

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on "Policy processes and reform"

**Anne-marie Boxall
PhD student
Australian Health Policy Institute**

Abstract

EXPLAINING HEALTH POLICY REFORM USING MEDIBANK A CASE STUDY

Anne-marie Boxall, Stephen Leeder and Jim Gillespie
Australian Health Policy Institute, The University of Sydney

Major reforms in health policy are frequently called for in Australia, but rarely achieved. One of the few examples of successful structural reform is the introduction of Medibank in 1975. Although its life was short, it paved the way for the introduction of Medicare in 1984, which has endured to this day.

This paper describes existing theoretical explanations for policy reform and argues that they are unable to adequately explain the introduction of Medibank. An alternative framework for understanding policy reform is offered, which looks at the influence of factors such as policy ideas and the arguments used to justify them, prevailing political ideologies, changes in social and economic conditions, design and relationships between political institutions, interest group dynamics, problems with past policies and political leadership.

Using this framework, evidence from government archives, political speeches, advertising material, opinion polls and interviews with key participants was collected and is used to explain how, despite the numerous obstacles, the Whitlam government managed to successfully introduce Medibank. The most important reasons they were successful were that they:

- Developed a policy that solved urgent problems in the health system
- Managed to keep the Medibank policy idea intact over time, despite numerous challenges
- Were able to bypass political and bureaucratic institutional obstacles
- Redefined the nature of the debate on health insurance policy and secured public support for Medibank

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on HIV/AIDS

Andrey Zheluk
PhD candidate at the University of Sydney

ABSTRACT

AN HIV POLICY INTERVENTION IN POST-SOVIET CENTRAL ASIA: POTENTIAL INDICATORS OF SUCCESS?

The former USSR has the highest rates of HIV growth on the globe. Since 2001, new heroin routes north out of Afghanistan threaten to overwhelm post-Soviet Central Asia with new injection-driven epidemics of HIV. Policy interventions are generally accepted as central to preventing the expansion of post-Soviet HIV epidemics.

In post-Soviet Central Asia, international donors have developed the "Spectrum of Services" HIV policy intervention. The Spectrum is analogous to DOTS (Directly Observed Treatment Short Course for tuberculosis), as it packages a range of evidence –based HIV services into a single, politically saleable intervention. Similarly, it requires local political commitment for its implementation.

Successful HIV interventions ultimately aim for biological outcomes. UNAIDS has suggested "coverage", the percentage of population covered by an HIV service, as an appropriate initial non-biological indicator of HIV intervention success in low and middle income countries. While the "Spectrum of Services" may be a policy intervention, developed-country measures of success are not appropriate in Central Asia. Can an increased understanding of informal governance assist HIV policy transfer in the region?

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on "Policy processes and reform"

Bev Majda

PhD student and sessional tutor
University of South Australia

Abstract

'POLITICAL IDEOLOGY: THE UNDER-EXAMINED VARIABLE IN HEALTH POLICY REFORM'.

Health service financing through public universal insurance (Medicare), private health insurance, and intergovernmental resource distribution mechanisms have undergone major and incremental changes since the election of the federal Coalition government in 1996. However, federal policy actors disseminate minimal evaluation data about the reforms or 'dismiss' adverse research findings. When policy reforms are unable or prevented from addressing 'public tests of evidence' or informing public judgement, these reforms become rhetorical justifications and expressions of political ideology in practice.¹

The current research explores in what ways political ideology has led to the reforms of Australia's health system since the federal Coalition's 1998 re-election. Political ideology is defined by this study as 'thought-actions', the connection of political thought (ideas) and political action.² The thesis maintains that political ideas, both normative and prescriptive, influence all aspects of the policymaking and political process. The primary research intent is to identify and analyse political ideology within the policy agenda and priority setting decisions, communicated objectives and rationales, and the consultation and federal-state processes that emerge from the reform process. The role and communicative strategies of policy elites, particularly federal ministers and their interconnection with Cabinet and intergovernmental decision making processes is the explanatory focus of this research.

To provide conceptual understanding, this ideologically-centred analysis is studied through a neo-Gramscian lens. A neo-Gramscian perspective contends that hegemonic *consent* is increasingly more important than *coercion* in contemporary sociopolitical structures.³ Critical discourse analysis provides the analytic underpinning of this research to balance the exploration of theory, and the practical application in the production and reproduction of knowledge.

