



Australian Government

Department of Health and Ageing



Australian-American Health Policy Fellowship Brochure

2010-11

Application Deadline:
August 15, 2009

Administered by the Australian Government Department of Health and Ageing
in collaboration with The Commonwealth Fund

2010-11 Australian-American Health Policy Fellowship

Overview

On behalf of the Australian Government Department of Health and Ageing, The Commonwealth Fund is pleased to announce the Australian-American Health Policy Fellowships. This program offers a unique opportunity for outstanding, mid-career U.S policy researchers and practitioners to spend up to 10 months in Australia conducting original research and working with leading Australian health policy experts on issues relevant to both countries.

This program is the successor of the Packer Policy Fellowship Program, which ran from 2003-2009.

The Australian-American Health Policy Fellowship has three goals:

- To enable fellows to gain an in-depth understanding of the Australian health care system and policy process, recent reforms, and models for best practice, thus enhancing their ability to make innovative contributions to policymaking in the United States.
- To improve the theory and practice of health policy in Australia and the United States by stimulating the cross-fertilization of ideas and experience.
- To encourage ongoing health policy collaboration and exchange between Australia and the United States by creating a network of international health policy experts.

The Fellowship

The Australian Government Department of Health and Ageing hopes to enrich health policy thinking as Australian-American Health Policy Fellows study how Australia approaches health policy issues, share lessons learned from the United States, and develop an international perspective and network of contacts to facilitate policy exchange and collaboration that extends beyond the fellowship experience.

Australian-American Health Policy Fellowship is open to accomplished, mid-career health policy researchers and practitioners, including, academics, physicians, decision makers in managed care and other private sector health care organizations, federal and state health officials, and journalists.

The Fellowship provides up to \$55,000 (AUD) for terms of six to ten months, with a minimum stay of six months in Australia required.

Focused on issues of common concern to Australian and U.S. policymakers, the fellowships are structured around areas of mutual policy interest, for example: health care quality and safety, the private/public mix of insurance and providers, the fiscal sustainability of health systems, the health care workforce, management and efficiency of health care delivery, and investment in preventive care strategies. (See page 7, “2010-11 Australian-American Health Policy Fellowship Areas of Interest”).

Candidates must complete a formal application, including a project proposal for a study that will inform health policy in Australia and the United States. Proposals should address one of the program's areas of interest and clearly demonstrate:

- the intention to combine research and practical experience;
- relevance to both the United States and Australia;
- achievable outcomes, given the duration of the placement; and
- the potential to advance policy in Australia and the United States.

Candidates may indicate the organizations to which they would prefer to be attached, but final decisions on placements are made by the program's Advisory Committee in Australia.

The deadline for receipt of applications for the 2010-11 fellowship is August 15, 2009.

Applicants may obtain an application online at www.commonwealthfund.org/fellowships

One fellow will be selected annually. Once selected, the Australian Government Department of Health and Ageing will assist the Fellow in undertaking his project. A Departmental Advisory Group will be established for the Fellow and comprises representatives from relevant areas of the Department. This Advisory Group guides and assists the Fellow in his project. Depending on the nature of the project, the Fellow will be based at academic institutions, in Commonwealth or State health departments, or at other health agencies. The Fellow will also have a mentor to supervise their research, provide technical expertise and guidance, and facilitate access to data, colleagues, and organizations.

The 2010-11 Australian-American Health Policy Fellow will arrive sometime between July 2010 and January 2011, depending on their proposed length of stay in Australia and the project they wish to undertake. In addition to undertaking original policy research, the fellow will participate in a program of seminars and policy briefings. These may include seminars, which will include health leaders, senior officials at the Commonwealth and State levels, Ministerial officers, service providers, academics, and other stakeholders in the public and private sectors.

At the end of his/her tenure, the fellow is expected to produce a final report and present project findings to senior government officials and policy experts at a final reporting seminar. From the beginning of his/her fellowship, the fellow will be encouraged to think creatively about dissemination opportunities and vehicles in Australia and the United States, including peer-reviewed journal articles, policy briefings, op-ed articles for major newspapers, testimony before legislative committees, and presentations at professional meetings. Selected papers may be published and disseminated by the Australian Government Department of Health and Ageing and The Commonwealth Fund.

