

## MESH: the answer to Abbott's paternalism

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*Reprinted with permission from Online Opinion, posted Thursday, 29 June 2006*

Federal Health Minister Tony Abbott has advocated the use of administrators to improve life in some remote settlements. He talks of a vacuum of authority in many Indigenous communities. "Paternalism based on competence rather than race is really unavoidable if these places are to be well run," he is quoted as saying.

One has to wonder when this government, aided by compliant media, will recognise that Aboriginal people know best what their problems and their solutions are. What Aboriginal people need is not another lecture from a latter day A.O. Neville (the former chief protector of Aborigines) but support to rebuild their communities in the way that they want according to their cultural values. They do not need non-Aboriginal administrators to be sent into their communities to ensure that "these places ... are well run".

A different approach is needed to ensure Aboriginal people have a real say in how to improve the life of their communities. An alternative approach which I developed with an Aboriginal colleague Shane Houston is based on what we have called 'MESH' infrastructure. MESH infrastructure can be built in many ways but is likely to involve **m**anagement skills, **e**conomic resources, strong **s**ocial institutions and **h**uman capital.

Some communities manage their affairs well, others struggle. The idea behind MESH is to accept this diversity as the starting point. Those communities that have good infrastructure have considerable capacity to benefit from any program resources they receive. Other communities are not so well placed to use program resources efficiently. Such communities would - under a MESH intervention - have their capacity to benefit improved over time.

More of the effort in Aboriginal health in Australia needs to include a strong and appropriate emphasis on involving the communities themselves and, in many policy areas, but especially primary health care, actual community control of services. There is a need to recognise that in many Aboriginal communities the MESH infrastructure on which success might be built is not there. This needs to be taken into account when designing, delivering and funding Aboriginal services in those communities.

The adoption of MESH is important not only in economic terms but also politically. The idea that Aboriginal people are getting more than a fair share of public funding and then wasting most of the money is a common myth. Nonetheless there are cases

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## MESH: the answer to Abbott's paternalism

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where monies have not been well used. Most often this has been because of poor management or lack of leadership; essentially lack of MESH.

The explicit recognition of this through labelling this as lack of MESH invests this construct with political importance. It then follows that funding and resource allocation formulae need to be couched in terms of two strands: one for explicitly building up MESH and the other for program funding (with acknowledgement that the MESH stream will decrease in size over time). The approach thus argues for investing in interventions that will first strengthen the formal and informal institutions and knowledge-skills base in Aboriginal communities and which will in turn foster the capacity to benefit of those specific communities which are struggling.

There is a need to decide what proportion of any overall spending that is to go to Aboriginal communities should go to MESH and what residual proportion should go to actual programs. The initial work done in Western Australia using the judgment of key Aboriginal figures suggests that in the immediate future MESH on average might account for about 40 per cent of any new spending.

The overall spend also needs to be radically increased given Aboriginal needs and access barriers. In primary health care alone the increase needed to allow Aboriginal people to have a just share of the primary health care budget is about five times the current level. That could be paid for by reducing the 30 per cent tax rebate on private health insurance to about 15 per cent.

It has become clear from discussions with Aboriginal leaders in Western Australia that to them the concept of MESH is very real. MESH factors of leadership, community cohesion, community skill levels and strength of culture, however, clearly involve subjective assessments.

Previously, ATSIIC assessed the capacity of organisations and communities to manage grants provided to them for a variety of services. Other government agencies currently undertake to differing degrees an assessment of risk of host communities when granting funds for community based initiatives. In most jurisdictions such assessments are considered obligatory components of the financial accountability responsibilities of agencies. Examples such as these demonstrate that MESH-type assessments are possible and can be made credible.

Whatever is spent on Aboriginal health and their well-being more generally, the key is to build Aboriginal community autonomy. Abbott's paternalism will just destroy that. Sadly, that is precisely what it is aimed to do.

# What happened to COAG's Mental Health reform agenda?

*Valerie Gerrand, Member, Mental Health Special Interest Group*

Early this year, signs were positive for a fresh national approach to mental health reform.

