

# Presidents report

Vol 18 No 1 February 2001



It's a pleasure and an honour to have been appointed President of the PHAA last November. I have been associated with the Association for almost twenty years and I am well aware, and proud, of the expertise, commitment, passion, diversity, optimism and endurance of our members. I am also aware that although the Association's aim is to promote public health, being a member can also be extremely beneficial to personal health – I count many of our members among my closest personal friends and I greatly enjoy my contact with them during meetings and conferences. I'm also aware of the history and achievements of the PHAA and I hope that during the next two years we will be able to build on those to promote the health and wellbeing of all Australians, but especially the health of the most disadvantaged.

I am not the only new appointment, however. We have a new national executive committee, new state branch committees, new office bearers in many SIGs, new journal editors and a relatively new Executive Director. I wish to take this opportunity to thank all these people for contributing to the PHAA. I do not know them all personally but I do know that they are all filled with ideas, enthusiasm and commitment for

the Association. You should acquaint yourself with the identity of the officials in your areas of interest. The office bearers and secretariat will do much of the work of the Association but we do not have a monopoly on good ideas or energy and I encourage you take every appropriate opportunity to let us know your views and/or offer your services to assist with the Association's work.

I have attended a couple of workshops on behalf of the PHAA recently, which will be of interest to some members. Last October the Population Health Division of the Commonwealth Department of Health and Aged Care organized a two-day workshop to help them identify the preliminary steps involved in the development of a process for a more 'holistic and collaborative' approach to adolescent health and wellbeing. The Department is aware that much action is already going on at local, state and territory levels and wishes to 'add value' to this work through improved collaboration. The Department is clearly very committed to promoting adolescent health and will be producing a discussion paper based on the discussions and ideas that emerged at the workshop. Anyone interested in receiving a copy of the discussion paper when it is released should leave their contact details with the PHAA secretariat.

Around the same time I participated in a half-day workshop organised by NSW Health to discuss the consultation paper *'General Practice and Population Health'*. The paper was prepared by the Joint Advisory Group on General Practice and Population Health established by the Federal Minister for Health – the 'joint' referring to the General Practice Partnership Advisory Council and the National Public Health Partnership. The consultation paper identifies some principles to underpin a role for general practitioners in population health, some appropriate population health activities for

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GPs and some key issues for resolution. I have to confess that I have always been a bit of a sceptic when it comes to GPs being involved in population health but this consultation paper seems to have adopted a very reasonable and pragmatic approach.

On the GP theme, I have accepted an invitation to participate in a workshop organised by the Department of Health and Aged Care in late March to set priorities for primary health care research,

evaluation and development. Also, the Association has been invited by the Joint Advisory Group on General Practice and Population Health to comment on the *'Draft Framework for Developing Integrated Approaches to Behavioural Risk Factor Management within General Practice'*.

Copies of this document are available at <http://www.health.gov.au/pubhlth/about/gp/>. Anyone wishing to contribute to our response should send their comments to the national secretariat.

What all this indicates is that there is considerable interest at present in the role of GPs in public health. The PHAA will take every opportunity to ensure that our experience and expertise influences the decisions taken. Helen Keleher, Pieta Laut and I would be pleased to hear from any members who wish to be involved in developing our responses to the issues that arise.

Best wishes to all members and their families for 2001.

**Peter Sainsbury, National President**

## Publications of Interest

### 1. Priorities for Action in Cancer Control

The Health Industry and Investment Division of the Department of Health and Aged Care has released a draft document: *Priorities for Action in Cancer Control 2001-2003*. The document aims to provide a framework for a national collaborative approach to cancer control and to offer some high priorities for nationally coordinated action. Copies can be obtained by contacting: Ms Jennifer Smart  
Phone: (02) 6289 4260  
Email: [jen.smart@health.gov.au](mailto:jen.smart@health.gov.au)  
Submissions on the document are due by Friday 9 March 2001.

### 2. NPHP Consultation Paper

The National Public Health Partnership has recently release a Consultation Paper: "The Role of Local Government in Public Health". The paper aims to:

- examine the relevant legislation which sets out the role of local government in relation to public health throughout Australia;
- identify those public health responsibilities that local

government is charged with under legislation and relevant policies throughout Australia;

- identify areas of commonality and differences between jurisdictions with respect to local government involvement in public health; and,
- identify legislative issues requiring further examination.

Copies of the paper can be obtained from the Partnerships website <http://www.nphp.gov.au>

### 3. Consumer Focus Strategy

The Commonwealth Department of Health and Aged Care is developing a series of publications emerging from its Consumer Focus Strategy. Projects funded through the strategy are intended to promote integrate and disseminate information and increase consumer involvement in health service planning, delivery, monitoring and evaluation. For information on the availability of publications contact the : Information Manager  
National Resource Centre for Consumer Participation in health (NRC) Phone: (03) 9479 3614  
Freecall: 1800 625 619 Website <http://nrccph.latrobe.edu.au>

### 4. Health & Economics: Bridging the Abyss

In March of this year the Medical Council of WA hosted an event titled "Health & Economics: Bridging the Abyss". This event involved 150 health professionals across the public and private sectors who discussed and debated the principles for prioritisation for health resources.

