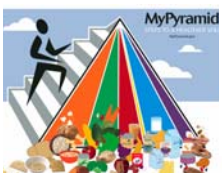
WELLNESS & AGEING

GAP CONGRESS REPORT • FEBRUARY 2007







GAP Congress on Wellness and Ageing

"Breaking the barriers: the role of Government, Industry, providers and consumers"

Melbourne, Australia

15 - 16 February 2007

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Executive Summary

The GAP Congress on Wellness and Ageing - *"Breaking the Barriers: The role of Government, Industry, Providers & Consumers"*, was held on 15 and 16 February 2007 in Melbourne.

Jointly hosted by the Australian National Consultative Committee on Electronic Health (ANCCeH) and Sydney-based policy network Global Access Partners (GAP), this high-level conference brought together senior executives from relevant departments of State and Federal Governments, pharmaceutical companies, hospitals, research facilities, health insurers and other experts to focus on the prevention, early detection and management of chronic diseases.

The Congress promoted a holistic, patient-centric approach to chronic disease management, highlighted the role of technology, such as electronic health records, in delivering quality of care and stressed the role that prevention and health education can play in improving the health of a nation.

The key discussion points of the GAP Congress on Wellness and Ageing 2007 included the following:

- MANAGING CHRONIC DISEASE: Chronic conditions, such as diabetes, Alzheimer's, osteoporosis, arthritis and heart disease, pose the greatest threat to an aging population, however, the hospital and health system is still geared to fighting acute infection and injury. Chronic disease demands the management of knowledge, not hospital resources.
- Heart disease, diabetes, stroke and mental health are clinically interdependent and account for 75% of Australia's health burden. Reducing smoking and obesity and improving exercise and diets from a young age will reduce the onset of chronic conditions in the future, while drugs such as statins hold out hope the situation can be improved for those already exhibiting risk factors.
- Cardiovascular disease, which absorbs 40% of the hospital budget, can be tackled by preventative strategies, early testing and better use of proven drugs - ACE inhibitors, lipid lowering drugs and aspirin - and other therapies.
- The National Reform Agenda aims to boost productivity, improve workforce participation, invest in 'human capital' from early childhood to university and improve standards of health, as the key to competitiveness.
- Improved IT will enable health teams and patients to monitor and treat chronic conditions more effectively with the use of health care plans. Future bio-, nano- and microtechnology and advanced materials will radically change diagnostics and drug delivery

using smart biochips and tailored implants. If chronic disease increases past the capacity of any health care system to manage it, future monitoring of chronic patients will have to be done by non-specialists or technology, overseen by health care professionals.

- HEALTH PROMOTION: 22% of Australians were born overseas and health promotion must be targeted at them, in their first languages, to be effective. Native Australians are particularly hard hit by chronic disease. Most Australians have an 80% chance of reaching 65. Only 30% of indigenous females and 25% of indigenous males do so.
- People do not always act rationally regarding their own health and it is irrational to assume they always will. However, a punitive attitude and the 'medicalisation' of risk factors may be less effective than an approach which encourages individuals to value, and therefore look after, themselves. Effective harm reduction approaches can be more effective than blanket, unobserved, prohibitions.
- TRAINING: Doctors and health workers need training in health communication. A yearly lecture is neither absorbed nor acted upon. A consistent health campaign, combined with social pressure, has been effective in combating smoking and drink driving and provides a model for future action to promote healthier lifestyles.
- An authoritative source of health advice which people could trust amid conflicting media claims would aid public understanding and improve health outcomes. Most Australians have the time, money and desire to manage their own fitness and long term health prospects.
- PREVENTATIVE MEDICINE: Private health insurance funds should become more involved in funding health prevention. Investment in preventative medicine is highly cost effective, but preventative measures are always the last to be funded, despite saving most lives in the long run. A preventive services task force could identify effective strategies and a benefits advisory committee could consider funding options and implementation. New drugs may deal with problems such as obesity which are currently seen as social problems.
- There will never be problem-free health systems, as the public demand for the best service, delivered immediately for free, is impossible to meet. Dismay at their occasional failures should not obscure their great strengths and achievements in improving the quality of life. Most medical costs are incurred in the last 18 months of a person's life, be they 65 or 85, so longer life expectancies do not add greatly to costs if people are generally healthy up to that point through better living standards and preventative care. (*for the full Report of the Congress' proceedings, see pages 19-36)*

DISCLAIMER: This Report represents a wide range of views and interests of the participating individuals and organisations. Statements made during discussions are the personal opinions of the speakers and do not necessarily reflect those of the organisers and sponsors of the Congress.

The Steering Committee

The Steering Committee of senior business executives and health experts worked over two years on the Congress' programme, topics for discussion and a continuity strategy, to ensure outcomes are achieved beyond the event.

The members of the Steering Committee for the GAP Congress on Wellness and Ageing 2007 were (in alphabetical order):

The Hon. Neil Batt AO
Executive Director
Australian Centre for Health Research

Mr Paul Cray
Managing Director
Roche Diagnostics Australia

Mr Peter Fritz (Chair)
Group Managing Director
TCG Group
Managing Director
Global Access Partners

Prof Michael Georgeff
Director of e-Health Research
Monash Institute of Health
Services Research

Mr Michael Gill
Lead, Internet Business Solutions
Group, CISCO

Mr Jim Jefferis
IBM Client Executive
NSW Health and Life Sciences

Ms Megan Kennedy
Marketing Manager
Health & Life Sciences
IBM Australia Ltd

Ms Liz Kerrigan Benson
Chief Executive Officer
Diabetes Australia
Western Australia

Dr Michael Krien
Department of Innovation,
Industry & Regional Development
State of Victoria

Dr George Margelis
Industry Development Manager
Digital Health Group
Intel Australia

Prof Paul Zimmet AO
Director
International Diabetes Institute

Partners & Sponsors

The GAP Congress on Wellness and Ageing 2007 was coordinated by Global Access Partners (GAP) Pty Ltd – an influential network that initiates high level discussions on global issues, encouraging the sharing of knowledge, progress and policy change (*see App. 2, page 41*). GAP structures each initiative around the desired business outcomes of its partners and sponsors.

The Congress was co-sponsored by GAP's partners whose role extends beyond the event through membership in the Australian National Consultative Committee on Electronic Health - a powerful multidisciplinary group of senior Government and business executives and health professionals. It was established in 2004 following the GAP Forum on Better Health Care Through Electronic Information. The Committee aims to influence the jurisdictional public and private health agenda in Australia to promote, explore, define and realise better patient health outcomes through the application of information technology to improve efficiency, safety and productivity. The group also provides a forum for public-private partnerships in order to promote improved execution and industry development.

Our thanks for their contribution and foresight go to the following organisations (listed in alphabetical order):

- Australian Unity
- Cisco
- Roche Diagnostics Australia
- Intel Australia
- Victorian Government

(for more information on the sponsors of the GAP Congress on Wellness and Ageing, see App. 2, pages 39-44)

Keynote Speakers

The Congress took place over two days. Day One included the opening dinner (15 February 2007, Sir Redmond Barry Room, Investment Centre Victoria), while Day Two consisted of one morning and two afternoon plenary sessions (16 February 2007, Legislative Assembly Chamber, Parliament House of Victoria) under the following headings: "Chronic Disease Management and Quality of Care", "Technology and Innovation", "Health and Government Policy" (*for a full programme, see App. 1, pages 37-38)*. Each session began with thought provoking addresses from the keynote speakers and continued as a dialogue between delegates in a 'think tank' mode.

The keynote speakers and session chairs of the GAP Congress on Wellness and Ageing were (in alphabetical order):

The Honourable Tony Abbott MP
Minister for Health and Ageing
Australian Government

Mr Peter Allen
The Under Secretary, Portfolio Services and Strategic Projects Division, Department of Human Services
State of Victoria

The Honourable Neil Batt AO
Executive Director, Australian Centre for Health Research

The Honourable John Brumby MP
Treasurer of Victoria, Minister for Regional & Rural Development, Minister for Innovation, Government of Victoria

Prof Lesley Campbell
Principal Research Fellow, Diabetes & Metabolism Research, Garvan Institute of Medical Research, Professor of Medicine UNSW, Director, Diabetes Centre, St Vincent's Hospital

Mr Paul Cray
Managing Director
Roche Diagnostics Australia

Mr Peter Fritz AM
Chair, GAP Congress Steering Committee, Managing Director, Global Access Partners, Group Managing Director, TCG Group

Prof Michael Georgeff
Director of e-Health Research, Monash Institute of Health Services Research, Monash University

Mr Michael Gill
Director, Internet Business Solutions Group, Cisco; Chair, Australian National Consultative Committee on e-Health

Dr Mukesh Haikerwal
President, Australian Medical Association

Dr Kim Hobbs
AP Director of Wellbeing, IBM

Mr Jim Jefferis
IBM Client Executive, NSW Health & Life Science

Prof Henry Krum
Director, NHMRC Centre of Clinical Research Excellence in Therapeutics, Department of Epidemiology & Preventive Medicine, Department of Medicine, Monash University Alfred Hospital

Dr George Margelis
Industry Development Manager
Intel Digital Health Group

Mr Rohan Mead
Group Managing Director
Australian Unity

Prof Brian Oldenburg
Chair, International Public Health
Department of Epidemiology & Preventive Medicine, Department of Medicine, Monash University, Alfred Hospital

Prof Andrew Tonkin
Head Cardiovascular Research Unit, Department of Epidemiology & Preventive Medicine, Department of Medicine
Monash University

Ms Elaine Warburton
Chief Executive Officer
Opaldia UK

The Honourable Tony Abbott MP

Tony Abbott was elected Member for Warringah at a by-election in March 1994. Prior to entering Parliament he was Executive Director of Australians for Constitutional Monarchy from 1993-94. From 1990-93 he was press secretary and political advisor to the Leader of the Opposition, Dr John Hewson. His previous career was in journalism, where he wrote as a feature writer for 'The Bulletin' and 'The Australian'. On the election of the Howard Government in 1996 Tony was appointed Parliamentary Secretary to the Minister for Employment, Education, Training and Youth Affairs. In this role, he was responsible for the establishment of the successful Greencorps program for young people. Following the 1998 election he was appointed to the new portfolio of Minister for Employment Services. As Minister, he oversaw the development of the Job Network and a major expansion of Work for the Dole. In January 2001, Tony was promoted to Cabinet as Minister for Employment, Workplace Relations and Small Business. Following the 2001 election he was appointed Minister for Employment and Workplace Relations, Leader of the House and Minister Assisting the Prime Minister for the Public Service. Tony was appointed Minister for Health and Ageing on the 7 October 2003. He has written two books in defence of the existing constitutional system, "The Minimal Monarchy" and "How to Win the Constitutional War".