At the February COAG deliberations, the Commonwealth and States and Territories agreed to develop a joint action plan for mental health reform, for July release. The Department of Prime Minister and Cabinet took the lead role in shaping the federal government's mental health agenda, evidence that it was being taken seriously.

On 5 April however, the Prime Minister bypassed the collaborative process, unilaterally announcing \$1.9b Commonwealth funding over five years for specific initiatives, and challenging the States and Territories to match these funds.

This pre-emptive action did not stop joint planning by the two levels of government. The new National Plan of Action on Mental Health 2006-2011 (henceforth the Plan) was released on 14 July, with all parties as signatories.

It is less clear whether States and Territories made more funds available for reform. In the Plan, each identifies its separate initiatives and associated funding. Funding from 2006-2007 to 2010-2011 roughly totals \$2.17b, exceeding the Commonwealth's \$1.9b. However, the \$2.17b includes \$457.4m for one-off capital works - a third of NSW's 'new' money.

Moreover, the timeframe varies: WA funding ends in 2010, not 2011. Besides, it is only possible to identify genuinely new funding if it is known what money had already been allocated. Furthermore, counting dollars distracts from the fundamental issue of what reform is actually required and how much this would cost. Unfortunately, neither question is tackled in the Plan.

On a more positive note, the new Plan is refreshingly straightforward in

language and presentation. It identifies five broad objectives, targets four outcomes and then specifies how these will be measured.

The five overarching themes are familiar:

- promotion, prevention and early intervention;
- integrated care;
- participation in the community;
- coordinated care; and
- increased workforce capacity.

The outcomes sought are:

- reduced prevalence and severity of mental illness;
- reduced prevalence of risk factors;
- increased proportion of people with mental illness getting timely treatment; and
- increased participation in employment, education and training.

There are twelve progress measures, including broad indices like the rate of suicide, and more specific ones, such as rates of community follow-up within seven days of hospital discharge. Progress in implementation will be monitored by a COAG mental health group in each State and Territory, with Commonwealth representation. The Plan will be independently reviewed after five years.

What is novel about the Plan? Several Commonwealth initiatives are new. The most radical is introducing Medicare rebates for individual or group sessions with psychologists, social workers or occupational therapists. Access is constrained however, by a GP referral being required, and sessions capped at twelve. Another innovation is funding mental health nurses for private psychiatry and GP practices, to provide follow-up and medication management. A third initiative targets the workforce, with extra places and scholarships funded for mental health nursing and post-graduate psychology students.

A major departure for the Commonwealth is direct funding of non-government organisations to employ specific numbers of workers (900 'personal mentors' across Australia) and provide a specified number of extra places in rehabilitation programs (7,000), and respite care (660). How these numbers were derived is not explained. As yet, their distribution is unclear, given States and Territories vary markedly in their existing non-government infrastructure. Lastly, the Commonwealth is silent about restoring its contribution to funding public housing, severely curtailed in recent years.

The specific State and Territory initiatives show common themes. They include improved emergency responses, more step-up/step-down services, extra acute, forensic and longer-term clinical beds, additional community treatment services, and more housing and support packages, including funding for public housing. However, the level of funds committed varies widely, and it is difficult to gauge their likely impact without knowing in detail what is already in place.

In conclusion, although flawed, the Plan is a welcome new commitment to national mental health reform. Its impact will be followed with interest.

The Plan can be downloaded from [www.coag.gov.au/meetings/140706/index.htm#mental](http://www.coag.gov.au/meetings/140706/index.htm#mental).



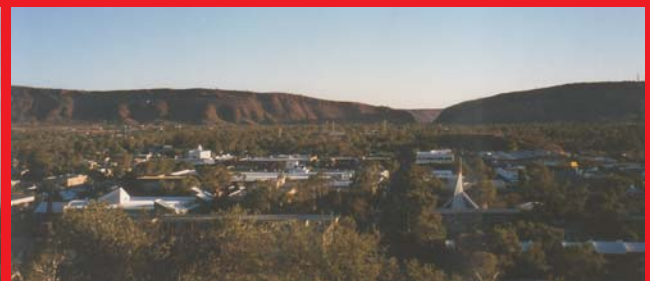
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# Hepatitis C and Australian Prisons: A terminal sentence?