A number of recommendations arose out of this event, the two most significant being a belief across the industry and citizens that more resources should be allocated to public health and prevention and that equity issues within health need to be more adequately addressed.

A booklet summarising the development, process and outcomes of this event has been produced and if you would like a copy of this document, please e-mail your postal address to:

[Carmel.DiPetta@health.wa.gov.au](mailto:Carmel.DiPetta@health.wa.gov.au)  
or telephone 9222 2071. Please include the heading - "Summary Document March 2000" - in your e-mail.

# HIV AIDS: 'Para 55'

At the request of the Secretariat, I attended a meeting conducted by the Australian Federation of AIDS Organisations on 18 January 2001.

At the meeting of the Commonwealth Heads of Government in Durban, last year, the official communiqué contained one very important public health paragraph:

"Heads of Government expressed grave concern over the devastating social and economic impact of HIV/AIDS, particularly in sub-Saharan Africa. They agreed that this constituted a Global Emergency, and pledged personally to lead the fight against HIV/AIDS within their countries and internationally. They urged all sectors in government, international agencies and the private sector to co-operate in increased efforts to tackle the problem, with greater priority given to research into new methods of prevention, the development of an effective vaccine and effective ways of making affordable drugs for the treatment of HIV/AIDS accessible to the affected population."

A spokeswoman from the Commonwealth Medical Association informed the meeting of the significance of Paragraph 55. There a number of important issues arising out of this statement. The most important is that it has been accepted by everyone of the 153 heads of Government attending, since there is no provision for a majority vote, not for a minority dissent. The second issue is the magnitude of the Global Emergency. Members of COHG come from every

continent except South America, Asia and Siberia. The countries that belong to the Commonwealth have 29% of the world's population. They also have 60% of HIV infectivity. Marianne Haslegrave told us of the formation of an advocacy and lobbying group "Para 55", and of what NGOs throughout the Commonwealth can do. Marianne Haslegrave divided her address into several components, and this report will precis her points.

CMA is a pan-Commonwealth organisation, funded by the Commonwealth Fund, a funding body, set up by the Commonwealth Secretariat, but separate from it. It is designed to allow NGOs to have a platform to put their ideas and needs before the CHOG meeting, by using an exhibition, a seminar program, and an arts and cultural program. These run immediately before and during the meeting, and usually attract the Head of the Commonwealth, some of the Heads of Government, and many of the support staffs. These are one of the best ways of visually lobbying, but the real work is done through both the Head of Government's office, and, in public health matters, through that Ministry.

After the Durban Communiqué, many of the sub-Saharan Commonwealth countries held discussions about HIV/AIDS, as did the Caribbean countries. One of these joined with a number of other UN members, to initiate a United Nations General Assembly Special Session on HIV/AIDS. This is a laborious process, but approval has been given to this

Special Session taking place on 25-27 June, some four months before the CHOG meeting in Brisbane in October. It is interesting to note that this initiative was not sponsored by UNAIDS. Lobbying the UNGASS is nearly impossible, so this has to be done through government to their envoy.

Besides the actual meeting of the HOGs, there is also a committee of the Whole, where advisers are also involved. It is this group of some 400 persons who decide on the contents of the communiqué, and the decision must be unanimous. So, an informed group of advisers is very significant. She pointed out that there is no Pan-Commonwealth AIDS organisation in existence. Nor, for that matter, is there a Pan-Commonwealth Public health organisation, either. It is worthwhile to note that the agenda for the meeting at Brisbane is drawn up by the host Head of Government. It is also important to realise that any material that is to go to the Secretariat for the CHOGM must be in its hands by the end of May. Marianne also stressed how important it is to have a single, very focused issue as a basis for lobbying. And, with in view, she commended the notion that national groups seek press corps accreditation for the Meeting, since quite a deal of informal press briefings are provided by the Secretariat, the advisers and the individual HOGs. AFAO's interest is in getting implementation for Para 55. To achieve this, materials from all NGOs must get to UNAIDS well before the Special Session. Whether or not a government also

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## Branch News Annual Conference - A High Priority

The NSW Branch Committee has a very clear priority: the successful planning, preparation and running of the 33rd National Conference, *2001 A Public Health Odyssey*, in Sydney, 23-26 September 2001. As is always to be expected, the Conference responsibilities are split between the Secretariat, a scientific committee and an organising committee. They have already had one teleconference, and will have a meeting on 9 February.