Mr Peter Allen

Peter Allen is Under Secretary, Portfolio Services and Strategic Projects in the Victorian Department of Human Services and Victoria's Chief Drug Strategy Officer. Since joining the Victorian Public Service in 1986, Mr Allen has been Secretary of the Department of Tourism, Sport and the Commonwealth Games, Secretary of the Department of Education, Director of Schools, Deputy Secretary Community Services, and Director of the Premier's Drug Advisory Council. Before joining the public service Mr Allen was Director, Social Policy and Research at The Brotherhood of St Laurence.

The Honourable Neil Batt AO

Neil Batt joined the Australian Centre for Health Research Ltd as Executive Director upon launch. In a distinguished political career, he is a former Tasmanian Deputy Premier, Treasurer and Ombudsman for Tasmania and was the National President of the Australian Labor Party. As former Resident Director of TNT Ansett Group in Western Australia and TNT in Victoria, and a former Chairman of Heine Management Limited and CSL as well as General Manager Victoria of the Australian Health Insurance Association, he has also had a notable executive career. Mr Batt is currently an independent Director of Netwealth Investments Limited and a consultant to Australian Unity. Until recently he was President of the International Diabetes Institute and remains on the Executive.

The Honourable John Brumby MP

John Brumby is the senior economic Minister in the Bracks Government holding the offices of Treasurer, Minister for State and Regional Development and Minister for Innovation. As Treasurer, he is responsible for the financial management of Victoria's $30 billion Budget sector, which represents over 13 per cent of the State economy. A leader in economic and regulation reform in the Bracks Government, he has worked hard to ensure Victoria is the leading State to live, work and invest. He has implemented major taxation reforms, bringing the total amount of tax cuts announced by this Government to over $3 billion; overseen the establishment of Partnerships Victoria to encourage private sector involvement in the development of major infrastructure projects; managed Victoria's National Competition Policy and the establishment of the Victorian Competition and Efficiency Commission; and overseen the implementation of the Essential Services Commission, an independent regulator of energy, gas, rail, grain, ports and the water industry. Mr Brumby is currently the longest serving of Australia's State Treasurers. In addition to his Treasurer responsibilities, he is also the Minister for State and Regional Development. In this role he has overseen the establishment of Regional Development Victoria to promote and drive economic growth and prosperity outside Melbourne. He has also established Australia's first Regional Infrastructure Development Fund, which includes $70 million to undertake the biggest natural gas rollout in provincial Victoria since the 1970s. In February 2002, John was appointed as Victoria's first Minister for Innovation. John actively promotes innovative, creative and knowledge-intensive industries such as biotechnology, environmental technologies and advanced manufacturing. A key part of this exciting vision is the development of the $206 million Australian Synchrotron at Monash University's Clayton campus, which is set to revolutionise scientific R&D in Australia.

Prof Lesley Campbell

Prof Lesley Campbell is the Director of Diabetes Services, Senior Staff Specialist at St Vincent's Hospital, a Professor of Medicine at the University of NSW, and a Principal Research Fellow in the Diabetes and Obesity Program at the Garvan Institute of Medical Research. She is involved in clinical research and practice in diabetes, obesity, metabolic syndrome and nutrition. She has published over 140 peer-reviewed papers of studies in the United Kingdom and Australia; edited "Diabetes for Dummies", and wrote chapters in many books and manuals. She was on the Organising Committee of the 2006 International Congress on Obesity, and the NHMRC Type 2 Diabetes Guidelines Committee, The International Consensus for the Diabetic Foot Working Group. She is a past President of the Australasian Society for the Study of Obesity.

Mr Paul Cray

Paul Cray is the Managing Director of Roche Diagnostics Australia; is a Board Member of Roche Diagnostics Asia Pacific; and is a member of the Global Pathology Portfolio Board for Roche Diagnostics worldwide. Paul has over 20 years experience in the In Vitro Diagnostics industry, undertaking numerous overseas roles with increasing marketing strategy and general management responsibility in the UK, Canada, USA, Switzerland and Germany. The most recent post in Germany was that of Senior Vice President, Global Marketing for Roche Diagnostics. Paul has both British and Australian nationality; is forty six years old; holds a Bachelor of Science from the University College of Wales, UK; and has undertaken numerous post graduate courses at INSEAD, France and IMD Switzerland. Paul is a Member of the Australian Institute of Company Directors.

Mr Peter Fritz AM

Peter Fritz is Managing Director of GAP, and Group Managing Director of TCG Group - a network of private, independent and mutually supportive companies which over the last 36 years has produced many breakthrough discoveries in computer and communication technologies. In 1993, some of the 65 companies in the TCG Group were publicly floated on the Australian Stock Exchange as TechComm Group Limited (now called Utility Computer Services UXC), with great success. Another former TCG company floated on the New York Stock Exchange in November 1997 for US$600m, making it the largest technology company to be established in Australia until that time. Peter's innovative management style and corporate structuring has lead to the creation of a business model which is being copied by many successful entrepreneurs, and has become part of university undergraduate and masters programs in business management in Australia and around the world. Peter Fritz chairs a number of influential government and private enterprise boards and is active in the international arena, including having represented Australia on the OECD Small and Medium Size Enterprise Committee. He is the holder of six degrees and professional qualifications, is a recipient of the Order of Australia, and has received many other honours.

Prof Michael Georgeff

Prof Michael Georgeff is Principal of Precedence Research and Director of the e-Health Research Unit at Monash University. He is a consultant to government and industry in the US, Europe and Australia on information technology strategy in health care and e-business and serves on the boards of various companies. He has over 25 years experience in software innovation and bringing these technologies to market. In the 1980s, Prof Georgeff was Program Director in the Artificial Intelligence Center at SRI International and a

member of Stanford University's Center for the Study of Language and Information. During this period, he and his team created one of the first implementations of an intelligent software agent used to help control NASA's space shuttle during space missions. In 1988, Prof Georgeff was invited back to Australia by the Prime Minister, Mr Robert Hawke, to set up the Australian Artificial Intelligence Institute. As Founding Director, he established AAII as a world leader in intelligent agent technology and its application to solving a wide range of commercial and social problems. In 1997, he founded Agentis International, a US software company. Prof Georgeff is a Fellow of the American Association for Artificial Intelligence and a Fellow of the Australian Computer Society. In 1990, the Bulletin proclaimed Prof Georgeff one of Australia's "national assets". He holds a PhD from Imperial College, London University, a B Eng degree from Sydney University and a B Sc degree from The University of Melbourne. He is currently leading a number of initiatives in Australia to establish a broadband health network focused on the management of chronic disease.

Mr Michael Gill

Michael is the lead in Australia and New Zealand for Cisco's Internet Business Solutions Group (IBSG). He brings over 20 years of experience across both public and private sectors. Michael's primary role is to work with executives of Australia's largest firms and organisations and assist them in accelerating their online business and services agenda. Customer engagements include State and Federal Governments, National Australia Bank, ANZ Banking Group, Coles Myer, the Department of Defense and the New Zealand Ministry of Health. The Internet Business Solutions Group (IBSG) is the consulting arm of Cisco Systems and is prohibited from selling. IBSG maintains a global health team focusing on issues and practices associated with connectivity and better health outcomes. As a group IBSG has had extensive experience in various health areas including the NHS, the Italian health system, Welsh Health, NSW Health and the New Zealand Ministry of Health. Examples of our focus areas include: the importance of architecting health connectivity; telehealth; health and safety related to better connectivity; RFID and wireless solution business case development; global innovations; and other related matters. In recent years Michael has been heavily engaged with the Health and Retail sectors. In Health he has developed a wide range of activities among senior health decision makers and provided strategy advice linking architecture and ICT innovation with improved health outcomes at a system level. In the Retail sector, Michael's work includes portal development, project prioritization, advanced technology business case development, functional reviews and multi channel retailing strategy work in Australia, New Zealand and in the People's Republic of China.

Dr Mukesh Haikerwal

Dr Mukesh Haikerwal was elected as President of the Australian Medical Association in May 2005. Having advocated for his colleagues from his medical school days, representative roles in the AMA was a natural progression. Dr Haikerwal also held the position of Vice President of Australian Medical Association from 2003 – 2005 and President of the Australian Medical Association (Victoria) from 2001 to 2003. In his AMA roles, Dr Haikerwal has represented the medical profession to the public, across all levels of government and in the electronic and written media. He maintains that the twin roles of the AMA are to represent the medical profession and advocate for its independence and vital role in health care; and keep the public aware of the significant public health challenges we face as a nation, as well as appraise the public of the needs of the Australian health care system and the effects of proposed policy announcements. Dr Haikerwal is a General Practitioner in a small group practice in Altona North, Melbourne. He has consulted in all aspects of general practice for over 15 years. Educated in the United Kingdom, Dr Haikerwal trained as a specialist general practitioner. He attained additional qualifications in emergency care, obstetrics and gyneacology, and family planning.

Dr Kim Hobbs

Dr Hobbs is the Director of Global Well Being Services and Health Benefits, IBM Asia Pacific. She has worked in the fields of occupational medicine and public health medicine for 25 years, and has experience in the Petroleum Exploration and Production, Chemicals and Information Technology industries. Her current role entails design and delivery of Well Being Services (Occupational Health and Safety) and of Health Benefits Services for the IBM Business across the Asia Pacific region. Dr Hobbs is a medical graduate of the University of Sydney and has a Master's Degree in Public Health from that same university. She has a fellowship in the Faculty of Public Health Medicine and in the Faculty of Occupational Medicine, from the Royal Australasian College of Physicians.

Mr Jim Jefferis

Jim has been one of IBM UK and Australia's top achievers with IBM's major customers across a range of industries for the past 29 years. Since 2004 he has lead the IBM approach into Health and Wellbeing, and covered clients including the NSW Health, Private Hospital and Medical Imaging networks, NSW Health Insurers and large Pharmaceutical companies. Jim sits on the Postgraduate External Advisory Board for the University of Sydney, School of Information Technology within the Faculty of Science. He has been a committee member of GAP forums running multi-disciplinary events on Electronic Health Records and Wellness programs to change Australia's political and commercial focus.

