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Playing the blame game no solution to child abuse

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October 17, 2005*

*Dr Garth Alperstein
NSW Branch President*

The failings belong more to state and federal government policies, writes Garth Alperstein.

The NSW Ombudsman reports that "children as young as two weeks old have died and others have been left in grave risk of abuse because of under-resourcing, and poor judgements by the Department of Community Services".

Will an adequately resourced and functioning department prevent child abuse and neglect and child deaths due to abuse?

Child abuse and neglect is related mostly to poverty, poor educational status, poorly functioning communities and unsupported families. Australia has two to three times the proportion of children living in poverty of Scandinavian and some other northern European countries. Countries with a smaller gap between rich and poor have lower rates of child abuse. Australians think of themselves as living in an egalitarian society, but the wealthiest 50 per cent hold 93 per cent of the wealth and the least wealthy 50 per cent possess only 7 per cent of the wealth. Poverty rates and the distribution of income in a country are determined by government economic policies.

Child abuse and neglect have been shown in a number of studies to be related to lack of social capital - trust, networking, support - in a community. Social capital can be either supported or eroded by government policy and leadership.

In addition to government economic, educational and social policies, there is overwhelming evidence that nurse home-visiting programs that provide intensive support to poor disadvantaged and unsupported first-time young mothers, starting during pregnancy and continuing until the child is two, reduce

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the rate of child abuse and neglect by around 50 per cent. The State Government should be applauded for its Families First Initiative, of which home visiting is a crucial component. However, despite the evidence, this component of home visiting has not yet been funded. The only component of home visiting that is funded at present is a single home visit to all newborn babies, which will have no effect on reducing rates of child abuse.

The NSW Government has also claimed it is funding early intervention for families. Every \$US1 spent on early intervention results in \$US7 returned to society through reduction in crime. That data comes from the Perry Preschool program in the US, a high-quality preschool program for disadvantaged three- to five-year-olds. It is combined with parental involvement in child care, and child-care workers enhancing the developmental environment in the home. The Perry children were followed up at age 27 and at 40, when the return to society had increased to \$US12.90.

Neither the NSW Government nor the Federal Government has funded a Perry Preschool-type program. Access to quality child care has only been made more difficult through insufficient government funding for public child care and the proliferation of private for-profit child-care centres. Once again, government policy on child care can provide a free universal system like Sweden, or a restricted system.

To have an impact on longer-term intergenerational child abuse and neglect there is once again ample research to support investment in the early years of life. The 2000 Nobel laureate in Economic Sciences, James Heckman, stated that “investments in social policies that intervene in the early years have very high rates of returns, while social policies that intervene at later stages in the life cycle have low economic returns”. Crucial in the early years are home-visiting programs, high-quality, accessible child care, Perry Preschool-type programs in disadvantaged areas, early literacy programs, support for parents through adequate paid parental leave, availability of high-quality parenting programs and strategies that support all Australians attaining the highest possible level of education.

Do we do something to stop the bodies falling into the river upstream, or do we merely continue to give more money to the Department of Community Services to attempt to pull out a never-ending stream of bodies further down the river and continue to use it as the scapegoat for failings that belong more to state and federal government policies, and how they choose to spend taxpayers' money?

ABS-AIHW report *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, launched on 26 August 2005

The 2005 report provides a comprehensive picture of the health and welfare of Australia's Indigenous population. It covers a range of topics- and includes new information on the links between health and education, housing and homelessness, and disability and ageing.

(Catalogue no. 4704.0, AIHW Catalogue no. IHW 14) price \$65.00 or the report can be accessed free of charge on the AIHW website.

"Govt promotes uni nurse practitioner scholarships"

The Queensland Government is starting to advertise 20 university scholarships for nurse practitioners. Nurse practitioners can carry out duties outside the scope of traditional nursing, like prescribing some medication and referring patients to specialists. Some doctors had been critical of the Government's plan to expand the role of nurses in the Queensland health system. But Health Minister Stephen Robertson says nurse practitioners will play an important role across the state.