Throughout the fellowship and afterwards, the Fellow will also benefit from established links with the Harkness Fellowships in Health Care Policy and Practice, a parallel program sponsored by The Commonwealth Fund that enables Australian, German, Dutch, New Zealand, Norwegian, Swiss, and U.K. professionals to undertake policy research in the United States and gain firsthand exposure to the U.S. health care system. Since 1998, the program has included over 100

health policy fellows, many of whom have moved into positions of leadership in their home countries.

Australian-American Health Policy Fellows will have opportunities to participate in Harkness alumni activities and become part of this vital health policy network.

The Australian-American Health Policy Fellowship is administered by the Australian Government Department of Health and Ageing, with guidance from an advisory committee consisting of members including from the Department, State government, and academic institutions. Administration of the program in the United States is provided by The Commonwealth Fund, a New York City–based private foundation that supports independent research on health care issues and makes grants to improve health care practice and policy within its mission to promote a high performing health care system.

Selected Fellowship Highlights

“The biggest highlight was watching policymakers respond to new policy directions with innovative transformative ideas. It’s given me greater confidence that good internal as well as imported ideas can take hold in Australia and that we can translate successes into the U.S. context. I expect to watch this process unfold through ongoing collaboration with researchers and individuals that I worked with, over the long term.”

-- Moira Inkelas, Ph.D., 2007-08 Packer Policy Fellow, Assistant Professor of Health Services, UCLA School of Public Health, and Assistant Director, Center for Healthier Children, Families, and Communities

“Studying another system—even one that has its own institutional idiosyncrasies—can be a useful way to get at the important broader issues. The work I started in Australia has been useful for my understanding of the basic economics of insurance. Being at CHERE was a wonderful opportunity professionally. I am currently collaborating with colleagues there on projects related to our shared interests. On a personal level, the year in Australia was a terrific experience for me and my family. We fell in love with Sydney and made lifelong friends.”

-- Thomas C. Buchmueller, Ph.D., 2006-07 Packer Policy Fellow, Waldo O. Hildebrand Professor of Risk Management and Insurance, University of Michigan, Ross School of Business

“The Packer Fellowship was an incredible experience and life-changing in terms of perspective and exposure. I learned a great deal from my research and have established strong ties that will continue well into the future. I continue to be active in the International Medical Workforce Collaborative and have the opportunity to meet with colleagues from Australia and other countries on regular basis.”

-- Valerie A. Hepburn, Ph.D., Interim President, College of Coastal Georgia, and Professor, University of Georgia College of Public Health, Medical College of Georgia, and Georgia State University

**For profiles of all Packer Policy Fellows (2004-2009), please visit:
<http://www.commonwealthfund.org/fellowships>**

The Health Care System and Health Policy in Australia

Australia's public health insurance scheme, Medicare, commenced in 1984, provides universal coverage for citizens, permanent residents, and visitors from countries which have reciprocal arrangements with Australia. The aim of the national health care funding system is to give universal access to health care while allowing choice for individuals through a substantial private sector involvement in delivery and financing. Australian Medicare is financed largely from general taxation revenue, which includes a Medicare levy based on a person's taxable income.

Under Australia's federal system of government responsibility, funding and delivery of health services is shared between the Commonwealth (Federal) and the eight State and Territory Governments.

- The Commonwealth Government has a national leadership role in health policy-making and is responsible for key public health, health protection and quarantine services. Its role in service delivery is, however, limited and it operates primarily as a funder/insurer of medical, pharmaceutical and aged-care services. It also plays an important role in regulating and subsidizing private health insurance; as well as contributing funds to support State and Territory Governments' provision of health services.
- State and Territory Governments own and operate public hospitals as well as delivering a variety of mental health, dental, health promotion, school health and community health programs.

