RESPONSE TO 'A HEALTHIER FUTURE FOR ALL AUSTRALIANS' NATIONAL HEALTH AND HOSPITALS REFORM COMMISSION (NHHRC)

Overview: The NHHRC report is shown to be a recipe for too many chiefs and not enough Indians so an alternative direction for achieving all goals better is suggested.

The key recommendations addressed below from 'A healthier future for all Australians', the product of the National Health and Hospitals Reform Commission (NHHRC), are mainly likely to produce new, dysfunctional, professional health service silos, because the report is clearly a product of many collegiate cultures pursuing vested interests which are either unspoken or misspoken (as our US brethren say). The problem is that for various reasons, the richest and the poorest working in health and community services refuse to recognize themselves as industrial, financial or related economic actors. The US health promotion direction that many of those in Australia appear to be following is not designed to face work or children as stressors, to obtain personal choice in death, or to flick the switch to vaudeville when necessary either. The NHHRC report is more like a prescription for professional domination of communities driven by the private sector, than the Alma-Ata direction on health promotion supported by the United Nations (UN) and Australian governments. Perhaps the NHHRC thinks their colleagues are nicer than this, especially the poor old faceless health plans with no right to refuse an individual. (Did you ever see a dream walking?)

Forgive my cynicism, but I recently saw US Treasury Secretary, Timothy Geithner, discuss the government's pump-priming and better regulation for more profit approach to leading US financial recovery on 'News Hour' on SBS. The assumption, shown already to be false in Australian health care and insurance, appears to be that a return to more conservative market approaches will deliver the goal that Americans and individuals everywhere most want to see – profit return. Maybe, but this is unable to achieve the World Health Organization (WHO) or UN goals for health and sustainable development which are most in the interests of current and future generations. To achieve these one needs triple bottom line accounting, designed clearly to achieve social and environmental as well as economic goals, as indicated in previous submissions to the NHHRC. A market driven approach has delivered good health to fewer and fewer in the US, so why should it be able to deliver a better environment for all? Not even the Republicans support the Democrat plan. A better approach is necessary and from his interview on the 'News Hour' recently, I bet William Isaac, former Federal Deposit and Insurance Commission (FDIC) official is just the man to help. (We could do with one of those. Why do all the hopeless US economists have Nobel Prizes? Is this an example of irony?)

However, NHHRC recommendation 2.9, which calls for the development of a person-controlled electronic personal health record, is strongly supported as a necessary first step in any national, more openly evidence-based service delivery in future. In recommendation 14.5 the NHHRC also states 'We support national registration to benefit the delivery of health care across Australia'. Here is the chance to prove it. Rather than setting up a National Clinical Education and Training Agency, as in recommendation 14.4, the NHHRC should first focus on achieving rational and open national health

curricula to assist the development of health and sustainable development nationally and internationally. This can best be done through urgent pursuit of a related communication and education revolution in partnerships with industries and communities to serve all sustainable development goals and triple bottom line accounting. Consider the Australian and New Zealand Standard Industry Classification (ANZSIC) and related occupation, treatment classification and funding information in the course of implementing all relevant recommendations. This direction is also discussed in the following attachments:

- Submission to Australian Health Ministers' Advisory Council on a national registration and accreditation scheme for the health professions
- Submission to Productivity Commission inquiry into copyright restrictions on parallel importation of books

It is currently necessary for ministers to treat NHHRC calls for more money with extreme caution because the absence of effectively patient centred management in health care means the recommended expenditures are likely to support vested practitioner interests rather than client or broader community interests. For every new health management body or practice the NHHRC recommends, the ministers should ask that others of equal or more value are suggested and justified for destruction, on the grounds that they maintain comparatively narrow, closed, silo driven and dysfunctional professional or bureaucratic approaches to work, which are not in keeping with more broadly scientific national and international approaches to gaining health and sustainable development. Alternative recommendations, which are based primarily on analysis of particular NHHRC recommendations for more funding are made below and supported in two attachments which are referred to directly below. See others on the right for old people to choose death so we can donate our organs, and on a Saudi Arabian PhD proposal for dental research which also presents opportunities to provide postmenopausal women with oestrogen replacement therapy supposedly as a preventive measure for osteoporosis. Finally, we call on Broadway and claim the musical is back, especially in the army. (Sport can take care of itself. It bores me rigid.)

DISCUSSING THE REPORT AND RECOMMENDING SOMETHING BETTER

Recommendation 1: Support Rec. 2.9 of 'A healthier future for All Australians', which is the development of a person-controlled electronic personal health record

In the article entitled 'Just what the doctor ordered' in the Sydney Morning Herald (SMH, 21-22.2.09, News Review p.7) Dr Christine Bennett, Chairwoman of the NHHRC is quoted as saying that an electronic health record is arguably the single most important enabler of truly person-centred care. I agree completely because most of us are incapable of reporting reliably on what we have previously experienced and the results are multiple repeat prescriptions and tests from various circles of practitioners which is highly undesirable from any individual or community health and related economic perspective. Without the electronic health record, the recommendations of the NHHRC report appear largely to be a call for practitioners to get more money at the expense of the national community and their clients. Without the electronic health record it will be

impossible to take responsibility; connect care; identify and resolve inequities or drive quality performance, as the NHHRC states are its goals. Email provides a potentially related record of what has gone before. I would be lost without it.

