1, and aspects of 2 and 3. Decisions yet to be made about remaining issues will influence the extent to which the system is weighted in favour of CQI.

Abstract Number 119

Pay for performance in general practice: What we can learn from the United Kingdom

Verna Smith¹

¹ACC

Abstract:

Objectives

A new General Medical Services contract was implemented in England in 2004, incorporating a quality and outcomes framework which incentivised performance in general practice. In New Zealand a small set of targets for population based health improvements, and accompanying incentive payments, were introduced to Primary Health Organisations in 2006.

This research is comparing the performance of England and New Zealand in introducing these pay-for-performance schemes. The level of uptake and achievement of the English scheme has been high while the New Zealand scheme has not achieved an equivalent integration of the interests of clinical, management and funder stakeholders. The study has explored the extent to which the literature has informed the process of policy design. It will also assess the extent to which the paradigms for policy design (rationalist, stakeholder, participatory and neo-liberal) set out by Davis and Ashton (2000) are evidenced in the two case studies and whether these models have provided an adequate framework for observing and evaluating the actions of decision makers in both countries.

Methods

This is the report of qualitative research and the approach is one of grounded theory. The findings from the first phase of data collection (semi-structured interviews with key participants in the two policy design and implementation processes) will be presented. The English scheme has the character of a critical case which yields rich information and has great impact on the development of knowledge.

The extent to which known barriers to the effectiveness of pay for performance schemes have not been overcome in either England or New Zealand will be presented and assessment made of the extent to which these were explicitly identified and traded-off in the design phase so as to maximize chances of success in each initiative. The extent to which these barriers are overcome by iterative development of the initiatives will be hypothesised. Utilizing the evidence, the research will seek to predict best practice approaches to the design and implementation of pay-for-performance schemes.

**Tuesday December 4th
(1.30pm - 3.00pm)**

Concurrent Sessions: Chronic Care Management

Abstract Number 120

Development of a multidisciplinary, community based, integrated primary-tertiary level diabetes service

Dr. Deborah Askew¹, A/Prof. Anthony Russell², Professor Claire Jackson¹, A/Prof. Jenny Doust¹, Dr. John Prins², Dr. Clare Maher¹, Dr. Ian Scott², Pat Matthews³, Deborah Miller³

¹University of Queensland, ²Princess Alexandra Hospital, ³Queensland Health

Abstract:

Objectives

In 2004/05, at least 850,000 Australians, 25 years or older, had been diagnosed with Type 2 Diabetes Mellitus (DM), with associated risks of micro and macro-vascular diseases. We report the development (and proposed evaluation plan) of an innovative, multidisciplinary, community based, integrated primary-tertiary diabetes service in a disadvantaged multicultural outer suburb of Brisbane aiming to improve health outcomes and quality of life.

Methods

Each patient will be triaged using evidence-based protocols to determine their individual clinical, allied health and lifestyle requirements. An appropriate mix of allied health professionals and a GP with advanced diabetes management skills will develop

individualised care plans. An endocrinologist will review and endorse the proposed care plan for each patient. Referring GPs can co-consult with the endocrinologist and participate in an upskilling program.

We will use an interrupted time-series and geographical control to evaluate the service by comparing the following outcomes: clinical (HbA1c, BP, lipid status); health service delivery/efficiency (patient access to specialist services, skill acquisition, cost-effectiveness of care); patient-related (quality of life; satisfaction; diabetes self efficacy).

Conclusion

To date, a strong collaborative relationship has been developed between representatives of primary and tertiary care. Whilst the intervention is being piloted in diabetes, the model is scalable to serve other chronic disease populations. It also provides a useful case study in effective collaboration between researchers, clinicians and policy makers in the primary and tertiary care sectors.

Abstract Number 121

Effects of Chronic Care Model oriented interventions on diabetes care: a systematic review

Dr. Damin Si¹, Ross Bailie¹, Tarun Weeramanthri²

¹Charles Darwin University, NT, ²Australia, Department of Health and Community Services, NT, Australia

Abstract:

Objectives

The Chronic Care Model (CCM) has been widely used in a variety of health care settings to guide system improvement for chronic illness care, including diabetes care. However, evidence base for the specific components of the model has not been systematically reviewed. This review aimed at examining the extent to which interventions featuring the CCM components improve diabetes care and determining relative effectiveness of different CCM components.

Methods

We systematically searched MEDLINE (1966 to December 2004), the Cochrane Effective Practice and Organisation of Care and the Cochrane Controlled Trials Register, to identify interventions featuring one or more system components of the CCM for diabetes care. Outcome measures included HbA1c, blood pressure and blood lipid control.

Results

69 studies (43 randomised controlled trials and 26 controlled before-after studies) met inclusion criteria and were included in this review. Overall, included trials reported a mean reduction of 0.46% (95% CI 0.38%, 0.54%) in HbA1c, mean reduction of 2.2 mmHg (95% CI 0.9, 3.5) in systolic blood pressure, mean reduction of 1.3

mmHg (95% CI 0.6, 2.1) in diastolic blood pressure, and mean reduction of 0.24 mmol/L (95% CI 0.06, 0.41) in total cholesterol. For specific CCM components, interventions addressing delivery system design reported the largest improvements in patient outcomes, followed by those employing a self-management support component. Interventions involving decision support or clinical information systems reported relatively smaller effect sizes.

Conclusion

Interventions featuring CCM components produced small-to-moderate improvements in HbA1c control, but had limited effects on blood pressure and lipid control among diabetes patients.

Abstract Number 122

Evaluation of an integrated chronic care management program

Dr. Peter Carswell¹

¹University of Auckland

Abstract:

Objectives

The Counties Manukau District Health Board chronic care management program is intended to improve the clinical outcomes for patients enrolled in the programs for diabetes (n=9118), chronic heart failure (n=419), cardiovascular disease (n=841), and chronic obstructive pulmonary disease (n=506). This paper reports on an external evaluation of the program. One aspect of the evaluation required collecting data on relevant clinical outcomes that had been gathered over the preceding five years. Another aspect of the evaluation was a series of semi structured interviews with a range of health professionals in the primary care sector, who had responsibilities for growing and delivering the program. Analysis of the quantitative data show that the clinical outcomes are similar to other international evaluations of chronic care management programs. One issue identified is the level of engagement from both patients and practitioners. While the number of enrolments is increasing exponentially, the subsequent level of engagement from patients is significantly less. Qualitative data suggests that a number of practices are losing energy and motivation in the CCM programme because of difficulties with prioritising time, accessing appropriate workforce, problems with IT issues, and not receiving payment in a timely manner. Those who are actively engaged with the program are doing so because of a belief in the philosophy of the program. This belief means that the practitioners are putting in considerable extra effort to overcome problems in program implementation. It is in these practices that there is evidence of change in practice to respond to the demands of the programme, and the needs of their patients.

Abstract Number 123

Chronic disease management: improving general practice performance in five countries

Professor James A Dunbar¹, Professor Prasuna Reddy¹, Dr. Adrian Schoo¹

¹Flinders and Deakin Universities

Abstract:

Objectives

Chronic disease management (CDM) refers to interventions designed to manage or prevent a chronic condition using a systematic approach to care, potentially by employing multiple treatments and delivered by several disciplines. This study investigated CDM in general practice across countries with differing service provision.

Method

Data were gathered for a metanarrative systematic review funded by APHCRI as part of the Stream Six – Workforce. In addition to searching electronic databases, a series of key informant interviews were conducted in Australia, Canada, Netherlands, New Zealand, and the United Kingdom. Narratives were compiled of the levers and incentives to improve CDM over the past decade.

Results

In each of the countries, different combinations of remuneration packages, including performance based, have been used. There have been differing levels of incentive to develop CDM teams including nurses, and differing levels of investment in change management at practice or supra-practice organisational level (e.g. divisions of general practice or PHOs). The influence of patients on the system varies from country to country. In four countries, collaboratives have made substantial improvements in measures of CDM. Randomised control trials and a systematic review provide evidence of their effectiveness.

Conclusion

Currently no country has a deliberate approach to organisational development in general practice (i.e. a set of behavioural science theories, values, strategies, and techniques aimed at the planned change of organisational performance). This paper identifies a number of interesting initiatives which could contribute to strengthening the Australian GP workforce to improve performance in chronic disease management.

