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DR JANE YOUNG, NEWLY APPOINTED
PROFESSOR OF CANCER
EPIDEMIOLOGY

HEALTH REFORM

BY GLENN SALKELD

The new year starts with the good news that the STEP (Screening Test Evaluation Program) NHMRC Program Grant has been renewed for another five years. To get one five year program grant is a major achievement, a 5 year renewal is outstanding but a second 5 year renewal is truly exceptional. It is a testament to the whole team of researchers in STEP who have built a track record based on high quality and high impact research. It is part of the School's broader reputation for high quality research and teaching that continues to attract more postgraduate coursework and higher research degree students. Last month I welcomed a dozen AusAID funded MIPH students from Uganda and Papua New Guinea. That was followed by a visit by William Bazeyo, the Dean of Public Health at Makerere University in Kampala, Uganda. Dr Bazeyo was in Sydney as the special guest for a University symposium on Africa. As our university forges closer links with Africa, the School of Public Health is well placed to build closer ties with our colleagues in African countries through student placements and academic exchanges.

As I write this introduction we are just days away from knowing the outcome of Barack Obama's health reforms. We are many weeks away from knowing the outcome of Federal negotiations on health reforms in Australia but we are all in a position to influence the policy debate. Lesley Russell's article on mixing policy and politics: lessons from the US provides a very useful set of practical tips in how we can individually and collectively make an impact on health policy. Some might say that health reform is the 'perfect storm' – too late it has already happened. Turn to our centre piece and see the perfect dust storm that descended upon our colleagues at the UDRH in Broken Hill.

DIARY DATES

SPH SEMINAR

Speaker: Victor M. Montori, Professor of Medicine at the Mayo Clinic in Rochester, USA
Tuesday, 25th May, 1pm
More information (available soon) at www.sydney.edu.au/medicine/public-health (see 'events')

GLOBAL HEALTH LECTURE SERIES

Climate Change & Health

Tuesday 4 May, 6-7.30pm

Tropical Infectious Disease

Tuesday 11 May, 6-7.30pm

More information: www.sydney.edu.au/global-health/news-events/events.php



PRIME MINISTER KEVIN RUDD AND PROFESSOR DAVID LYLE DISCUSS THE PRIME MINISTER'S RECENT ANNOUNCEMENT THAT \$1.9 MILLION WILL BE INVESTED INTO STUDENT ACCOMMODATION AND EDUCATION FACILITIES AT THE BH UDRH

STEP AWARDED MULTIMILLION DOLLAR GRANT

Congratulations to the Screening and Test Evaluation Program (STEP) which was recently awarded an \$8,915,000 National Health and Medical Research Council (NHMRC) grant.



One of the most contentious issues in modern medicine is the safety and efficacy of screening and testing for disease, balancing the benefits against risk and costs. The grant announced on 25 February is the third grant for the STEP team and will allow more than a decade's research to continue.

Medical tests - for screening, diagnosis and monitoring - are often poorly evaluated and poorly used. This program, run by an established team with skills in public health, clinical epidemiology, biostatistics, health economics and behavioural science, addresses the under-researched issues of whether, when and how to use medical tests.

A common approach throughout is the identification of the benefits and harms of testing and assessing their trade-offs.

The research is relevant to all partners in healthcare – consumers, clinicians and policymakers – who currently are being tested, or implementing tests without being fully informed about their accuracy and effect.

One of STEP's chief investigators Professor Les Irwig says STEP's examination of screening and medical test efficacy extends across disease groups to cover everything from cardiovascular disease to cancer. Professor Irwig says the funding will allow the research to continue for the next 5 years to examine in greater detail the importance of testing in the area of disease monitoring.

THIS PROGRAM GRANT ALLOWS US TO CONTINUE SUPPORTING AN OUTSTANDING RESEARCH TEAM BUILT OVER A DECADE AND TO AFFECT HEALTH POLICY AND DOCTOR-AND-PATIENT DECISION-MAKING THROUGHOUT THE HEALTH SYSTEM.