The development of the electronic health record ideally enables clients, health practitioners and all related communities to focus comparatively, in more reliable ways, on apparent types and outcomes of treatment, often for the first time ever. Without this development, I predict geriatric psychiatrists and their legal and financial mates will scoop the pools, followed by other medical specialists and some dentists. I predict the others will trail behind according to their associations. (I taught the sociology of health.)

Professional knowledge, remuneration, risk aversion and related research drivers all appear more likely to ensure that the practitioner driven approach to treatment occurs rather than a patient centred approach, at least outside hospital based care. In hospitals, patients are much more likely to be acutely ill and practitioners clearly need to work together as sensibly as possible, to prevent any imminent and upsetting deaths. Their general success in this is perhaps why they are often revered by many people. (I can certainly understand the feeling.) Outside hospitals, clients often rely upon practitioners they have found themselves or have been sent to for advice on future treatment. Once such a client has contacted any health care provider, the latter may drive processes, with the interests of their closest colleagues and other associates also firmly held in view. However, few of us want to have to go to hospital in order to get decent treatment. We prefer to treat ourselves as much as possible by computer or TV. (No kidding.)

Rec. 1.7: **calls for the establishment of an independent national health promotion and prevention agency.**

In the light of the comparatively clear and helpful direction outlined in the Declaration of Alma-Ata at the World Health Organization (WHO) International Conference on Primary Health Care in 1978, one wonders how many of those currently working in health care understand this direction and can or want to implement it. My educated guess is few, which is supported later and in attachments. One also wonders exactly what role, if any, the 'citizen juries' recommended in 13.2 will play is relation to health promotion and injury prevention, and how all are related to the NHHRC discussion of raising and spending money for health services. Who is envisaged as being on juries – captains of industry, some local community voices, or others entirely? What will juries do? They sound like legal rubbish to me, rather than a more openly consultative and data driven approach to service delivery. In the current international context of financial crisis, such questions are vital, because the US, rather than the European or WHO policy direction often drives Australian health care professionals and academics. They may also have vested interests in undermining Australian government policy directions and health service efforts so that they can make more money at the expense of everybody else.

There is much self-interested professional and related academic thinking about 'health promotion' and 'the determinants of health' to be faced. For example, while the Sydney University Act seeks free enquiry, the Sydney University website says the university

seeks ‘a paramount fiduciary duty of loyalty to the University’ and ‘an atmosphere of mutual trust and respect’. The latter two may not comfortably co-exist with the unhindered search for truth, which is ideally also regarded as being the same as free inquiry. The Sydney University Act and Sydney University website also have opposing views on the importance for decision making and related accountability of the senate and the vice-chancellor (VC). In the legislation, the VC is a powerless figurehead and the senate makes all decisions. One ideally prefers the Sydney University approach, where the VC rather than the university senate appears accountable for decisions. The Senate cannot govern effectively because it represents a large collection of narrowly informed and partial collegiate interests which it is also difficult to hold accountable for decisions and their continuing outcomes. The university rests largely on groups of feudal brotherhoods with mutually supporting, powerful financial interests. (What else is new?)

I am suspicious about how Fig. 1.3, on the social determinants of health (NHHRC, 2009 p. 58) may be interpreted and driven in a narrowly and professionally defined health climate. For example, the Australian text book ‘Understanding Health, A Determinants Approach’ edited by Keleher and Murphy and published by Oxford University Press (OUP 2004) informs one that the WHO, Alma-Ata and Australian government approved definition of health as ‘a state of complete physical, mental and social wellbeing’:

> ‘confuses the actual state of health with what it is that determines health. It is a definition that masks the determinants by making the state of health itself the object of measurement, rather than focusing on the determinants as an object of measurement. (p, 99.)’

The authors, rather than the WHO, the Declaration of Alma-Ata, or Australian governments, seem most confused, from my perspective. The latter seeks to follow WHO, International Labor Organization (ILO) and related United Nations and Australian policy directions, to promote health and sustainable development more competitively. If academics like Keleher, Murphy and those who wrote with them are encouraging mass student and health professional rejection of the WHO and Australian government definitions of health, this is a key concern in regard to health promotion from any Australian government, industry and related community perspectives which also seek to develop partnership approaches to gaining health and sustainable development.
An attack on dysfunctional professional regulation and related administration is necessary in order to gain more open and evidence based approaches to all service delivery in national, regional and international industry and community arenas. Many professionals tend to resist any attack upon their multiple closed shops, which are generated through the universities, state registration and other places. This must be discussed openly but is considered too rude, including by the NHHRC. (Try it in your next mixed tea room.)