The Branch is also hosting a seminar with the NSW Chief Health Officer, to allow him to present the Strategic Directions for Public Health to 2003. This

meeting, at which we will invite two or three other public health professionals to take part, is set for 22 March. It promises to be informative and a little contentious. Maintaining a political, economic and professional balance is very challenging.

The President, Peter Sainsbury, sent a warm letter of congratulations to Professor Marie Bashir, AO, on her accepting the commission to be the next Governor of NSW. Marie Bashir has been a member of PHAA for many years, and the NSW Branch sees this as a singular honour to all the Branch's members.

And, of course, we are starting the process of planning our AGM for July. But that will be another story.

**Peter Trebilco**  
NSW Branch President

## New Members

### New South Wales

Maureen Chapman  
Cheryl Johnson  
Mary-Rose Birch

### Victoria

Claire Daly, Deborah Hilton  
Brian Dunn, Sharon Matthews  
Lisa-Maree Muller, Dianne Beck  
Wendy Hunter, Dianne Wilson

### Queensland

Eleanor Coyne

### Western Australia

Liz Ernst  
Community, WA Aids Council

### South Australia

Christine Caleidin

### Northern Territory

Annie Whybourne

### Overseas

David Vance, South Korea

## The Public Health Council of WA: Public Health Advocacy in Practice



Despite the usual rumours of early elections, the West Australian Court Coalition Government realised its stated intention by completing its full 4 year term. A traditional late summer date (February 10<sup>th</sup>) is set as the day the WA voters could have their say.

Knowing an election was near, public health professionals spent much of 2000 expressing private concerns over the future of public health in the state. The chief area of concern was the obvious decay in infrastructure with health outcomes starting to be measurably effected. Public health programs, training, resources, services and influence all seemed to be flagging, failing or simple nonexistent. The usual lamenting at professional and private events gave way to a more determined action plan as some of the key players compared notes, and in mid 2000 an informal meeting was called to formulate an election strategy to promote public health goals.

Representatives from the PHAA joined with leaders from academic institutions, other professional groups, larger non-government health agencies and public health research groups and as a result, the Public Health Council of WA (PHCWA) was born. Encouraging a broad support base, an early decision was made to open membership to like-minded groups, and a number were approached. Current membership includes:

- Australasian Faculty of Public Health Medicine (WA Regional Committee)
- Australian Health Promotion Association (WA Branch)
- Cancer Foundation of WA

- Combined Universities Centre for Rural Health
- Department of Public Health, The University of WA
- Derbarl Yerrigan Health Service
- Division of Health Sciences, Curtin University
- Health Consumers Council of WA
- National Heart Foundation (WA Division)
- Public Health Association of Australia (WA Branch)
- School of Nursing and Public Health, Edith Cowan University
- TVW Telethon Institute for Child Health Research

The primary task of the Council was to develop an election manifesto on public health issues, which was to be presented to the main political parties and to the WA community through the mass media. High profile researcher and public health advocate (and PHAA member) Professor Fiona Stanley was elected as the Founding Chair of the PHCWA.

Early meetings focused on strategies to bring public health concerns onto the political agenda and a lobbying document, with a hand full of specific examples, was developed. Its aim was to highlight the nature of the problem - particularly where WA was performing poorly against national standards or against historical data. Major themes included inequalities, aboriginal health, child health, prevention of alcohol related harm, tobacco, obesity and injury as well as physical activity and diabetes, mental health and leadership and accountability.

Specific examples of poor progress included infant drowning rates (linked, in part, to poor legislation on isolation pool fencing), a

cessation in the decline in tobacco smoking prevalence and IHD and suicide rates among people with mental health problems

Examples of past successful interventions were also highlighted, as were concerns relating to more subtle difficulties such as leadership within government, and infrastructure issues.

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## DISTANCE EDUCATION COURSES FOR HEALTH PROFESSIONALS

- Graduate Certificate in Health Services Research and Evaluation

- Introduction to Health Program Evaluation

(Professional Development Course)

These two courses are on offer early 2001 both nationally and internationally. For more information please contact Jenni Livingston or Helen Jordan at the Centre for Health Program Evaluation or visit our website at <http://ariel.unimelb.edu.au/chpe/>

Telephone: (03) 9496 4440

Fax: (03) 9496 4424

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[joymy@unimelb.edu.au](mailto:joymy@unimelb.edu.au)



MELBOURNE



THE UNIVERSITY OF  
NEW SOUTH WALES



School of Health Services Management  
FACULTY OF MEDICINE

## GRADUATE CERTIFICATE IN HEALTH SERVICES MANAGEMENT THE SOCIAL DETERMINANTS OF HEALTH

The Medical Faculty at the University of New South Wales and the Centre for Health Equity Training, Research & Evaluation are pleased to announce a new program, to begin in 2001. The Program is designed specifically for policy makers, managers, clinicians and consumers interested in tackling inequalities in health.