Prof Henry Krum

Professor Henry Krum is a well recognised figure in the area of cardiovascular clinical pharmacology and therapeutics, attested to by his extensive professional activities in this area. Prof Krum is also a physician at the Alfred Hospital in Melbourne and heads Clinical Pharmacology at Monash University and the Alfred Hospital. He has extensive research experience in cardiovascular diseases and clinical pharmacology, something to which his publication record testifies. His interests lie with heart failure and hypertension, and his work spans the fields of both basic and applied sciences. Professor Krum has been a member of numerous International Steering and Executive Committees for major clinical trials in the area of cardiovascular pharmacotherapy. He is currently Principal Investigator of a number of multicentre investigator-initiated trials testing cardiovascular therapeutic strategies

Dr George Margelis

George took on the role of Industry Development Manager for Intel's new Digital Health Group in November 2005. For him it was an opportunity to take an active role in changing the way healthcare was delivered in Australia. Prior to moving to Intel Australia George has been very active in the healthcare informatics arena as Medical Director and then CIO of a private hospital group in Sydney, manager of an innovative software development group developing solutions for healthcare providers and consumers, and board member at the state and national level of the Health Informatics Society of Australia. George is a registered medical practitioner having graduated from the University of Sydney. He is also a registered optometrist and holds a graduate degree in E-Business from the University of Southern Queensland. He ran a successful software company during the heady days of the late 80's and early 90's and has been an active computer enthusiast from the late 70's when he acquired his first PC, a Sinclair Z80. George has worked in large and small hospitals in NSW, as well as in private practice. He has been involved in providing clinical care for over 20 years, but has concentrated on the role information technology can play in improving clinical care for the last 5 years. His experience includes working with hospitals and health care providers to determine the requirements for technology projects, active involvement in implementations of health technology systems, and the evaluation of projects. He has presented at national and international conferences on health technology and was chairman of the 2006 Health Informatics Society of Australia annual Health Informatics Conference held in Sydney in August 2006.

Mr Rohan Mead

Rohan Mead was appointed Group Managing Director of Australian Unity Limited on 1 July 2004. Up until this time, he held the position of Group Managing Director (Designate), from 15 December 2003. Mr Mead is also a director of Australian Health Insurance Association Limited (the peak representative body for the health insurance industry) and of Australian Health Service Alliance (a cooperative hospital contracting and data management company formed by 24 health insurance funds). He is Chairman of Platypus Asset Management, Deputy Chairman of Acorn Capital and Director Australian Centre for Health Research. Prior to joining Australian Unity, Mr Mead was employed by Perpetual Trustees Australia Limited (1996 – 2003) in a range of senior roles, most recently as Group Executive – Personal Financial Services. In other leadership roles at Perpetual, Mr Mead was involved in marketing services, corporate affairs and strategic development. Prior to his work at Perpetual, Mr Mead was employed by Blake Dawson Waldron, Lawyers as head of marketing and communications.

Prof Brian Oldenburg

Brian Oldenburg has recently been appointed to the role of inaugural Professor and Chair of International Public Health, Department of Epidemiology and Preventive Medicine at Monash University. He is the immediate past Professor and Head of the School of Public Health at Queensland University of Technology. He is also a Regional Director of the Asia-Pacific Academic Consortium of Public Health (APACPH) and he is an inaugural Director of the Australian Institute of Health Policy Studies which is a national institute devoted to studying the ways in which health policy can improve the health of Australians. Professor Oldenburg's interests include understanding how to improve health policy and how such improvements can lead to improvements in the primary and secondary prevention of chronic diseases and their associated social and behavioural risk factors. He also leads and collaborates on a number of trials in Australia and other countries (including Finland, Malaysia and China) aimed at better prevention and management of chronic diseases such as diabetes and heart disease. He currently holds many honorary positions with the National Heart Foundation of Australia, NHMRC and other government and non-government organisations in Australia and internationally.

Prof Andrew Tonkin

Andrew Tonkin is Head of the Cardiovascular Research Unit, Department of Epidemiology and Preventive Medicine, Monash University. He has Professorial appointments with Monash University, the University of Melbourne, RMIT University, and Flinders University of South Australia. He is a consultant cardiologist at the Austin and Repatriation Medical Centre, Melbourne, where he was previously Director of Cardiology. He has recently departed from the National Heart Foundation of Australia where he was also Chief Medical Officer. Professor Tonkin has been a member and past chair of the National Heart, Stroke and Vascular Health Strategies Group and chairs the Steering Committee for the National System for Monitoring Cardiovascular Disease. He has also chaired national working parties developing best-practice cardiology guidelines. He is a member of the Executive Board of the Council of Clinical Cardiology of the World Heart Federation, and of the Board of the International Task Force for Prevention of Coronary Heart Disease. Professor Tonkin's particular interests include coronary artery disease, preventive cardiology, epidemiology and clinical trials. He has twice been awarded the R.T. Hall prize, the major research award of the Cardiac Society of Australia and New Zealand.

Ms Elaine Warburton

Elaine is Chief Executive Officer of Opaldia Limited, a UK company focused on the delivery of Wellness technologies as a means of early and improved detection of disease. A chartered accountant, nurse and geneticist by training, Elaine has spent the last 25 years in healthcare initially as a clinical practitioner and latterly as part of the Board of Directors of the UK's largest independent hospital, directing its business development and expansion strategies. In-between, she spent time with KPMG as part of KPMG's healthcare team advising the UK government on reconfiguring its public healthcare system. Recognising a real need to address the escalating costs of healthcare, Elaine launched Opaldia late 2005, supported by a veritable 'who's who' in European medicine, to develop a sustainable model of healthcare using innovative diagnostic and screening technologies to embrace the old adage 'early diagnosis, better prognosis'.

Participating Organisations

Participation in each GAP Congress is by invitation only. The Congress is attended by the top echelon of government and industry. Delegates from the following 71 organisation participated in the GAP Congress on Wellness and Ageing 2007 (*for the full list of delegates, see App. 3, pages 45-49*):

- Adjunct Solutions
- Australian Centre for Health Research
- Australian Disease Management Association
- Australian Divisions of General Practice
- Australian Health Industry Association
- Australian Health Policy Institute
- Australian Health Service Alliance
- Australian Medical Association
- Australian Unity
- Bayside Health
- Bellberry Limited
- Body Active Consultancy
- Bond University
- Business Review Weekly
- Centre for Health Innovation
- Charles Darwin University
- Cisco
- CRS Australia
- Deloitte Touche Tohmatsu
- Department of Communications, Information Technology and the Arts, Australian Government
- Department of Finance and Administration, Australian Government
- Department of Health and Ageing, Australian Government
- Department of Health and Human Services, State of Victoria
- Department of Innovation, Industry and Regional Development, State of Victoria
- Diabetes Australia - Western Australia
- e-Health Research Centre
- Filligent Limited
- Finlaysons
- Health Informatics Society of Australia (HISA) Ltd
- Health Insurance Restricted Membership Association of Australia (HIRMAA)
- Hill Young & Associates
- IBM Australia/NZ
- Information Integrity Solutions
- Integrated Wireless Pty Ltd
- Intel Australia
- International Diabetes Institute
- La Trobe University
- LCM Healthcare
- MBF
- MedCare Group of Companies
- Melbourne Pathology Services
- Microsoft Australia
- Monash Institute of Health Services Research
- Monash University
- National Consultative Committee on Security & Risk
- Navy Health
- Neoteck Business Solutions

- NSW Health
- Office of the Minister for Health and Ageing
- Office of the Treasurer of Victoria, Minister for Regional and Rural Development, Minister for Innovation
- Opaldia, UK
- Plenty Valley Community Health
- Residential Aged Services Pty Ltd
- Roche Diagnostics Australia
- St John of God Health Care
- St Vincent's Hospital Sydney
- Sullivan Nicholaides Pathology
- Symbion Health
- TCG Group
- Telstra
- The Alfred Service & Care
- The Brain Resource Company Ltd
- The University of Notre Dame
- TressCox Lawyers
- University of Sydney
- University of Sydney at Westmead
- University of Technology, Sydney
- University of Western Australia
- University of NSW
- WA Institute for Medical Research
- Working Systems Solutions

Report of the Congress Proceedings

The key points made by each speaker are outlined below. Full transcriptions of the speeches are available on request from GAP.

Mr Michael Gill
Director, Internet Business Solutions Group, Cisco
Chair, Australian National Consultative Committee on e-Health

In his introductory address, Michael Gill observed that funding is heavily weighted to the hospital sector, despite most health care taking place outside hospitals. He advocated the use of area based electronic services for case management and video based communications in mental health and distance surgery to standardise clinical processes and facilitate a shift towards team based care delivery.

The Hon. John Brumby MP
Treasurer of Victoria, Minister for Regional & Rural Development, Minister for Innovation, Victorian Government

The Hon. John Brumby said Australia faced challenges from the low cost 'BRIC' economies of Brazil, Russia, India, China and a major demographic shift caused by decreasing workplace productivity and participation from an aging population.

The Victorian Government has successfully championed a National Reform Agenda, which aims to boost productivity and workforce participation, by investing in 'human capital': lifelong learning and health as key to continued global competitiveness. Minister Brumby saw it driving a 5% increase in GDP after 10 years and 14% after 25, increasing tax revenues which should be re-invested in these human capital foundations of future competitiveness.

Minister Brumby argued that Improvements in the health of Australians have generated $5.4 trillion between 1960 and 1999, equivalent to 46% of domestic consumption.

Two thirds of all humans who have lived past 65 are alive today. By 2050, 2 billion people will be over 60, more than the entire population 100 years ago. This success has created new challenges. Although Australia's population will increase by 20% over the next 20 years but the number over 65 will more than double, increasing the incidence of age-related diseases including Alzheimer's, osteoporosis, arthritis and blindness caused by macular degeneration. Chronic diseases such as diabetes, cardiovascular disease, lung cancer and depression account for over 80% of mortality in western countries yet health systems are still organised as they

were to treat injury, infection and communicatable disease.

Clean water, immunisation and antibiotics saved countless people from water-borne diseases, smallpox, measles and polio and bacterial infections such as tonsillitis and blood poisoning, but there are no such magic bullets for chronic complaints caused by longevity and more affluent lifestyles.

The Victorian Department of Human Services estimates that over $1 billion of income is lost per annum by 25 to 64 year old Victorians due to poor health associated with smoking, obesity and high blood pressure. Healthier people mean a more capable workforce.

Type 1 diabetes affects six in a thousand children and new cases have doubled in the past 20 years. Nearly 1.5 million Australians have Type 2 diabetes with 100,000 people developing it annually, usually as a result of poor diet and lifestyle. The Australian Diabetes Obesity and Lifestyle Study found that almost one in four Australians over 25 has impaired glucose metabolism, which typically leads to diabetes in later life. A 30% improvement in the prevention of Type 2 diabetes would save up to $1 billion a year.