Prisons are a high risk environment for the transmission of hepatitis C - a blood borne virus that targets the liver. Approximately 75% of people exposed to the hepatitis C virus will be chronically affected. Between 1-2% of Australians are estimated to have hepatitis C antibodies, indicating that they have been exposed to the virus. The prevalence of hepatitis C antibodies amongst prisoners, however, is much higher, with approximately half of all inmates estimated to have hepatitis C antibodies.

A significant proportion of inmates report engaging in behaviours where there is a risk for transmission whilst in prison. In one study, 62% of female and 48% of male inmates with a history of injecting drugs reported injecting while in prison - the majority of which report re-using or sharing injecting equipment. Studies have also indicated approximately 40% of inmates receive a tattoo in prison, many of whom are likely to use non-sterile equipment. The high prevalence of hepatitis C combined with transmission risk behaviours amongst inmates has resulted in imprisonment being an independent risk factor for hepatitis C.

A hypothetical discussion hosted by the Australian Hepatitis Council and Schering-Plough on October 3, 2006 took a closer look at the management of hepatitis C in Australian prisons. Chaired by ABC's Dr Norman Swan, the hypothetical featured nine expert panelists, including former Deputy Prime Minister Brian Howe. Despite a diversity of opinions of what could be done to more effectively address hepatitis C in Australian prisons, panelists were united in emphasising that there is much we can do. The discussion centred around the need for brave and innovative responses to minimise the harm associated with tattooing and injecting drug use in prisons.

One such response is the introduction of prison needle and syringe programs. A common objection to introducing such programs is that they lead to a higher prevalence of injecting drugs, along with

an increase in risk to the safety of prison officers and other prisoners. International experience, however, has demonstrated the contrary. Indeed, they led to a reduction in the risk of transmission of blood borne viruses in prisons. Furthermore, they present an opportunity to provide health promoting information, health advice and services for other health issues.

The challenge of demonstrating the viability of prison needle and syringe programs and other prison harm minimisation interventions to the media, the public and political decision makers was acknowledged. This challenge, however, was thought to be surmountable. A number of panelists advocated 'eating the elephant one bite at a time' by introducing a needle and syringe program trial in one Australian jail in the first instance. Others acknowledged that a necessary first step is wide spread acknowledgement of the uncomfortable reality of illicit drug use and tattooing amongst inmates.

The hypothetical discussion concluded by highlighting the current disparity in testing and treatment for hepatitis C between individual prisons. Service provision in prisons is dependent on the state or territory authority governing the prison and whilst high standards are evident in some prisons these are far from universal. A nationally coordinated response and the implementation of consistent processes was cited as necessary to more effectively address the hepatitis C crisis in our jails across the country.

An edited DVD of the hypothetical discussion is being produced and will shortly be available from the Australian Hepatitis Council at no cost for the first copy.

If you would like to receive a copy of the DVD please email a request to: [ahcinfo@hepatitisaustralia.com](mailto:ahcinfo@hepatitisaustralia.com)  
For further information about hepatitis C visit:  
[www.hepatitisaustralia.com](http://www.hepatitisaustralia.com)



**Australian Hepatitis Council**

# A continuous quality improvement approach to mental health reform in South Australia: 12 months into the QMS Psychosocial Rehabilitation Support Service Standards project

As reported in the September 2005 *InTouch*, Quality Management Services (QMS) were commissioned in 2005 by the Mental Health Unit of the South Australian Department of Health to develop standards for South Australian psychosocial rehabilitation support services. This is a sector development strategy designed to support reform in the mental health sector and aimed at developing a recovery-oriented service system.

QMS is a licensed provider of the Quality Improvement Council (QIC) Standards and Accreditation Program, which offers a core module of standards for health and community services and a series of modules specific to service delivery including the *QIC Mental Health Services Standards*. The Commonwealth Department of Health and Ageing has approved the combined use of QIC core and *Mental Health Services Standards* modules in lieu of the *National Standards for Mental Health Services*.

QMS is experienced in the development of standards and is an approved provider of external assessments using the South Australian Service Excellence Framework (SEF) and appraisals against the Home and Community Care (HACC) National Service Standards.