**Tuesday December 4th
(1.30pm - 3.00pm)**

Concurrent Sessions: Round Table

Abstract Numbers 124 — 127: Round Table

Abstract Number 124

The need for and challenges of developing post-graduate courses in Health Services Research for Australia and New Zealand

Marion Haas¹, Terri Green², Jackie Cumming³

¹Centre for Health Economics Research and Evaluation (CHERE), Sydney, NSW, Australia, ²University of Canterbury, ³Victoria University of Wellington

Abstract:

Objectives

Many institutions in the USA and the UK as well as some in Europe offer specific post-graduate courses aimed at training health services researchers. Whilst the subjects studied differ and the overall emphasis varies, most subjects are similar to those offered in many Australian and New Zealand universities in postgraduate courses in public health, clinical epidemiology or policy analysis. Therefore, it is possible that the skills and expertise are available in Australia and/or NZ to offer a specialized postgraduate course in HSR. What we do not know is whether there is a demand for such a course and what the ideal components would be. The aim of this round table discussion is to begin to answer these questions. If the discussion produces sufficient interest in the development of such a course, a series of recommendations about further investigation of the demand and the way in which the development of such a course should proceed.

Abstract Number 125

HSR specific post graduate courses: what do they look like?

Marion Haas¹

¹CHERE, University of Technology

Abstract:

The definition of HSR indicates that a broad range of skills and expertise is needed for researchers in this area. The types of subjects offered in post graduate HSR courses in Europe and the USA will be compared with those available in Australia and NZ as part of MPH and similar courses. The “core” subjects will be discussed in terms of their appropriateness for HSR. Marion Haas teaches some HSR-related subjects at UTS.

Abstract Number 126

The benefits of specific HSR qualifications

Terri Green¹

¹University of Canterbury

Abstract:

Objectives

It is tempting to assume that quantitative researchers can easily apply their skills to health services research. The aim of this presentation is to identify the benefits of a dedicated health services qualification when undertaking quantitative health services research. Each stage of the research process is examined including project scoping, data collection, analysis and interpretation of results. Common pitfalls for newcomers to quantitative research in health services are also identified. From this a preliminary list of potential required skills is compiled.

Abstract Number 127

Developing capacity and capability in health services research

Dr. Jacqueline Cumming¹

¹Health Services Research Centre

Abstract:

Dr. Cumming has spent 14 years working at the Health Services Research Centre at Victoria University, six of those years as Director. In this presentation, she will discuss the challenges and issues which have arisen in building capacity and capability in health services research in New Zealand and the benefits she sees of a focused qualification in this area. She will also discuss the challenges with the current funding environment and in association with Professor Claudia Scott draw on the experience of the Australia New Zealand School of Government in running courses across the two countries.

**Tuesday December 4th
(1.30pm - 3.00pm)**

Concurrent Sessions: Identifying Service Needs

Abstract Number 128

Rehabilitation for NZ Burn Patients: Exploring psychosocial outcomes and unmet needs

Dr. Jeanne Reeve¹, Dr. Frances James², Dr. Linda Cameron¹, Dr. Paul Brown¹, Dr. Rob McNeill¹, Lana Jago¹, Stephen Mills²

¹University of Auckland, Auckland, ²Middlemore Hospital

Abstract:

Objectives

Research in the UK and elsewhere has provided evidence that the psychosocial rehabilitation of people with disfiguring injuries such as burns can be a long and difficult process which they often face with insufficient ongoing support. The purpose of this study was to explore the experiences and health services use of burn patients in New Zealand in order to shed some light on the recovery process and the unmet health needs of patients with who are returned to the community after suffering a serious burn.

Methods

Participants (50 burn patients who were at least a year post discharge) completed a questionnaire. The questionnaire comprised a variety of standard measures (e.g. Burn specific health scale and HADS) plus a range of questions exploring changes to living conditions and health service usage.

Results

The results highlight the differences between participants in psychosocial outcomes and access to health services. The findings also identify the areas of particular need and explore the relationship between health and psychosocial outcomes and health service usage.

Conclusion

The study provides information to assist in the tailoring and provision of appropriate services to maximise the potential for positive rehabilitation outcomes.

Abstract Number 129

Support Needs And Health Service Use In Gynaecologic Cancer

Lisa Walton¹, Paul Brown¹, Jeanne Reeve¹,
Cynthia Farquhar¹

¹University of Auckland

Abstract:

Objective

Annual Conference presentations 2004-2007 inclusive Australasian Society of Behavioural Health and Medicine (ASBHM). Topics: Breast cancer patient decision making, Gynaecologic Cancer support needs University Inter-Departmental presentations 2004-2007. Session presenter and organising Committee member ANZSPM Hospice and Palliative Care Conference, Auckland, 2004

Effective psychosocial care from health services is a pre-requisite of quality cancer care (Cancer Control Strategy, 2003). Little is known about the support needs and health service use of gynaecologic cancer patients in New Zealand. Evidence from the authors' preliminary qualitative study with women (n=28) at various stages in the cancer trajectory indicates there are issues with continuity of care, particularly in survivorship. After treatment finishes, new needs may emerge, or become more salient. At the same time there is decreased access to specialist cancer care and a move towards community support services and primary healthcare. The aim of the present study is to (a) identify survivors' information and support needs across quality of life domains (2) uncover personal and environmental barriers that inhibit access to support; and (3) examine patterns of health care use. A structured telephone survey currently is being undertaken with a clinically and demographically representative sample of survivors (n~200). Women are eligible if they have finished treatment for a first incidence or recurrence of any gynaecologic cancer. Findings will provide information about the care pathway with potential for delivery of integrated psychosocial care for both survivors and future patients diagnosed with gynaecologic cancer. This research project is being conducted with the Auckland regional gynaecology oncology service. A reference group has been formed comprising gynaecologists, oncologists, specialist nurses, psychologists and Cancer Society representatives, and the authors. The first author LW is supported by a Cancer Society Training scholarship.

Abstract Number 130

Economic evaluation of the treatment of obstructive sleep apnoea syndrome

Helen Scott¹

¹Scott Economics

Abstracts:

Objectives

Some sleep disorders lead to serious consequences for society in the form of increased morbidity and accidents. The aim of this study was to improve the information available on obstructive sleep apnoea syndrome (OSAS) for both clinical and policy decision-makers.

Methods

An outcome tree and decision analytic model for OSAS were constructed and used to estimate base case costs. Sensitivity analysis using Monte Carlo methods was undertaken.

Results

The total base case societal costs of OSAS are \$40 million or \$419 per case. The incremental net cost of treating OSAS is \$389 per case treated. Incremental net direct medical cost per QALY gained (when OSAS is successfully treated) is \$94. For 90% of the 10,000 Monte Carlo iterations the total societal cost of treated and untreated OSAS ranged between \$33 million and \$90 million, the net incremental cost of treatment per case ranged between \$338 and \$427, and the net direct medical cost per QALY gained ranged between \$56 and \$310.

Conclusion

This study is the first in New Zealand to attempt to quantify the costs of OSAS and to provide a tool that can be used to investigate treatment options and the impact of sleep disorders on various population groups. As accidents generate 59% of the total costs efforts should be made to reduce this rate.

Abstract Number 131

Cost of health services for older people: Comparing the MDS-HC and NSAC assessment tools

Dr. Paul Brown¹, Laura Wilkinson-Meyers¹, Dr. Rob McNeill¹, Dr. Matthew Parsons¹, Kate Weidenbohm¹, Theo Brandt¹

¹University of Auckland

Abstract:

Objectives

For older people to receive appropriate health services, health funders need an assessment tool that correctly identifies unmet needs. Many DHBs in New Zealand are adopting the MDS-HC, but little is known about how the MDS-HC differs from the current tool (NASC). The purpose of this study was to compare

the health services recommended and delivered for older people under each assessment tool. As part of the Tauranga Older Person Comprehensive Assessment Trial (TOPCAT) (randomised controlled study of 316 participants), assessors were asked to indicate the health services that were recommended. Data on health service usage four months post assessment was analysed to identify differences in service delivery. The results suggest slight differences in some categories of recommended and delivered services (e.g. home help) and the MDS-HC resulted in additional services being recommended (e.g. mammography) but often not delivered. Overall, the cost of recommended services for clients who had an MDS-HC assessment was slightly higher for older people assessed with the MDS-HC (\$1,699) than with the NASC (\$1,674), with expected personal health costs tending to be higher under the MDS-HC assessment than the NASC but disability support services slightly lower. This pattern was evident for both high and low needs clients. Taken together, the results suggest health services usage and cost associated with the MDS-HC assessment were similar to the cost of the NASC, but there were differences in the pattern of health service delivery. This applicability of these results to other District Health Boards is discussed.