This critical policy analysis examines the text and context of federal government policy documents, intergovernmental communiqués, parliamentary proceedings and reports, and ministerial media statements and speeches from 1998 to 2005. A second component of the research explores policy process experiences and perceptions from a sample of Australian health policy academics, analysts, bureaucrats and health organisation peak bodies. The final component of data collection is a comparative analysis of Canadian and New Zealand health policy reforms that take a different path to the Australian policy course. The study has an expected completion date of 2008.

1 F Fischer and J Forester, 'Editors' introduction', in F Fischer and J Forester (eds), *The argumentative turn in policy analysis and planning*, Duke University Press, Durham, 1993, p.3.

2 M Freedon, *Ideologies and political theory: a conceptual approach*, 2nd edn, Oxford University Press, Oxford, 1998, p.76;

A Finlayson, 'Political science, political ideas and rhetoric', *Economy and Society*, 33 (4), 2004, p.544.

3 T Purvis and A Hunt, 'Discourse, ideology, discourse, ideology', *British Journal of Sociology*, 44 (3), 1993, p.474;

J Nederveen Pieterse, 'Metamorphoses of power: from coercion to cooperation?', *Asian Journal of Social Science*, 33 (1), 2005, p.15.

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on "Health Economics"

Michelle Cunich
University of Sydney

Abstract

NURSE EMPLOYMENT BEHAVIOUR IN NEW SOUTH WALES

Michelle Cunich* and Stephen Whelan*,#

The retention of nurses has become a key issue for governments in Australia and overseas. Policy makers and health care administrators point to a shortage of nurses, driven in part by nurses exiting the profession at a rapid rate. The causes of this are multi-faceted and include the ageing of the nursing work force, more stringent educational requirements being placed on nursing students and a greater range of work opportunities open to new nursing graduates. This paper examines the employment behaviour of registered nurses in New South Wales between 1986 and 2002. Using a unique dataset we identify the determinants of nurse retention and movement within the health care sector in New South Wales during this period. We estimate a series of duration models to identify the effect of a change in the nature of registered nurse education, from hospital based training to university based training on labour market behaviour.

* Discipline of Economics H04
University of Sydney NSW 2006

SPEAR Centre, RSSS
Australian National University ACT 0200

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on "Contentious Issues in Health Policy"

Adam G Elshaug
PhD Candidate
Discipline of Public Health
The University of Adelaide, Australia.

Abstract

STUCK WITH THE OLD AND OVERWHELMED BY THE NEW: CHALLENGES IN THE POLICY PROCESS FOR THE DISINVESTMENT OF NON-EFFICACIOUS HEALTH CARE PRACTICES IN AUSTRALIA.

*Adam G Elshaug, Janet E Hiller and John R Moss.

Australia is internationally regarded as a pioneer and leader in the evidence-based processes for assessing new health technologies to gauge their safety, effectiveness and cost-effectiveness in order to determine their eligibility for public reimbursement and therefore universal access. Unfortunately Australia also suffers from a legacy whereby many currently implemented health care interventions were diffused prior to cost-effectiveness becoming a criterion. Thus many health services of limited effectiveness may still be in practice nation-wide. We conducted a multi-centre retrospective clinical audit of surgery for the treatment of adult Obstructive Sleep Apnoea. Results (n=94) demonstrate that individuals received 41 varying combinations of surgery with an overall physiological success rate of 13%. These surgical interventions are thus not clinically effective or efficient resource allocations. Reimbursement approval for new products, as well as the withdrawal of reimbursement for existing services rests with the Minister for Health, under advice from the Medical Services Advisory Committee (MSAC). Yet MSAC faces issues in its policy processes and capacity to address this kind of situation. Whereas for new devices or pharmaceuticals the burden of proving effectiveness lies with the sponsor, for obsolete technology there appears to be a reversal; it is the regulator who firstly has to identify or be made aware of a doubtful practice, to commission reviews, and then mount a compelling argument for ineffectiveness/cost-ineffectiveness. To define and prove inferiority is conceptually difficult but even if it were not, MSAC must deal with applications for new and emerging technologies and hence has limited capacity to address existing services. The disinvestment of existing health care practices that offer no or low health gain is a policy challenge that requires greater attention, both for quality of care and sustainable resource allocation.