Keleher and Murphy informed the reader earlier (p. 10) that:

> ‘Determinants of health are often divided into distal and proximal determinants. A proximal determinant of health is one that is proximate or near to the change in health status. By ‘near’ one can mean near in either time or distance, but generally

> it refers to any determinant of health that is readily and directly associated with the change in health status. Proximal determinants are also referred to as downstream factors. In contrast, a distal determinant of health is one that is distant either in time or place from the change in health status. The association between the change in health status and the determinant may be indirect or hard to see because of other intervening events and locations. Distal determinants of health are also referred to as upstream factors.'

I have no idea what they are talking about and I have read the book. The associated Table 2.1 entitled 'The (possible) determinants of Ama's death' makes little sense to me. The discussion which follows on the upstream, midstream and downstream factors (ie. 'the determinants of health') is confused and in my view the concept of a factor is not as strong as a determinant. This may not be trivial to anyone who hates a narrow, ignorant, authoritarian, personality. Keleher and Murphy say: (2004, p. 5)

- Downstream factors are those at micro level including treatment systems, disease management and investment in clinical research
- Midstream factors are those at the intermediate level including lifestyle, behavioural and individual prevention programs
- Upstream factors are at the macro level including government policies, global trade agreements and investment in population health research

I fail to see what makes investment in clinical research a downstream factor and investment in population health research an upstream factor. This is not explained. The patient or client also seems absent from the analysis. Their 'health status' appears to stand for them instead. On page 110 one is told that governments are typically more concerned with downstream and midstream approaches than with upstream approaches and that genuinely collaborative, multidisciplinary downstream, midstream and upstream actions are necessary. I have no idea what these are expected to look like, but I bet health professionals ideally see themselves as driving in all directions. (They are far from fit.)

The above is not the ideal regional, holistic, community based and client centred approach to health promotion which was ideally outlined in the Declaration of Alma-Ata and followed by Australian governments. From example, in the Declaration of Alma-Ata, primary health care 'involves, in addition to the health sector, all related sectors and aspects of community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors'. Keleher and Murphy's discussion of 'upstream and downstream' bears no resemblance to the regional approach to health and sustainable development envisaged in the Alma-Ata direction and supported by the UN and Australian governments. The ideal approach sees all work and play as located in communities and environments from which risks and many related challenges arise. The identification and control of the major risks to health are ideally conducted in this context. There will be many environmental challenges along the way. (Baby, believe me.)

Rec. 2.2: calls upon the Commonwealth to foster the widespread establishment of Comprehensive Primary Health Care Centres.

One wonders about the proposed definition and range of primary care services which are to be included under the concept of primary health care discussed by the NHHRC, and guess that more practitioners will increasingly try to find a better way to benefit economically from the term, especially if they can remove themselves from comparative community and government scrutiny, while also driving up their costs to everybody. Services must be clearly and openly defined to prevent this and also to encourage trust. The Commonwealth Medical Benefit Schedule system and a broadly related casemix approach such as that used in hospitals may be usefully adaptable management tools for guaranteed or variable funding in a range of related community service areas.

However, there are many associated problems. For example, a recent newspaper article (SMH 27.2.09, p.5) entitled 'Scan scams: doctors with conflicts of interest reported', claims Medicare is investigating evidence that some doctors are referring patients to diagnostic centres in which they have financial interests and this also raises the risk of overexposure to radiation. US research is cited that doctors with such interests are associated with rates of referral up to seven times higher than usual. The Royal Australian and New Zealand College of Radiologists condemned 'for-profit' (sic.) referrals, saying they pose the risk of inappropriate servicing, overuse of radiology and erosion of patient choice and industry viability. The college president, Mark Khangure, told the Herald that in most states, including NSW there are groups of doctors, often medical specialists, including gastroenterologists, cardiologists and chest physicians, who have shares in diagnosing and imaging centres and refer their patients to the centres. These referrals are on the rise. Liberal senator Gary Humphries expressed concern about general over-servicing and the Minister for Health, Nicola Roxon, said it was 'obviously unacceptable' if anyone was making referrals to drive up their profits. One wonders how to prevent this practitioner behaviour. (Many are blind to their condition as workers.)

The last time I had a pap smear taken by a general practitioner, Symbion pathologists tried to charge me highly because they used a form of technology which was supposedly in advance of the approved Medicare standard to assess the smear. (Surprisingly, this information was written on the bill.) I refused to pay their amount because I was not asked whether I wanted to be treated with technology not approved under Medicare. It was impossible to speak to anybody from Symbion about this and they would not reply to letters. They just set debt collectors onto me until the latter got sick of listening to my views on Symbion undermining Medicare. The general practitioner who took the pap smear has since moved to a new practice which looks very much like the kind of Comprehensive Primary Health Care Centre the NHHRC would like to see. I went there in 2008 when I had sudden vomiting and diarrhoea which seemed like food poisoning. Another general practitioner gave me a script but said old people sometimes get diverticulitis. He gave me a container and suggested I take a stool sample for Davis Campbell de Lambert pathology and bring it to him. I thought this suggestion was utter nonsense and see the current practitioner trend to preventing illness in old people as extremely dangerous, especially in the absence of an electronic patient record.