**Wednesday December 5th
(8.30am - 10.00am)**

**Concurrent Sessions: Issues in
Primary Health Care**

Abstract Number 132

Primary health care reform in New Zealand: Are fees falling and are consultation rates rising?

Dr. Jacqueline Cumming¹

¹Victoria University of Wellington

Abstract:

Objectives

The New Zealand government introduced the Primary Health Care Strategy in 2001, with the aim of improving health status and reducing inequalities in health. New funding has been provided to increase the payments providers receive for delivering care and to provide subsidised care to all New Zealanders. It is expected that the fees that patients pay when using services will fall and that consultation rates in primary health care will increase as a result of falling fees and the provision of new funding for new services. This paper provides an analysis of findings from quantitative analyses of data from New Zealand general practices about the changes in fees and the changes in consultation rates which have occurred since the introduction of the Strategy.

Methods

Data were collected from 99 randomly selected general practices from around New Zealand. Descriptive statistical methods were used to analyse the data.

Results

The presentation will focus on the changes in fees and consultation rates which have occurred since the introduction of the Strategy. The presentation will analyse the changes for different population groups in New Zealand.

Conclusion

The Strategy has resulted in reductions in fees and increases in consultation rates over the past few years for many groups in the New Zealand population. The findings will be discussed in terms of the government's policy aims of reducing fees, increasing consultation rates and reducing inequalities in health.

Abstract Number 133

The state and primary health care in New Zealand: shifting boundaries

Judith Smith¹, Peter Crampton², Jackie Cumming¹, Nicholas Mays¹

¹Health Services Research Centre, ²University of Otago, Wellington

Abstract:

Objectives

New Zealand has made an explicit commitment to developing its primary health care system in line with the principles of Alma Ata (WHO, 1978) whereby primary health care is viewed as fundamental to improving health, developing communities, and reducing inequalities. There is however a history of different primary health care ownership arrangements within New Zealand, the two main models being community-governed/ownership and private/proprietary ownership. These models represent two very different approaches to how the state relates to primary health care providers. In this paper we analyse the relationship between the state and primary care providers in New Zealand using the following framework:

- 1 determining what policy objectives New Zealand is trying to achieve in respect of its primary health care system;
- 1 exploring the past, current and evolving relationship between the state and primary health care provider organisations in New Zealand, focusing on models of ownership and approaches to funding;
- 1 examining the different organisational options potentially available to the New Zealand government in seeking to achieve its primary health care policy objectives in the future; and
- 1 determining what each of these options might entail for the evolving relationship between public funders and private providers of primary health care.

Conclusion

We conclude our analysis by setting out a series of policy options for the New Zealand Government in relation to the future organisation of primary health care, making clear the advantages and disadvantages of each option, and outlining the implications for the state, providers, and the public.

Abstract Number 134

Self-Determination and Indigenous primary health care services: a cross-national analysis

Dr. Josée G. Lavoie¹,

¹University of Northern British Columbia, Canada

Abstract:

Objectives

This paper is concerned with the emergence indigenous primary health care organisations in Australia, New Zealand and Canada. In Canada, First Nations primary health care services are a result of the Health Transfer Policy. In Australia, Aboriginal Community Controlled Health services first appeared in the 1970s as a result of community mobilization, aiming to provide some access to free health care to Aboriginal people. In New Zealand, Maori providers emerged as a result of the market-like conditions implemented in the 1990s. Although national policies promote indigenous engagement as the mechanism to address health inequalities, an analysis of the contractual environment that emerged as a result of these policies suggests instead that the contractual environment limits opportunities to achieve health gains. This presentation concludes by proposing a framework for evaluating contractual environment's performance.

Abstract Number 135

PHC care coordination: what is needed?

Gawaine Powell Davies¹, Anna Williams¹, Karen Larsen¹, David Perkins¹, Mark Harris¹, Martin Roland²

¹University of New South Wales, ²National Centre for Primary Care Research and Development, Manchester, UK

Abstract:

Objectives

Coordinating chronic and complex care is an increasingly important role for primary health care. Through a systematic review we identified the main strategies used to coordinate care at the patient/provider level and assessed their effectiveness in relation to patient satisfaction, health and economic outcomes.

Methods

We analysed 85 experimental studies involving coordination of care within PHC or between PHC and other services, in Australia, UK, US, Canada and the Netherlands. Major focuses included mental health, chronic disease care, aged and palliative care. Strategies for coordinating care were grouped into broad strategy types. Effectiveness was assessed by the number of studies using a strategy type reporting significant positive outcomes.

Results

Six main types of strategy were identified. Three involved communication and individual support: Communication between service providers (e.g. case conferencing); Support for service providers (supervision, joint training); Support for patients (joint education, reminders). Three involved systems and structures to support care coordination. Arrangements for coordinating serviced provision (joint assessments, agreed schedules of service provision); Structuring relationships between service providers (co-location, multi-disciplinary teams); Systems for supporting coordination of care, (information systems, shared decision support).

Strategies involving systematic support for care coordination were more strongly associated with improved health outcomes, those involving communication and individual support with improved patient satisfaction. Multiple strategies were more successful than single strategies. The presentation will include a discussion of the policy implications of these findings.

Wednesday December 5th (8.30am - 10.00am)

Concurrent Sessions: Public Health

Abstract Number 136

The impact of Celebrity Cancer Diagnosis on Provider Referred Breast Imaging among Young women

Dr. Margaret Kelaher¹, Professor David Studdert¹, Dr. Jennifer Cawson², Dr. Julie Mills³, A/Prof. Anne Kavanagh¹, A/Prof. David Dunt¹

¹University of Melbourne, ²BreastScreen, ³Melbourne Health

Abstract:

Objectives

We live in an age of celebrity worship. When a celebrity falls ill or undergoes medical treatment, the event may trigger intense media coverage, raise public awareness of the relevant condition, and change health-related behaviours. Previous studies have emphasised the potential for such exposure to deliver public health benefits by improving clinically-appropriate screening practices. In contrast, the potential for inappropriate responses has received relatively little attention. In this study we examine levels of provider referred breast imaging among women too

young for routine breast imaging (25-44 years) before and after Kylie Minogue's diagnosis with breast cancer. We then assess the appropriateness of changes in breast imaging rates by examining changes in the number of women progressing to biopsy and to the removal of malignancies.

Results

Breast imaging increased significantly for women aged 25-34 years and 35-44 years in the post-Kylie periods. A similar increase was apparent in biopsy rates. However rates of removal of malignancies were much lower in the post-Kylie period compared to the pre-Kylie period. This suggests that a much lower risk population was being screened post-Kylie.

Conclusion

The results highlight the importance of managing the media surrounding celebrity health events and the need to develop policy to assist doctors adhere to evidence based guidelines in the face of media coverage.

Abstract Number 137

The impact of the HPV vaccine on women's preferences for cervical screening in Australia

Dr. Marion Haas¹, Dr. Denzil G. Fiebig², Dr. Ishrat Hossain¹, Dr. Rosalie Viney¹

¹Evaluation (CHERE) University of Technology, Sydney,

²University of New South Wales

Abstract:

Objectives

In Australia, the National Cervical Screening Program (NCSP) has been an important public health achievement. Although there continue to be debates amongst clinical and academic communities about the optimal design for this programme (i.e. type of screening test to use, screening interval, age to commence and age to cease screening), such discussions have not generally included the general public. However, the recent introduction of the HPV vaccine (commencing April 2007) in Australia has raised the profile of screening for cervical cancer. We undertook research about women's preferences for and attitudes to Pap tests prior to the introduction of the vaccine and took advantage of its introduction to repeat the research.

Methods

Two interviewer-assisted surveys, including a discrete choice experiment (DCE), were conducted with random samples of women in New South Wales, Australia. The first was undertaken in 2004 and the second in June 2007.

Results

167 women completed the first survey and 154 the second. Results will include comparison of the extent to which women

chose an HPV test (in the DCE), their attitudes to and self reported behavior in relation to Pap tests and HPV tests and the relationship between their testing behaviour and factors such as who provides their Pap tests (e.g. GP, gynaecologist, women's health nurse), history of abnormal results, cost of tests and sociodemographic factors.

Abstract Number 138

The role of income and locality in breast screening participation

Minh Vu¹, Kees van Gool¹, A/Prof. Elizabeth Savage¹, A/Prof. Marion Haas¹, Professor Stephen Birch^{1,2}

¹Evaluation (CHERE) University of Technology Sydney,

²McMaster University

Abstract:

Objectives

Under the auspices of BreastScreen Australia, women aged 40 and over are able to access mammography services free at the point of delivery. One of the stated aims of the program is to provide equitable access to all women in the target group. This paper examines the extent to which participation is equitable by analysing the influence of socio-economic status (SES), using both individual and area-based indicators of SES.