## **The project in perspective**

The development and piloting of the Psychosocial Rehabilitation Support Service Standards (PRSSS) in South Australia has provided a framework to support sector change where quality improvement is a key driver to grow and develop the sector and better respond to the needs of individuals. The development of the Standards coincided

with the commencement of the Non Government Organisation (NGO) sector providing a broader range of services to the mental health consumer group. The Standards emphasise working in partnership with NGOs, the consumer and the local public mental health service. This model places the consumer at the centre of service provision and is strengthened by the capacities of both clinical and community services.

In developing the PRSSS it was recognised early in the process that the Standards needed to move beyond rhetoric and become a living document that inspired the sector to ownership. For this reason the project has and continues to be an inclusive one, engaging consumers, clinical and community-based services. It has a broad scope of concern, ranging from the language used to the capacity of services to adopt the Standards and a monitoring process that relies on sector expertise and peer support.

Parallel to this activity is a focus on having the PRSSS endorsed by other quality and accreditation programs, including endorsement of the Standards by the QIC and mapping of the Standards against the South Australian SEF. This is particularly pertinent in light of the interest in the PRSSS from the disability sector and given the range of services that have multiple compliance burdens. The PRSSS were developed with methodological monitoring in mind and are designed to complement other standards and for simultaneous use with these and other accreditations or quality reviews.

## **The project process**

Following a literature review, development of underpinning principles and formation of an Advisory Group, the Standards were the subject of a March 2006 consultation attended by consumers, government representatives, service providers and specialist mental health services. Feedback led to a new draft which was endorsed by the project's Advisory Group in April 2006.

During August to October 2006 a range of mental health and rehabilitation support service providers and consumer groups participated in pilot workshops to identify strengths and opportunities for improvement in services and the sector. The

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# A continuous quality improvement approach to mental health reform in South Australia: 12 months into the QMS Psychosocial Rehabilitation Support Service Standards project

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workshops provided organisations and consumer groups with an opportunity to comment on the Standards and associated tools. Recommendations will be made to government regarding the Standards, their implementation and monitoring.

**(See figure below)**

### The project pilot workshops

To date, 133 people have participated in 14 workshops with some organisations involving both senior and more junior staff whilst others included quality coordinators or key sector partners. Workshops focused on applying the principles and Standards and highlighted the relevance for direct care staff through to systemic, sector activities or strategies.

### Feedback

Feedback from the sector is that the PRSSS are an excellent tool for helping organisations determine what constitutes

a quality service. The PRSSS help organisations to identify gaps in providing quality services and to work towards introducing appropriate systems and practices.

Over 90 per cent of participants agree that the workshops have provided them not only with a good introduction to the principles and Standards but with a high degree of confidence about putting these into practice.

### Next steps for the project

The completion of the pilot workshops dovetails with a Good Practice Showcase to be held in November 2006, providing an opportunity to celebrate the journey of the project and the successes of organisations involved.

The Showcase is also a key springboard for sector endorsement of the Standards and for sending a message to government about the desired future of the Standards and their implementation.

### Further information

For further information please contact Alison Sinclair, Executive Manager, Review Services [alsions@qms.org.au](mailto:alsions@qms.org.au) or Trish Jean, Project Officer [trish.j@qms.org.au](mailto:trish.j@qms.org.au) at QMS South Australia (08) 8332 8277.



# Mind and Body: an innovative curriculum approach in health science

*Santha James and Ken Jones, Faculty of Medicine, Nursing and Health Sciences, Monash University.*

The interdependence of physical and mental health and individual and population health are widely accepted. Yet undergraduate foundation courses taught in health science departments throughout the world deal with the introductory physical and psychological concepts in separate airtight compartments of the disciplines of biology and psychology. The erroneous consideration of mind and body as independent entities leads to separate systems of disease treatment and prevention, which is costly and inefficient.

When the School of Primary Health Care at Monash University introduced the Health Sciences Peninsula Program in 2005, we proposed to develop a double credit point unit called Mind and Body as an innovative approach to integrate essential principles of physiology and psychology to study the whole person across the lifespan. The curriculum components of this unit have been developed by different weekly teams of multidisciplinary staff from various departments in our Faculty. This holistic look at the individual was intended to complement the ecological determinants approach to health followed in the mainstream health science courses taught at Peninsula.