On the other hand, a couple of years earlier I had gone to see a different general practitioner for a pap smear and she suggested I also have a cholesterol test. I agreed as I had never had one before. I received a pathology report which I hardly glanced at, until she called me back because she said I had high cholesterol and recommended I change my diet and return in six months. Because of my weight, diet and the fact that I walk everywhere and have exercised at the gym for three to four hours per week since the age of thirty, I couldn't believe I had high cholesterol and confirmed this by learning from the appropriate health website how to read the report she had misread. (Basically, there appears to be two kinds of cholesterol and I had more of the good kind, which she misread as bad.) I was very impressed by the power of the website to help consumers.

Practitioners cling to collegiate cultures. However, from a public and individual interest in achieving quality performance, connected care and many related economic and social goals, there are often far too many chiefs and not enough Indians working in health care and its related collegiate systems and silos. In the most prestigious collegiate cultures, where ideally all are equal, it has historically been assumed that each in the medical club has his own area of particular expertise, as accredited by similarly expert colleagues, such that hardly anybody outside his narrow field, except a court, can ever question him about his practice or ever tell him what to do. (This is a laugh, as all courts are feudally driven.)

Such sets of professional assumptions have been undermined on one hand and supported on the other by the 20th century increase in the range of taxpayer funded health care and related forms of education. In the 21st century, such professional assumptions may make the comparatively new concept of multi-disciplinary teams look like a heavenly new status to all those working in health care who have ever wished they were, or at least appeared to be, as important, well remunerated and independent in their actions as a medical specialist, or even a general practitioner. Thus the client may be metaphorically cut up into smaller and smaller bits, which an increasing range of self-defined specialists may focus on to get ahead in increasing intensity and isolation from each other. A person who knows more and more about less and less is one definition of an expert. My dentist and I resist this view and he has promised never to try to send me to his special gum man.

In keeping with their feudal and related collegiate origins, writers of the (NHHRC) report are little different to most of their professional and related academic colleagues in largely refusing to recognize that according to nearly all economists, all people are driven by their search for money. Even if economists are wrong in their assumptions, health care practitioners still remain supported by their work and by related investments in an industry in which the treatments provided are usually paid for by a much broader community than their immediate clients. The wider communities and the sick people in them are also subject to the problems of much dysfunctional industry regulation driven by occupational and related career and employment interests on one hand and by commercial in confidence, market driven investment systems on the other. This is an extremely dangerous combination in terms of its capacity to provide primarily for well-connected practitioners, rather than for their patients or communities. This may increasingly be done from a public purse prized open with very little unseemly effort.

Rec. 2.6: calls for Divisions of Primary Health Care to replace existing Divisions of General Practice.

How could this be successful without bucket loads of money and what exactly would be the point? (I assume the divisions primarily are separate sites for practitioner education leading to higher practitioner payment.)

Rec. 6.12: includes capacity for electronic prescribing by medical practitioners attending aged care homes and provides financial incentives for electronic transfer of clinical data between services and settings such as general practitioners, hospitals and aged care providers, subject to patient consent.

In my view, these transfers of clinical data between services are ideally expected by government as a natural part of all services provided and enabled by the personal electronic record. Other ways of payment seem expensively dysfunctional from a bureaucratic or scientific perspective. The concept of advanced care plans, discussed in Figure 7.4 (p. 188) (which is a discussion and not a figure) perhaps reflects the worst of all worlds to come, in that some old people may fear that their carers can suddenly become their registered killers, while others may not have a clue what is meant by statements they are supposed to have made, such as 'that all possible measures be taken to exclude any reversible cause of the health crisis……. and that her preference would be to return to the nursing home to be cared for by her 'second family'. (Search me).

A Catholic medical ethicist alerted me to such fearful problems, which I discuss along with organ donation in the attached. If some of us oldies eventually wish to kill ourselves to donate our bodies, as I do, this may be an exceptionally good thing for society and the environment. The view may not be popular with Christians, but may suit some other tastes which surely deserve recognition, and which may appear even more advanced. (Like soldiers, we are ideally applauded by all for freely choosing our inevitable death.)

Rec. 8.4: proposes the establishment of a National Aboriginal and Torres Strait Islander Health Authority to purchase services specifically for Aboriginal and Torres Strait Islander Australians.

From a scientific perspective a National Aboriginal and Torres Strait Islander Health Authority like the above is a bad idea because there is no reliable definition of belonging to these groups. The NHHRC comparison of indigenous people with veterans is misguided because in the veterans' case they are known by army records, but indigenous heritage cannot be reliably verified. People should not normally be given special economic incentives to define themselves as indigenous, especially if this gives power to certain of their peers to verify or negate that self definition on grounds which cannot be effectively validated. It may generate resentment and discord wherever benefits are available only to some in any community, because most adults are taxed to pay for it.