The Graduate Certificate in Health Services Management – The Social Determinants of Health can be completed in one-year part-time study. It is offered internally and externally. Some courses are offered in workshop mode to minimise disruption to your professional and personal life.

The emphasis is on sharing expertise and applying new approaches to your current and future working life. You need to have a Bachelor qualification and a minimum of three years' experience working in the health care field.

Courses include: Child Health Services, Community Development, Culture, Health and Illness, Demography, Health Care Systems, Health Promotion, Inequalities and Health, Influencing Health Beliefs and Behaviours, Introduction to Public Health, Primary Health Care –Issues in implementation, Qualitative Research Methods, and Sociology, Ethics and Health.

This program of study brings you right up to date with current international and local evidence, know-how and experience with the social determinants of health, and what you can do about it.

Program Director & academic enquiries:  
Dr Stephanie Short  
School of Health Services Management  
Faculty of Medicine UNSW, NSW 2052

Telephone: 02 9385 2592, Facsimile: 02 93851036  
Email: [s.short@unsw.edu.au](mailto:s.short@unsw.edu.au) or [www.med.unsw.edu.au/shsm/short.htm](http://www.med.unsw.edu.au/shsm/short.htm)

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The challenge was to make the document succinct, powerful and accessible to non-health professionals. Graphics telling a clear story were a key ingredient. The document titled "Investing in Public Health" was then launched to the media on December 8. On the day before it was sent to the Premier and the Leader of the

Opposition. Copies were sent to all major political parties.

Spokespeople including Fiona Stanley, Ted Wilkes (Director of Derbarl Yerrigan Health Service) and UWA Professor of Public Health D'Arcy Holman gained blanket coverage on radio, TV and newspapers.

While writing such a document within a committee can be a slow and painful process, it is worth acknowledging some individuals who made special efforts to ensure its completion. Maurice Swanson and Betty Durston (NHF WA), Mike Daube, (CFWA) D'Arcy Holman, Fiona Stanley, Charles Douglas and Bret Hart (AFPHM) played major roles. All are current PHAA members and/or former branch office holders.

Subsequently the ALP health policy launch clearly showed the influence of the PHCWA document, with references in the Opposition health policy to PHCWA recommendations. At the time of writing the Coalition Health policy has yet to be released. Of course this, and to a greater extent the election outcome, will tell the full story of the success or otherwise of the strategy. I hope I can bring you up to date after Feb 10 when, Florida voting mishaps notwithstanding, the party governing WA, and the real impact of the fledgling PHCWA, will be known.

Regardless of the outcome, perhaps a moral of the story might be that with an energetic, determined and most importantly, a co-operative public health community effort, we can not only hope to influence government policy and action on public health, but we should expect to do so. With a Federal election in the offing in 2001, the ball is in (y)our court.

Further information regarding the PHCWA document can be gained by contacting Terry Slevin via email: [terry@cancerwa.asn.au](mailto:terry@cancerwa.asn.au)

**Terry Slevin, National Vice President, Development.**

# Why a Hearing Screening Conference?

On Saturday March 24<sup>th</sup> 2001, the Universal Neonatal Hearing Screening Working Party (SA), the PHAA Child Health SIG and the Women's and Children's Hospital will co-host a one day National Conference in Adelaide to discuss the implementation of universal hearing screening in newborn children throughout Australia (see advertisement this issue).

As background to this meeting it is worth noting that between 1 and 3 children in every thousand born in Australia (around 500 children every year) has a permanent hearing impairment (PHI). The impairment is often detected as a result of an investigation into developmental problems or inappropriate reactions to sound – and the average age at which a problem is detected is typically around two years or more – although Victoria could proudly lay claim to a much earlier age at detection (around 1 year) as a result of its universal screening using a 'distraction' test at around 7 – 9 months of age.

It will come as no surprise to anyone, that children who are deprived from birth of the sensory inputs so intimately involved in the acquisition of language,

commonly suffer serious delays in learning to communicate. But they are also far more likely to become socially isolated; to fall behind the academic achievements of their normal peers; to suffer from a number of behavioural problems; and to have low self esteem.

On commonsense grounds alone, it might seem reasonable to conclude that the earlier the problem is detected in a child, the quicker an appropriate hearing aid can be fitted, and the adverse outcomes associated with PHI will all be less severe. In an age of increasing demand for evidence-based health care it is remarkable how little solid evidence has been published in support of this appeal to commonsense – and lobbyists for early detection currently base their arguments on a handful of observational studies. While these studies do indeed support the notion that the earlier the impairment is detected and treated, the better the outcomes in the child, their emphasis has been principally on the domain of language skills; and the complete absence of any randomised clinical trial means that the introduction of screening is not supported by any Level 1 or 2 evidence.