"This program grant allows us to continue supporting an outstanding research team built over a decade and to affect health policy and doctor-and-patient decision-making throughout the health system," Professor Irwig says.

"The newest component of the research plan is to assess tests used for monitoring people with a disease, to assess whether treatment is working and whether their disease has progressed. The evidence base for what monitoring tests are useful and how frequently patients should be monitored is much poorer in this area than for tests used for screening or diagnosis."

"The challenge we have in STEP is to bring an evidence-based approach to help people make informed health decisions in relation to screening, diagnostics tests and therapeutic treatment. We apply population principles of weighing up the benefits, harms and costs of screening and tests and conduct research with patients, the lay public and health professionals on how best to use that information to make informed decisions. With this latest grant, I hope that we can take our research findings and use Web 2.0 technology to allow health professionals, patients and the public make sense of the complex health

choices that they face.," said Professor Glenn Salkeld, Head of School and one of the STEP group's Chief Investigators.

NHMRC program grants are awarded to research groups which have shown outstanding productivity.

The Chief investigators associated with STEP and its NHMRC grant are:

From the University of Sydney

Professor Les Irwig, University of Sydney

Professor Jonathan Craig, Sub-Dean (Clinical Epidemiology)

Professor Glenn Salkeld, Professor (Health Economics)

Associate Professor Petra Macaskill, (Biostatistics)

From Bond University

Professor Paul Glasziou, currently Professor of Evidence-based medicine in Oxford, who is returning to Australia on an Australia Fellowship.

More information sydney.edu.au/medicine/public-health/research/centres.php.

MIXING POLICY AND POLITICS: LESSONS FROM THE U.S

BY LESLEY RUSSELL

In Washington President Obama's push for health care reform, suddenly stalled following the Massachusetts Senate election, is back on the agenda. There has been the usual mad rush of analyses and commentary around the President's bill aimed at bridging the differences between the House and Senate bills, the Republican counter-proposals, and the televised White House summit discussion and debate.

Congress, bureaucracy, think tanks, academia

I am constantly struck by the ferment of ideas in Washington and the incredible level of interaction between the Congress, bureaucracy, think tanks (there are hundreds, addressing issues large and small across the political spectrum) and academia. This provides an enormous vibrancy and depth of ideas, incredible expertise and substantial institutional memory. It highlights something unique in American political and policy culture which is represented not just by the exchange of phone calls and papers but by the actual movement of people in and out of jobs.

For example, at the Center for American Progress (CAP), the progressive think tank where I am a Visiting Fellow, I share an office with Judy Feder, who is also a Professor of Health Policy at Georgetown University. Judy and I worked together on Capitol Hill many years ago, and she also worked in the Clinton White House. At nearby George Washington University, Professor Sara Rosenbaum, who was a member of the Clinton White House Domestic Policy Council, heads up the Department of Health Policy where I hold a Visiting Professorship. She is a regular commentator on health issues, and together with her departmental colleagues, is regularly consulted by the Congress.

Most mornings the senior health and communications staff at CAP have a phone hook-up with the White House

policy team, senior Democrat staffers on the Hill and other like-minded think tanks and organisations. We use this time to share strategies, information about what is needed, and what projects are underway. We get calls from lawmakers and their staff asking for specific information, help on drafting amendments or talking points, and from media wanting either background information or comment.

Proactively driving agenda

Our effectiveness depends on our ability to respond very quickly, accurately and reliably. Often we are required to deliver information in mere hours; there's no time for academic niceties and long-winded statements, although double and triple fact-checking is crucial. It's very reminiscent of policy war rooms during election campaigns. But alongside being instantly reactive, we also try to proactively drive the agenda with reports, discussion papers and analyses. Some of these are done in-house, others are contracted out to academic experts. These are generally released on our website, accompanied by a broad-based media strategy.