"But also important roles in rural and remote communities as well because they can fill very important roles when we find it difficult to recruit doctors," he said.

For further details visit the following link:

<http://www.abc.net.au/news/newsitems/200510/s1481986.htm>

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Unique Leadership Opportunity in a Leading Australian University

Professor and Head School of Health Sciences

RMIT University is seeking to appoint a Head of School for the School of Health Sciences to provide strong leadership and direction during the Schools next stage of development.

The Head of School will be responsible for fostering excellence in all activities with a focus in strengthening interactions with industry and professional associations, continuing to build partnerships and linkages to reinvest in the future development of the School.

The School of Health Sciences is one of the largest health sciences schools in Australia. Currently, it offers education and research training to more than 2,200 students in the following six academic disciplines: Chinese Medicine, Chiropractic, Disability Studies, Nursing & Midwifery, Osteopathy and Psychology. Although these are distinctively independent professions, they share a common feature of producing recognised healthcare professionals.

The School has a significant number of active and productive researchers in a broad range of areas in health and wellbeing, with particular strength in acupuncture, herbal medicine, and psychology. This School is also the home of the only World Health Organisation Collaborating Centre for Traditional Medicine in Australia which is an internationally recognised centre of excellence in traditional medicine education, research, policy development and clinical practice.

The successful candidate will have a distinguished record of leadership and research achievement either in academia or the relevant industry sector and previous experience in a similar role.

Appointees will be offered a 5 year contract as Head with a continuing appointment as Professor subject to academic qualifications, experience and background. The University reserves the right to determine the level of appointment.

For application details please visit the website listed below.

For further information about the position please contact
Professor Daine Alcorn - PVC SET on +61 3 9925 4548.

Quote Ref. No: 50015317

Applications close: 7 November 2005

GED520686

 www.rmit.edu.au/pc/jobs

WHO's new report, Health and the Millennium Development Goals, provides an overview of progress towards the MDGs to date and identifies five challenges to be addressed if we are to meet the goals:

● **strengthen health systems:** without more efficient and equitable health systems, countries will not be able to scale up the disease-control programmes required to meet the health goals

● **ensure that health is prioritised within overall development and economic policies** by looking beyond the health system to address the broad determinants of health. Fragile states and countries emerging from conflict have specific and different needs from other developing countries.

● **develop health strategies that respond to the diverse and changing needs** of countries by designing strategies which address all health challenges, now and in the future.

● **mobilize more resources for health in poor countries:** low-income countries cannot 'afford' the MDGs and aid is not filling the gap.

● **improve the availability and quality of health data**, to inform global and national policy-making and accountability.

By examining these five challenges, the report focuses on policy issues of relevance to the health sector as a whole. It does not look at progress towards the health MDGs on a county-by-country basis, however it does provide a global overview of progress towards each of the health MDGs, identifying areas where there has been success and many others where progress has been slower than hoped.

Governments of rich and poor countries, development organizations and civil society groups look to WHO for leadership and guidance on achieving the health MDGs. This report presents the essential elements -the strategies and inputs- that will help the international community, working collectively, to tackle the health crisis facing many poor countries and in doing so, contribute to poverty reduction. For more information email: bookorders@who.int

Vacant positions in public health: What employers seek and what they find.

Vacant positions in public health: What employers seek and what they find.

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Introduction

Our analysis of some 500 public health job descriptions for posts advertised in the press in mid-2003 provided information regarding employers seeking staff, what they wanted, and where the jobs were (Rotem et al 2005a). That examination of the demand side of the public health workforce labour market did not tell us anything about the response or the respondents to the advertisements, nor did it indicate how far the employers' advertised needs were met. Our 2004 study was an attempt to look at both the demand and supply sides of the market, and also considered the potential usefulness of further work along these lines (Rotem et al, 2005b). The findings of this second study are summarised here.