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on "Contentious Issues in Health Policy"

Gisselle Gallego

Research officer for the Centre for Health Economics Research and Evaluation (CHERE) at the
University of Technology in Sydney

Abstract

**THE ROLE OF THE PUBLIC IN SETTING PRIORITIES IN HEALTH CARE – HIGH COST
MEDICATIONS (HCMS) AS A CASE STUDY**

Gisselle Gallego¹ BPharm, PhD, Research Officer;
Susan J Taylor² BPharm, MSc(Clinical), PhD, Senior Lecturer;
Jo-anne E Brien^{2,3,4} BPharm, BS(Pharm), PharmD, Professor

¹Centre for Health Economics Research and Evaluation (CHERE), University Technology
Sydney, Australia

²Faculty of Pharmacy, University of Sydney, Australia

³Therapeutics Centre, St Vincent's Hospital, Sydney, Australia

⁴Faculty of Medicine, University of New South Wales, Australia

Health care decision-makers make choices about patients and/or treatments in resource constrained environments. However, there is a lack of adequate guidance for those decisions based on community views.

Aim: This research project explored health care decision maker's perceptions about public involvement in decision-making priority setting for High Cost Medications (HCMs) in public hospitals in Australia.

Methods: In depth semi-structured interviews were conducted with key decision-makers in the South East Sydney Area Health Service (SESAHS). Interviews were audiotaped, transcribed verbatim, thematically content analysed and coded using NVivo® software. The analysis incorporated principles of grounded theory

Results: The majority of participants perceived that the "rationing debate" needs to happen in Australia and the community at large needs to understand that health care resources are limited and choices need to be made. The role of the public according to participants was considered diverse (tax payers, patients, consumers) and due to the complexities of the health care system their involvement in decisions regarding access to HCMs in public hospitals was considered limited. For participants the role of the public was more likely to be at the macro level, deciding how much they were prepared to spend on health care. Most considered that the general public should be aware that if they want access to HCMs they may need to pay more taxes.

Conclusion: The role of the public in decision-making priority setting for HCMs in public hospitals was perceived as limited. However since rationing is unavoidable, there should be an explicit debate about the principles and issues concerned.

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on "Policy processes and reform"

Deborah Gleeson
School of Public Health
La Trobe University VIC 3086
Ph. 0423 209029
Email: dhgleeson@students.latrobe.edu.au

Abstract

HEALTH POLICY CAPACITY AND THE POLICY PROCESS

Deborah Gleeson¹, David Legge¹ and Deirdre O'Neill²

1. School of Public Health, La Trobe University, and 2. Australia and New Zealand School of Government

This paper discusses preliminary findings and a framework for analysing data from a study of policy process and policy capacity being undertaken in the Victorian Department of Human Services (DHS). The project methodology includes four stages: a comparative review of public sector policy capacity research; in-depth interviews with policy practitioners; development of case studies of episodes of policy making; and focus groups with experienced policy makers who will reflect on the case studies in terms of organisational and individual capacity. Data analysis involves two stages: describing the policy process and evaluating this description in terms of policy capacity. The paper canvasses a number of metaphors (theories, models and perspectives) which appear to be promising for describing the policy process, illustrates these metaphors using examples from the in-depth interview data, discusses possible coding themes arising from the metaphors and examines the implications for how policy capacity is understood. Metaphors explored in the paper include rational decision making, incrementalism, policy networks and communities, garbage can and 'three streams' metaphors, a number of metaphors relating to implementation, a production metaphor and the metaphor of conversation and argument. These metaphors illuminate different dimensions of policy capacity, such as resources for policy development, building vision and relationships, including implementers in policy making, coordination and institutional processes, institutional culture and opportunities for people to talk to each other.

Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006

Session on "Technology and Health Policy"

*Henry Ko*¹, *Koichi Mikami*²

¹*Graduate School of Biomedical Engineering
University of New South Wales, Sydney, NSW, 2052, Australia*

²*James Martin Institute
Said Business School, University of Oxford, Park End Street, Oxford, OX1, 1HP, UK*

Abstract

**AN EXPLORATION OF THE CONUNDRUMS FOR DEVELOPING POLICIES
GOVERNING THE UTILIZATION OF EMERGING BIOMEDICAL TECHNOLOGIES.**

We live in a society that is increasingly embracing the biomedicalization of health care services and health in general [1]. Are we creating policies that consider the impact of breakthrough health technologies on society [2]? Is the public properly informed on emerging biomedical technologies [3]?