Methods

Data on self-reported utilisation of breast screening services, socio-economic status and locality came from the 2002 and 2004 NSW Health Surveys. Probit regression analysis was used to examine the relationship between SES and breast screening behaviour of women in NSW.

Results

The results show that SES can have a significant impact on the likelihood that a woman chooses to screen for breast cancer at regular intervals – providing evidence of a positively sloped income gradient. Further, this relationship remains robust regardless of a woman's locality of residence or age group.

Conclusion

These results indicate that providing women with "free" access at the point of care is insufficient to ensure equitable take-up of mammography services. Furthermore, our analysis of the role of individual level and area-based variables has important implications on the way SES is routinely analysed and reported.

Abstract Number 139

Cost-effectiveness of folate fortification compared to other alternatives

Kim Dalziel¹, Professor Leonie Segal¹

¹University of South Australia

Abstract:

Objectives

A comparative cost effectiveness analysis of alternative strategies for reducing the incidence of neural tube defects (NTDs) was performed in response to a Ministerial request to Food Standards Australia and New Zealand (FSANZ).

Methods

A literature review was performed to inform the selection of interventions. Data was extracted on the impact of the interventions (change in folate levels and NTDs) and the description of cost inputs. Outcomes and costs were modelled in terms of \$/NTD prevented and \$/QALY (or DALY) prevented along with sensitivity analyses to inform comparisons.

Results

For Australia and New Zealand a health promotion campaign to promote supplement use will have the greatest impact preventing an estimated 27 and 8.7 NTD cases respectively. Mandatory fortification is estimated to prevent 23.8 and 7 NTD cases respectively (representing <10% of all NTDs). Extending voluntary fortification appears highly cost-effective as do all approaches to promoting supplement use (<\$60,000/NTD prevented). Mandatory fortification does not appear a cost-effective strategy for New Zealand, at over \$500,000 per NTD prevented and for Australia performance depends on the cost of implementation (cost per NTD prevented ranging from \$84,000 to \$600,000). Dietary interventions generally do not appear cost effective.

Conclusion

Investment in several of the interventions aimed at preventing cases of neural tube defects fall well within accepted societal norms for the funding of health interventions, suggesting that funding cost-effective options would meet societal goals. These findings will be discussed in relation to the recent Government decisions to implement mandatory fortification with folic acid.

Abstract Number 140

Being fat in today's world: The experiences of people living with obesity in Australia

Samantha L. Thomas¹, Asuntha Karunaratne¹, Jim Hyde¹, Paul A. Komesaroff¹

¹Monash University, Melbourne, Australia

Abstract:

Objectives

To develop an in-depth picture of both lived experience of obesity and the impact of socio-cultural factors on people living with obesity.

Methods

The study, based in Victoria, Australia, employed a rigorous qualitative methodology, utilizing in-depth semi-structured interviews with a community sample of obese adults (BMI \geq 30). Community sampling methods were supplemented with purposive sampling techniques to ensure a diverse range of individuals were included.

Results

76 individuals (aged 16-72) were interviewed. Most had struggled with their weight for most of their lives (n=45). Almost all had experienced stigma and discrimination in childhood (n=36), as adolescents (n=41) or as adults (n=72). About half stated that they had been humiliated by health professionals because of their weight. Participants felt an individual responsibility to lose weight, and many tried extreme forms of dieting to do so. Participants described an increasing culture of 'blame' against people living with obesity perpetuated by media and public health messages. 80% said that they "hated" or "disliked" the word obesity and would rather be called "fat" or "overweight".

Conclusions

There are four key conclusions: 1) the experiences of obesity are diverse, but there are common themes; 2) people living with obesity have heard the messages but find it difficult to act upon them; 3) interventions should be tailored to address both individual and community needs; and 4) we need to rethink how to approach obesity interventions to ensure that avoid recapitulating damaging social stereotypes and exacerbating social inequalities.

**Wednesday December 5th
(8.30am - 10.00am)
Concurrent Sessions: Planning and
Evaluation of Child Health Services**

Abstract Number 141

**Responding to the mental health
needs of Victorian children: using
data to drive policy and service
reform**

**Dr. Sharon Goldfeld¹, Linda Hayes¹, Pamela
Muth¹**

¹Victorian Department of Education and Early Childhood
Development

Abstract:

Objectives

Evidence suggests that mental health problems in children and young people are increasing. In order to respond at a policy and service level data have become increasingly important to adequately respond to risk and protective factors for mental health prevention and promotion.

Methods

Computer assisted telephone interviews were undertaken on behalf of randomly selected Victorian children. 3370 parents with children aged 4-12 years reported on their child's mental health, their own mental health and socio-demographics. Variables within an ecological model for risk and protective factors were included for analysis. Population estimates and odds ratios were calculated with 95% confidence intervals (CI).

Results

11.6% (CI=10.3-12.9%) of Victorian children are estimated to be at risk of having mental health problems, (5.6% (CI=4.7-6.5%) obtained scores indicating their mental health is 'of concern' and 6.0% (CI=5.0-7.0%) obtained 'borderline' scores).

After multivariate analysis only 5 (of 16) factors remain significant predictors of poor child mental health ('of concern'). These include children with special health care needs (OR=7.7, CI=5-11.9), unhealthy family functioning (OR=2.6, CI=1.6-4.1) parental mental health problems (OR=2.6, CI=1.2-5.9), living in a rural area (OR=2.0, CI=1.3-3.0), and living in a neighbourhood perceived as unsafe (OR=2.4, CI=1.2-4.8).

Conclusion

While the mental health of Victorian children compares favourably to that of children nationally, a significant proportion of children are at some risk of mental health problems. The limited but important number of predictors of children's mental health suggests that the policy solutions will need to extend beyond those offered by traditional mental health service systems.

Abstract Number 142

**Admissions to hospital of injured
children: experiences of
whanau / families**

**Brooke Arlidge¹, Sally Abel¹, Lanuola Asiasiga¹,
Sharon Milne¹, Sue Crengle¹, Sandar Tin Tin¹,
Shanthi Ameratunga¹**

¹University of Auckland

Abstract:

Objectives

New Zealand has very high rates of childhood injuries relative to other high-income countries, with Maori and Pacific children experiencing a disproportionately higher burden relative to other New Zealand children. Despite the acknowledged disparities in the occurrence of significant injuries, little is known about the experiences of the families that care for them.

Methods

This multi-ethnic qualitative study explored the experiences of the families of 24 children aged less than 15 years admitted to hospital for an unintended injury. The families – of Maori, Pacific and Pakeha ethnic groups – were interviewed by researchers of these major ethnic groups. While the severity of the physical injuries varied among the children, most had minor to moderate injuries requiring three or fewer days in hospital. A major focus of the analysis was to describe the key issues confronting the families as they negotiated the hospitalisation process.

Results

The family interviews revealed important concerns regarding the encounters with hospitals and related health and support services. These included inadequate communication and information, difficulties negotiating a foreign hospital environment, the stress of conflicting demands placed on families, and issues relating to ethnicity and cultural miscommunication. The implications for professional and institutional practices with regard to the delivery of health services are discussed. The findings also speak to the need for wider societal policies that increase Maori and Pacific whanau/families' sense of entitlement to the full range of available support services and reduce alienation of these communities within public institutions such as hospitals.

Abstract Number 143

Caring for injured children and their families: perspectives of health service providers

Shanthi Ameratunga¹, Sally Abel¹, Brooke Arlidge¹, Sharon Milne¹, Lanuola Asiasiga¹, Sandar Tin Tin¹, Sue Crengle¹

¹University of Auckland

Abstract:

Objectives

Injuries kill, maim or disable children at much higher rates in Aotearoa/New Zealand than in most OECD countries. Not surprisingly, preventing childhood injuries has been an important focus of attention, but the response of health services to those for whom prevention failed has received little scrutiny.

Methods

As part of a larger multi-ethnic qualitative study, 21 providers from a range of health and support services interacting with children and their families following an injury-related admission were interviewed one-on-one (11) or in focus groups (10).