Method

As in previous studies (Rotem et al, 1995 and 2005a), of the public health workforce, we adopted a functional definition of the public health workforce:

"People who are involved in protecting, promoting and /or restoring the collective health of whole or specific populations (as distinct from activities directed to the care of individuals"

Stage 1 of the study involved the content analysis of public health jobs advertised in main newspapers across all states during the month of March 2004 and from the Public Health Association job alert email system. Full job descriptions were requested and received for 193 advertisements. Some adverts covered more than one vacant post and so we analysed 211 job descriptions overall.

Stage 2 required detailed analysis of the supply side of this labour market by exploring the recruitment process and the availability of appropriate personnel through telephone interviews with employers to determine:

- Whether the position was filled,
- Whether the pool of candidates was adequate or in short supply (the number of applicants and suitability for the position e.g. specific qualifications, types of experience, competencies and other attributes)
- Whether it was necessary to make adjustments in order to fill the position
- What lessons were learnt from the way the position was advertised

Findings

The study presents a snapshot of the mid-2004 job market for public health personnel. It shows the wide diversity of jobs, employers, locations, salaries, and conditions of employment currently being offered, as well as the formal qualifications, experience and other attributes of the workers being sought.

The most common role advertised included management or coordination of public health programs and services (59.7%). Some jobs required unique combination of skills, such as a mix of clinical, population health and management skills.

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Regarding professional knowledge and experience, almost all the job descriptions called for one or more formal qualifications, and/or relevant experience, and/or registration by a professional registration body.

The most commonly sought personal competencies, skills and experience focused on "Personal working capabilities" (92.4% of jobs). These included ability to think conceptually and analytically, report writing and record keeping, ability to meet deadlines and respond to emergencies, working with minimum supervision and working with teams. "Interpersonal activity capabilities" ranked a close second (88.2% of jobs) - a constellation including the ability to interact effectively with a broad range of people, to network and liaise effectively as well as negotiating and influencing skills. These skill sets, required for many different jobs in various public health settings, are similar to the generic employability competencies included in the Employability Skills Framework recently proposed by the Commonwealth Department of Education, Science and Training. (DEST, 2004)

Qualifications, types of experience, competencies and other attributes that were in short supply included:

- Insufficient understanding of/and experience in relevant context/setting,
- Insufficient orientation to and/or understanding of public health/population health/health promotion.
- Insufficient knowledge or experience in specialised areas. For example, difficulties mentioned related specifically to reproductive and sexual health, drug and alcohol, mental health, dental health, OH&S, environmental health and management/leadership.
- Insufficient experience and/or understanding of a particular health context/setting.
- Inappropriate skill mix. It seems that people working in public health roles and settings are often required to have combinations of very specific skill mixes such as health and education or health and IT as well as generic competencies especially in the areas of communication.
- Insufficient knowledge and skill in research and evaluation. For example, there was a demand for candidates who were strong in both quantitative and qualitative research skills.

Other reasons for employers non-acceptance of applicants or vice versa included:

- Applicant's unwillingness to work at a particular location, particularly rural locations.
- Inadequate salaries and conditions relative to applicant's expectations. (Salaries offered ranged from \$23,670 to \$107,674 per annum.)

Most positions were eventually filled but 26% needed to be re-advertised. The most common adjustment to selection criteria in order to accept an otherwise suitable applicant regarded lack of experience in a specialised area (such as adolescent health, Drug and Alcohol, sexual health, OHS, rural and management experience) or in particular skills (such as administrative, management, qualitative research skills).

Conclusions

The study demonstrated again the heterogeneity of the public health workforce and highlighted the difficulties in defining what constitutes the public health workforce.

It pointed to the immediate and real staffing requirements of public health services and presents a speedy and relatively cheap way of assessing those requirements. This approach to study of workforce requires repeated snapshots at regular intervals at different times of the year to gain the most benefit and to identify trends. Options for addressing these can include the examination of:

- Monthly or quarterly samples over a 12 month interval to provide continued snapshots of the generic public health workforce and/or

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Vacant positions in public health: What employers seek and what they find - continued from previous page

- Samples of particular disciplines/occupational groups within the public health workforce; e.g. health promotion workers, epidemiologists etc, and/or samples of public health workers within specific program areas, e.g. drug and alcohol, skin cancer etc.