With advanced biomedical health technologies continually integrating into society, health policies needs to better consider the impact of emerging technologies on the healthcare system. For the effective, timely, and efficient utilization of emerging health technologies that will benefit society, there needs to be more emphasis on developing health policies where interdisciplinary thinking has resulted in the understanding of socio-techno issues for governing utilization of technologies in the healthcare system. Complex technical, governance, philosophical and social issues concerning emerging technologies on longevity, human performance, happiness, and cognition need to be comprehensively explored.

To increase public feedback, and develop well-thought policies that may potentially govern the use of emerging health technologies, better public communication and understanding about emerging health technologies needs to be increased and discussed in a more collaborative manner [4].

1. Clarke, A.E., et al., *Biomedicalization: Technoscientific transformations of health, illness, and US biomedicine*. American Sociological Review, 2003. **68**(2): p. 161-194.
2. Zucker, H.A., *American Society for Artificial Internal Organs: the government's role in advancing regenerative medicine and tissue engineering*. ASAIO Journal, 2004. **50**(6): p. xix-xxi.
3. Allen, E.E. and L. Hood, *Biotechnology, inquiry, and public education*. Trends in Biotechnology, 2000. **18**(8): p. 329-30.
4. Davies, K.G. and J. Wolf-Phillips, *Scientific Citizenship and good governance: implications for biotechnology*. Trends in Biotechnology, 2006. **24**(2): p. 57-61.

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on "Issues in Indigenous Health"

Jane Lloyd
Menzies School of Health Research & School of Public Health, University of Sydney

ABSTRACT

HOW IS ABORIGINAL HEALTH POLICY IMPLEMENTED?

Jane Lloyd, Marilyn Wise, and Tarun Weeramanthri

Aboriginal health policy development has improved and is now closer to meeting the standards of good practice, but much less attention has been given to implementation. There is a perception in the literature and among public health practitioners that many policies are not implemented and as a result Aboriginal health has not improved. In other words, even when culturally safe and potentially effective policies are developed, there is failure at the implementation stage. However it is possible that failed implementation is an outcome but not a diagnosis of where the policy to action continuum failed. The research was based on a case study of the implementation of the Northern Territory Preventable Chronic Disease Strategy and involved 35 in-depth interviews with service providers and administrators across urban and remote areas of the Northern Territory. Initial findings reveal that there were major changes to the Northern Territory Preventable Chronic Disease Strategy as it was implemented. This demonstrates that:

- Policy evolves as it is implemented (as opposed to emerging complete and ready for adoption).
- Implementation occurs through a process of collective negotiation.
- The composition of the workforce influences what is implemented, and what is implemented affects the workforce. This is a self reinforcing cycle which leads to further strengthening of existing professional groups. This raises questions about equity in the implementation process, and actual capacity to do things differently.

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on "Contentious Issues in Health Policy"

Jennifer Smith
Australian Health Policy Institute

ABSTRACT

Regulating ethically? Policy making for reproductive technologies

In Australia over 60,000 have now been born with the assistance of reproductive technologies. However there is still a dearth of legislation and regulations governing the use of these technologies. Policy making for reproductive technologies is fraught with difficulty because of the moral weight of many of the questions that need to be dealt with. This paper presents a work in progress as I tackle the question of how policy making for these technologies may be best achieved so that it addresses both the moral and ethical questions dimensions of their use and the practical needs of those using and administering the technologies.

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on "Health Service Delivery and Mental Health"

Stephen Kilkeary
Specialist Men's Counsellor
Life Links for Men Project
Centacare Sydney
61 2 9390 5366 [t]
0408 678 935 [m]

ABSTRACT

SERVICE RESPONSES TO SUICIDAL MEN

In its 2005 research report, 'Closing the Gap', the peak body for suicide prevention in Australia, Suicide Prevention Australia (SPA), recommended that 'the first person, lived experience of suicidality is a research priority in order to bring the expertise of those who know suicidality "from the inside" into the discipline' (p.31). To date, there has been a dearth of research evidence on this subjective viewpoint. Further, although men in Australia have persistently been four times more likely than women to commit suicide (ABS figures, 2004: 1,661 men, 437 women), there remains little known about the gender-based behaviours that contribute to this disparity.