Results

Study participants identified several major challenges in ensuring quality of care including their limited ability to meet the emotional needs of children with mild injuries; the lack of adequate psychological support for families; poor staff continuity and coordination; lack of accessible and comprehensive information for children and families; complex issues that compromise care for Maori and Pacific families; and difficulties managing the transition of care within hospital, and from hospital to community settings. The participants echoed many concerns identified by families in the larger project and exhibited strong empathy and insight into the innumerable issues faced by children and their caregivers. The principles that can guide the response to these issues are articulated in the Medical Council of New Zealand's policy on cultural competence, the Health and Disability Sector Standards for Children and Young People, and the Paediatric Society of New Zealand's statement "Through the Eyes of a Child". Addressing the gaps between principles, policy and practice require more attention.

Abstract Number 144

Evaluating community-based early childhood development initiatives: Experience from across the ditch

A/Prof. David Dunt¹, Dr. Margaret Kelaher¹

¹University of Melbourne

Abstract:

Objectives

Best Start is an early child development initiative of the Victorian state government in Australia closely modeled on the local community initiatives of Surestart in the UK. It is aimed at eleven disadvantaged communities and two Aboriginal communities. Best Start aims to engage families, local services and local government in a collaborative local planning Partnership leading on to the development and implementation of projects in priority areas defined either by thirteen evidence-based outcome indicator areas (e.g. breastfeeding) and/or subsidiary aim areas (better access to services by vulnerable families and better service planning and cooperation).

Methods

A number of tools were developed to measure these parameters before and after Best Start by comparison with suitable control communities. These included eight ECD indicators using statewide datasets at LGA-level as well as more localised level for breastfeeding and attendance at Maternal and Child Health (MCH) centres as well as surveys of parents of three year old children site.

Results

Results indicated that there were significant improvements in five of seven areas of Partnership functioning. Four of eight nominated service co-operation and co-ordination activities became more frequent. New projects focused on health promotion/social marketing and promoting service cooperation and new service infrastructure. These Partnership and service cooperation activities led on to improved breastfeeding, attendance at MCH Centres measured using both routinely collected data and survey of parents. This was not typical though for other parameters.

Conclusion

Community-based ECD initiatives aimed at disadvantaged communities are able to improve core child health outcomes.

**Wednesday December 5th
(8.30am - 10.00am)
Concurrent Sessions: Development of
Nursing Services**

Abstract Number 145

Nurse churn and turnover: rates and relationships

Dr. Nicola North¹, Mary Finlayson¹, Frances Hughes², Erling Rasmussen³, Toni Ashton¹, Taima Campbell⁴, Sharon Aull⁵, Judy Kilpatrick¹

¹University of Auckland, ²UTS, ³AUT, ⁴Auckland DHB, ⁵Counties Manukau DHB

Abstract:

Objectives

In a context of global nursing shortages high nursing turnover at unit level continues to be a problem. Using a systems framework, this study was part of an international study using a validated protocol, data dictionary, design and methodology, for the purpose of collecting evidence on the costs, the impacts of nursing turnover on patient and nurse adverse outcomes, and the relationship with staffing practices.

The study was conducted between 2004-2006, data was then collected monthly for 12 months from 22 randomly selected general medical and surgical units in 11 DHBs on costs related to termination, temporary cover, recruitment and hiring, and induction and on-job training. Results were reported using descriptive statistics. Regression analysis was used to identify what, if any relationship existed between turnover rates, costs and impacts and staffing practices.

The study found a high turnover rate of on average 39%, including internal transfer and external turnover; at unit level. Leaving nurses were replaced in 2/3 of cases by inexperienced nurses, that is new graduates and overseas trained nurses. These two groups of nurses were the most expensive to train until full productivity was reached and were positively associated with numbers of adverse nurse and patient events. The study also found high average occupancy rates at 91.8%; on average 1.88 FTE fewer staff nurses were employed than budgeted for; and an average 4.99 hours of direct nursing care per patient per 24 hours. The relationship of these to turnover rates, costs and impacts were tested using regression analysis.

Abstract Number 146

**A Behavioural Economics Perspective
on Nurse Employment Policy**

Marlene Eggert¹, Dr. Thomas Faunce¹

¹Australian National University

Abstract:

Objectives

In this paper I apply Frey's non-classical economic theory of personal motivation (1) to Australian research findings on nurses' job motivations and the nursing supply shortage.

Traditional policy responses to nurse shortages largely follow classical labour economic theory and focus on wage rises to boost supply (2). However, international research indicates that nurses are fairly unresponsive to pay rises (3,4). Australian research shows clinical nurses to be deeply dissatisfied with their jobs and highly motivated by non-wage rewards (5). One such non-wage motivator is a specific-to-nursing reward relating to nurses' ability to help others and work closely with people (6). This intrinsic motivator is strongly correlated with clinical nurses' job satisfaction (7). Taking account of intrinsic motivators and non-wage rewards is essential for ensuring organizations' future nursing supply.

Frey's economic theory of personal motivation (1) applied to workplaces indicates that poorly designed organizational interventions can, under specific conditions, negatively affect intrinsic motivation and result in hidden costs. Organizational interventions which crowd-out nurses' intrinsic job motivators result in hidden costs such as loss of staff good-will and loss of efficiency. The concept of crowding-out intrinsic motivation also explains the observed low morale of nurses in Australia (8). Organizational policies designed to take account of nurses' intrinsic work motivators make sense from an economic perspective as they reduce the creation of other marginal costs such as transaction costs, organizational sabotage and loss of quality.

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The authors thank Professor Geoffrey Brennan, Research School of Social Sciences, Australian National University, for advising them on Professor Bruno Frey's work.

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8. Commonwealth of Australia (2002 B). *The patient profession. Time for action.* Canberra, Parliament of Australia: Senate: Community Affairs Report.

Abstract Number 147

The development of primary health care nursing in the PHO environment

Dr. Mary Finlayson¹, Dr. Nicolette Sheridan¹, Dr. Jackie Cumming²

¹University of Auckland, ²Victoria University of Wellington

Abstract:

Objectives

The introduction of The Primary Health Care Strategy in 2001 represented a significant change of focus for the delivery of primary health care. It provided an important opportunity for the development of the role of nurses, who make up the largest group of health professionals in the primary health care workforce.

Methods

This paper examines the development of primary health care nursing in New Zealand since the introduction of the Strategy, as well as recent developments, innovations and issues in primary health care nursing in a number of similar countries. It assesses the degree to which the intentions of the Strategy, as they relate to nurses, have been met, and draws attention to the barriers which prevent further development of nursing roles.

Results

The study reviews relevant literature, evaluates existing models of care and reports on key informant interviews undertaken in 2006 with 20 leaders in nursing from academic, government, DHB and nursing bodies.

Conclusion

The findings indicate the need for: nurses to be more involved in clinical governance, a structured education and career pathway that recognises population based practice, role development including roles for Nurse Practitioners, and more effective teams; and recommends changes for organisations and funding.

Abstract Number 148

Establishing and sustaining successful innovation: The Primary Health Care Nursing Innovations

Dr. Katherine Nelson¹, Trish Wright²

¹Victoria University of Wellington, ²Waikato Institute of Technology

Abstract:

Objectives

In 2002/3, as part of implementing New Zealand's Primary Health Care Strategy the Ministry of Health purchased Primary Health Care (PHC) Nursing Innovation projects throughout Aotearoa New Zealand. The innovations were to i) support the development of innovative models of primary health care nursing practice; ii) allow for new models of nursing practice to develop; iii) reduce current fragmentation and duplication of services; and iv) assist in the transition of primary health care delivery to new health service structures. An independent evaluation found that each of the 11 Innovations purchased had distinctive characteristics but at a broad level, they fell into one of two general models characterised by their primary focus. One model, the Leading PHC Nursing Development Model, focused on leading broad-based change involving primary health care nurses across DHBs and/or PHOs and NGOs. The other model, the PHC Nursing Practice Model, focused on the development of new, expanded or modified forms of nursing to deliver a nursing service to particular groups of people. Innovations were found to have varying levels of success. This paper presents the key findings related to what supported the two models of Innovation in their establishment phase to develop as successful Innovations, and what contributed to their sustainability beyond Innovation funding. The paper concludes with a focus on the lessons learnt in relation to establishing and sustaining primary health care nursing development.

Abstract Number 149

Better all round for everybody : Community nurses in cancer care

Dr. Heather McKenzie¹, Dr. Lillian Hayes¹, Dr. Sue Forsyth¹, Dr. Maureen Boughton¹

¹University of Sydney

Abstract:

Objectives

Community nurses have been identified as key players in cancer care with research suggesting that they are integral to successful patient outcomes. Unfortunately, though, many patients are either not referred, or referred to community nursing services at a late crisis point in the cancer illness trajectory. For many people such crises may have been avoided or at least minimised with the earlier involvement of community nurses. This paper draws on

two qualitative research projects that have studied the interactions of community nurses and cancer patients in New South Wales regional and Sydney metropolitan areas.