Indigenous people are part of broader communities and probably vary a lot in their individual attitudes and behaviour, much like anybody else. However, as Eddie Cantor pointed out a long while ago, the rich get richer while the poor get children. The NHHRC report will not squarely face the problems for many unplanned siblings who cannot be cared for to an expected community standard. The writers point out that:

> In many remote areas, high birth rates present the system with an immediate challenge as to how best to support children to be productive and healthy adults, and to give the children soon to be born the best start in life (p. 226).

The most obvious answer to that challenge, from the national public interest based, scientific, and related systemic, community or personal level, is for some women to have fewer children, especially those which have not been previously planned. Perhaps only the Chinese are allowed to point out this bit of the bleeding obvious, because on page 207, a table on 'the indigenous burden and health gaps', establishes eleven risk factors for indigenous community health, without mentioning the related number of children a woman and her community are responsible for bringing to adequate adulthood. Women of European and other middle class backgrounds accept that children are a great time and economic burden as well as an emotional comfort and historically have fought for and practiced birth control rigorously. It is paternalistic, career based indifference posing as tolerance, to pretend the necessity for this rigorous practice does not exist for all women and communities who want to be comparatively healthy and wealthy. Peter Costello might want three children but I bet his wife makes the ultimate considered decisions on such issues in the family interest as she sees it. He worked hard as economic provider. Policy concerns about growing populations as a result of migration are a separate issue.

In most cases, once children are born and immunized, the prevention of sickness and tooth loss throughout the life span often lies in implementing relatively straightforward messages which we may all ignore and probably often do at any age. These are:

1. Eat a healthy diet
2. Exercise regularly
3. Don't smoke
4. Don't drink or take other mind altering substances to excess
5. Get enough sleep
6. Avoid pregnancies and other high risk situations related to sex
7. Only undertake relatively safe and preferably interesting work (This may be hard)
8. Only undertake relatively safe entertainment (Males may find this particularly boring and one can only learn mastery of an environment through facing its risks)
9. Try to learn to recognize and deal sensibly with personal stressors (This is hard.)
10. Brush teeth properly and much more often than currently

The above list is mainly a more forceful statement of the ten major public health concerns in the US (p. 66). That list, like the eleven risk factors related to indigenous health discussed earlier, is designed to ignore mention of work. I guess this must be the free market approach where we, the approved professionals, will do things for you, the client,

preferably using other peoples' money. This ignores the centrality for individual and community health of industry and its financial operations. In regard to the US list of health concerns one wonders what the 'responsible sexual behaviour' that is requested should look like and how it relates to the risk of 'unsafe sex' in the indigenous list. I expect marriage. (Just kidding, I tired of the institution early and never looked back.)

Health messages can probably be taught most painlessly through appropriate media and supported in child care and schooling. The holistic approach to treating identified risks in an environment so as to promote community or personal health (for example by establishing effective education and related work opportunities) may be more likely to succeed in community partnerships with managers in many industries other than health.

In the related rehabilitation context one needs more explanation of figure 2.2 entitled 'Allied health services funded by MBS under the enhanced primary care program (p.87). The largest number of services provided for 2007-2008, according to this table, is for podiatry (491,257) followed by physiotherapy (463, 695). The smallest number of services provided is for aboriginal health workers (51), followed by audiology (716). One wonders what on earth drove the podiatry extreme. No explanation is provided. One also wonders what kind of health workers the Nganampa Health Council used to achieve results which it and other Aboriginal Community Controlled Health Services considered good (p.204). Why do aboriginal health workers appear hardly ever used?

Rec. 10.2: seeks an Early Psychosis Prevention and Intervention Centre model.

If this model content is not openly available to anybody and on computer or other media, I expect it to be very costly. The word 'psychosis', is apparently used by the NHHRC 'to describe conditions that affect the mind where there has been some loss of contact with reality' (p. 242). This is broad enough to describe all of the people who ever sat in a tea room with one exception. Isn't there also a Brain Institute? Where is it left – ruling? Psychiatrists and psychologists appear to be the most likely people to control the proposed early psychosis prevention and intervention model. They are ubiquitous and often scarily and narrowly focused on their own ends, in my experience. For example, many of these people may be dangerously authoritarian if they think they are scientists, rather than social scientists, as most appear to do at Sydney University. They usually rely for their treatment on what their clients tell them, often as a response to practitioner questions which are formed as a result of particular practitioner interests, with the responses turned into numbers. This may give them a quasi-scientific air, to which they are actually not entitled. The favourite US market driven concept of 'behavioural science' must be debated before the proposed centre. Is behavioural science considered science, social science, or something else, and does it matter? (Freud, the father of psychiatry and psychology, thought he was a scientist but Jung naturally questioned this.)