It is recommended that findings from studies such as these be disseminated appropriately to inform decision-making in education and practice.

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We acknowledge with much appreciation the support of the Commonwealth Department of Health and Aging in the conduct of these workforce studies

Further Progress on Our Yakkum Bali Project

As members who attended the recent Annual Conference in Perth are aware, our Public Health Education and Research Trust continues to support the Yakkum Bali project via donations. The conference raised \$540 and post the conference the Trust received an extremely generous donation of \$2,500. This has allowed the Trust to forward \$4,790 to Bali, providing further support to Balinese people in need of re-education due to disabilities.

Members continued support for this project is more than welcome. We started out hoping to put something back into Bali after the terrorist bombing in Kuta, something that would help the local people who were so devastatingly affected. Now we have, via your donations, managed to support two complete projects. Congratulations to all who have provided contributions.

The Trust will continue to accept donations for the project in the hope that we will be able to support a third project in the near future.

The Contribution of Biological Diversity to Pharmacy and Human Health

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Pharmacy has a deep connection with species of the natural world through the delivery of an enormous array of potent drugs which have been our 'tools of trade'. Indeed, this great bounty for humankind has been milked from our surrounding biology for centuries and has undoubtedly shaped the societies in which we live.

The Recent Significance of Drugs Derived From Nature

Grifo et al (1996) [1] undertook an analysis of the top 150 proprietary (trade name) drugs from the United States National Prescription Audit January to September 1993, published by *IMS America*, (currently known as *IMS Health*). The top 150 drugs compiled by IMS was based on the number of times a prescription for a particular drug was filled by a pharmacy, not the amount prescribed, and not the cost.

This analysis investigated the discovery process leading to each drug and classified them into three categories: *Natural Product* if the drug compound consisted of unaltered natural product; *Semisynthetic* if the structural lead preceding the drug's creation came from nature or if the compound is a combination of a lead from nature with a synthetic structure; and *Synthetic* if the drug was entirely synthesised without specific reference to a compound found in nature.

Their findings showed that 57% of the top 150 brand names prescribed in this time period contained at least one major active compound now or once derived (*Natural Product*) or patterned after compounds derived (*Semisynthetic*) from biological diversity.

Nature's Contribution to the Australian PBS

Taking a lead from Grifo et al (1996) [1] mentioned above, it is interesting to assess how much influence mother nature has had in delivering the drugs in current use on the Australian PBS. As an indicator, a list of the top 25 PBS drugs by generic name for the year ending December 2003 (by volume - all forms and strengths for each drug)[2] were assessed as to their origin.

As with the Grifo et al analysis, the results take account of the discovery process, dividing the drugs into three categories as described above: *Natural*, *Semisynthetic* and *Synthetic*.

This analysis shows how potent the intellectual property contribution from nature has really been. The total cost (government subsidy plus patient contribution), of the top 25 generic drugs in the 12 months to December 2003 came to A\$2.343 billion [2], and represents approximately 40% of the total PBS costs for that year. Of this, some 65% of the expenditure was for drugs which have been sourced either directly or indirectly from a biological source. This is a simple but genuine statement of how much we depend on the natural world for our pharmaceutical wellbeing. It is also a potent statement of how much connection we pharmacists have with the fruits of biological diversity.

Future Relevance of Natural Sources in Drug Discovery

In a review by Newman, Cragg et al (2000) [3], the authors emphasise the impact that natural products have had to date on conventional drug development and point to positive future trends. They discuss three 'blooming' areas of

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The Contribution of Biological Diversity to Pharmacy and Human Health

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development of novel agents derived from natural biological compounds. The authors suggest that ‘as yet uncultured microbes’ from both the marine and terrestrial environments, in combination with DNA manipulation and cloning technologies, may offer up ‘a vast new area of chemical diversity’. The authors also suggest that drug lead development using ‘optimisation of a lead structure’ (e.g. from active but toxic prodrug) will remain a viable strategy. However this technique could be combined with new rapid combinatorial/parallel synthesis methods to produce ‘new and improved’ molecules.