One of the most significant findings from these studies is the extent to which community nurses fulfil a pivotal role in the care of cancer patients, liaising in a timely fashion with other health professionals to ensure that the fluctuating needs of patients and their families are appropriately met. Community nurses conduct comprehensive, often daily, assessments of immediate patient needs that enable them to (i) make complex clinical judgments about care; and then (ii) liaise in a timely fashion with specialist nurses, medical practitioners and allied health professionals to ensure that patients receive appropriate care.

We argue here that it is the unique nature of nurse-patient relationships and encounters that enables nurses to take on this pivotal role. This paper focuses on the multiplicity of ways in which nurses work in this arena and recommends the timely involvement of community nurses in the care of cancer patients.

Wednesday December 5th (8.30am - 10.00am)

Concurrent Sessions: Round Table

**Abstract Numbers 150 — 155:
Round Table**

Abstract Number 150

Facilitating strong partnerships between researchers and research users for policy relevant research

Barbara Beacham¹, Professor Ian Anderson², Professor Ross Bailie³, Mark Thomann⁴, Alwin Chong⁵

¹Cooperative Research Centre for Aboriginal Health, ²ONEMDA VicHealth Koori Health Unit, ³Menzies School of Health Research, ⁴Office of Aboriginal and Torres Strait Islander Health (MDP: 17), ⁵Aboriginal Health Council of SA

Abstract:

Objectives

This session aims to strengthen links between researchers, policy makers and community people in health service research. Strong partnerships between researchers and research users (policy makers, practitioners, and community people) are gaining increasing recognition as important mechanisms in transferring health services research findings into policy and practice. Establishing and maintaining such partnerships takes planning, infrastructure, resources and facilitation.

The Australian Cooperative Research Centre for Aboriginal Health (CRAH) has been developing an organisational

approach to research, grounded in research transfer theory, which manages each of these components to foster strong partnerships and mediates the working of those partnerships. So far experience indicates that the approach supports robust engagement of stakeholders from different backgrounds and can produce health services research that is focused on areas highly relevant to both policy makers and practitioners. The benefits so far have included providing research users, particularly the CRAH's Aboriginal constituency, more influence in both setting the research agenda and the conduct of the research.

Various perspectives on the CRAH research approach and partnerships in research will be presented during the session, and discussion fostered including benefits, strengths and weaknesses, and the perceived needs of various stakeholders in relation to optimising research partnerships for research transfer.

Researchers and policy makers participating in the session will:
Gain knowledge about an organisational way of doing research that has been demonstrated to strengthen links between researchers and research users .

Gain insight into how to develop and manage collaborative research partnerships between researchers and research users from an organisational perspective.

Broaden their knowledge about how to develop research that has intrinsic potential to promote the uptake of findings.

Abstract Number 151

The Cooperative Research Centre for Aboriginal Health's approach to developing research

Professor Ian Anderson¹

¹ONEMDA VicHealth Koori Health Unit

Abstract:

Objectives

Professor Ian Anderson, one of Australia's leading Indigenous health experts, is the foundation Chair in Indigenous Health at the University of Melbourne. The first Aboriginal Australian to hold a chair in Indigenous Health, he is a strong advocate of Aboriginal-led health initiatives for Indigenous people. His family are Tasmanian and through his mother Palawa Trouwerner with links to Plaimairrenner and Trawlwoolway clans. Professor Anderson is currently Deputy Head of the University's School of Population Health, and Director of its Centre for Health and Society and the Onemda VicHealth Koori Health Unit. Ian has been playing a lead role in development work around the CRAH approach to research.

Ian will chair the session, and where appropriate, can raise issues and contribute to discussion from an organisational development and academic perspective.

Abstract Number 152

Managing research partnerships: optimizing links between researchers and research users

Barbara Beacham¹

¹Cooperative Research Centre for Aboriginal Health

Abstract:

Objectives

Barbara is the Program Manager for the CRCAH Comprehensive Primary Health Care Health Systems and Workforce Program; where the CRCAH approach has been implemented to develop a number of key research projects. She has a Bachelor of Social Science (Human Services) and a Masters of Community Development and Management. Her major areas of interest include health system and collaborative research, developing effective research partnerships between Indigenous and non-Indigenous stakeholders and the transfer of research findings into practical change that makes a difference to people's lives and circumstances. Barbara can raise issues and contribute to discussions from an organisational management perspective.

Abstract Number 153

Reflections on the CRCAH approach to research: a researcher's perspective

Professor Ross Bailie¹

¹Menzies School of Health Research

Abstract:

Objectives

Professor Ross Bailie is an NHMRC Senior Research Fellow based at Menzies School of Health Research in Darwin, Australia. His current research programs are focussed on improving primary level health services and environmental health in Indigenous Australian communities. His undergraduate training in medicine and his post-graduate training in maternal and child health and public health were undertaken at the University of Cape Town. He spent the several year interval between these courses of study as a clinician in rural general practice in New Zealand and in Accident and Emergency and Paediatrics in South Africa.

Ross has been actively involved, as a Program Leader in the Comprehensive Primary Health Care Health Systems and Workforce program, in developing the CRCAH approach to research and can raise issues and contribute to the discussion from a researcher/academic sector perspective.

Abstract Number 154

Reflections on the CRCAH approach to research: a policy maker's perspective

Mark Thomann¹

¹Budget and Planning Branch

Abstract:

Objectives

Mark is the Assistant Secretary of the Budget and Planning Branch in the Commonwealth Office for Aboriginal and Torres Strait Islander Health, with responsibility for budget and financial management and program management and development. During his career, Mark has worked in both the community and public sector in housing, health and community services. In the community sector, Mark has managed community housing and supported accommodation services managed by community based and tenant controlled boards of management. More recently, Mark has worked in various policy, program and information management roles in the Australian Public Service in supported accommodation, disability, aged and community care, housing and health programs.

Mark has experience, as a research partner, of the CRCAH approach to research and can raise issues and contribute to the discussion from a policy sector perspective.

Abstract Number 155

Reflections on the CRCAH approach to research: an Aboriginal community health sector perspective

Alwin Chong¹

¹Aboriginal Health Council

Abstract:

Objectives

Alwin is the Senior Research and Ethics Officer with the incorporated Aboriginal Health Council of South Australia Inc., which is the peak State Aboriginal Community Controlled Health Organisation. One of the major responsibilities of this position is the development and implementation of a research agenda that identifies Aboriginal and Torres Strait Islander community's research topics rather than academic driven research topics. An essential component of this position is the management of the Aboriginal Health Research Ethics Committee (AHREC), a sub-committee of the Council and the peak ethics body for Aboriginal health in South Australia, which involves working with researchers. The major benefit is the continual involvement in the debate surrounding methods and methodologies. The AHREC is recognised by the National Health and Medical Research Council as a Research Ethics Committee.

Alwin has experience, as a research partner, of the CRCAH approach to research and can raise issues and contribute to the discussion from an Aboriginal community health sector perspective.

**Wednesday December 5th
(10.30am - 11.45am)
Plenary 6: Looking to the Future in
Health Services Research**

Abstract Number 156

**Toward a High Performance Health
System**

Karen Davis¹

¹The Commonwealth Fund (New York, NY)

Abstract:

All major industrialized countries are confronting the challenge of providing their populations with accessible, high quality, safe and efficient care. Recent results of an international survey of health care quality reveal that having a "medical home" that provides accessible, continuous, and coordinated care makes a difference in health care quality outcomes. Cost and coverage estimates of a series of incremental policy steps that could be phased in to achieve near-universal coverage in the United States demonstrate that accessible and efficient health care is within our reach. This presentation will offer new comparative analysis of international health care experiences as well as specific policy strategies – such as medical homes, care coordination, pay for performance – to move every country toward a higher performing health care system.

Abstract Number 157

**Health services research in the age of
health care reform**

Jane Hall¹

¹University of Technology, Sydney

Abstract:

The future for health services research will be shaped by the new fads and fashions in health care policy, and the response of the research community both in what issues it chooses to research, and how it communicates with policymakers. In this presentation I will review the current fashion in health care reform, identify some issues which emerge from those themes, and which have to be resolved in our developing research approaches. Finally I will consider the challenge that developing adequate research capacity presents.