I get the impression that a lot of psychologists work in health promotion. Are there any others who call themselves behavioural scientists and where are they? When working at Sydney University, I tried to read Nutbeam and Harris's book about health promotion entitled 'Theory in a Nutshell' a number of times but it made little structural or cumulative

sense to me, in spite of some headings and linking passages which suggested it should. I found myself asking why any particular methodology was being described, rather than any other, in any particular section. I also wondered about the difference between a theory and a methodology. To me this book mainly seemed to be describing methodologies, some of which were also related to behaviour prediction. What exactly is the point of these from any broader community health perspectives? I assume a theory may also be defined as a hypothesis, and that one can have a hypothesis about anything and devise a related methodology. Nutbeam and Harris, however, say that a theory is:

> 'Systematically organized knowledge applicable in a relatively wide variety of circumstances devised to analyze, predict or otherwise explain the nature of behaviour of a specified set of phenomena that could be used as the basis for action'.

I think this primarily defines a methodology which aims to be repeated, not a theory. I think their definition of theory is an example of the ideological reification of various possible approaches to understanding and tackling health or other social issues in order to address them better. This reification often occurs when groups of academics with vested status and economic interests establish empires of influence which information technology systems may then cement and multiply. The power of such people has grown massively, expensively, and often wrongly, from my WHO and national perspective.

While the depressed are always welcomed by health practitioners, the angry are much more likely to be handled by police. (The former are often timid, in my experience.) One wonders why the table entitled 'We need to train more Aboriginal and Torres Strait Islander health professionals' (p. 329) appears to mention all the likely suspects except psychologists. Are they in the 'Aboriginal and Torres Strait Islander Community Controlled Services within defined regions' referred to in recommendation 9.2? Much more clarification is required. Most practitioners below the doctor would naturally love to diagnose, prescribe and see themselves as just as scientific. This is a potential social menace and follows a narrow approach to community health the US often adopts at great social cost because it prefers the lies of every market peddler to any starker reality, so the rich ones win. (How else could the US have ever got to its current economic situation?)

Rec. 11.3: supports an equitable approach to financing a universal dental scheme linked to the Medicare levy.

Unless this is delivered in an unusually sensible fashion, such as through schools and child care centres, and for a clearly defined set of conditions, I think this would lead to an explosion of dental services taken up largely by the people who are already well schooled and acceptant of visiting dentists. I think such people are likely to be young women or their parents who would love them to have a more Hollywood set of teeth and elderly Methodist style women who fear losing teeth. For example, my dentist is now trying to get me to see him every three months, but I have fought him back to six. I have seldom known a man who saw a dentist unless he absolutely had to. Am I wrongly stereotyping men and boys in assuming that most will hardly ever go? See the related research discussion attached which is about tooth loss, osteoporosis and giving women hormone

replacement treatment in Bahrein, which somebody in Saudi Arabia unexpectedly sent me when he was seeking a supervisor. (Truth is stranger than fiction. God knows how most students and supervisors get together. It always seemed to be others' trade secret.)

Rec. 14.4: proposes a National Clinical Education and Training Agency and in recommendation 14.5 the NHHRC states 'We support national registration to benefit the delivery of health care across Australia'.

Alternative Recommendation 1: The NHHRC should first focus on achieving rational and open national health curricula to assist the development of health and sustainable development nationally and internationally by urgent pursuit of a related communication and education revolution in partnerships with industry and communities. This direction is also discussed in the attached submissions.

One wonders exactly how the National Clinical Education and Training Agency proposed by the NHHRC would relate to the current myriad of international and Australian educational institutions and their related bodies, and what it would be expected to do, other than make more money for certain practitioners, academics and others assisting some more powerful closed shops. For example, a Martian might assume that the easiest and best way to provide practice for a student wishing to be a dentist or a doctor would be in the treatment rooms of a dentist or a general practitioner, in the manner of apprentices in industries other than health care. In my view, the fact that the apprenticeship model of career development is not broadly and seriously discussed, let alone planned or developed in the upper echelons of health care, is a testament to the historical power of doctors to define their own closed shops, by using education, their state registration acts and others to do it. All allied occupational groups naturally try to follow suit as much as possible. This supports many practitioner club lands which lead others very expensively.

The NHHRC should instead help implement the mass communications and education revolutions necessary for sustainable development, which are addressed in the attached submissions and also in those I sent earlier. These addressed the government inquiries into the impact of the global financial crisis on regional Australia, and the choice of emissions trading as the central policy to reduce Australia's carbon pollution. Tradesmen working in construction, which is the foundation of nearly all other business operation, also have a lot to learn about accountability from practices in health care. (But I digress.)