Lessons for Australia

I'm inevitably drawn to pondering how we could generate such lively and fruitful policy debates and interactions in Australia, and how we could manufacture a role for the Menzies Center for Health Policy, and indeed the School of Public Health, in this.

Of course, Australia and the United States are different in so many respects, and nothing will translate directly from one country, or one political system, to another. Interestingly, the current outbreak of partisanship in Washington, with Republicans inherently opposed to any Democratic idea, makes the political system here look more like the Westminster system every day!

I offer these thoughts on what is



needed for individuals and academic groups to play a more active role in policy-making in Australia:

- Be aware – of the issues of the day. There's no point in hawking policies if there are no votes for them and you need to know who the key players are on any issue, both inside and outside the political system.
- Be pragmatic – don't push for the impossible, especially if it's expensive.
- Be bold – be prepared to speak out with succinct submissions that get into the political arena, using data and logic to support your arguments.
- Be trustworthy – politicians often need to work under circumstances where leaks cannot be tolerated. And while it's nice to be seen as without political bias, being neutral may render you ineffectual.
- Be responsive – quick turnarounds, in language without jargon, is usually what's needed.
- Be innovative - we need to have the academic powers-that-be recognise that the impact of good research is not measured solely by peer-reviewed publications.

It's a challenging topic for future conversations!

DUST STORM APPROACHING BROKEN HILL, 1 FEBRUARY 2010

This stunning photograph was taken by Tim Gimbert who works at the Mental Health & Drug & Alcohol Service, GWAHS at the Broken Hill University Department of Rural Health (BH UDRH)



ABOUT THE BH UDRH

The Broken Hill University Department of Rural Health aims to improve health care in far western NSW by providing high quality support, education and training for rural and remote health workers.

Its focus is to establish relevant teaching and support environments, promote opportunities for student placements in the region, and deliver a successful rural attachment program for medical, nursing and allied health students.

The organisation also encourages experienced academic staff to spend time in the bush and foster partnerships to improve the quality of health care for rural Australians.

Overall the BH UDRH has a strong population health focus and supports existing health providers to improve health service development, especially in public health and primary health care.

More information: sydney.edu.au/medicine/drh/

Did you know?

- The City of Broken Hill is the largest regional centre in the western half of New South Wales.
- It lies in the centre of the sparsely settled New South Wales Outback, close to the South Australian border and midway between the Queensland and Victorian borders. The nearest large population centre is Mildura in Victoria, three hundred kilometres distant to the south on the Murray River.
- The nearest large city is Adelaide, capital of South Australia, approximately 500 kilometres to the southwest.
- Because of its location Broken Hill has strong cultural and historical connections with South Australia and operates on Central Australian Time, one half hour behind Eastern Standard Time.

www.brokenhill.nsw.gov.au



Q&A WITH GLENN SALKELD

Q. Your first degree was in business majoring in economics. How did you become interested in health economics?

In the mid 1980s I graduated from the Australian College of Health Service Executives training program. The program sent us budding hospital administrators to a different hospital every six months. We learnt the trade on the job doing everything from pushing patient trolleys, crunching numbers, to working with the hospital CEO and Board (funny how hospital Boards might make a comeback!). It struck me at the time that hospital administrators didn't much like information because it complicated the otherwise simple joy of making decisions. (Little did I know that John Kenneth Galbraith had made that observation about managers some decades before I did!). I thought the complexity of hospitals deserved a bit of information and that led me into health economics.



Q. What led to you pursuing a career in public health?

It was a complete accident. One of my training placements was to the teaching and research division of Westmead hospital. All my compatriot trainees commiserated with me for drawing the short straw. Nothing happens in teaching and research they said. Well, I discovered Steve Leeder and his Department of Community Medicine at Westmead and I found my vocation. Within 18 months I was back at Westmead as a NHMRC Public Health Training Fellow in Health Economics working with Jane Hall and Karen Gerard. I started work at Westmead on the same day as Simon Chapman. Bob Cumming was Steve's registrar. Westmead opened my eyes to the importance of social context and institutions in health and the power of a multidisciplinary approach to research. It also taught me something else – allow for randomness in your life. Who'd have thought that my backwater placement at Westmead would ignite a passion for public health.