Speaker Index

Allan, Julaine Monday 3 Dec 3.30pm-5.00pm	70	Chong, Alwin Wednesday 5 Dec 8.30am-10.00am	155
Ameratunga, Shanthi Wednesday 5 Dec 8.30am-10.00am	143	Clarke, Frankie Tuesday 4 Dec 11.00am-12.30pm	96
Anderson, Ian Wednesday 5 Dec 8.30am-10.00am	151	Clinton, Janet Sunday 2 Dec 9.00am-12.30pm, Monday 3 Dec 1.30pm-3.00pm	1, 45
Anderson, Warwick Monday 3 Dec 5.15pm-6.15pm	85	Conaty, Stephen Tuesday 4 Dec 1.30pm-3.00pm	117
Appleton, Sarah Monday 3 Dec 1.30pm-3.00pm	47	Connelly, Luke Monday 3 Dec 11.00am-12.00pm, 3.30pm-5.00pm	7, 66
Arlidge, Brooke Wednesday 5 Dec 8.30am-10.00am	142	Cook, Linda Tuesday 4 Dec 11.00am-12.30pm	98
Asch, Steven Monday 3 Dec 1.30pm-3.00pm	52	Crampton, Peter Tuesday 4 Dec 8.45am-10.30am	88
Ashton, Toni Monday 3 Dec 11.00am-12.00pm	11	Crengle, Sue Tuesday 4 Dec 8.45am-10.30am	86
Askew, Deborah Tuesday 4 Dec 1.30pm-3.00pm	120	Cronin, Paula Tuesday 4 Dec 11.00am-12.30pm	105
Bailie, Ross Wednesday 5 Dec 8.30am-10.00am	153	Cumming, Jacqueline Monday 3 Dec 1.30pm-3.00pm, Tuesday 4 Dec 1.30pm-3.00pm, Wednesday 5 Dec 8.30am-10.00am	32, 34, 127, 132
Barnett, Pauline Monday 3 Dec 11.00am-12.00pm	8	Dalziel, Kim Wednesday 5 Dec 8.30am-10.00am	139
Beacham, Barbara Wednesday 5 Dec 8.30am-10.00am	150, 152	Davies, Philip Tuesday 4 Dec 3.30pm-5.00pm	
Beddoes, Lenore Tuesday 4 Dec 11.00am-12.30pm	102	Davis, Karen Wednesday 5 Dec 10.30am-11.45am	156
Bindman, Andrew Monday 3 Dec 8.45am-10.30am	4	De Raad, Jean-Pierre Tuesday 4 Dec 1.30pm-3.00pm	116
Boulton, Amohia Monday 3 Dec 3.30pm-5.00pm	59, 61	Derrett, Sarah Monday 3 Dec 11.00am-12.00pm	24
Bramley, Dale Monday 3 Dec 8.45am-10.30am		Dickinson, Helen Monday 3 Dec 11.00am-12.00pm	30
Brown, Paul Sunday 2 Dec 9.00am-12.30pm, Tuesday 4 Dec 1.30pm-3.00pm	1, 131	Dobson, Rebecca Monday 3 Dec 3.30pm-5.00pm	75
Burns, Lucy Tuesday 4 Dec 11.00am-12.30pm	107	Duckett, Stephen Monday 3 Dec 8.45am-10.30am	5
Carswell, Peter Tuesday 4 Dec 1.30pm-3.00pm	122	Dunbar, James Tuesday 4 Dec 1.30pm-3.00pm	123
Chapman, Adam Monday 3 Dec 11.00am-12.00pm	18		

Dunt, David Wednesday 5 Dec 8.30am-10.00am	144
Dy, Sydney Monday 3 Dec 1.30pm-3.00pm	53
Eades, Sandra Tuesday 4 Dec 8.45am-10.30am	87
Eggert, Marlene Wednesday 5 Dec 8.30am-10.00am	146
Elshaug, Adam Monday 3 Dec 3.30pm-5.00pm	68
Farmer, Tanja Monday 3 Dec 1.30pm-3.00pm	57
Finlayson, Mary Monday 3 Dec 11.00am-12.00pm, Wednesday 5 Dec 8.30am-10.00am	15, 147
Ford, Jane Tuesday 4 Dec 11.00am-12.30pm	108
Gallego, Gisselle Monday 3 Dec 3.30pm-5.00pm	67
Gardner, Karen Tuesday 4 Dec 1.30pm-3.00pm	118
Gauld, Robin Tuesday 4 Dec 11.00am-12.30pm	92
Gibson, David Monday 3 Dec 3.30pm-5.00pm	65
Gilbert, Kate Monday 3 Dec 3.30pm-5.00pm	78
Goldfeld, Sharon Wednesday 5 Dec 8.30am-10.00am	141
Goodall, Stephen Tuesday 4 Dec 11.00am-12.30pm	90
Green, Terri Monday 3 Dec 1.30pm-3.00pm, Tuesday 4 Dec 1.30pm-3.00pm, 3.30pm-5.00pm	54, 126
Greenhill, Jennene Monday 3 Dec 3.30pm-5.00pm	73
Gruen, Russell Monday 3 Dec 11.00am-12.00pm	17, 21
Guthrie, Jill Monday 3 Dec 11.00am-12.00pm	26

Haas, Marion Tuesday 4 Dec 1.30pm-3.00pm, Wednesday 5 Dec 8.30am-10.00am	124, 125, 137
Hadfield, Ruth Tuesday 4 Dec 11.00am-12.30pm	109
Haines, Mary Monday 3 Dec 1.30pm-3.00pm, Tuesday 4 Dec 1.30pm-3.00pm	43, 111
Hall, Jane Monday 3 Dec 1.30pm-3.00pm, Wednesday 5 Dec 10.30am-11.45am	55, 157
Harris, James Monday 3 Dec 1.30pm-3.00pm	38
Hauck, Katharina Monday 3 Dec 1.30pm-3.00pm	41
Hawe, Penny Sunday 2 Dec 4.30pm-5.30pm	3
Hider, Phil Monday 3 Dec 11.00am-12.00pm	14, 16
Jackson, Claire Monday 3 Dec 1.30pm-3.00pm	58
Jorm, Louisa Tuesday 4 Dec 1.30pm-3.00pm	115
Joyce, Catherine Monday 3 Dec 1.30pm-3.00pm	39
Karunaratne, Asuntha Wednesday 5 Dec 8.30am-10.00am	140
Kelagher, Margaret Wednesday 5 Dec 8.30am-10.00am	136
Kenny, Patricia Monday 3 Dec 3.30pm-5.00pm	76
Kinsman, Leigh Monday 3 Dec 1.30pm-3.00pm	42
Kletchko, Sharon Tuesday 4 Dec 3.30pm-5.00pm	
Knox, Stephanie Monday 3 Dec 3.30pm-5.00pm	64
Koea, Jonathan Monday 3 Dec 11.00am-12.00pm	19