Conclusion

The world’s biological diversity has delivered invaluable benefit to the human species over millennia via its armoury of remedies which are effective against the maladies from which we suffer. For some today, however, it is tempting to believe that our need for nature in progressing medicine has now passed into history, replaced by new technologies involving gene technology, supercomputers and new synthetic methods of chemistry. One day this may be so, but it is clear that presently our links to biology as a primary source of medicine are still very substantial. And the progress of drug development into the foreseeable future will depend significantly on nature’s molecular inventions – yet to be discovered.

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Hot Topics for Advocacy

Two public health topics that are getting quite a run in the media at the moment are mental health, and, abortion. The Mental Health SIG has been advocating strongly for practical steps to be undertaken by all levels of government in the near future to address the immediate needs of those suffering from a mental illness. Copies of the letters that were sent to the Age and the Australian can be found on the PHAA website under Advocacy.

The Women’s Health SIG has been working collaboratively with a number of other organisations to encourage a review of the ‘Harradine ammendment’ - which denied women access to Mifepristone as an emergency contraceptive. More information about emergency contraception can be found in the recently adopted Emergency Contraception Policy Statement.

More nurses should be encouraged to undertake research-an example from Stroke.

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Nursing is a key element of any healthcare system because nurses have a constant presence along the healthcare continuum. They are therefore able to influence many processes of care aimed at disease prevention and/or minimising the impact of disease. However, only 1% of nurses currently undertake research,¹ which limits the capacity of nursing to contribute to the evidence-base for clinical practice.

Currently, in Australia there are about 227,000 registered nurses.¹ The ageing population will increase demand for healthcare, in particular in the area of chronic disease. The most recent labour force statistics for nurses indicate that approximately 11% work in aged-care, whilst about 3% work in rehabilitation/disability settings.¹ Thus, not only will there be a need to increase the workforce in these areas, but also ensure that clinical practice is continually evaluated through research so that health outcomes are optimised. These looming public health issues can be further explored through the example of stroke.

In Australia, stroke is the second greatest cause of disease burden.² Using current stroke incidence rates³ and population projections⁴ we have predicted that over the next 10 years the number of incident stroke cases will increase by one third because of the ageing population. The majority of strokes (about 89%)³ are treated in hospitals and the cumulative risk of a recurrent event is approximately 43% or being disabled/deceased about 86% at ten years following a first-ever event.^{5 6}

Similar to other vascular diseases, stroke is associated with a range of modifiable risk factors such as hypertension, diabetes, atrial fibrillation and tobacco consumption. Opportunities to reduce the stroke burden therefore include the optimal implementation of effective prevention and treatment interventions that are universally accessible. Interventions that improve stroke outcomes are currently limited to stroke unit care,⁷ aspirin⁸ and intravenous thrombolysis within 3 hours of ischaemic stroke onset.⁹

Stroke units that are underpinned by a coordinated and dedicated multidisciplinary team are the most generalisable form of treatment. However, there is little evidence regarding the contribution of the different clinical team members or the processes of care that lead to the observed better outcomes. In particular, there has been limited exploration of the contribution of nursing interventions and processes that lead to better outcomes for patients with stroke.¹⁰ Important aspects of stroke nursing care that have been identified in the literature relate to the provision of information and advice, provision of emotional and practical support and care-giver support, in addition to monitoring and liaising with other health professionals.¹¹

The number of nurses involved in research may be underestimated. Possible reasons include the way in which this workforce data is collected or that nurses conducting research move out of the

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More nurses should be encouraged to undertake research - an example from Stroke - continued from previous page

nursing field or do not acknowledge their nursing background, for example if they re-train as epidemiologists and allow nursing registration to lapse. Part of the problem lies in the work culture, where clinical nurses are required to have patient loads with little opportunity for non-clinical downtime. This restricts the ability of nurses to undertake research, which may result in nurses leaving the clinical area.