*But what makes this discussion so important in child health today?*


The answer to this question lies in the technological developments of the 1990s. Not just one, but two methods, have been developed for detecting a very high proportion of all children with permanent hearing impairment at a very early age. One astonishingly clever method relies on the finding that the hair cells in the cochlea of a child with good hearing respond to sounds by vibrating and generating a sound of their own. These otoacoustic emissions (OAE), as they are called, can be detected and measured – and a small probe which sits in the outer ear can be used to assess the hair cell functioning of a resting or sleeping baby in one or two minutes. The other method, automated auditory brainstem response (A-ABR), relies on detecting the electrical potentials evoked in the brain of a sleeping infant by sound stimuli delivered through a headphone.

Such has been the enthusiasm generated by these new technologies that the American National Institutes of Health Consensus Statement, 1993, the

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Members of the Universal Hearing Screening Working Party (SA), the Public Health Association of Australia Child Health Special Interest Group, and the Women's and Children's Hospital invite you to:


Public Health Association of Australia



Child Health Special Interest Group

**Universal Neonatal Hearing Screening**  
**A National Forum for**  
**Consensus and Implementation**

Saturday March 24, 2001



Women's and Children's Hospital

Queen Victoria Lecture Theatre, Women's and Children's Hospital, North Adelaide, SA.

Hear about the British and American experience of UNHS from Dr Albert Mehl (US) and Prof. John Bamford (UK) – and share pilot experience and strategies with others who wish to see Universal Neonatal Hearing Screening implemented throughout Australia  
Cost of registration \$100. Forms and program details from: [antonioug@mail.wch.sa.gov.au](mailto:antonioug@mail.wch.sa.gov.au)

European Consensus Statement, 1998, the American Academy of Pediatrics, 1999, and the US Joint Committee on Infant Hearing have all supported their application in universal neonatal hearing screening programs. Neonatal hearing screening is mandatory in several states of the USA, and large-scale, but not universal, screening is underway in Western Australia. At centres using the new screening technologies for neonatal screening, the average age at detection of PHI has decreased dramatically to below one year – and in one of the most cited studies in the hearing screening literature, Christine Yoshinaga-Itano of Colorado, has presented data indicating that if an impairment can be detected and acted upon before 6 months of age then children with PHI can achieve their maximum potential linguistic and communication skills.

The sudden availability of two methods for the early detection of PHI has been a mixed blessing. The OAE method is cheaper to implement than the ABR method, but it generates many more ‘false positives’, especially within the first few days of life when the passages within the ear may still be ‘drying out’. Informing parents that their baby requires further investigation for a possible hearing impairment may engender anxieties which could compromise the process of bonding with the child, if only, in the vast majority of cases, until the screening is repeated. On the other hand, the A-ABR method usually requires the baby to be ‘dotted’ with electrodes and wires, which may be less acceptable to anxious parents than the apparently less invasive method of placing a

miniaturised sensor in the outer ear to stimulate and measure OAEs. The important question of whether screening should be universal – or whether it should be targeted at specific high risk groups, such as children of parents with PHI or infants requiring neonatal intensive care, has not been resolved to everyone’s satisfaction. While as many as 50% of all children with PHI may be detected in this way, principles of equity must surely demand that we strive to make any screening program universal.

Just how to maximise the coverage of a neonatal hearing screening program so that it approaches universality is another issue that may require careful consideration. While screening in hospitals may seem an obvious and convenient way of accessing a high proportion of babies, there are difficulties in ‘catching’ infants who are born at home, in birthing centres, or whose mothers are discharged shortly after an uncomplicated delivery. In Adelaide, for example, over 20% of all women delivered at the Women’s and Children’s Hospital go home within two days of delivery, and at the Lyell McEwin Hospital a Dutch model of obstetric care currently under trial encourages women to go home within hours of an uncomplicated delivery. And can the acquisition of screening equipment be justified for small rural hospitals where only a few births occur every year? Arguments for a component of screening activity in the community setting are becoming increasingly compelling – and given the diversity of organisations delivering health care for children across Australia it seems likely that a variety of approaches to screening will be essential. Another major problem

confronting delegates to the March 24<sup>th</sup> meeting must also be how to engage governments, both state and federal in the implementation of a universal hearing screening program. The Commonwealth/State divide, already a complicating factor in the delivery of many health care services, is looming as a problem for neonatal hearing screening as well. The federal government, through its Department of Health and Aged Care has already assumed responsibility for the care of hearing impaired people of all ages. Children with hearing impairments are diagnosed; given appropriate hearing aid equipment, and monitored until the age of 21 at Australian Hearing for a nominal annual charge. But it argues that screening activities of all kinds (metabolic, seeing, hearing) is entirely the responsibility of the states – and in the current climate of health care funding it is difficult to see states diverting money away from acute treatment needs to a new universal hearing screening program. And even though the costs of hearing screening can almost certainly be justified in terms of the savings recouped in the size and intensity of remedial education programs of children with PHI, the fact that expenditure in health service delivery will be largely recouped in the education sector means that only a whole-of-government approach to the detection and treatment of PHI is likely to be successful.