Chronic illness requires close monitoring and ongoing management by a team of professionals using a patient care plan detailing medications, treatment and tests. Unfortunately, health providers still tend to operate in disconnected silos, hindering such continuity of care.

Victoria aims to promote care in the community, early intervention and self-management in a modernised and integrated health care system which meets the needs of people rather than service bureaucracies. Its 'Go For Your Life' strategy aimed to increase public awareness of the risks of physical inactivity, obesity and high blood pressure. The 'Nurse on Call' initiative provides the latest health information and advice over the telephone 24 hours a day, 7 days a week.

Looking further into the future, bio, nano and microtechnologies and advanced materials will radically change the way we detect, manage and cure disease. These will increasingly facilitate self-testing, diagnosis and treatment, supported by computer guided devices and personalised medical databases. Technology will allow the elderly and vulnerable to be monitored more effectively and helped immediately if needs be.

IT will allow health care professionals to manage client profiles, access specialist knowledge and deliver more specialised service and advice. As patients better manage their health at home, institutional services will become a last, not first, resort.

The Minister praised the Australian Centre for Health Care Innovation and Victoria's record in improving life expectancy and diabetes management. Victoria had been a leader in medical IT and research and development in stem cells and the cervical cancer vaccine.

Australian Governments have begun to implement the National Reform Agenda, which saw agreement in February 2006 to a $1.1 billion health care package which included a $500 million lifestyle diseases prevention push

In concluding, Minister Brumby highlighted the need for a National Innovation Agenda, to allow us to better develop the skills, technologies and services needed to meet future healthcare challenges.

Session I – Chronic Disease Management and Quality of Care

Prof Henry Krum

Department of Epidemiology & Preventive Medicine, Faculty of Medicine Nursing & Health Sciences Monash University

Prof Krum discussed chronic heart failure, which affects half a million Australians, costs one billion dollars a year, and damages a patient's quality of life more than arthritis and chronic respiratory disease. Its annual patient mortality ranges from 10% to over 50%, worse than all but the most aggressive cancers. It has a known epidemiology and clear risk factors and therefore can be tackled by preventive strategies, but the difficulty lies in translating theoretical strategies into effective action on the ground. Effective, inexpensive drugs are underused, as are home based management, physiotherapy, cognitive support and exercise programs.

Prof Krum hoped phone schemes to remind patients to take medication would be proved effective by Monash University's CHAT study within a year.

More high tech approaches, such as implanted devices to correct irregular cardiac function, are also effective and can gather real time information on a patient's haemodynamic status which can be relayed via phone lines to the supervising physician.

Finally, Prof Krum advocated better early diagnosis through improved blood tests and imaging techniques. Testing all older people is not cost effective and merely testing existing patients misses the vast majority who would benefit most from early intervention. People with high risk factors can be given a brain natriuretic peptide to detect a stressed, and therefore vulnerable, heart. Early and aggressive treatment can then help prevent serious disease. The health and insurance benefits from such an approach are clear.

Prof Krum advocated more publicity for the topic, especially in the political sphere.

Prof Andrew Tonkin

Head Cardiovascular Research Unit, Department of Epidemiology & Preventive Medicine, Department of Medicine Monash University

Prof Tonkin said great gains had been made in tackling heart, stroke and vascular disease with a 70% decrease in their mortality over

the last 40 years. Unfortunately, such diseases still kill an Australian every ten minutes and one in four people will die of it, one in three of those without warning.

Cardiovascular disease costs $7.6 billion, 11% of total health spending and 40% of total hospital care. As a disease of aging, it will only increase as medical advances extend life expectancy. Coronary artery disease will become the world's major public health problem in the next decade.

A study of heart attacks in 52 countries and 30,000 individuals showed that 90% of the variation in rates of cardiac disease was due to independent risk factors such as abnormal blood fats, high blood pressure, tobacco smoking, abdominal girth and diabetes. Alcohol has a slight protective effect and psychosocial factors such as depression, social isolation and lack of quality social support were shown to be important. Heart disease, diabetes, stroke and mental health are clinically interdependent and account for 75% of Australia's health burden.

Atherosclerosis, hardening of the arteries, can be observed in people in their twenties. The earlier people change their life styles, the more benefit can be reaped. There is little difference in rates of cardiac disease between men and women or different ethnic groups when other factors are accounted for.

22% of Australians were born overseas and English is not the first language in many homes, so health promotion in English tends not to reach them. A telephone service offering advice in a variety of languages would be useful as a result, as would a system to track and treat rheumatic fever in indigenous people. Prof Tonkin advocated the use of 'geo mapping' and the linking of health care data sets to identify health care problems. He said the current clinical situation, in which it is easier to repeat a test than find the results of an old one, is an obvious absurdity.

He called for innovation to support the 30% of people who live outside metropolitan areas, as they tend to be older than the norm, and advocated stricter controls over smoking. He deplored the action of 'the stores lobby' in defeating a Northern Territory proposal to reduce fruit and vegetable prices for aborigines and noted, with regret, that 50% of money spent by Aboriginal people goes on tobacco and alcohol.

Prof Tonkin advocated 'high risk approaches' to remedy the current situation, in which one third of people become aware of heart problems only when they have a heart attack He did not believe the punitive 'medicalisation' of risk factors such as hypertension and cholesterol was useful as most people exhibit such risk factors. Improved testing will only increase the number of people held to be 'at risk', but cost effective measures can be taken to improve prospects for those at intermediate risk.

Prof Tonkin believed that high risk groups, rather than individuals, could be targeted with statins and similar drugs. He said that doctors needed to be taught how to communicate the concept of relative risk to patients and that they should make use of people's inherent valuation of their own quality of life. In closing, he noted that the Access Economics Report reported a $5 per $1 return on investment in preventative R & D, and $8 on $1 for cardiovascular disease.

Discussion

Prof Andrew Tonkin said Government schemes could affect behaviour and had been effective in reducing tobacco usage. The New Zealand government has provided ten weeks' free nicotine replacement therapy to the disadvantaged and shown that it saves money. He said professionals should use socio-culturally sensitive language to communicate effectively.

He lamented the public's lack of understanding of percentages and therefore health risks, commenting that people rate a 16% chance of having a heart attack or stroke in the next five years as low risk, but a 1 in 6 chance of a heart attack in the same period as high.

It was observed from the floor that people would respond to incentives to look after their own health, and as a by-product, help the economy.

Prof Branco Celler, MedCare Group of Companies, said studies had shown hospitalisation from chronic heart failure could be reduced by over 80% through active disease management by patients using simple technology.

Prof Henry Krum said most physicians practised such management already by encouraging patients to control their diet and weight and adjust their water medications to their current clinical status.

Dr Marco Bonollo, Australian Disease Management Association, pointed out that patients with chronic kidney disease are 20 times more likely to die of a heart attack or stroke, than to need dialysis. He said patients should be empowered to demand simple evidence based treatments - ACE inhibition, lipid lowering and aspirin – from their doctors, as merely disseminating guidelines at the primary care level seems to have failed.

Prof Andrew Tonkin forecast an inevitable shift to funding health deliverers, institutions and individuals, on the basis of care delivery. He wanted an authoritative source of health advice,

such as a government agency or respected charity, to help people make the right lifestyle choices amidst a flood of competing media claims and stories.

The Hon. Dr Michael Armitage, CEO Australian Health Industry Association, questioned why rural patients might have less access to common drugs.

Prof Henry Krum said it perhaps reflected rural physicians not prescribing ACE inhibitors, beta blockers and diuretics, rather than supply problems or prescriptions not being filled.

Prof Don Campbell, of Monash Institute of Health Services Research, said per capita bicycle ownership is 40% greater in Victoria than in New South Wales, and believed this shows how public policy and the provision of facilities can influence private behaviour.

Mark Armstrong, Body Active Consultancy, said that doctors needed to develop interpersonal communication skills, put messages into terms the patient would understand and remember the importance of social skills in delivering educational programs.

Prof Peter Smith, UNSW, mentioned the polypill which incorporates a generic thiazide, generic statin, and aspirin. Studies showed they reduced adverse cardiovascular events by 30% when applied on a population basis.

Prof Andrew Tonkin agreed that a study in the British Medical Journal had argued that statins would theoretically decrease rates of myocardial infarction and stroke by 80%, but that when the same methodology was applied to lifestyle measures such as activity, fish intake, fruit and vegetable intake, alcohol the risk of heart attack was reduced by a similar degree. He said the polypill had great potential, as the problems of combinatorial chemistry had been overcome, and its cheapness made it equitable. By definition it does not allow flexibility of dosing, but its very simplicity means it is more likely to be taken, particularly by older people.

Malcolm Crompton, Information Integrity Solutions, commented how drink driving has been greatly reduced through legal measures and social pressure, as has smoking to a lesser extent.

Suzy Hooper, St John of God Health Care, discussed Cardiac Rehab. She said prevention programmes had minimal uptake in people with risk factors because heart disease is not visible and therefore is not taken seriously. People only take such programmes seriously after their heart attack, when the damage is done. Acute funding gets the money now and prevention will in the future, but cardiac rehab must be catered for, too.

Prof Michael Kidd emphasised a previous speaker's point about engaging the family in promoting mutual health care. 90% of the population visit their general practitioner at least once every year, giving a great opportunity to carry out preventive health care and health promotion. As a GP, he knew that 30% of prescriptions to low socioeconomic groups were never dispensed but he did not know which 30%.

Philip Davies, Deputy Secretary, Department of Health & Ageing, pointed out that prevention does not save money in the long run. The National Health Service in Britain was supposed to save money by keeping people healthy, but in reality curing people from a succession of serious diseases after they reach pensionable age costs money. The wealthier the country, the more it chooses to spend on health care.

The National Institute of Clinical Studies shows 50% of general practitioners do not know whether their patients smoke, and appropriate antismoking counselling is not given to half of those who do. Most Australians have the time, money and knowledge to manage their own fitness and their long term health care. Money needs to be spent on those who do not have those advantages.

Session 1 (continues) – Chronic Disease Management and Quality of Care

Prof Lesley Campbell

Principal Research Fellow, Diabetes and Metabolism Research Program Garvan Institute of Medical Research Director, Diabetes Centre, St Vincent's Hospital Sydney, Senior Staff Specialist Department of Endocrinology

Prof Campbell spoke from her 25 years of practical and academic experience in the field to warn against obesity, which affects 2 out of 3 men. She observed that no man thinks that he is fat while every woman does, regardless of the reality.

80% of cardiovascular disease occurs in people with diabetes or impaired glucose tolerance. Some diabetes is genetic, as survival pressures in the past favoured those with a good ability to store fat, but this trait is now a problem rather than an advantage.