Speaker Index continued

Lavoie, Josée Wednesday 5 Dec 8.30am-10.00am	134	Moulding, Richard Monday 3 Dec 11.00am-12.00pm	27
Lockett-Kay, Jan Monday 3 Dec 3.30pm-5.00pm	61	Mukhtar, S.Aqif Monday 3 Dec 11.00am-12.00pm	13
Lorenz, Karl Monday 3 Dec 1.30pm-3.00pm	50, 51	Nelson, Katherine Wednesday 5 Dec 8.30am-10.00am	148
Lujic, Sanja Monday 3 Dec 11.00am-12.00pm	12	Norman, Richard Tuesday 4 Dec 11.00am-12.30pm	104
Luxford, Karen Monday 3 Dec 11.00am-12.00pm	31	North, Nicola Monday 3 Dec 11.00am-12.00pm, Wednesday 5 Dec 8.30am-10.00am	25, 145
Mackay, Mark Monday 3 Dec 1.30pm-3.00pm, 3.30pm-5.00pm	37, 79	O'Dea, Des Tuesday 4 Dec 11.00am-12.30pm	106
Mackie, Jen Monday 3 Dec 3.30pm-5.00pm	59	O'Donnell, Kim Monday 3 Dec 3.30pm-5.00pm	62
Madden, Richard Tuesday 4 Dec 11.00am-12.30pm	103	Olds, Robin Monday 3 Dec 5.15pm-6.15pm	84
Mahoney, Faith Monday 3 Dec 1.30pm-3.00pm	49	O'Meara, Peter Monday 3 Dec 3.30pm-5.00pm	69
Marmor, Ted Sunday 2 Dec 2.30pm-3.30pm	2	Osborne, Richard Monday 3 Dec 3.30pm-5.00pm, Tuesday 4 Dec 11.00am-12.30pm	74, 93, 95
McDonald, Julie Monday 3 Dec 1.30pm-3.00pm	35	Pere, Lynne Monday 3 Dec 3.30pm-5.00pm, Tuesday 4 Dec 11.00am-12.30pm	63, 99
McDonnell, Geoff Monday 3 Dec 3.30pm-5.00pm	80, 81	Perkins, David Tuesday 4 Dec 11.00am-12.30pm	97
McKenzie, Heather Wednesday 5 Dec 8.30am-10.00am	149	Pirkis, Jane Tuesday 4 Dec 11.00am-12.30pm	101
McKernan, Stephen Tuesday 4 Dec 3.30pm-5.00pm		Pitt, Veronica Monday 3 Dec 11.00am-12.00pm	20
Mirzaei, Masoud Monday 3 Dec 1.30pm-3.00pm	48	Powell Davies, Gawaine Wednesday 5 Dec 8.30am-10.00am	135
Mitchell, Lisa Tuesday 4 Dec 11.00am-12.30pm	94	Preen, David Monday 3 Dec 11.00am-12.00pm	23
Mitchell, Penny Tuesday 4 Dec 11.00am-12.30pm	100	Prowse, Naomi Monday 3 Dec 1.30pm-3.00pm	56
Monaghan, Jennifer Tuesday 4 Dec 11.00am-12.30pm	96	Rasmussen, Shayne Monday 3 Dec 1.30pm-3.00pm	36
Moorin, Rachael Monday 3 Dec 11.00am-12.00pm, Tuesday 4 Dec 1.30pm-3.00pm	22, 113		

Raymont, Antony Tuesday 4 Dec 11.00am-12.30pm	89	Viney, Rosalie Tuesday 4 Dec 3.30pm-5.00pm	
Rees, David Monday 3 Dec 1.30pm-3.00pm	44	Vu, Minh Wednesday 5 Dec 8.30am-10.00am	138
Reeve, Jeanne Tuesday 4 Dec 1.30pm-3.00pm	128	Walker, Agnes Monday 3 Dec 1.30pm-3.00pm	46
Reid, Papaarangi Sunday 2 Dec 4.30pm-5.30pm		Walker, Judi Monday 3 Dec 3.30pm-5.00pm	71
Roberts, Christine Tuesday 4 Dec 11.00am-12.30pm	110	Walker, Tai Monday 3 Dec 3.30pm-5.00pm	60
Robertson, Hamish Monday 3 Dec 3.30pm-5.00pm	82	Walton, Lisa Tuesday 4 Dec 1.30pm-3.00pm	129
Scott, Helen Tuesday 4 Dec 1.30pm-3.00pm	130	Wano, Hayden Tuesday 4 Dec 3.30pm-5.00pm	
Semmens, James Tuesday 4 Dec 1.30pm-3.00pm	112	Wells, Robert Monday 3 Dec 3.30pm-5.00pm	72
Senes, Susana Tuesday 4 Dec 11.00am-12.30pm	91	Wenitong, Mark Tuesday 4 Dec 3.30pm-5.00pm	
Sheridan, Nicolette Monday 3 Dec 11.00am-12.00pm	10	Wilkinson-Meyers, Laura Monday 3 Dec 3.30pm-5.00pm	77
Si, Damin Tuesday 4 Dec 1.30pm-3.00pm	121	Xiong, Linping Monday 3 Dec 3.30pm-5.00pm	83
Sinclair, Sue Monday 3 Dec 11.00am-12.00pm	28	Zwar, Nicholas Monday 3 Dec 1.30pm-3.00pm	40
Smith, Judith Monday 3 Dec 1.30pm-3.00pm, Wednesday 5 Dec 8.30am-10.00am	33, 133		
Smith, Verna Tuesday 4 Dec 1.30pm-3.00pm	119		
Stringer, Bernadette Monday 3 Dec 11.00am-12.00pm	29		
Taylor, Lee Tuesday 4 Dec 1.30pm-3.00pm	114		
Tenbensen, Tim Monday 3 Dec 11.00am-12.00pm	9		
Thomann, Mark Wednesday 5 Dec 8.30am-10.00am	154		

Programme at a Glance

Sunday December 2nd

9.00am - 12.30pm **Pre-Conference Workshop:**
Mixed Methods for Programme Evaluations of Health Services and Interventions
Tamaki Room

2.00pm - 2.30pm **Conference Opening**

Arawa Room

2.30pm - 3.30pm **Plenary 1**
Fads and Fashions in Health Services
Arawa Room

3.30pm - 4.00pm **Afternoon Tea**

4.00pm - 5.30pm **Plenary 1: Continued**
Arawa Room

5.30pm - 7.00pm **Welcome Reception**

Tiri/Toroa Room

Monday December 3rd

8.45am - 10.30am **Plenary 2**
Developments in Health Services Research
Arawa Room

10.30am - 11.00am **Morning Tea**

11.00am - 12.30pm **CONCURRENT SESSIONS**

Australian Primary Health Care Research Institute Workshop
Arawa Room

Health Sector Reform
Akarana Room

Hospital Quality and Clinical Governance
Tamaki Room

Organised Session – Regionalisation of Cancer Services: In Search of Evidence-Informed Policy
Hauraki Room

Access and Utilisation
Westhaven Room

Workforce Collaboration
Nikau Room

12.30pm - 1.30pm **Lunch**

Lunchtime discussion:
Pursuing Excellence in Purchasing for Population Health Gain: Lessons from New Zealand
Arawa Room

1.30pm - 3.00pm **CONCURRENT SESSIONS**

Round Table – Building Comprehensive Primary Health Care through Primary Care Organisations: A Cross County Comparative Analysis
Arawa Room

Developing the Health Workforce
Akarana Room

Hospital Efficiency, Resources, Outcomes
Tamaki Room

Evaluation
Hauraki Room

Organised Session – Towards a More Humanistic Healthcare: Emerging Measures for Palliative Quality Measurement
Westhaven Room

Linking Policy and Research
Nikau Room

3.00pm - 3.30pm **Afternoon Tea**

3.30pm - 5.00pm **CONCURRENT SESSIONS**

Health Services and Indigenous Health
Akarana Room

Funding and Prioritising Health Services
Tamaki Room

Rural Health
Hauraki Room

Identifying Service Needs
Westhaven Room

Modelling for Service Planning
Nikau Room

5.15pm - 6.15pm **Plenary 3**

How Will Health Services Research be Funded?
Arawa Room

7.30pm **Conference Dinner**

Tuesday December 4th

8.45am - 10.30am **Plenary 4**
Collaboration in Health Services Research: the way forward
Arawa Room

10.30am - 11.00am **Morning Tea**

11.00am - 12.30pm **CONCURRENT SESSIONS**

Primary Health Care Services
Akarana Room

Organised Session – Policy, Innovation and Reform: the Victorian Orthopaedic Waiting List Program
Tamaki Room

Mental Health
Hauraki Room

Measurement and Methods for Health Services
Westhaven Room

Maternity Services
Nikau Room

12.30pm - 1.30pm **Lunch**

12.30pm - 1.30pm **The Harkness Fellowship Experience**

Arawa Room

1.30pm - 3.00pm **CONCURRENT SESSIONS**

Round Table – Data Linkage – a Burgeoning Resource for Health Services Research
Arawa Room

Purchasing and Payment Systems for Primary Health Care
Tamaki Room

Chronic Care Management
Hauraki Room

Round Table – The Need for and Challenges of Developing Post-Graduate Courses in Health Services Research for Australia and New Zealand
Westhaven Room

Identifying Service Needs
Nikau Room

3.00pm - 3.30pm **Afternoon Tea**

3.30pm - 5.00 **Plenary 5**
Panel session – What do Policy-makers, Funders and Health Providers Want from Health Service Researchers?
Arawa Room

Wednesday December 5th

8.30am - 10.00am **CONCURRENT SESSIONS**

Issues in Primary Health Care
Akarana Room

Public Health
Tamaki Room

Planning and Evaluation of Child Health Care Services
Hauraki Room

Development of Nursing Services
Westhaven Room

Round Table – Facilitating Strong Partnerships between Researchers and Research Users for Policy Relevant Research
Nikau Room

10.00am - 10.30am **Morning Tea**

10.30am - 11.45am **Plenary 6:**
Looking to the Future in Health Services Research
Arawa Room

11.45am - 12.00pm **Prizegiving and Conference Close**
Arawa Room