Nurses need to be more visible and to be encouraged to not only work in the area of chronic disease, but to also embrace research as a career option. The constancy of nursing care provision permits frequent clinical observations and other regular interactions with patients in relation to their disease management. Thus, nursing interventions are able to influence many of these important processes of care and patient outcomes. Nurses who are expert in their field and conduct research as well as maintaining a clinical role have the greatest opportunity to influence practice change and will continually seek to answer contemporary clinical practice questions. This was highlighted this year during the Stroke Society of Australasia inaugural Nursing Symposium, conducted as part of the annual scientific meeting, which recognised the need to bring nurses together and encourage research activities in this discipline.

Health services, together with schools of nursing and more generic scientific groups, should consider how nurses could be encouraged and supported to undertake quality research. This requires not only capacity building, but also appropriate mentoring and work place flexibility so that nurses can maintain both clinical and academic research roles.

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Australia's Health Workforce – A summary of the findings of the Productivity Commission

The Productivity Commission was requested by the Australian Government in March 2005 to undertake a research study to examine issues impacting on the health workforce, including supply of and demand for health workforce professionals, and to propose solutions to ensure the continued delivery of quality health care over the next ten years. On 21 September 2005, the Commission published a Position Paper for comment. This Paper is available from www.pc.gov.au/study/healthworkforce

The major findings outlined in the Position Paper are:

- there are considerable pressures on Australia's health workforce, as evidenced by shortages of supply, particularly outside metropolitan areas, and by a significant reliance on overseas trained professionals;
- ageing will compound other factors that will increase the demand for health workforce services;
- boosting education and training places will be important to meeting current and future demand for health workers; and
- there is scope and need to increase productivity and effectiveness of the available workforce and reduce its maldistribution.

The Commission's Position Paper states that its proposed reforms are designed to:

- facilitate major health workforce innovations on a national, systemic and timetabled basis through the introduction of an advisory health workforce improvement agency;
- promote more responsive education and training arrangements, including through creation of an independent council to assess new health workforce education and training models, and greater transparency and contestability of funding for clinical training;
- lend further impetus to integrated workplace reform (nationally uniform registration standards, staged introduction of a single national accreditation regime and agency);
- encourage complementary reform of registration arrangements (including mutual recognition); and
- improve funding-related incentives for workforce change through transparent evaluation of requests to extend the coverage of the MBS to new services and professional groups by a more broadly based and independent assessment body, and through progressive introduction of MBS rebates for a wider range of delegated services.

Amongst the many issues raised in the Paper, it was noted that "The health behaviors of the population are driving some of these [burden of disease] changes, including an increase in the number of people who are overweight or obese. Many participants in this study have argued that a stronger emphasis on preventive health care is also warranted, not only to improve the health status of Australians, but also as a means of containing the increased demand for some care services."

The paper also noted that the Australian health workforce arrangements are extraordinarily complex and interdependent, with more than 20 bodies involved in accrediting health workforce education

continued on next page

Australia's Health Workforce – A summary of the findings of the Productivity Commission (continued from previous page)

and training courses and over 90 boards that register health professionals. It was also noted that this complexity was compounded by fragmented roles and responsibilities, inadequate coordination mechanisms, inflexible and inconsistent regulation, perverse funding and payment incentives and entrenched workplace behaviours.

In the Position Paper, the Commission has outlined out a series of reforms that it believes could assist in development of sustainable and responsive health workforce arrangements. In summary the Commission's draft proposals are to:

- establish an advisory health workforce improvement agency to examine major workforce innovation opportunities, particularly those that would cross current professional boundaries;
- consider shifting primary responsibility for allocating the quantum of funding available for university based education and training from DEST to DOHA;
- establish an advisory health workforce education and training council to provide for systemic and integrated consideration of different health workforce education and training models and their implications for courses and curricula;
- improve understanding of the operation of the clinical training regime and enhance transparency and contestability of funding frameworks;
- in a staged manner, move towards a single consolidated national accreditation agency for university-based education and training and post graduate training, subsuming existing accreditation functions as part of this process;
- introduce nationally uniform registration standards based on the work of the proposed national accreditation agency, and a more focused role for registration boards;
- improve operation of mutual recognition; explore alternatives to formal registration; consider consolidation of registration functions across professions; and improve governance structures for registration boards;
- amend registration Acts accordingly;
- establish an independent review body (subsuming the existing committees) to advise on services to be covered by the MBS and on referral and prescribing rules;
- progressively introduce (discounted) rebates for a wider range of delegated services;
- concentrate formal projections on the key workforce groups;
- rationalise structure through the abolition of AMWAC and AHWAC;
- make explicit provision for consideration of rural and remote issues in all systems-wide frameworks in the health workforce area; initiate a cross program evaluation exercise; and
- make explicit provisions to consider the needs of groups with special needs in all broad institutional frameworks.