The Council of Australian Governments (COAG) first called for national standards for health and environment protection, related occupations and supporting education in 1990. In 2008, COAG still seeks a single national registration and accreditation scheme for health professionals. Put the National Clinical Education and Training Agency on the back burner and help achieve the former first. The attached submission to the Australian Health Ministers Advisory Council on a national registration and accreditation scheme for the health professions suggests putting all the key curriculum content taught on a table and coming up with a sensible national curriculum which rationally links curriculum taught in universities and other registered training organizations, so an education revolution to gain more sustainable development can be progressed. This ideally occurs

through all natural avenues like open computer sites, TV, videos, radio, books and by any other means which appear to be broadly consistent with the NHHRC report directions which seek to engender informed responsibility and the related NHHRC goals.

My previous submission to the NHHRC discussed a press report that Aspen Medical won $37.25 million of medical contracts over the period of Labor government, which was the highest payment made to all consultants, followed by payment of $18.68 million made to Boston Consulting for management and policy advice. One wonders what such payments were for and whether they should be repeated, from a triple bottom line perspective which involves economic, social and environmental indicators of performance to achieve key project aims. Does the NHHRC know? We all should as we paid for them through tax. All regional health management matters require effectively integrated consideration, which is also why I seek to interest the NHHRC in the general policy direction recommended here and in related attachments. The Australian Financial Review observed (AFR, 20.2.09, p.1) that a consultancy culture curtails policy makers. However, as Humpty Dumpty realized, whether this is so is largely dependant on who is to be master, which is also what the NHHRC never mentions, at least in public. One always worries about silence, confusing messages and closed doors. These are private sector norms. (Who is behind the proposed health plans?)

Alternative Recommendation 2: Treat NHHRC calls for more money with extreme caution because the current absence of effectively patient centred management in health care means the recommended expenditures are likely to support vested practitioner interests rather than client or broader community interests.

Alternative Recommendation 3: For every new health management body or related practice the NHHRC recommends, the ministers should ask that others of equal or more value are suggested and justified for destruction, on the grounds that they maintain comparatively narrow, closed, silo driven and dysfunctional professional or bureaucratic approaches to work, which are not in keeping with more broadly scientific national and international approaches to gaining health and sustainable development cost-effectively. (N.B. This is different to wiping out the smallest provider groups, as the latter popular strategy usually just maintains the self-accrued privileges of the collegiate controllers of the status quo. Brendan Nelson and Peter Shergold wiped me out for psychologists and others at Sydney University)

Health care practitioners and students generally like to avert their eyes from the kind of crude reality above. When they drag their gaze from the various bits of other people's bodies, health care practitioners, including those in the NHHRC, appear to find it hard to define or categorize themselves as workers or investors with any degree of interest or clarity. In their collegiate cultures they appear a little like disciples of religion who are so determined to appear to identify purely with ministering to others that they do not recognise themselves as active industrial, political and economic agents in any broader contexts. These collegiate and related occupational or other investment mate ships, where some are so much more equal than others in regard to their power to command resources, also appear to resist focus on their own work from any scientific management

perspective. In this collegiate and investor friendly, industrially and managerially muddled context, one naturally wonders what attitude the NHHRC has to ANZSIC and related occupational systems. The Chair should 'sift' (her word) through the submissions again and find those with scientific responses to this question, wherever they come from.

Industrial blindness on the part of those working in health care is particularly dangerous when so many new health management structures and organizations are also being recommended by the NHHRC. Developing consistent service definitions, which is necessary for gaining the appropriate, reliable and cost-effective treatment which is in turn necessary for improving service quality through related and supporting research depends on this. For example, the NHHRC report provides little clear picture of the core of 'primary care' services envisaged for publicly funded provision and I have no idea what 'scoping' primary health care means, as contained in the heading on page 81. I heard the normal industrial classification systems or others supported by the Australian Bureau of Statistics mentioned by hardly any of my colleagues when I worked for ten years in the College of Health Sciences at Sydney University. For example, a Review of Basic Sciences in the Faculty of Health Sciences praised the customer service culture. However, it seems that those who wrote that Review report did not recognize health care as being in an industry. Page 16 stated about the Bachelor of Health Sciences (BHS):

> 'The BHS is designed to give its graduates the opportunity to become involved in contemporary healthcare by linking the three arms of healthcare – practitioners, the healthcare system and industry – in a unique manner.'

As I wrote to the review - practitioners, the healthcare system and industry are not the three arms of healthcare. This statement is nonsense because practitioners and the healthcare system are ideally part of broader health and community service industry approaches to obtaining health nationally, regionally and internationally. People who do not appear to understand or be willing to accept the concept of health care as an industry cannot talk seriously about implementing a customer service culture.

Alternative Recommendation 4: Consider the Australian and New Zealand Standard Industry Classification (ANZSIC) and related occupation, treatment classification and funding information in the course of implementing the earlier recommendations outlined above and as a means of 'strengthening the governance of health and health care' (p. 38), achieving 'a sustainable health workforce for the future' (p. 40) and 'fostering continuous learning in the health care system' (p. 41).

Alternative Recommendation 5: Flick the switch to vaudeville.