The Commonwealth Government's Medicare Benefits Schedule lists a wide range of consultations, procedures, diagnostic examinations and tests, and the Schedule fee applicable for each of these items. Proposed listings of new medical procedures and new technologies on the Schedule are assessed by the Medical Services Advisory Committee on the basis of evidence of safety, cost-effectiveness and of real benefit to patients. Although Schedule fees are used to calculate Medicare benefits entitlements, doctors can charge whatever fee they wish, provided the service is not "bulk-billed". The benefit received by a patient ranges from 75 to 100 per cent of the Medicare Benefits Schedule fee depending on factors such as where and by whom the service was delivered. Any difference between the benefit received and the fee charged must be met by the patient as an out-of-pocket (or "gap" payment). Where a patient or family receives many services in a year, there is a safety net, which reduces their out of pocket cost. When one person's or a family's "gap" payments exceed a certain threshold amount in a calendar year, all further benefits in that year are paid at 80 per cent of the actual fee charged. Some kinds of services are not covered by Medicare benefits, for example cosmetic services, services for which State or Territory governments have been provided with Commonwealth funding, and services covered by workers' compensation insurance.

Doctors can choose to charge a fee which is equal to the patient's benefit entitlement under Medicare. In such cases the patient faces no out-of-pocket costs for the service in question and their benefit is claimed directly by the doctor. Services delivered in this manner, with no patient "gap" payment, are said to be bulk-billed. Typically, more than 70 per cent of all Medicare-

eligible services are bulk-billed although the actual proportion, being a reflection of individual doctors' fees relative to benefits payable, varies significantly between specialties and localities. Until recently Medicare Benefits were only payable in respect of services delivered by medical practitioners but they are now also available in defined circumstances to patients who use practice-based nursing, psychology, dental and other allied health services. Generally such services must be delivered as part of a planned program of care, and specifically requested by the patient's physician, before a benefit can be paid.

Medicines and pharmaceuticals are directly subsidized by the Commonwealth Pharmaceutical Benefits Scheme (PBS). The PBS provides subsidies for about 600 kinds of drugs in nearly 1,500 formulations. Additional drugs are added when assessed as meeting safety, quality, effectiveness, and cost-effectiveness criteria. Most people are required to make a co-payment for subsidized pharmaceuticals.

A mix of public and private sector providers deliver health services. The majority of doctors are self-employed, and a small proportion of doctors are salaried employees of State or Territory Governments. Salaried specialist doctors in public hospitals often have rights to treat some patients in these hospitals as private patients, charging fees to those patients and usually contributing some of their fee income to the hospital. Other doctors may contract with public hospitals to provide medical services.

Australia actively encourages private insurance to supplement public coverage. Private health insurance can cover private and public hospital charges (public hospitals charge only patients who elect to be private patients in order to be treated by the doctors of their choice), and a portion of medical fees for private patients' inpatient services. Private insurance can also cover allied health/paramedical services (such as physiotherapists' and podiatrists' services) and some aids and appliances (such as eye glasses). Private insurance covers 43.1% of the population. Expenditure by private health insurance funds accounts for 7.1% of total health expenditure. The Australian Government encourages Australians to take out private health insurance through a 30% - 40% rebate on premiums, depending on age. The Government has also introduced the Lifetime Health Cover initiative designed to encourage people to take out private hospital coverage early in life and maintain their coverage. People who join a health fund before they turn 31 years old and who stay in private health insurance will pay a lower premium throughout their lives relative to people who delay joining regardless of their health status. People over the age of 30 will generally face a 2% increase in premiums over the base rate for every year they delay joining. Private health insurance in Australia is community-rated. The Government has recently announced a package of changes to private health insurance regulations, including expansion of hospital cover to outpatient and out-of-hospital services, as well as chronic care management for conditions such as diabetes and asthma, and disease prevention measures. There will also be some important consumer information initiatives, e.g., insurers will be required to provide standard product information to help people compare policies and to understand their entitlements under their policies.