Prof Campbell rejected the punitive approach now in vogue regarding life style and health. Blood pressure was, not long ago, virtually untreatable with drugs, but now there are good drugs to combat it. Malignant hypertension has been eradicated by new drug therapies, not the boiled rice, low sodium diet which was previously prescribed. People are told to eat a low saturated fat diet, but the main factor in preventing heart disease has been statin drugs. A Nobel Prize was awarded for the discovery that some people are genetically unable to lower their cholesterol. Prof Campbell predicted that obesity would be treated the same way, through drugs rather than difficult life style changes.

She said people without power in society tended to suffer from more health problems. People tended to look after themselves if they felt they controlled other aspects of their lives and

environments. She called for commitment from health care professionals too. People felt more motivated if their Doctor cared enough to be on 24 hour call, rather than just hand out a leaflet once a year.

Prof Campbell deplored the popular fashion for thinking proven effective drugs were somehow inferior to worthless 'natural' substances. Alternative medicine should not be marketed in pharmacies and given a veneer of medical respectability they did not deserve. In closing, she said social solutions to wider problems will improve health outcomes as much as high tech, medical treatments.

Mr Peter Allen
The Under Secretary, Portfolio Services & Strategic Projects Division
VIC Department of Human Services

Peter Allen said our children's generation can expect to die younger than their parents due to increasing obesity and its role in chronic disease. The problem has been discussed in detail over the past decade, but it has only got worse. What is needed is preventative education and early diagnosis.

Discussion

Prof Peter Cameron, The Alfred Service & Care, disagreed with Prof Campbell's faith in future drug solutions. A change in culture, rather than new drugs, is necessary.

Prof Lesley Campbell pointed out that nobody wants to be fat and that overweight people often waste a great deal of time and effort in trying to lose weight. Girls harm their health by smoking to keep their weight down. She believed that drugs could solve what are now seen as behavioural problems, such as alcoholism.

Michael Gill, of Cisco, advocated using technology to improve the flow of information between patient and doctor.

Dr Marco Bonollo believed chronic disease was increasing past the capacity of any health care system to manage it. Future monitoring of chronic patients would have to be done by non specialists or technology, overseen by health care professionals.

Prof Branco Celler queried the reliance on education as a solution as only 5% of any lecture is actually absorbed. The fact that a doctor has told a patient what to do, does not mean that information has been taken on board. Engaging a patient in their own ongoing care is more effective than merely lecturing them.

The shift of funds meant to encourage children's exercise to elite athletics was criticised from the floor, as was a lack of action on high GI foods and a perception of a long lag between information becoming known and action being taken.

The role of food manufacturers and other vested interests with great financial resources pushing a contrary health message, through the advertising of junk food, for example, was raised.

Victor Perton criticised the lack of personalised health planning available to people who would act on it if they could. He advocated greater patient control over their own medical data.

Peter Allen outlined a range of government initiatives to tackle these problems, including COAG's investment of $130 million in electronic health. He said measures such as the access card could improve information sharing but were stymied by public suspicion of their use. Such initiatives had to have community support to effectively utilise their technology.

Julia Nesbitt, of AMA, disputed any assertion that fund holding leads to improved patient outcomes. She said general practises were willing to work in teams if funding and organisational issues were addressed to enable them to do so. GPs were only paid if they treated chronic patients themselves and so had no incentive to diversify this care.

Dr George Margelis, Intel Digital Health, argued for more study of the communication problems which bedevil health education.

James Kelaher, Neoteck Business Solutions, agreed with John Brumby's advocation of a 'human capital' approach to the benefits of better health and disease prevention. People would take action to improve their own health if they felt valued as individuals rather than economic units.

He agreed that a medical approach to what now seemed social or moral issues, like obesity, would be increasingly accepted by future generations. He advocated giving people the choice of sharing their health records for the sake of convenience in place of today's assumption of blanket confidentiality.

Session II – "Technology and Innovation"

Prof Michael Georgeff
Director of e-Health Research
Monash Institute of
Health Services Research
Monash University

Prof Michael Georgeff observed that while ICT has revolutionised many industries, it has barely affected health care. Technology could help patients keep to their health care plans, saving billions in health care costs and presently lost productivity.

The ICT solutions required for home management of chronic disease are fundamentally different from those for acute care in hospital. Chronic disease demands the management of knowledge, not hospital resources, but care teams are made up of autonomous organisations and individuals - private businesses, government hospitals, private hospitals – which do not yet work as a unified system.

Modern communication technology uses distributed models, such as the internet, while modern health care still focuses on industrial scale enterprises – big hospitals – to gain economies of scale. This concentration drives out diversity in the name of uniformity and smothers innovation where it is needed most.

The internet thrives precisely because it is not standardised, controlled, directed and limited, what matters is connectivity, rather than huge computing power.

Metcalf's Law states the value of a system increases as the square of the number of systems or people it is connected to. Google, e-Bay and Skype thrive through such connectivity.

Prof Georgeff advocated a policy of encouraging similar connectivity in the health care system and allowing standards and accepted practise to emerge, rather than creating centrally planned systems doomed to failure.

The business and private infrastructure which underpins the internet was produced by huge government schemes or investment, it emerged in a free market of ideas and innovation.

Businesses make their high volume, high value transactions electronically, and health care should do the same with electronic discharge summaries, referrals and drug histories to avoid adverse drug reactions. If people can manage their taxes over the internet, why not their medical records?

Prof Georgeff said the business case for IT in chronic health care was better than for electronic health records in isolation. As the right information is already entered into computers, the task is now to connect all those computers up.

Dr George Margelis
Industry Development Manager
Digital Health Group
Intel Australia

Dr Margelis reiterated that health care faced a crisis from increasing numbers with chronic diseases and decreasing numbers of people in the work force to fund and care for them. Treatments

are becoming more expensive and doctors, through fear of litigation, are using more diagnostic tests than they might otherwise choose to. Although future technology might solve the situation, existing methods would have to be utilised for now.

Dr Margelis discussed the nature of knowledge which he saw as the key to a solution. He sought collaboration between the health care and computing industries to find effective solutions, just as the body's immune system co-operates to defeat infection.

Bedside IT allows evidence based searches for treatments in seconds, instead of the hours it would take using a library. Hospital electronic medical records, although still to meet their potential, allow health workers to predict problems by following trends in data. On a wider level, symptoms and syndromes can be tracked electronically on a regional, national and global basis to predict pandemics. It can also speed up payments, keeping the system afloat.

In conclusion, Dr Margelis quoted Einstein: "Computers are incredibly fast, accurate and stupid. Human beings are incredibly slow, inaccurate and brilliant. Together they are powerful beyond imagination".

Mr Michael Gill
Director, IBSG Cisco; Chair, ANCCeH

Michael Gill discussed aged care and electronic health. He pointed out that acute care delivery is ten times more expensive than care delivery in residential settings for the aged. Elderly people want both independence and access to services when they need them. In the future simple screens could monitor drug use and remind them when to take their medicine, avoiding the complications which often arise through under or over dosing.

Radiofrequency identification bands could help monitor for falls while carers could access health information via computer. The internet could help maintain social networks and therefore improve quality of life. In the Dutch town of Nuenen, 9,000 mostly older people formed their own cooperative IP based networked community to deliver health and social services. This could prove a model applicable in other geographies.

Mr Gill strongly suggested that industry should co-operatively develop open standards for device connection for solutions in the aged sector. In addition, he also advocated the development of a national connectivity strategy for the delivery of electronic healthcare and safety to aged persons living at home or in institutions.

Discussion

Dr David Dembo, Microsoft Australia, said Microsoft and other firms already connect systems, facilitate collaboration and provide clinically relevant data at the point of care. The limiting factors are not technological, but the appetite for IT by health care providers. Medicine was once seen as an art form, and then hard science, but must now adjust to becoming part of a world based on interconnectivity of information.

Michael Gill observed that the beneficiaries of IT were often not the ones who paid the costs. Electronic discharges benefit the patient and GP, but the hospital is expected to fund them. Similarly, admissions information benefits the hospital, but is paid for by the GP. Incentives must be in place to encourage the right behaviour, or it will not happen.

Prof George Ruben, University of Sydney at Westmead, asked why proven American systems, such as the Harvard Health Plan, have not been adopted in Australia.

Michael Gill replied that, although many foreign systems were very good, it was the nature of news that only their problems tended to be reported, mitigating against their export and adoption. Cultural barriers persisted where technological ones did not.

Prof Michael Georgeff reiterated that if stakeholders cannot profit by adopting e-referral, then its take up would be slow.

Melissa Mowbray-d'Arbela, Filligent Limited, discussed the problems caused by tobacco. Australia has reduced smoking from 75% down to 17%, but is still one of the highest per capita consumers of tobacco in the world. The choice offered to Australia's 3.5 million smokers is quit or die, an approach which still sees 19,000 nationally, and 5 million people globally, choosing to die. Health programmes fail because smokers are addicted, and governments are conflicted between improving health outcomes and generating tax revenue which helps to pay for health care. This is why cigarettes, though poisonous, are not regulated under the Australian Therapeutic Goods Act. A policy of harm reduction might be more effective just as condoms, seatbelts and the Geneva Convention mitigate the harmful but inescapable dangers in life.

Harm reduction requires knowledge from science, technology and competition from business and regulation by government. 85% of smokers would switch to a less toxic cigarette, but no government measures the relative toxicity of cigarettes, preferring zero tolerance public health approaches. A 1% cigarette market share is worth $1 billion US and, because brand switching is a zero sum gain, there are powerful interests with no incentive to change things.

Prof Branco Celler held Australia to be a leader in innovation, but said progress from innovation to commercialisation was poor. Promising projects die through lack of investment and expansion.

Tam Sheppard, IBSG Cisco, stated that patients are the main beneficiaries of IT in medical care, not doctors, as it saves them time and mishaps.

Julia Nesbitt praised the AMA's development of a general practitioner hospital integration policy in the requirement of hospitals to provide discharge summaries for patients. She noted that care plans have only been running since July 2005 and have been highly successful, although government figures measure compliance rather than patient outcomes.

In June 2005 the government gave every aged care facility in the country $1,000 per patient and suggested they use it on IT. Ms Nesbitt thought much of this has been wasted or spent on other things. She said 96% of general practitioners now use computers and have met ever more stringent standards for the use and protection of patient information, but that other health care stakeholders, such as hospitals, were not using IT to communicate with GPs.