See also: Policy on Neonatal Hearing Screening adopted by the PHAA in November 2000, at the Annual Conference in Canberra.

**Peter Baghurst**  
**Child Health SIG Convenor**

## Financial Report : July 2000 through to December 2000

	December	Budgeted	\$Difference	%Difference
<b>Income</b>				
Branch Income	\$37,246.01	\$0.00	\$37,246.01	NA
Interest Received	\$19,338.48	\$12,502.00	\$6,836.48	54.70%
In Touch Advertising	\$6,836.32	\$12,502.00	(\$5,665.68)	-45.30%
Membership	\$355,511.45	\$352,000.00	\$3,511.45	1.00%
Secretariat Income	\$96,214.52	\$105,668.00	(\$9,453.48)	-8.90%
Journal (ANZJPH)	\$38,035.67	\$25,000.00	\$13,035.67	52.10%
Project Grants	\$19,612.96	\$0.00	\$19,612.96	NA
Workshop Income	\$2,604.56	\$0.00	\$2,604.56	NA
SIG Carried Fwd Income	\$66,953.41	\$0.00	\$66,953.41	NA
Branch: Ttl. Carried Fwd	\$57,855.20	\$0.00	\$57,855.20	NA
<b>Total Income</b>	<b>\$700,208.58</b>	<b>\$507,672.00</b>	<b>\$192,536.58</b>	<b>37.90%</b>
<b>Expenses</b>				
Branch Expenditure	\$45,684.00	\$25,000.00	\$20,684.00	82.70%
Communication	\$21,672.91	\$20,999.94	\$672.97	3.20%
Operating Costs	\$82,579.93	\$189,498.08	(\$106,918.15)	-56.40%
Journal Expenditure	\$64,114.56	\$0.00	\$64,114.56	NA
InTouch Expenditure	\$15,587.46	\$0.00	\$15,587.46	NA
Salaries & oncosts	\$77,208.05	\$159,499.92	(\$82,291.87)	-51.60%
Office Equipment	\$1,970.35	\$2,499.96	(\$529.61)	-21.20%
Projects	\$19,338.79	\$4,999.98	\$14,338.81	286.80%
<b>Total Expenses</b>	<b>\$328,156.05</b>	<b>\$402,497.88</b>	<b>(\$74,341.83)</b>	<b>-18.50%</b>
<b>Operating Profit</b>	<b>\$372,052.53</b>	<b>\$105,174.12</b>	<b>\$266,878.41</b>	<b>253.70%</b>
<b>Conference Income</b>				
Conference Income	\$418,325.89	\$490,000.00	(\$71,674.11)	-14.60%
<b>Total Conf. Income</b>	<b>\$418,325.89</b>	<b>\$490,000.00</b>	<b>(\$71,674.11)</b>	<b>-14.60%</b>
<b>Conference Expense</b>				
Conference Expenses	\$386,825.97	\$379,342.63	\$7,483.34	2.00%
<b>Total Conf. Expense</b>	<b>\$386,825.97</b>	<b>\$379,342.63</b>	<b>\$7,483.34</b>	<b>2.00%</b>
<b>Net Profit/(Loss)</b>	<b>\$403,552.45</b>	<b>\$215,831.49</b>	<b>\$187,720.96</b>	<b>87.00%</b>

(continued from page 3)

takes action will depend on the quality and intensity of lobbying of the Health Ministry and the Prime Minister's Office. It was suggested that Human Rights might well be the vehicle that allows any of the Pan-Commonwealth governments to intervene. Whether they use any of the Faith Committees is a decision yet to be made. However, both the last President of the USA and the President of the World Bank put considerable emphasis

on involving Faith Committees. In Australia, interested parties might consider who are the key faith leaders?

The last matter that was mentioned is that the ASEAN heads of Government will meet in Brunei in December, with HIV/AIDS as a major issue for discussion. Some of these are also members of the Commonwealth. Andy Quan, International Policy Officer for AFAO there outlined some of the ideas that could help

promote action under Para 55: in view of the fact that the Foreign Minister, Alexander Downer has publicly committed funds for HIV/AIDS work in the South West pacific region, AFAO proposes to hold its AGM in Brisbane on 5<sup>th</sup> October; this to be followed by a seminar program on 6<sup>th</sup> October, which coincides with the CHOGM opening, and to continue on 7<sup>th</sup> October. These events would take place in the Commonwealth People's Centre, which is organised and partly funded by the Commonwealth Foundation.

It would seem that PHAA and its members who take an interest in HIV/AIDS might collaborate with AFAO, and start a practical policy of active lobbying. It is important that any funding is precisely directed at the three aims of prevention, a vaccine and affordable and accessible drugs.

**Peter Trebilco**  
NSW Branch President

### New National Executive Biographies: Angela Taft Special Interest Groups' Representative



Has a long history in women's health advocacy/activism, policy, programs and research.

