

BLAST FROM THE PAST

intouch April 1998

Doing our best? Best practice revisited

The gap between best practice and current practice yawns widely. How to bridge this gap was the subject of a national forum convened by the National Health & Medical Research Council's (NHMRC) Health Advisory Committee in Canberra in March 1998. Speakers and 95 invitees – from medical and nursing organisations, administrative and bureaucratic agencies, consumer groups, pharmacy, academia, general practice divisions and various NHMRC committees – considered where we are up to in applying best practice and where the gaps are in relation to three conditions: heart disease, muscle and joint problems and mental health disorders.



Stephen Leeder 1998

Professor Stephen Leeder provides an edited recap of his report on the forum published in the April 1998 issue of *inTouch*:

National Health Forum Aims for Best Practice

Stephen Leeder

Dean of the Faculty of Medicine, University of Sydney, National President of the Public Health Association of Australia and Chair of the National Health Advisory Committee of the NHMRC.

There was a pervasive sense of how unbelievably disjointed the current health care system is! Perhaps it was having a group which spanned the spectrum of health care so effectively, but the impression I gained early on, which I could not shake, was how relatively little we all have to do with one another!

We moan about Commonwealth-State divides, but these are emblems of a much more prevalent separation of those involved in delivering health care. That was what made discussion around coordinated care trials so interesting, because here, it seems, we have the beginning of an attempt to bring players together. Pylons have been driven into the ground - general practitioners, hospitals, community-based services, private enterprise physios, pharmacists - and yet they are lucky if they are linked by phone, let alone anything more substantial.

I had not expected to be so struck by this perception at the forum, but it kept washing over me as the day unfolded. And yet attempts to bring the various groups together through such mechanisms as a unique identifier for patients and possibly a portable health record sent rumbles through the group. Such proposals were especially a problem to the consumers present, although on another occasion I recall watching a privacy lawyer drop his jaw at a national conference on health information when Jann Graham, a well known consumer representative, told the assembly that unique identifiers for patients were 'not a consumer problem', they are legal problems.

What came out of it all? First of all, there was no antipathy towards the notion of doing our best to assemble available information to guide best practice in the *clinical* setting. My experience with raising notions of best practice in *public health* includes accusations of methodological fascism. Perhaps we are relaxing with the idea that 'best' does not mean 'invariably' or 'perfect' but that it means what it says. Best practice is what the pooled evidence would suggest generally confers the most benefit, leaving the practitioner - clinical or public health - to negotiate an approach that takes evidence into account.

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Secondly, the facilitatory role of the NHMRC in this process was endorsed, although it was accepted that this would need to change. Previously the NHMRC did the guideline development through its own working parties. In future, these will be developed by others, with the NHMRC handling the public consultation phase and assuring the quality of the final product.

Thirdly, there was clear recognition for the need to become much more sensitive, through appropriate research and development, to what is needed to turn guidelines into clinical and public health practice: crossing the knowledge/behaviour gap. The rhetoric is in place and we speak about breaking down tribal walls, but this is not enough. Attention needs to be given to rewards - especially economic and professional accreditation - for using best practice guidelines wisely, although not unthinkingly or slavishly.

The meeting concluded with a strong commitment to the future formulation of evidence-based guidelines in both clinical and public health practice, the definition of financial incentives to support such practice, the need to disseminate information about effectiveness more comprehensively to consumers and improved communication and dissemination methods to achieve these goals.

The day brought to national attention just how far we have to go in 'doing the good that we would', but more encouragingly, it demonstrated the enthusiasm of health professionals and consumers from across the spectrum to see definite and substantial progress - Commonwealth/State and public/private chaos notwithstanding!



Intouch, September 1997

The tax debate and public health – Terry Slevin, Vice President WA Branch

Why promote tax rises?

The most important function of tobacco and alcohol tax is, from a public health standpoint, to increase the price of products acknowledged as being our biggest drug problems. Like all products, higher prices leads to reduced demand. Less demand for booze and cigs is a health benefit to the community

In Touch, June 1995

OECD lead risk reduction activities

The OECD Joint Chemicals Group and Management Committee is scheduled to consider lead risk reduction this month. They intend to determine whether there is consensus on action, and whether it is to take the format of a Council Act, Action Plan, or other measure.