In my research study, I intend to investigate the subjective experiences of 20 men who have, after attempting suicide or with suicidal ideation, come into contact with workers in mental health services. Through semi-structured interviews, each man's evaluation of these services in terms of what helped or hindered their suicide issues will be explored. All interviews will be tape recorded and later transcribed. The common and distinct themes will be noted and set against the wider literature on the phenomenon of male suicide in general and men's help-seeking behaviours and subsequent service responses in particular.

At this stage of my research, and what I want to focus on in my presentation, is to raise the hypothesis that the problems often attributed to men's poor help-seeking behaviours might better be explained by the manner in which men deal with their problems and the manner in which mainstream mental health services are delivered.

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on "Health policy: Evidence and Evaluation"

Caroline Turnour, Lesley King, Marilyn Wise
NSW Centre for Overweight and Obesity, University of Sydney

Abstract

**CHILDHOOD OBESITY - TIME FOR STRATEGIC POLICY TO BACK UP
PRACTICAL ACTION**

In 2002 the NSW Government was one of the first Australian governments to respond to the escalating rate of childhood obesity by developing the *Prevention of Obesity in Children and Young People: NSW Government Action Plan 2002 – 2007*. The Plan contains 34 actions across seven priority areas involving six NSW Government agencies. Using the NSW Government Action Plan as a case study this paper highlights the strengths and weaknesses of practical action preceding the development of a strategic childhood obesity policy. The paper assesses the Action Plan against the International Obesity Taskforce (IOTF) principles and recommended actions. The results have significant policy implications for the development of a whole-of-government response aimed at preventing childhood obesity.

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on HIV/AIDS

Klara Henderson
PhD Candidate
School of Public Health at the University of Sydney

ABSTRACT

SWAps in health and HIV/AIDS responses: a difficult union?

The meeting of two seemingly opposing trends in health policy is raising difficult questions for those working in developing countries. On one hand there is growing literature on the benefits of sector wide approaches (SWAp) to health. SWAps are designed to prioritise health needs and reduce gaps and duplication of effort that can be created through ad hoc, short-term donor driven projects. A key objective of a SWAp is to provide the mechanisms to create the best possible health outcomes through priority setting. This relies on the tenet of pooling and coordination of funds for those priorities.

On the other hand there are increasingly vast amounts of funds available from bilateral and multilateral donors for the development of HIV/AIDS responses. The funds play a very significant role in a country's ability to respond to the epidemic and many HIV/AIDS programs would simply not exist on the scale that they do without donor support. Yet the funding of programs in this way can be at odds with the tenets of a SWAp and raises policy dilemmas. Will the effectiveness of the HIV/AIDS response be diluted if not included in the SWAp? Or is the opposite true – will including HIV dilute the HIV response? What of the impact for the SWAp, will including HIV/AIDS policy and associated funding undermine the objectives of a SWAp by skewing health priorities?

These questions will be explored through examination of the HIV/AIDS policy in East Timor following the vote for independence.

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on HIV/AIDS

Katherine Lepani
PhD Candidate
Gender Relations Centre, Research School of Pacific and Asian Studies
Australian National University
Email: katherine.lepani@anu.edu.au

ABSTRACT

**CONVERGING INTERPRETIVE FRAMEWORKS FOR MAKING SENSE OF HIV AND AIDS
IN THE TROBRIAND ISLANDS, PAPUA NEW GUINEA**

Concurrent with the global spread of HIV are multiple ways of comprehending the virus as different knowledge and belief systems converge and interact. Western models of disease, risk, and behaviour change, and the sexual moralities these models impute, all influence the interpretive process of making sense of HIV and AIDS in diverse cultural contexts, potentially affecting the capacity to articulate local knowledge and form cognitive links with new information. My presentation considers this interpretive process by looking at a particular cultural model of sexuality and disease in the Trobriand Islands of Papua New Guinea. I argue that evidence based policy responses to the epidemic need to be cognizant of cultural mediations of information in order to close the persistent gap between people's knowledge about HIV and the behaviour change necessary for prevention. Drawing on ethnographic research, I examine the Trobriand phenomena of *sovasova*, or chronic illness that results when members of the same matrilineal clan have sexual relations, and I consider the implications for effective responses to HIV. The signs and symptoms that herald the onset of *sovasova* are similar to representations of AIDS-related illness—weight loss, pallor, and malaise. Affected people use herbal and magical treatments to manage *sovasova*, and the sickness can be avoided altogether by simply not having sex with a clan member. The broad comparisons drawn between *sovasova* and AIDS create tensions as Trobrianders contemplate HIV prevention based on their own model of sexuality and disease. The Trobriand model implicitly critiques conventional public health meanings about what constitutes 'healthy' and 'risky' sexual behaviour, and questions the assumptions of standard HIV prevention messages.