## **Aims and objectives**

The Mind and Body unit aims to provide students with an overview of the structure and function of body systems and introductory psychology, while making them confident in the use of medical terminology to communicate in health and social care teams.

Objectives of the unit expect students to be able to:

1. Account for some of the factors that influence physical, physiological, cognitive, social and affective development in humans;
2. Demonstrate an understanding of the importance of observable behaviour as a source of information about the individual and explain differences in reactions to illness and loss;

3. Examine the relationship between biological factors, psychological factors and well-being and between lifestyle choices and health outcomes in conditions affecting selected systems across the lifespan;
4. Explain the role of stress in illness and how stress management is a key component of preventive health and personal well-being; and
5. Explain the biological basis for mind-body interactions in health and disease.

## **Teaching and learning**

Each week's curriculum focus was driven by a case study introduced in a two-hour small group class on Mondays. Students worked in groups posing problems, trying solutions and presenting conclusions that represent their findings to their peers. The staff collaborated in the learning process as facilitators only. The group process was intended to enhance the students' ability to work collaboratively with colleagues in the health and social care team setting which is an important criterion for future professional success.

A double lecture on relevant physiological aspects and another one on psychological aspects followed. A dozen contributors from Psychology, Science and General Practice were involved in giving lectures with constant reference to the case study.

On Wednesdays, students attended one three-hour session of laboratory work related to the theory and case study for the week. Further two-hour sessions on Thursdays were meant for case study solutions, presented by student groups and assessed against given criteria.

A workshop presenter with specialist knowledge or practical expertise from the community was used to help students consolidate the theoretical principles, practical aspects and case study relevance for the week's themes and show its relevance for professional practice. The presenters included clinicians, researchers, educators and social workers from various institutions in Melbourne.

Assessment tasks for the unit were built into the Teaching and Learning activities in line with educational philosophies that are embedded in student-centred learning. The formative and summative assessment tasks included quizzes, lab. and case reports, group seminars and a two-hour end of semester examination. The group process in problem solving and presentation was assessed formatively by self, peer and tutor evaluations.

In spite of the heavy workload, students reported enjoying learning about Mind and Body through the variety of activities.

## **Conclusion**

One of the fundamental requirements of holistic health promotion and the new public health movement is the appropriate education and training of the future workforce. Positive student feedback encourages the adoption of this integrated multidisciplinary model for studying the whole human being who functions as part of the wider society and to extend it to the teaching of other health science areas such as health services, health communication, health promotion and health management.

# NEW HEAD FOR WHO INFLUENZA CENTRE

## Media Release

Minister for Health and Ageing

Tony Abbott MHR

October 2006

Professor Anne Kelso, a Queensland expert in vaccines and immunology, has been selected as the new director of the Commonwealth-funded World Health Organisation Collaborating Centre for Reference and Research on Influenza in Melbourne.

The collaborating centre is one of only five WHO collaborating centres for influenza worldwide. It became a Regional WHO Influenza Centre in 1951 and was designated as a WHO Collaborating Centre for Reference and Research on Influenza in 1992.

The centre is an important source of flu expertise in Australia and the southern hemisphere. The centre has direct access to the WHO global influenza network and

early-warning systems and is regarded by the Government as a significant asset to our pandemic preparedness and response activities. After an international search, Professor Anne Kelso was chosen for the position by a selection committee headed by Australia's Chief Medical Officer, Professor John Horvath.

Professor Kelso has an international reputation in immunology, including work on influenza, as well as strong leadership and management credentials. She has been a member of the Government's National Influenza Pandemic Action Committee since 2002 and currently holds research and professorial positions at the Queensland Institute of Medical Research, the University of Queensland and Griffith University. From 2000 to 2005/6 she was director and chief executive of the Cooperative Research Centre for Vaccine Technology based in Queensland.