Philip Davies wondered how the attitude that innovations in health IT could only be driven by government subsidy could be overcome. He noted that $40,000 has already been given to every general practitioner over the last five years for IT, and said an appeal to professional pride might more effectively motivate connectivity. The College of General Practitioners could take a lead and declare a failure to use IT as professionally derelict as using non sterile instruments. Mr Davies believed informed demand from patients for electronic, rather than paper, prescriptions would drive their adoption.

Another commenter pointed out the credit cards, such as American Express, already work as a distributed model all over the world, and a similar model could be adopted for health cards. The focus should be on technology which is useful to individuals, rather than power bases within the medical profession and business.

Dr George Margelis revealed that his five years of involvement with personal health record projects had failed to produce results until the last six months ago when IBM, Intel, Microsoft and Oracle began to become involved.

Comments from the floor suggested progress was being made in this area.

Session III – "Health and Government Policy"

Prof Brian Oldenburg
Chair, International Public Health Unit Department of Epidemiology and Preventive Medicine, Monash University

Prof Oldenburg discussed the issue of financing and the purchasing of prevention. He said that systems tended to fail because not enough account was taken of real life human behaviour. People did not always act rationally and it is irrational to assume that they always will.

Prof Oldenburg advocated delivering effective evidence based prevention programs, but also seeking input and support from the broader Australian community.

Improved health outcomes increase, rather than decrease, the amount spent on health. This made prevention all the more vital and much good evidence exists as to what is effective in terms of reducing smoking and the transmission of AIDS and improving measles immunisation and road safety.

Prof Oldenburg noted the widespread assumption that acute services have a right to funding while preventative programmes must beg for funding. Prevention is perceived as being less urgent as it is less tangible compared to treatment services.

He criticised the lack of a single authoritative source of guidance on prevention and the fragmented nature of the Australian system which encourages cost shifting between providers and funders and creates no incentives for prevention.

Prof Oldenburg believed prevention must become indispensable, rather than optional. Businesses understand that a healthy workforce is both more productive and has more to spend if less money has to be spent on spiralling health care costs.

The demand to spend a dollar on saving an acute patient will always be more insistent than spending it on prevention, despite the fact that prevention saves more lives.

Prof Oldenburg advocated the formation of a preventive services task force and a benefits advisory committee that could consider funding options and implementation steps, once a preventative method was identified as effective. He saw huge scope to expand the role of private health insurance in prevention. A 1% prevention investment by health funds would generate a hundred million dollars in spending, improving health and reducing costs for the insured and so boosting their financial bottom line.

Dr Mukesh Haikerwal
President
Australian Medical Association

Dr Haikerwal praised the standard of Australian health care, its mix of public and private financing and provision and its underpinning by the independence of the medical profession, which ensured doctors worked for the benefit of the patient above any other considerations. However, he believed that critical health care can be hampered by excessive red tape, poor patient access, affordability and workforce shortages and that the indexing of Medicare rebates should receive appropriate funding.

He noted that chronic disease was caused by both excess and neglect and that changes in behaviour could reduce, but not eliminate, their impact on an aging population.

Education and public health measures were again seen as the keys to prevention. Primary prevention, interventions prior to the exhibition of symptoms of a condition, involved measures such as immunisation, while secondary prevention, tackling people with risk factors but no disease, might include persuading people to give up smoking. Tertiary prevention aimed to minimise the impact of diagnosed disease, such as reducing complications from diabetes.

Dr Haikerwal praised the Federal Government for supporting the new 45 to 49 year old health care check and paying a Medicare benefit rebate for a preventive service. He noted that PAP smears and bowel, skin and breast cancer screening aid early diagnosis, early intervention and community based rehabilitation.

He praised the Broadband for Health scheme which improved connectivity for general practices and pharmacists and the potential inherent in the access card. He advocated the formation of an independent national nutrition centre for the collection of data on obesity and diet, clearer food labelling and the banning for junk food advertising on TV at times children would be watching. He wanted healthier food in schools, better town planning to encourage cycling and walking and community facilities to encourage children to exercise. He wanted more controls on tobacco and alcohol and action regarding the indigenous population. The chance of living to 65 for most Australians is about 80%. For an indigenous female it is 30% and for an indigenous male it is 25%.

Dr Haikerwal repeated the AMA's opposition to the Government's current approach to streamlining the registration of health workers. He said each of the nine existing boards offered special skills which should be retained.

Mr Rohan Mead
Group Managing Director
Australian Unity

Rohan Mead saw no contradiction between improving both economic and health outcomes. A fifth of all health spending is borne by individuals, while

Federal spending on health rose 138% in the last ten years. The growth as a proportion of GDP could affect spending on other areas, such as education or defence, unless it is carefully managed.

A century ago people mostly faced short but severe episodes of acute disease, but now chronic disease accounts for 80% of the total disease and injury burden in Australia.

Yet we still have an edifice of medicine that in almost every aspect is inflected by its origins in acute care, with structures and policies that have emphasised narrow areas of specialisation rather than a coordinated response to long-term, chronic conditions.

Mr Mead said Australian Unity had launched Dr Margarite Vale's COACH program to reduce the risk of second heart attacks as such programmes benefited patients, fund members and the wider community.

Health funds are logical partners in helping drive co-ordinated care for complex conditions and co-morbidities because they care both about members' health and about a sustainable system.

The Hon. Tony Abbott MP
Federal Minister for Health
Department of Health & Ageing
Australian Government

The Hon. Tony Abbott said the Howard Government aimed to improve Medicare incrementally, not fundamentally change it. General practitioner management plans, team care plans and the introduction of nurses into general practice improved the prevention and treatment of chronic disease in the community.

He outlined a number of proposals to improve the efficiency of health care provision and the financial arrangements which surround and drive it, including allowing health care funds to offer treatments and programs which can prevent or substitute for hospital treatment. He said it was not the Government's place to prescribe what treatments should or should not be available, provided they complied with legislation, but noted that dialysis, cataracts and chemotherapy can now be provided safely, conveniently and efficiently outside hospital.

The Minister explained the Government's role in reducing patient's out of pocket medical expenses, which had averaged $720 per private hospital admission in 2005. Today, in contrast, in 84% of privately insured episodes, patients faced no out of pocket expenses or gave informed financial consent in advance.

The Minister stated the Government's willingness to legislate in this area if voluntary measures failed to offer patients choice and full information. He believed the rapid growth in procedural fees, 10% a year over the past three years, risked undermining the private health sector. He considered the idea of doctors and funds selectively negotiating own standard fees to increase fee income for doctors while reducing the number of medical services with large 'gaps' - such as the average $850 patients pay for orthopaedic services.

He restated the Federal Government's commitment to maintaining the Federal States' control of public hospitals. If central government were to take control, their running would inevitably be handed over to an unaccountable board which would simply demand more money, opening up the issue of who would pay for it. Such a hypothetical board would cannibalise demand driven, market orientated programs such as Medicare and PBS to support bureaucratically driven, budget limited programs such as public hospitals and become an out of control conglomerate dominated by internal politics rather than service to patients.

The Minister said the next health care agreements should clarify responsibilities, rather than further blur them. The states should deliver services in the most convenient and efficient way while the Federal Government should have at least some authority over the funding it provides for public hospital services.

States are already transferring as many patients as they can from publicly funded hospitals to Medicare funded private inpatient and public outpatient services, and this could be formalised in the future if agreement can be reached on the details.

At the Council of Australian Governments meeting last June, the Prime Minister and the Premiers agreed on a national registration system for doctors and other health professionals, ensuring that a doctor registered anywhere in Australia can practice everywhere in the appropriate setting or specialty.

The draft scheme circulated last year proposed a single national health registration board, with authority over all the professions. A national advisory committee, perhaps comprising the chairman of the various national registration boards, now seems more feasible.

Practice nurses have arguably been more effective than nurse practitioners in reducing doctor-centric primary care. Debate about whether pharmacists or nurses might take on some of the responsibilities of doctors should not be

mixed into the process for national registration.

There will never be problem-free health systems, if only because the public demand for the best service, delivered immediately for free, is impossible to meet. There will always be aspects of the systems which can be improved, but dismay at their occasional failures should not obscure their great strengths and achievements. Trying to change too much too soon can easily make an unsatisfactory situation worse, particularly in an area as important and as sensitive as health. The principle for politicians as well as doctors should be 'first do not harm.'

Discussion

Ian Ferres, TressCox Lawyers, pointed out that most medical costs are incurred in the last 18 months of a persons life, be they 65 or 85, so longer life expectancies do not add greatly to costs if people are generally healthy through better living standards. The aging population is not necessarily a problem if preventative care can increase the quality of later life and avoid the need for successions of expensive acute treatments.

Prof Branco Celler observed that a lot of health care for the elderly was carried out by not-for-profit organisations and wondered how GPs could manage health care in that situation.

Dr Mukesh Haikerwal said GPs should create a plan which could then be partially carried out by others.

Prof Peter Cameron, The Alfred Service & Care, noted that health costs are always rising and questioned how cost-benefit analysis could best be carried out.

The Hon. Tony Abbott said new drugs were put through the PBS process to determine their cost effectiveness, and reiterated his belief that the Australian health care system ranked with any in the world, particularly for middle class urbanites.

Chris Pearce, Australian Divisions of General Practice, said general practice had computerised to save time, and because it enjoyed some Government support. Small organisations found it easier to change than large ones such as hospitals, and support networks existed to help navigate the change.

Dr Nikolajs Zeps from Radiation Oncology in Perth observed that people want to be happy, and that can mean eating a cream cake or smoking a cigarette as much as living as long as possible. As the great British comedian Eric Morecombe said, if you do not smoke, drink or have sex you may or may not live to a great age, but it will certainly seem to last a very long time.

Peter Fritz wrapped up proceedings by explaining the GAP consultation process, thanking the sponsors for their support, the speakers for their presentations and all delegates for attending.