In my experience, those engaged in health promotion need to lighten up, because you can lead a horse to water but you can't make it drink. Personally, I liked the Colgate lady who used to talk about tough teeth and have also learned a great deal about mental health from pop songs, beginning when Rogers and Hammerstein lyrics and other shows provided a generation of female children with a more real understanding of the meaning of the declaration of human rights and better female role models than lawyers ever could.

(To me the all-American singing Jews are tops. Some may also feel like cheaper Freud.)

In relation to the NHHRC report, for example, one remembers Kinky Friedman who sang that you can pick your nose or pick your friends but you can't flick your friends off the saddle. 'They don't make Jews like Jesus any more' is good too. Similarly, in the current international context, one remembers Randy Newman's great prophetic album 'Sail Away' from 1972, in which the song 'Political Science' discusses the American psyche and its relationships with others. It is reproduced below. One wonders, for example, if many already know or would appreciate it in Iran and other parts of the axis of evil or semi-evil outside the US. Ahem. (She sings).

> No-one likes us, I don't know why,
> We may not be perfect, but heaven knows we try
> And all around, even our old friends put us down
> Let's drop the big one, and see what happens.
> We give them money, but are they grateful?
> First they're spiteful; then they're hateful
> They don't respect us, so let's surprise them
> We'll drop the big one and pulverize them
>
> We'll save Australia; don't wanna hurt the kangaroo
> We'll build an all-American amusement park there
> They've got surfing too.
> Boom goes London! Boom Paree!
> More room for you and more room for me
> And every city, the whole world round, will just be another American town
> Oh how peaceful it will be; we'll set everybody free
> You'll have a Japanese kimono, Baby, Italian shoes for me
> They all hate us anyhow, so let's drop the big one now!

However, one hopes we will soon be past the old and current unpleasantness, towards healthier communication and development as required in the Alma Ata Declaration which also suggests 'a better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts'. The Declaration further states:

> A genuine policy of independence, peace détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

Talk to the animals? I have always found that doing so is always the best way forward, which probably also seems an extremely strange idea to the average man. Please don't ask me to see a psychiatrist again. My colleagues upset me seriously through that.

In this broad health and communication context the NHHRC and universities ideally learn from the Australian Broadcasting Commission (ABC) view of self regulation and

from the multicultural approach of the SBS code of conduct. The latter states as its purpose: 'SBS leads the exploration of the real, multicultural Australia and our diverse worlds. This means:

- We are a pioneering broadcaster, going places that other broadcasters avoid; and
- We reflect real, multicultural Australia – contemporary Australia is multicultural and multilingual; and
- We explore and connect the diverse cultures and perspectives that make-up the worlds that we live in.'

The SBS code contains many statements like the above. I also answered the ABC's questions, such as those below, admittedly feeling a bit like Peter Cook:

Will there be a role for extended national broadcasting in education and training and particularly in the vocational education and training environment? Yes! You may start with the development of greenhouse gas audit and related green education and employment development strategies, with health and related environment development strategies – or with different development strategies that you like better, such as language and cultural teaching through entertainment. See attached directions and proceed as you consider best. (I would personally like to see Marx, Freud and Dylan recognized as the great modern Jewish prophets of the world's historical materialist and related democratic development traditions. Their legacies shine strongly through much high quality US entertainment culture but have been lost from much US professional discourse, which is collegiate, faux-scientific and ultimately feudal, like the US financial system it drives.)

Should consideration be given to expanding or enhancing services with other countries? Yes! Inform the Premiers the Prime Minister and relevant Ministers that you would like to begin developments, if possible, with the Open University at Milton-Keynes in England, with appropriate production sources in China, (which has the second most spoken language of the world), and with those anywhere else deemed relevant. Ask for their advice and assistance. (See attached related policy discussion and direction.)

What are the likely future training needs of the ABC in a converging media environment? There will be a need for:

- better organized educational and related entertainment product planning, production and dissemination systems
- supporting media content retrieval, acquisition and usage systems
- supporting complaints classification and handling systems so better coordinated education and entertainment delivery are possible across Australia.

Learn from those who currently lead the world in this development direction. God knows who that is. I would ask Google, State Libraries or the Australian Bureau of Statistics.

Can archives be more effectively used and accessed? Yes! Decide your education development direction and ask the Prime Minister (PM), other ministers and premiers for help with the related agenda for sustainable and fair development. The direction is developed in the attached discussions of carbon pollution reduction, healthy development and financial management in Australia and beyond.

Are there ways of enhancing the value of the national broadcasters' services to migrant groups? Yes! - by assisting skills development and education for sustainable development strategies to meet identified and prioritized industry and related community need. Mining, construction and agriculture are three of many related areas of concern.

In a Freudian slip above, I forgot about the army. Don't let that happen to you. Please note I invariably prefer a little marihuana joint to the constant legal and medical wine. I am now off to Broadway to collect my free Tropfest disc and the SMH. Thank you for the opportunity to comment on the NHHRC report. I practiced at Sydney University.