The WHO collaborating centre is currently hosted by CSL Limited. Later this year it will transfer to the Victorian Infectious Diseases Reference Laboratory (VIDRL), a division of Melbourne Health. The 2005-06 Budget provided \$23.2 million over four years to relocate and establish a new customised facility at VIDRL.

The centre's distinguished current director, Professor Ian Gust, has indicated his intention to retire when the centre is transferred to its new host.

Media contact: Claire Kimball - 0413 486 926

## Sponsors for the 2006 Public Health Association Annual Conference

The Public Health Association of Australia wishes to thank NSW Health and the National Health and Medical Research Council for their generous conference support.



# NSW HEALTH



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### Acknowledgements

The PHAA acknowledges the Office for the Aboriginal and Torres Strait Islander Health in supporting delegates to attend the conference.

# IN BRIEF

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## Drug statistics

This report, commissioned by the Australian Government Department of Health and Ageing, identifies and examines relevant Australian data sources in terms of their capacity to answer key questions about substance use among Aboriginal and Torres Strait Islander peoples. Options for improving and making better use of existing data sources are also highlighted.

Published 25 October 2006; ISSN 1442-7230; ISBN 1 74024 608 X; AIHW Cat. No. PHE 76; 182pp.; FREE

<http://www.aihw.gov.au/publications/index.cfm/title/10360>

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## Maternal deaths

'Maternal Deaths in Australia 2000-02' is the thirteenth report on women who die during pregnancy and childbirth. Maternal deaths are rare, catastrophic events and require monitoring and investigation. The report is an observational study of maternal deaths based on information provided by the states and territories. It includes information about the women, pregnancy, clinical care and the deaths. Maternal deaths that occurred up to year after the end of the pregnancy are included. Illustrative case summaries highlight key clinical and public health issues that may be causally related to maternal deaths. The report is produced by the AIHW National Perinatal Statistics Unit based at the University of New South Wales and will be particularly useful to maternity service planners and providers, consumers of maternity services, academics, students and those conducting research in maternity care.

ISSN 1449-8863; ISBN 1 74024 550 4; AIHW Cat. No. PER 32; 132pp.; \$30.00

<http://www.aihw.gov.au/publications/index.cfm/title/10207>

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## Health expenditure Australia 2004-05

Health expenditure Australia 2004-05 examines expenditure on health goods and services in Australia for 1994-95 to 2004-05. It shows that Australia spent over \$87 billion on health in 2004-05, an estimated rise of \$8 billion since 2003-04. This report presents expenditure estimates by area of health expenditure, as a proportion of gross domestic product (GDP), on a per person basis, by state and territory, by comparison with selected OECD and Asia-Pacific countries,

and by source of funding (Australian Government, other governments and the non-government sector). This report will be helpful to anyone interested in studying, analysing and comparing estimates of health expenditure in Australia.

AIHW catalogue number (HWE 35).

Available from Can Print for \$30 (1300 889 873).

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## Arthritis

Osteoarthritis, rheumatoid arthritis and osteoporosis are identified as the focus of the Arthritis and Musculoskeletal Conditions National Health Priority Area. This report describes the development of key indicators for monitoring these three conditions in Australia and provides operational definitions for their use. Monitoring and reporting against these indicators over time will inform decision making and assist the formulation and evaluation of public health strategies for arthritis and osteoporosis.

ISBN 1 74024 609 8; AIHW Cat. No. PHE 77; \$10.00  
View online for free at: <http://www.aihw.gov.au/publications/index.cfm/title/10235>

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## Cardiovascular disease series No. 26

This summary presents the key points detailed in 'Aboriginal and Torres Strait Islander people with coronary heart disease: further perspectives on health status and treatment'. That report builds on existing information on disparities between Aboriginal and Torres Strait Islander people and other Australians in the health status and treatment of coronary heart disease. New information on the incidence of major coronary events, case fatality, use of coronary procedures in hospital and case complexity in hospital has built a more complete picture of the coronary heart disease burden among Indigenous Australians. This summary will be of interest to those policy makers and health professionals who prefer an overview of the main points, as well as to the broader community.

ISBN 1 74024 605 5; AIHW Cat. No. CVD 34; 12pp.; \$13.00  
<http://www.aihw.gov.au/publications/index.cfm/title/10364>

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