The PHAA is preparing a submission in response to this Position Paper. If you would like to contribute to the submission or provide comments on its content, please contact Pieta Laut at plaut@phaa.net.au The submission has to be submitted by 11 November.

ITEMS OF INTEREST

Female SAAP Clients Escaping Domestic and Family Violence 2003-04

Domestic violence affects the physical, emotional, social and economic wellbeing of individuals and families. Domestic violence is also a major factor contributing to homelessness in Australia, particularly for women. In 2003–04, it is estimated that 33% (32,700) of the 100,200 clients accessing the Supported Accommodation Assistance Program (SAAP), the major government response to homelessness in Australia, were women escaping domestic violence. In addition, 66% (34,700) of the 52,700 accompanying children in SAAP were children who accompanied a female parent or guardian escaping domestic violence.

AIHW Catalogue No. AUS-64; Available from CanPrint (ph: 1300 889 873); \$10.00

Locality Matters – The Influence of geography on general practice in Australia 1998 – 2004

Locality matters: the influence of geography on general practice in Australia 1998-2004 is the 17th in the General Practice Series produced by the Australian General Practice Statistics and Classification Centre, University of Sydney, a collaborating unit of the Australian Institute of Health and Welfare.

It reports results from six years of the BEACH program, April 1998 to March 2004, using data reported by 6019 GPs on 601,900 GP-patient encounters. Each of the seven geographical categories of the Rural, Remote and Metropolitan Areas (RRMA) of Australia are compared with the national average, in terms of GP and patient characteristics, patient reasons for encounter, problems managed and treatments provided. Results are further analysed using the Australian Standard Geographical Classification (ASGC) Remoteness Structure. Summaries of results for each RRMA category and a summary of trends with increasing remoteness across ASGC categories are provided.

AIHW Catalogue No. GEP 17; Available from CanPrint (ph: 1300 889 873); \$27.00

The South Australian Dental Labour Force

The aims of the South Australian Dental Labour Force Project were to inform policy on the dental labour force through the provision of detailed estimates and projections on the supply of and demand for dental services in South Australia. This publication identifies trends in supply and demand, presents an overview of the aggregate shortage of the dental labour force and considers policy directions to address the supply-demand gap.

AIHW Catalogue No. POH 5; Available from CanPrint (Ph: 1300 889 873); \$21.00

Diabetes in Culturally and Linguistically Diverse Australians

Diabetes in Culturally and Linguistically Diverse Australians: Identifications of Communities at High Risk identifies those groups of people from culturally and linguistically diverse backgrounds that have a high prevalence or risk of diabetes compared with the Australian-born population. The report describes the demographics of these groups in relation to the size of the community, their proficiency in English, and location within Australia. The report also identifies gaps in the available literature and data.

AIHW Catalogue No. CVD-30; Available from CanPrint (ph: 1300 889 873); \$22.00

The European health report 2005 : Public health action for healthier children and populations

Governments and policy-makers in the WHO European Region know that good health is a fundamental resource for social and economic development. While rightly proud of the overall improvement in health in the Region, they still face a widening gap between the western and eastern countries in the Region and between socioeconomic groups in countries. Reducing these inequalities is increasingly vital. The European health report 2005 shows that it is also feasible. The report summarizes the major public health issues facing the Region, particularly its children, and describes effective policy responses. This helps to supply the reliable, evidence-based information needed for sound decision-making on public health.

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