Q. You've been involved in a World Health Organisation initiative which taught public health officials in developing countries how to apply an evidence-based medicine/cost

effectiveness approach to the selection and reimbursement of pharmaceuticals. How did this come about and what did this involve?

In the mid 1990s I was invited to become a member of the relatively new Pharmaceutical Benefits Advisory Committee Economic SubCommittee. Australia was the first country in the world to require cost effectiveness as part of the evaluation process for listing a new drug on the Government's price subsidy list (the PBS). This legislated requirement brought evidence-based medicine and health economics into front line policy making. The idea captured the attention of the Essential Medicines Division of WHO in Geneva. Led by David Henry at the University of Newcastle we developed a teaching module that equipped our students with the skills to become price setters and not price takers. Some low and middle income countries spend more than 30% of their health budget on pharmaceuticals. Getting lower prices for drugs buys you more health. It's a simple but powerful concept. It certainly got up the nose of the pharmaceutical industry. But since the landmark legal case in South Africa about the constitutionality of the Government in RSA to manufacturer Anti retroviral drugs (for HIV/AIDS

patients) in violation of patent protection laws the tide has turned somewhat. That showdown, plus a slowdown in blockbuster drugs and greater competition from generic drug manufactures in India, Brazil and China has empowered many governments to take a more active role in setting drug prices in relation to evidence-based clinical benefit and cost.

Q. You've been involved in a number of research projects investigating the application of discrete choice modelling. Tell us a little about some of these projects.

Discrete choice modelling attempts to decompose the constituent factors that influence a (health choice). Together with my colleagues at the Surgical Outcomes Research Centre we received the first NHMRC grant to apply DCE to colorectal cancer screening. We wanted to know whether people would trade the benefits of screening (averted deaths) with the harms (false positive induced colonoscopies) and the associated process attributes (dietary restrictions associated with using the old guaiac based test). Knowing this might just help design a successful population based colorectal cancer screening program. We found that about a

third of our respondents diligently attempted to trade the benefits and harms and costs in our carefully constructed scenarios, about a third picked whichever option saved the most lives (irrespective of the harms) and third thought we were out of our mind. The most interesting aspect of this work was the qualitative research we conducted on the rules of thumb and shortcuts that respondents used to simplify the choices we presented to them. Interesting stuff. It influences some of our thinking in the STEP group. How might we simplify the otherwise complex cognitive processes involved in making decisions about your health?

Q. You've been Head of School since 2007. What do you regard as the School's significant achievements during this time?

Creating an environment in which our research and teaching has flourished. The usual output metrics – students numbers, grant dollars, publications have all shown significant gains and everyone can share in that success, particularly our Director of Research, Simon Chapman, our Director of Teaching and Learning, Jo Lander and Director of Postgraduate Studies, Sue Quine. Most gratifying to me is to see new groups emerge, bridging university organisation boundaries and go on to prosper. I also take great pride in our professional services team. We have a very hard working, friendly, cohesive team of administrative staff. With high expectations from students and academics our admin staff deliver a high level of service and support.

Q. What do you hope can be achieved at the School over the next 5 years?

The next five years will require even more focus on what we do well and careful attention to succession planning. I want to see a new generation of lecturers appointed to the School and, at the same time, ensure that we invest the time and effort in advanced learning that cements our reputation as leading educators in public health. I also want to see greater connections with the public health work place and global public health education.