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on "Issues in Indigenous health"

**Alice Rumbold
Menzies School of Health Research
PO Box 41096
Casuarina, NT 0811
E-mail: alice.rumbold@menzies.edu.au**

Abstract

**EXPLORING THE CHARACTERISTICS OF THE INDIGENOUS HEALTH RESEARCH
WORKFORCE**

Rumbold AR^{1,2}, Cunningham J¹, Bailie RS¹, Hiller JE².

1. Menzies School of Health Research, Institute of Advanced Studies, Charles Darwin University, Australia.
2. Department of Public Health, The University of Adelaide

Improving the evidence base for Indigenous health policy requires high quality, effective and participatory research which can only be achieved when there is adequate research capacity. There is a critical shortage of trained Indigenous researchers, however little else is known about the current research workforce in Indigenous health, and whether there are particular barriers or incentives to working in this area.

We have conducted a brief survey of current and past researchers in Indigenous health to gain a better understanding of:

1. The main characteristics of researchers involved in the field of Indigenous health;
2. The opportunities and incentives to working in Indigenous health research;
3. The obstacles researchers face when entering and working in the Indigenous health research field.

The project involves the administration of a simple survey, by email or mail, to all researchers listed as an author on a published paper or who have completed a PhD or Masters research degree in the field of Indigenous health between 1995 and 2004. Our survey asks about current involvement in research and the research field, factors that make Indigenous health research attractive and unattractive as a field of work, training and employment, and demographic information.

We will present the first results of our survey, including the number of eligible authors identified and contacted and the summary of responses to date. We will discuss the implications these findings have for improving our capacity to undertake effective Indigenous health research, and the implications for Indigenous health policy.

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on "Issues in Indigenous Health"

Sophia Leon de la Barra
Masters Student
University of Sydney
Sax Institute

ABSTRACT

**HOW DO WE BENCHMARK POLICY FAILURE?
A CASE STUDY OF THE PETROL SNIFFING PREVENTION PROGRAM**

Evaluation is the barometer of benefit in the policy cycle. It is an opportunity to measure key indicators, evaluate if targets have been hit, and reflect on the hurdles of putting policy into practice. It is also a crucial strategy for informing the evidence base and future policy directions. Competent and informed policy is generated by a thorough and systematic approach to policy evaluation [1].

Critical deficiencies have been identified in the evidence-base and information systems of Aboriginal health research [2]. This is the result of policy and programming 'done on the run.' *Ad hoc* legislation is characterised by fragmentary policy decisions, one-off financial allocations, short-term interventions, and tenuous evaluations [3]. When evaluation is not integrated into the policy process, gaps of knowledge widen, programming is remedial, and social disadvantage persists [2,3,4].

To foster sustained policy commitments in Aboriginal health, commitment to evaluation of policy and programming is necessary. Strategies for systematic program evaluation and knowledge brokerage into the policy context must be utilised [2]. The Department of Health and Ageing has established the 'gold-standard' program logic model, which delineates the criteria and framework for policy evaluation in their guidelines to *Conducting Lapsing Program Evaluations*.¹

This paper utilises the evaluation principles of program logic as a theoretical framework to assess policy failure. Is admitting policy failure political suicide? Evaluations of the Petrol Sniffing Prevention Program² are used as a case study. The aims of this paper are to identify obstacles to performing systematic evaluations, and reiterate the importance of informed policy reformulation.

¹ Lapsing programs are defined as policy measures which Cabinet (PMC) has not specified if funding is ongoing or terminates. As of 2005, lapsing program evaluations are required by the Department of Finance and Administration (DoFA) for the purpose of Cabinet deliberation to review whether the original program objectives have been met, and the appropriateness of continued funding [5].