Recently awarded PhD follows my MPH study in primary health care responses to violence against women and children. Currently working towards a randomised community intervention study in abuse in pregnancy and post-partum with La Trobe University's Centre for the Study of Mothers' and Children's Health.

## New National Executive Biographies: Judith Dwyer - Treasurer



Judith Dwyer has recently moved from health care management to a position as Associate Professor, Health Services Management at the La Trobe School of Public Health. Judith is a former CEO of Southern Health Care Network in Melbourne, and of Flinders Medical Centre in Adelaide, and has worked in the Australian health system for 20 years in a broad range of community, hospital and government settings.

Judith leads LaTrobe's health services management education programs, and her major research and consulting work will be in the

areas of clinical governance and the reform of patient care processes.

### Further Background Information

A/Professor Dwyer holds a Masters degree in Business Administration. She contributes regularly to various national forums of the health industry, and has published widely on health policy and health care management. She is a member of one of the original 'learning sets' established by the Australian Healthcare Association, which provide a unique approach to continuing professional development for health care

executives. She holds an honorary appointment as Adjunct Professor in the Institute of Public Health and Health Services Research, Monash University.

Ms Dwyer has a long standing interest in women's health, and was awarded the inaugural AMA Women's Health Award in 1998. She was the foundation President of Women's Hospitals Australia, the national association of leading women's hospitals, and has served on various committees of the National Health and Medical Research Council and as a Director of the Board of the Australian Institute of Health and Welfare.

### 2001 General Practice & Primary Health Care Research Conference

#### Embedding Research in Practice

Stamford Grand Adelaide  
31 May & 1 June, 2001

#### CALL FOR ABSTRACTS

The purpose of this Conference (formerly GPEP) is to enable investigators at various stages of their research to benefit from interaction and exchange with each other. This is an important event for all those with an interest in general practice and primary health care research, evaluation and development.

There will be a combination of plenary sessions, workshops, paper and poster presentations.

Facilities will be available for participants to gain hands-on experience in the use of databases of GPEP research and Divisions' activities, developed by the National Information Service.

Abstracts for poster presentations are invited from investigators working in the field of general practice/primary health research. Closing date for receipt of abstracts is March 12.

#### Abstracts, registration and enquiries should be directed to:

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Deakin West ACT 2600  
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Fax: (02) 6285 1336

Email: [conference@conlog.com.au](mailto:conference@conlog.com.au)

### Logistic Regression and Survival Analysis in Epidemiologic Research

16 - 20 July 2001, Hobart

This intensive course provides theoretical and practical training for epidemiologists and professionals of related disciplines in statistical modelling, with a particular focus on logistic regression and survival analysis. It is suitable for those with some previous training and experience in epidemiology and/or biostatistics.

Topics include the logistic regression and Cox proportional hazards models that have become standard methods for regression analysis in the health sciences, as well as descriptive methods for survival data.

Course presenters are Professor Stanley Lemeshow (Ohio State University) and Professor David Hosmer Jr (University of Massachusetts). Both are Faculty members of the highly regarded New England Summer School Program.

For registration details please contact Wendy Spencer.  
Tel: (03) 6226 7701 Fax: (03) 6226 7704  
Email: [W.Spencer@utas.edu.au](mailto:W.Spencer@utas.edu.au)



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# Code of Conduct and Ethical Practice in Aged Care

In May 2000 the Minister for Aged Care, the Hon Bronwyn Bishop, set up her National Aged Care Accreditation and Compliance Forum. At the first meeting of the Forum the Minister proposed that there be a Code of Conduct developed for the aged care sector. With the agreement of the Forum she appointed a Working Group under the chairmanship of Dr John Fleming to produce a draft document. The draft *Aged Care Sector Code of Conduct and Ethical Practice for Commonwealth Residential and Community Aged Care Services Provided Under the Aged Care Act 1997*, was released for industry wide consultation at the end of 2000 and these responses are currently being collated.

The draft Code of Conduct sets ethical benchmarks for the safe and efficient delivery of aged care services. As the title implies, *The Code* applies to the provision of services that come within the Aged Care Act 1997, namely, services provided to older people in aged care facilities and in the community through the *Community Aged Care Packages (CACP)*.

Importantly, *the Code* has the distinction of proposing fundamental human values, derived from the recognition of the inherent dignity of the human person, as the basis upon which the delivery of aged care services are articulated, thereby shaping the culture in which aged care services are delivered. These values are universally recognised as integral to a civilized society and are universally agreed to be fundamental human values, transcending cultural, social,

religious, and other differences. These fundamental human values are to be found, expressed as rights and responsibilities, in the provisions of the Universal Declaration of Human Rights.