Australians enjoy generally good health status. Life expectancy at birth in 2002-04 was 83 years for females and 78 years for males, both of which are among the highest in the world (the equivalent figures for the USA were 80 and 75 years respectively). Australia's infant mortality

rate in 2004 was 4.7 per 1,000 live births, placing it in the middle range among developed countries. In the National Health Survey carried out in 2004–05, 84 per cent of respondents aged 15 years or over assessed their health as good, very good or excellent.

The averages cited above do, however, conceal some significant variations in health status especially as they affect indigenous Australians (Aboriginal and Torres Strait Islands people). For the period 1996–2001 life expectancy for indigenous Australians was estimated to be 59 for males and 65 for females; while the indigenous infant mortality rate was estimated to be about three times that of the non-indigenous population. Such differences can, in part, be attributed to the fact that indigenous Australians are disadvantaged across a range of socioeconomic factors that affect health: they typically have lower incomes, higher rates of unemployment, poorer education achievements and lower rates of home ownership than other Australians. However, such disparities in socioeconomic status do not explain all the variations in health status between indigenous and non-indigenous Australians with the former also having higher levels of smoking and alcohol misuse, and other risk factors such as poor housing and exposure to violence. Australia, in common with the U.S. and other similar developed countries, faces health policy challenges in relation to demographic change, affordability, safety and quality in health care, adoption of new treatment technologies, workforce issues and meeting the needs of special populations. In addition, Australia is currently engaged in policy debate on issues such as the balance between public and private funding and provision of health care; ensuring access to affordable primary care services; better integration of primary and secondary care; prevention and early intervention; reducing disparities in health status between indigenous and non-indigenous populations; and meeting the needs of rural and remote communities.

A long-term national health strategy

A new Commonwealth Government, under the leadership of Prime Minister Kevin Rudd, was elected in November 2007. The Rudd Government is committed to improving the overall health of Australians through improved preventative primary health, increased access to general practitioners and new dental care services. The Government is also committed to reforms to improve the hospital system to ensure Australians are able to access the best possible care when they experience serious illness or disease. The Government will also ensure a greater national medical research effort – particularly into the major disease categories impacting millions of Australian families.

These commitments present great challenges, but provide an opportunity for the Commonwealth to work cooperatively with state and territory counterparts to tackle these complex issues and improve health outcomes for all Australians.

The Rudd Government has already implemented some measures to reform the health system, laying the ground work for future solutions, including:

The National Health and Hospitals Reform Commission will drive the health reform process, covering both immediate and long term change for the health system. The Commission will give particular consideration to a well-qualified and sustainable health workforce into the future and aim to reduce overlap and duplication, including in regulation, between the Commonwealth and states (see: <http://www.health.gov.au/internet/main/publishing.nsf/Content/nhrc-1>)

The recently established **COAG Health and Ageing Working Group** is chaired by the Minister for Health and Ageing, the Hon Nicola Roxon MP, and has representatives from the Commonwealth and all states and territories. The Working Group's task is to oversee collaboration on implementing some of the key election commitments made by the Government.

The Government will also develop **National Primary Health Care Strategy** which will, inter alia, consider how to provide incentives for GPs to practice quality preventative health care, and review the Medicare Benefits Schedule. (see: <http://www.alp.org.au/media/1107/mshea170.php>)

The Commonwealth believes prevention should be front and centre of Australia's health policy. The Commonwealth has committed to a new **National Preventative Health Taskforce** which will be responsible for developing a strategy to tackle the growing burden of chronic disease, with an initial focus on alcohol, tobacco and obesity.

2010-11 Australian-American Health Policy Fellowship Areas of Interest

Applicants will be invited to propose topics of interest to them that they believe will advance the policy agendas of the two countries.

Below are examples of suggested topics around which applicants are encouraged to structure a project proposal. Reflecting the Australian Government Department of Health and Ageing's priorities, they offer opportunities to examine critical Australian health care issues, assess new approaches or innovative models, or compare aspects of Australian health care practice and experience with those of the United States.