² formerly named the Comgas scheme

References

1. Parkin A: **Evaluation** In *The Australian Policy Handbook*. 3rd edition. Crows Nest, NSW: Allen & Unwin; 2004: 130-138.
2. Anderson I: **Evidence and Aboriginal Health Policy**. In: *Evidence-based Health Policy*. Edited by Lin V, Gibson B. Melbourne, Oxford University Press; 2003: 224-236.
3. D'Abbs P, Brady M: **Other people, other drugs: the policy response to petrol sniffing among Indigenous Australians**. *Drug and Alcohol Review* 2004, 23: 253-260.
4. Behrendt L: *Achieving Social Justice: Indigenous Rights and Australia's Future*. Leichardt: Federation Press; 2003.
5. Department of Health and Ageing: *Conducting Lapsing Program Evaluations*. Canberra; 2005.

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on "Health Service Delivery and Mental Health"

Nikos Thomacos

Mr Nikos Thomacos & Dr Nancy E. McMurray
Department of Psychology, University of Melbourne, Victoria, 3010,
n.thomacos@latrobe.edu.au & n.mcmurray@unimelb.edu.au

ABSTRACT

**THE ROLE OF SUPPORTIVE RELATIONSHIPS IN THE DELIVERY OF
SUCCESSFUL HEALTH CARE SERVICES AND HEALTH PROMOTION**

Over the past twenty years a large and growing literature has demonstrated that important relationships, be they social, supportive or intimate, provide support and resources and enhance resilience in times of stress (e.g. Hatchett, Friend, Symister, & Wadhwa, 1997; Mickelson, & Kubzansky, 2003; Rosengren, Wilhelmsen, & Orth-Gomer, 2004). A smaller but none-the-less increasing literature has shows that these relationships can also adversely influence individuals' health and well-being (e.g. Okun and Keith, 1998, Rook, 1984).

While recognising that relationships are in fact dynamic, 'positive' supportive relationships are an important assumption underpinning health planning and service delivery as well as an important consideration in the implementation of public health and health promotion campaigns and activities.

This paper will examine the impact of the negative effects of supportive relationships across the lifespan using the Negative Effects of Relationships Scale (NERS) (Thomacos & McMurray, 2001). In doing so, an integrated view of supportive relationships that captures both the negative and positive effects of supportive relationships will be presented as well as an overview of how these relationships change across the lifespan.

Secondly, this paper will consider the practical applications of a dynamic model of relationships, particularly as they apply to the planning and provision of health care services. The findings have implications for health services and activities such as post-acute care discharge planning, chronic disease management and health promotion. Finally this paper will reflect on the policy implications that arise from the findings and explore how health care services across the continuum of health care are able to use these findings.

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on "Health Economics"

Bernard van den Berg
Centre for Health Economics Research and Evaluation
Faculty of Business
University of Technology, Sydney
Tel.: + 61 2 9514 4753, e-mail: bernard.vandenberg@chere.uts.edu.au.

Abstract

THE IMPACT OF PROVIDING INFORMAL CARE ON SELF REPORTED WELL-BEING

Bernard van den Berg¹, Denzil Fiebig^{1,2}, Jane Hall¹

¹CHERE, Faculty of Business, University of Technology, Sydney, Australia

² School of Economics, Faculty of Commerce and Economics, University of NSW, Sydney, Australia

Abstract

This paper estimates the impact of informal caregiving on self reported well-being. It uses a sample of 12,155 respondents of the first wave of the Household, Income and Labour Dynamics in Australia (HILDA). HILDA is a national representative sample of Australians collected in 2001. 10.5 percent of the sample provided on average 12.5 hours of informal care per week. The econometric estimates show that providing informal care has a clear negative effect on well-being. This effect is mainly because of providing care for someone of 18 years and older within the same household. Providing informal care to somebody outside their own household does not involve well-being losses.

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on "Health Economics"

Nada Wasi, Post Doctoral Research Fellow

Centre for the Study of Choice

Faculty of Business

University of Technology, Sydney

Tel.: + 61 2 9514 3259, e-mail: nada.wasi@uts.edu.au.