Q. What do you regard as the key challenges to public health education and research in Australia?

Our key challenge is to take the knowledge that our education and

research creates and ensure that we are relevant, influential and impact on the health of the population. To do that we will need to renew and refresh our public health work force (we are an ageing lot!) and put more effort into forming partnerships (local and international) The practical challenges will always be with us – proper funding of the higher education sector, securing space to accommodate new teams of people and making sure that the university environment is one that promotes new ideas, freedom of expression and is collegiate.

Q. Did you have a career mentor?

I have been fortunate to have several mentors. My first was Albert Himmelhoch, the Director of Medical Services at Hornsby Hospital in the early 1980s. Albert pioneered family medicine training and it was he who sponsored my admission into the Australian College of Health Service Executives training program. The second was Gavin Mooney, the foundation Professor of Health Economics at Sydney, and my PhD supervisor. It was Gavin, the wild Scotsman, who inspired and encouraged me to take the unknown

path into academe and Geoffrey Berry who took the punt to hire me. I've had lots of support along the way, from Steve Leeder, Charles Kerr, Les Irwig, David Henry, Michael Solomon. I think everyone can benefit from having good mentors.

Q. You undertook your postgraduate study at the University of Tromso, Norway. What did you think of student life there?

I don't know how students can afford to drink in Norway. Alcohol is prohibitively expensive. In fact I completed the degree by distance education. I did visit Tromso (the northern most university in the world) and loved the frontier town feel to the place.

Q. What is your favourite way to unwind?

Listening to Bach on my sound system.

Q. Describe your ideal holiday.

Being with my family in a place that has clean air, the opportunity for physical exercise, good food and electronic sensory deprivation (ie no mobile phones or internet). Lord Howe Island and Whistler do it for me.



STAFF NEWS

PROFESSOR DEBORAH SCHOFIELD JOINS THE NHMRC CLINICAL TRIALS CENTRE

In December 2009 Deborah Schofield was appointed as Professor of Health Economics.

Professor Schofield has an international reputation for her work in economic modelling of the health and welfare systems, establishing the first microsimulation models of health in Australia in the 1990s. Her experience spans the Australian Government public service, academia and clinical practice. She has 20 years of experience in research programs focussed on developing policy based on the best available evidence and tools. She has held senior leadership positions in government including Director of Health Policy at The Treasury and Director of PBS Budget Policy and Director of Acute Care Finance at the Department of Health and Ageing where she managed \$42 billion in funding for public hospitals.

At the Treasury she also worked as a specialist adviser in economic modelling. During this time she pioneered the methods for forecasting health expenditure used in the landmark Budget paper called "The Intergenerational Report (IGR)" and coined the now widely used term "non-demographic growth", which demonstrated the importance of new technologies and expansionary policy in driving up health expenditure. These methods are now used by the OECD.

She brings with her research programs focussed on the economic impacts of illness (personal loss of income and saving, and loss of taxes and social security payments for government) and health workforce planning. Moving to Sydney with her are two members of her team: Dr Rupendra Shrestha an experienced biostatistician and economic modeller and Ms Emily Callander a University medal winning environmental economist who has recently won an NHMRC PhD scholarship. The research program is funded by a number of ARC linkage grants co-funded by Pfizer Australia, an NHMRC grant and commissioned work.

In her new role she will add leadership of the application of economics to clinical trials. She is joined by Ms Hannah Verry at the CTC, who won numerous awards during her university degree in economics and who is now working on cost effectiveness studies for a number of clinical trials and Dr Merel Kinman a health economist who will join the team in April, coming from the Netherlands to work on systematic reviews of clinical trials related to health technology assessment.

In addition to her new role at the University of Sydney, Deborah was attracted to Sydney by the educational opportunities available to her son, evenings attending classical concerts and the pleasures of sailing on Sydney Harbour.

More information:

www.ctc.usyd.edu.au



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Please send your stories and event for the next issue of The Bridge to Felicity Barry (felicity.barry@sydney.edu.au). Deadline 4 June 2010.