Thus, the fundamental human values identified in *The Code* “will drive the way in which owners, approved providers, key personnel, managers, boards, administrators, all health professionals, and all other personnel, in partnership with the Commonwealth, make and implement policies which affect the delivery of those services for the benefit of aged care recipients.” (from the Preamble to *the Code*).

Two points need to be made in relation to the development of *the Code*. First, that its development does not mean that the industry has neglected standards in the provision of policies and practices of aged care services. *The Code* clearly identifies that the, “aged care sector is committed to the provision of care to a standard appropriate to the needs of all those who are recipients of aged care services under the *Aged Care Act 1997*”. The fact that fundamental human values are the primary source that supports the rest of the document is acknowledgement of the pre-eminent place that ethical practice, based on human values, has in health care. In this way *the Code* focuses attention on the primacy of values and ethics in the provision of care. It also reinforces the aged care sector’s commitment to the protection of human values which derive from recognition of the inherent dignity of the human individual, all of which can be at risk in the provision of aged care services.

Development of *the Code* is a milestone in the development of the aged care industry as a whole. It is evidence that the industry is able to move to the next level of service provision. Indeed many individual organisations have already identified the need for a Code of Ethics and have developed organisational Codes. However, this is the first time that such a document has been developed industry wide which brings with it consistency and agreement, benefiting the community as a whole.

Secondly, since fundamental human values are expressed as rights and responsibilities, *the Code* is “predicated on an understanding of the mutual obligations between all the parties involved”. While *the Code* seeks to protect vulnerable older people receiving aged care services, it also identifies the rights of all parties who provide and receive those services. The benefits of the application of such a comprehensive code of conduct and ethical practice are that it not only identifies the inherent rights of each party, but also identifies who has the responsibility to respond to those rights as well as the scope of the services reasonably needed to satisfy those rights. It moves away from one party subjectively determining the rights and obligations of other parties in a way which may impact adversely on the rights of others. It provides consistency across the industry at a national level, something that has not previously been obtained. It also supports an image of aged care services to the community and the professions that recognises a high

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standard of care, professional development of all staff, and that care is primarily focussed on the needs of the recipients of care.

*The Code* is not intended to replace organisational policies or detailed protocols and guidelines. Rather it is intended to be the basis for the development of those documents. One of the purposes of the Code is to provide a basis which will enable individual organisations to develop written protocols which will support and inform the ways in which care is delivered under *the Code*. To facilitate the implementation process the Commonwealth has agreed to assist in the development of a Handbook of Ethical Protocols which aged care facilities can use as a basis for staff education and professional development, and to ensure that the Code is complied with in the facilities. The draft Code of Conduct sets ethical benchmarks for the safe and efficient delivery of aged care services. What staff then need are clearly set out protocols which will enable them to comply with the standards and to deal with difficult issues which arise from time to time.

A writing team has been convened under the chairmanship of Dr John Fleming to develop the Handbook which should facilitate implementation of the Code. Any inquiries regarding the Code can be directed to Alma Quick at the Department of Health and Aged Care on Phone: (02) 6289 5217

[Joanne Ramadge MRCNA Royal College of Nursing, Australia](#)  
[Dr John Fleming Southern Cross Bioethics Institute](#)

## What's On

### 5-7 April 2001

Drug development & clinical research methods: Certificate Course, Monash University. Update in drug development, clinical trials methodology, drug epidemiology & pharmaco-economics. Information at [www.med.monash.edu.au/epidemiology/teaching/short\\_courses/drugdev.html](http://www.med.monash.edu.au/epidemiology/teaching/short_courses/drugdev.html), email [danila.ditrocchio@med.monash.edu.au](mailto:danila.ditrocchio@med.monash.edu.au) or phone Danila Di Trocchio, 03 9903 0048. Enrolments close 20th March.

### 14-16 May 2001

NCETA Workforce Symposium. Venue: Adelaide Town Hall Registration: \$280.50 (incl GST) Call for papers due 28 Feb 2001. For further information including themes and call for papers please Phone (08) 8201 7549, email [nceta@flinders.edu.au](mailto:nceta@flinders.edu.au) or online : [www.ncetasymposium.com](http://www.ncetasymposium.com)

### 16-18 July 2001

Nutrition and Food Safety Special Interest Conference. Further details will be printed in the March issue of *intouch* and available on the PHAA Website at [www.phaa.net.au](http://www.phaa.net.au).


### 7-8 September 2001, Melbourne

**The Shape of Things to Come:** National Body Image Conference Integrating Perspectives: Assessment, Treatment, Policy and Prevention. Joint Conference of Body Image & Health Inc & Deakin University. For further information email [thea@corporeal.com.au](mailto:thea@corporeal.com.au)

### 23-26 September 2001

33rd PHAA Annual Conference 2001: *A Public Health Odyssey - Popular Culture, Science and Politics* Hilton Hotel, Sydney. For further information please email: [conference@phaa.net.au](mailto:conference@phaa.net.au)

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