Abstract

CHRONIC CONDITIONS, FAMILY AND LABOUR SUPPLY

Nada Wasi* and Bernard Van den Berg**

UTS (*Centre for the Study of Choice, ** Centre for Health Economics Research and Evaluation)

Summary

When a child has a chronic health problem, parents are likely to be affected in various aspects. Previous studies in health policy and economics on informal caregiving have estimated labour market opportunity costs or well-being of patients and/or caregivers without complete information of the household structure. The effect of children's chronic health problem on parents' labour supply has been neither focussed nor estimated empirically. In this paper, we address this issue by employing the 5% sample Integrated Public Use Microdata of the United States in 2000. This large data set contains a rich set of characteristics of all members in the same household, allowing us to control for heterogeneous types of families. Our preliminary results suggest that on average mothers of children with chronic health problem are less likely to participate in the labour market. If they participate, they work less hours compared to mothers of children without health problem. There is no clear effect on fathers' labour supply decision. Understanding these labour supply effects is of policy importance because it is related to (1) the design of long term care policies; and (2) the evaluation of costs and effects of programs regarding chronic health conditions.

**Emerging Health Policy Research Conference
University of Sydney
Friday 13 October 2006**

Session on "Health Service Delivery and Mental Health"

Xanthe Glaw

ABSTRACT

**DEINSTITUTIONALISATION OF THE MENTALLY ILL AND ITS EFFECT
ON PSYCHIATRIC NURSING PRACTICE**

Professor Jocalyn Lawler: primary supervisor

Mr. Stuart Newman: secondary supervisor

This research project aims to examine the effects of the Richmond Reforms on psychiatric nursing practice. 1983 saw the deinstitutionalisation of the mentally ill in New South Wales, as a result of the Richmond Reforms. This Richmond Report recommended that the Wran Government decrease the size and number of mental hospitals and expand community networks to maintain the mentally ill in the community (Walker 2003). Many large "fifth schedule" psychiatric hospitals were closed or reduced in size and patients were sent to live and be cared for in the community, by community treatment teams. Patients were expected to live with their families or forced to sleep in crisis refuges, boarding houses, caravan parks, motels or on the streets (Moore 2003). Richmond (1983) argued that it was inappropriate to use custodial type care for the mentally ill and mental hospitals had failed to provide an adequate standard of treatment and rehabilitation. He argued that community care could result in far better care and clinical outcomes at a lower cost. However, twenty-three years on, we now have a problem as successive governments have progressively reduced the size and number of existing fifth schedule hospitals, yet have failed to fund and provide services in the community to adequately help people suffering from mental illness. We now have many mentally ill people either homeless, in jail or committing suicide (ABC 2005). Current state and federal governments have recognised the problem and have increased funding to the mental health care system (SMH 2006). What has not been widely acknowledged or researched is the loss of the psychiatric nurse. Changes to nursing education coincided with deinstitutionalisation, but were not specifically linked to the Richmond reforms saw nurse training became comprehensive in nature. This change resulted in mental health nursing becoming a component to the revised comprehensive syllabus in preparation for practising as a registered nurse; and psychiatric nursing as a separately registerable qualification ceased in NSW. Nurses now need to undertake postgraduate study to specialize in the field of psychiatric nursing, usually at their own expense. Two decades after the Richmond reforms began, we

have a shortage of properly trained and skilled psychiatric nurses, which is compounding the long-term effects of deinstitutionalisation. Although the causes of that shortage are due to many factors, there is a serious decline in the available number of registered nurses who are qualified and experienced in psychiatric nursing.

References

ABC – Australian Broadcasting Corporation (2005) *The 7.30 Report*, 19 October 2005

Department of Health, N.S.W., Division of Planning and Research (1983) *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled – “The Richmond Report”*, Haymarket, Department of Health, N.S.W., Division of Planning and Research

Moore C (2003) Matter of Public Importance – Mental Health Services, *NSW Legislative Assembly Hansard 12 November – Parliament of New South Wales*, [Online], Available: <http://parlinfoweb.aph.gov.au/p/web/results.aspx> [24 June 2006]

Sydney Morning Herald, 10 May 2006:3 (Budget 06)

Walker F (2003) Symposium 2003: Out of the Darkness and into the Light, *Schizophrenia Fellowship of NSW Inc. Symposium 2003: Frank Walker’s Opening Remarks*, [Online], Available: <file:///volumes/NO%20NAME/2004%20Schizophrenia%20Awareness%20Week.htm> [22 January 2006]