Appendices

PROGRAMME

Day One – Thursday, 15 February 2007

Sir Redmond Barry Room, Investment Centre Victoria
Level 46, 55 Collins St, Melbourne

6:30pm	*Pre-Dinner Drinks, Registration*	
7:00pm	*Dinner*	
	Welcome & Introduction	**Dr George Margelis** Industry Development Manager Intel Digital Health Group
	Keynote Address	**Ms Elaine Warburton** Chief Executive Officer, Opaldia, UK
	Vote of Thanks	**The Honourable Neil Batt AO** Executive Director, Australian Centre for Health Research
10:30pm	*Close*	

Day Two – Friday, 16 February 2007

Legislative Assembly Chamber
Parliament House of Victoria, Spring St, Melbourne

8:30am	*Registration*	
9:00am	Welcome & Introduction	**Mr Michael Gill** Director, Internet Business Solutions Group, Cisco Chair, Australian National Consultative Committee on e-Health
9:10am	Opening Keynote Address	**The Honourable John Brumby MP** Treasurer of Victoria, Minister for Regional and Rural Development, Minister for Innovation Government of Victoria
9:30am	Session One	"CHRONIC DISEASE MANAGEMENT & QUALITY OF CARE"
	Session Chair	**Mr Paul Cray** Managing Director, Roche Diagnostics Australia
		Prof Henry Krum Director, NHMRC Centre of Clinical Research Excellence in Therapeutics, Department of Epidemiology & Preventive Medicine, Department of Medicine, Monash University, Alfred Hospital
		Prof Andrew Tonkin Head Cardiovascular Research Unit, Department of Epidemiology & Preventive Medicine, Department of Medicine, Monash University

10:15am	Discussion	
10:45am	*Morning Tea Break*	
11:00am	Session One (continues)	
		Prof Lesley Campbell Principal Research Fellow, Diabetes & Metabolism Research, Garvan Institute of Medical Research
		Mr Peter Allen The Under Secretary, Portfolio Services & Strategic Projects Division, VIC Department of Human Services
11:40am	Discussion	
12:15pm	*Lunch*	**Parliament House of Victoria**
	Introduction	**Mr Jim Jefferis** IBM Client Executive, NSW Health & Life Science
	Keynote Address	**Dr Kim Hobbs** AP Director of Wellbeing, IBM
1:15pm	Session Two	"TECHNOLOGY & INNOVATION"
	Session Chair	**Prof Michael Georgeff** Director of e-Health Research, Monash Institute of Health Services Research, Monash University
		Dr George Margelis Industry Development Manager, Intel Digital Health
		Mr Michael Gill Director, Internet Business Solutions Group, Cisco
2:00pm	Discussion	
2:40pm	*Afternoon Tea Break*	
3:00pm	Session Three	"HEALTH &GOVERNMENT POLICY"
	Session Chair	**The Honourable Neil Batt AO** Executive Director, Australian Centre for Health Research
		Prof Brian Oldenburg Chair, International Public Health, Department of Epidemiology & Preventive Medicine, Department, of Medicine, Monash University, Alfred Hospital
		Dr Mukesh Haikerwal President, Australian Medical Association
		Mr Rohan Mead Group Managing Director, Australian Unity
	Keynote Address	**The Honourable Tony Abbott MP** Minister for Health & Ageing, Australian Government
4:05pm	Discussion	
4:40pm	Vote of thanks	**Mr Peter Fritz AM** Chair, GAP Congress Steering Committee Managing Director, Global Access Partners
4:45pm	*Close*	

Appendix 2 – Sponsors' Profiles

Australian Unity is a national health, financial services and retirement living organisation with more than 400,000 customers, including some 200,000 members, around $600 million in revenues and employing more than 1,300 people.

As a mutual organisation, Australian Unity has a heritage dating back more than 166 years. Australian Unity, as an entity, was formed with the merger of the Australian Natives' Association and Manchester Unity Independent order of Odd Fellows in Victoria in 1993. A further expansion took place in 2005 through a merger with Grand United Friendly Society Limited.

Today, Australian Unity provides health insurance cover for approximately 350,000 lives, through two health insurance companies; the Australian Unity retail health fund and the Grand United corporate fund.

Over the past decade, Australian Unity has pioneered services designed to help members protect and maintain their health and wellbeing, including providing information and personalised feedback on preventative health care.

In the area of financial services, Australian Unity's operations span investments, financial planning and general insurance.

In retirement living, Australian Unity owns and operates 12 retirement villages throughout NSW and Victoria.

The organisation also contributes to the community in a number of ways, particularly in the fields of health and wellbeing. These include a partnership with Deakin University to produce the Australian Unity Wellbeing Index, now in its sixth year. The Index measures the life satisfaction of Australians in seven areas – standard of living, heath, achieving in life, personal relationships, sense of safety, connection to the community and future security. Each survey also investigates a unique special topic, such as income security, and its impact on wellbeing.

In 2006, Australian Unity also founded the Australian Centre for Health Research, a public policy research organisation to raise and consider health and ageing issues. In future, operating funds for the Centre will be sourced from various additional private and public organisations and Australian Unity will become just one of many contributing organisations. The first two research papers released by the Centre focussed on the performance of prostheses and how Medicare might be improved.

A responsive and resilient healthcare environment enables caregivers to make timely decisions and facilitate better healthcare quality, safety and affordability. Technology enables healthcare organisations to achieve business and clinical objectives.

Cisco works with companies globally to revolutionise business and personal interactions by connecting people with the information they needed. Today, this "connected" approach is being applied in the healthcare sector as organisations align technology and operational needs to support and streamline information flows. Through its vision of Connected Health, Cisco is helping pave the way for a future in which all healthcare stakeholders can respond to consumers more efficiently, expand preventative healthcare initiatives and boost the overall health of communities.

The network is the backbone that supports and maximises technology. Intelligent networks transcend mere connectivity to become an essential element in transforming healthcare by enabling significant improvements in quality of care and productivity of caregivers - in short, enabling smart medicine. Networks must be medical-grade and position the healthcare organisation for integration of future technologies and systemic growth. Cisco Medical-Grade Networks introduce new ways to leverage networking technology, enabling caregivers to provide the highest quality care possible while improving business processes and increasing profitability. A Medical-Grade Network must be robust, responsive, enable a raft of services now and in the future, and must deliver information anytime and anywhere it is required.

Cisco's roadmap to Connected Health delivers a comprehensive approach to healthcare that addresses the industry's primary concern: providing efficient, affordable, accessible health services. Cisco is the leader in healthcare connectivity for collaboration and a catalyst in transforming healthcare based on its innovation, participation and collaboration.

Converting global issues into business opportunities

GAP is a proactive and influential network which initiates high-level discussions at the cutting edge of the most pressing commercial, social and global issues of today. Through forums, conferences, missions and advisory boards, we facilitate real and lasting change for our stakeholders, partners and delegates, sharing knowledge, forging progress and creating input for Government policy.

GAP promotes Australia's capacity to find novel solutions to the challenges facing the global community, and translates these innovative solutions into business opportunities. We focus on practical economic outcomes for Government and Business, and offer a landmark opportunity for those involved in the GAP process to discuss Australia's future in a high powered environment.

Moving from rhetoric to action

GAP's reputation for excellence is founded on its strong record of successful high-level national and global initiatives covering a wide range of industries and issues. In seeking to foster the links between Government, Business, Industry and Academia, GAP has developed its unique model of an interactive multidisciplinary task force. Each GAP project, be it a national round table or an international symposium, constitutes the beginning of a process. One of the major outcomes is the formation of Australian Government Consultative Committees, which work to ensure the recommendations flowing from each GAP initiative become reality.

"Any survival is the result of cooperation"

Global Access Partners is part of the TCG® Group of Companies – an Australian-owned group of independent, mutually supportive private enterprises. We have been in the business of building businesses for over 35 years.

GAP INITIATIVES

2008
- *GAP Congress on Regulatory Affairs*

2007
- *GAP Open Forum*
- *GAP Congress on Wellness and Ageing*

2006
- *Virtual Opportunity Congress IV: Identity & Access*
- *GAP Forum on Commercialising Nanotechnology*
- *GAP Forum on Leveraging Networks in Business*

2005
- *GAP Congress on Knowledge Capital*
- *Australian National Consultative Committee on Electronic Health*

2004
- *GAP Forum: Better Health Care Through Electronic Information*
- *Australian National Committee on Business Building Sustainable Cities*
- *GAP Forum on Ecological Sustainability*
- *Australian National Consultative Committee on Security and Risk*

2003
- *Virtual Opportunity Congress III: Security and Risk*
- *GAP Forum on Informatics in Biology and Medicine*
- *Australian Government Consultative Committee on Knowledge Capital*
- *Australia/Central Europe Entrepreneurial Study Mission*

2002
- *Vendor Management and Outsourcing Forum*

Drawing on Intel's heritage as a technology innovator, the Digital Healt Group brings Intel's knowledge and technical expertise to improve the overall healthcare experience, working with and listening to the experts from the healthcare industry. The Digital Health Group is working with both the information technology industry and the healthcare industry to deliver computing and communications solutions that connect people and information in new and important ways.

Today we face a worldwide growth in chronic conditions and an aging population that will place a potentially catastrophic burden on the healthcare system. Technology is the essential ingredient to evolving the current model of care and enabling seamless interaction and high quality information exchange throughout the complex healthcare system. Intel's Digital Health Group is helping accelerate healthcare quality improvement efforts around the world by delivering innovative, game changing digital technologies that make it possible for people to protect and enhance their health on a continuous basis throughout their lives independent of location - from the hospital to the home to the human body. Our mission is to enable patients, their families and healthcare providers to connect to the right information at the right time so they can make better and more informed decisions about their health.

Intel technology can drive a fundamental shift from episodic care – when a person's health is in crisis – to a more proactive model of care. Such a shift promotes wellness and independence on an ongoing basis. This in turn can help reduce the need for costly, acute care and increase quality of life by creating greater convenience and comfort for both patients and caregivers. This new model of technology-enabled continuous health creates a sustainable approach to healthcare in this new era of chronic conditions and an aging population. Intel technology can drive a paradigm shift in healthcare by connecting individuals to the most valuable health information at the most crucial time - and empowering them to take control.

Intel has been active in healthcare needs research for the last six years. The Digital Health Group is drawing on Intel's heritage as a technology innovator to focus first on the desired end-user benefit – imagining what's possible through people-centered research – and then designing and bringing to market platforms that deliver that desired experience.

Intel's strategy to drive technology-enabled continuous health is focused on improving acute care in the institutional setting; advancing personal health technologies; accelerating progress of the biomedical research enterprise; and advancing standards and policies that enable innovation and interoperability across the healthcare ecosystem. Taken together, these efforts can enable a wide range of stakeholders to better connect people and information in ways that advance prevention, early detection, treatment success, caregiver support and independent living.

As an innovation-driven global healthcare leader focused on diagnostics and pharmaceuticals, Roche brings pioneering products and services to market for every stage of the healthcare process, from identifying disease susceptibilities and testing for disease in 'at risk' populations, to prevention, diagnosis, therapy and treatment monitoring.

Roche aspires to be distinctive in its ability to drive value creation through the discovery, development and commercialisation of clinically differentiated products. More specifically, Roche is pursuing industry leadership in the emerging field of personalised healthcare, a field that is gaining in importance as advances in areas such as genetic profiling enable earlier diagnosis and facilitate better patient stratification. Because of their clinical and economic benefits, preventative therapies and targeted medicines will appeal not only to consumers, but to payers and regulators as well.

ROCHE DIAGNOSTICS AUSTRALIA

Established in Australia in 1972, Roche Diagnostics has demonstrated market leadership of diagnostics products and services nationwide for the past three decades, by continually striving to deliver significant benefits to patients and healthcare professionals, with innovative cost effective, timely and reliable diagnostic tools for pathology laboratory networks, patient self testing in the area of diabetes, and the research community in tertiary teaching hospitals. As regards, cost effectiveness and maximising use of resources, Roche Diagnostics estimates that increasing investment in diagnostic services by one percentage point may lead to savings of up to five percentage points in general healthcare costs.

Healthy Futures: Delivering better health, research and jobs for Victorians

The Life Sciences sector is one of the growth industries of the twenty-first century and will have a profound impact on the lives of people around the world.

Life science discoveries are leading to a greater understanding of the human body and our complex interactions with the environment. These discoveries are the basis of new treatments for many life threatening diseases and improvements in the quality of life for people living with the disabling effects of illness and injury.

Victorian scientists and institutions are a major part of this revolution in life sciences. The Victorian Government is taking action to ensure that our excellence in biomedical research brings about real improvements in the daily lives, health and wellbeing of people in Australia and the rest of the world.

It is the Victorian Government's goal to create a Life Sciences industry that is a world leader in translating scientific research into practical benefits.

The Victorian Government's strategy is to:

- Build on the State's strengths in medical research and life sciences;
- Expand our research infrastructure to attract the best people from Australia and overseas;
- Boost our capacity to translate research into practical outcomes that will benefit all Australians;
- Establish stronger links and connections between researchers and support approaches that bring together clusters of skilled people to work together on common problems;
- Create opportunities for national and international collaboration on major research projects;
- Develop an environment that is attractive to businesses wishing to invest in the products of life sciences research.

The Victorian Government has directed record investment into science infrastructure, developed the State's science and technology skills base and helped Victorian companies translate research into practical applications, products and services.

Over the past eight years, the Victorian Government has invested more than $1.8 billion in building Victoria's innovation capability. It is the biggest investment ever made by a State government in science, technology and innovation, and one that is also helping to provide a healthy future and improved wellbeing for Australians and people the world over.

Appendix 3 – List of Delegates

The Hon. Tony Abbott MP
Federal Minister for Health
Department of Health & Ageing
Australian Government

Mr Peter Allen
The Under Secretary, Portfolio Services
& Strategic Projects Division
VIC Department of Human Services

The Hon. Dr Michael Armitage
CEO, Australian Health
Industry Association

Mr Mark Armstrong
Managing Director
Body Active Consultancy

Prof Bruce Barraclough
Medical Director
e-Health Research Centre

Mr Robert Barter
Director
Bellberry Limited

Mr Silvio Basile
Senior Emerging Technology Specialist
Chief Technology Office, Telstra

The Hon. Neil Batt AO
Executive Director
Australian Centre for Health Research

Mr Fraser Bell
Director, Bellberry Limited
Partner, Finlaysons

Mr Michael Blanche
Director, Residential Aged Services Pty Ltd

Dr Marco Bonollo
Chair, Australian Disease
Management Association

The Hon. John Brumby MP
Treasurer of Victoria, Minister for Regional &
Rural Development, Minister for Innovation
Victorian Government

Prof Peter Cameron
Prof Emergency Medicine
The Alfred Service & Care

Prof Lesley Campbell
Principal Research Fellow, Diabetes and
Metabolism Research Program
Garvan Institute of Medical Research
Director, Diabetes Centre, St Vincent's
Hospital Sydney, Senior Staff Specialist
Department of Endocrinology

Prof Don Campbell
Director, Monash Institute of Health
Services Research

Dr John Carnie
Deputy Chief Health Officer
Public Health Branch
VIC Department of Human Services

Mr Alan Castleman
Chairman, Australian Unity

Prof Branko Celler
CEO and Chairman
MedCare Group of Companies

Ms Lucinda Chapman
Manager, MBF Foundation
Policy and Community Sponsorship, MBF

Dr David Charles
Chairman Insight Economics
Deloitte Touche Tohmatsu

Mr Paul Cray
Managing Director
Roche Diagnostics Australia

Mr Malcolm Crompton
Managing Director
Information Integrity Solutions

Mrs Gordana Culjak
Lecturer, Department of Information Systems
University of Technology Sydney

Mr Philip Davies
Deputy Secretary
Department of Health & Ageing
Australian Government

Dr David Dembo
Industry Manager Health & Human Services
Microsoft Australia

Ms Liz Develin
Director, Centre for Chronic Disease
Prevention and Health Advancement
NSW Health

A/Prof Isabelle Ellis
Associate Professor Chronic and Complex
Health Care, Charles Darwin University

Mr Ian Ferres
Consultant, TressCox Lawyers

Mr Peter Fritz AM
Group Managing Director, TCG Group

Mr David Gale
Honours Student, Biomedical Engineering /
Medical Science, University of Sydney

Prof Michael Georgeff
Director of e-Health Research, Monash
Institute of Health Services Research
Monash University

Mr Michael Gill
Director, Internet Business
Solutions Group, Cisco
Chair, Australian National Consultative
Committee on Electronic Health

Dr Stan Goldstein
Medical Advisor, Health and Benefit
Management, MBF

Dr Michael Guerin
Chief Medical Officer
Symbion Health

Dr Mukesh Haikerwal
President
Australian Medical Association

Dr Michael Harrison
Managing Partner, CEO
Sullivan Nicholaides Pathology

Ms Ros Hill
Manager E Health Strategy & Investment
Department of Health and Human Services

Mr Tom Hintz
Associate Dean (Research,
Policy and Planning), Faculty of Information
Technology, University of Technology Sydney

Dr Kim Hobbs
AP Director of Well-Being, IBM

Ms Suzie Hooper
Group Coordinator Rehabilitation
Service Development
St John of God Health Care

A/Prof Peter Hunter
Director of Sub-acute Medical Services, Division of Rehabilitation, Aged and Community Care, Bayside Health

Mr Jim Jefferis
Client Executive, NSW Health & Life Sciences, IBM

Mr James Kelaher
President, Neoteck Business Solutions

Ms Melany Kelly
Director, Insight Economics
Deloitte Touche Tohmatsu

Ms Megan Kennedy
Marketing Manager, Health & Life Sciences
IBM Australia Ltd

Prof Michael Kidd
Head of Discipline, Discipline of General Practice, Central Clinical School, University of Sydney

Ms Agnes King
Journalist
Business Review Weekly

Dr Michael Krien
Principal Adviser - Science Policy and Programs, VIC Department of Innovation, Industry & Regional Development

Prof Henry Krum
Department of Epidemiology & Preventive Medicine; Faculty of Medicine
Nursing & Health Sciences
Monash University

A/Prof Dr Elaine Lawrence
Department of Computer Systems, Faculty of Information Technology
University of Technology Sydney

Prof Stephen Leeder
Director, The Australian Health Policy Institute Co-Director, The Menzies Centre for Health Policy
Australian Health Policy Institute

Mr Trevor Lloyd
Partner, TressCox Lawyers

Dr Brendan Lovelock
General Manager
Health Informatics Society of Australia (HISA)

Ms Imelda Lynch
Business Manager, Bellberry Limited

Prof Malcolm Mackinnon
Director, Bellberry Limited

Dr George Margelis
Industry Development Manager, Digital Health Group, Intel Australia

Ms Helen Maxwell-Wright
Managing Director
International Diabetes Institute

Ms Patricia McAlpine
National Manager, Professional Practice for Service Delivery, CRS Australia

Mr James McCormack
General Manager, Broadband Development, Access & Consumer Division
Department of Communications, Information Technology & the Arts, Australian Government

Prof Allan McLean
Foundation Professor of Medicine and Associate Dean and Clinical Dean of the Victorian Clinical School
School of Medicine Melbourne
The University of Notre Dame

Ms Leslie McQualter
Australian Health Service Alliance

Mr Rohan Mead
Group Managing Director, Australian Unity

Mr Barry Metzger
Senior Security Solutions Specialist, IBM Software Group, Tivoli Security Solutions, IBM Australia Ltd

Prof Iain Morrison
Head of School of IT/Professor of Information Systems, Bond University

Mr Mark Mowbray-d'Arbela
Branch Manager, Legislative Review Branch
Financial Framework Division
Financial Management Group
Department of Finance and Administration

Ms Melissa Mowbray-d'Arbela
CEO, Filligent Limited

Mr Jason Murray
COO, The Brain Resource Company Ltd

Ms Julia Nesbitt
Director General Practice & eHealth Department, Australian Medical Association

Ms Jane Niall
Deputy Secretary, Business Development Division, Department of Innovation Industry & Regional Development
Victorian Government

Prof Brian Oldenburg
Chair, International Public Health Unit
Department of Epidemiology and Preventive Medicine, Monash University

Dr Christopher Pearce
Chair Information Management Committee
Australian Divisions of General Practice

Mr Victor Perton
Regulatory Affairs Advocate
Director, "A Regulatory Affair"

Mr Peter Riley
Director
Residential Aged Services Pty Ltd

Prof George Rubin
Professor of Public Health and Specialist in Preventive Medicine, University of Sydney at Westmead

Mr Tamati Sheppard
IBSG Cisco

Mr Leo Silver
Director, Integrated Wireless Pty Ltd

Mr Jack Singh
Director, Centre for Technology Infusion
La Trobe University

Mr Andrew Simpson
Adviser to the Hon. Tony Abbott
Office of the Minister for Health and Ageing

Prof Peter Smith
Dean of Medicine UNSW

Dr Saxon Smith
Medical Relations Officer, MBF

Ms Jane Tongs
Director, LCM Healthcare

Prof Andrew Tonkin
Head Cardiovascular Research Unit, Department of Epidemiology & Preventive Medicine, Department of Medicine
Monash University

Ms Elaine Warburton
Chief Executive Officer
Opaldia UK

Ms Justine Waters
Health Policy and Partnerships Manager
MBF

Mr David Watt
Business Unit Executive, Healthcare and Life Sciences A/NZ
IBM Australia/NZ

Mr Graeme Westaway
Head of Marketing and Product, Healthcare
Australian Unity

Mr Ron Willson
Executive Director
Health Insurance Restricted Membership Association of Australia (HIRMAA)

Mrs Robyn Woodburn-Dennis
Head of Laboratory
Melbourne Pathology Services

Mr Stewart Young
Executive Director,
Hill Young & Associates

Dr Nikolajs Zeps
Research Manager, Radiation Oncology
University of Western Australia
WA Institute for Medical Research