- *Quality of Care:*
 - What strategies have been successful in changing physician and organizational behavior to improve quality of care in Australia?
 - What strategies have been successful in changing physician and organizational behavior to improve patient safety and reduce medical errors?
 - What strategies have been successful in involving consumers in decision-making at a national level and to ensure that consumer feedback is used in improving quality at the service delivery level?
 - Why has information technology not been more widely adopted for quality improvement? What are the barriers and policy issues?
 - What innovative models have been developed for providing or coordinating acute and long-term care services for the elderly to increase service responsiveness? How effective have they been?
 - How effectively have initiatives promoted reliable care pathways between primary, acute, and long term care services?

- *Fiscal Sustainability of the Health Care System:*
 - What are the key cost drivers in the Australian health system?
 - What are the main determinants of demand in the Australian system?

- How can Australia improve the use of evidence derived from assessments of new and emerging technologies (including pharmaceuticals) to improve cost efficiency?
 - Do provider payment arrangements help or hinder the development of new approaches to care delivery in line with changing patient needs?
 - Is it feasible to expect medical practitioners to play a more active role in cost-containment and, if so, what approaches are likely to prove effective?
 - What are the key cost drivers influencing pharmaceutical prices? What strategies might be applied to contain growth in outlays on pharmaceuticals?
 - What are the implications of population aging for health care costs in Australia?
 - Are there better ways for the government to achieve the aims of the Life Saving Drugs program? (The program was created to allow some medicines to be subsidized that would not normally qualify for listing on the Australian Pharmaceutical Benefits Scheme).
- *Health Care Workforce:*
 - How are demographic considerations affecting the supply of nurses, physicians and other health professionals (e.g., the aging workforce, changing workforce participation patterns, and technology)? What are the implications for recruitment and retention?
 - How effective are existing policy tools, financial incentives, and organizational arrangements for promoting the most efficient use of the physician and nursing workforces?
 - How can education and training programs be better aligned with workforce needs to ensure not only adequacy of supply but the right mix of skills?
 - How has workforce planning contributed to the development of an appropriate health workforce?
 - Are current regulatory and financing mechanisms appropriate in the context of growing workforce pressures?
 - What approaches could be adopted to align the distribution of medical practitioners more closely with patterns of need, especially in rural and remote communities?
 - What has been the impact of recent changes to allow patients of professionals other than doctors to access Medicare benefits? What are the longer term implications for the cost and quality of health services of such steps towards workforce “substitution”?
- *Investing in Preventive Care Strategies:*
 - What organizational arrangements can be made for physician services to better integrate prevention with curative care services? How could financial incentives be used to support such developments?
 - What is Australia doing to collect and analyze evidence of the impact of preventive health programs on health and health sector costs?
 - How is innovation in preventive care encouraged? What steps can be taken to develop and test new approaches to prevention?
 - What innovative prevention programs have targeted teenagers? How effective have they been?

- *Indigenous/Minority Health:*
 - How effective are mainstream versus targeted services at addressing indigenous/minority health needs?
 - How can differential funding (level and approaches) for under-serviced population groups contribute to these populations' access to and quality of health care services?
 - How effective are existing policy tools, financial incentives, and organizational arrangements for promoting the development of health professionals from indigenous and non-English speaking backgrounds?

- *Health Care Service Delivery: Performance and Efficiency*
 - What steps are State and Territory Governments taking to improve the efficiency of their public hospital services; and how successful are they proving to be?
 - What is the nature and cause of variations in performance (quality, efficiency etc) among public hospitals within and between State and Territory Governments?
 - Is there scope to build aspects of 'pay for performance' into current funding arrangements for primary and/or secondary health care in Australia?
 - How can the performance of primary care practices be assessed; and what approaches might be adopted to encourage widespread adoption of 'best practice'?
 - What are the barriers to further uptake of contemporary information and telecommunications technologies among health care providers in Australia; and how might they be overcome?
 - What lessons might Australia learn from recent successes (and failures) experienced in the USA with regard to managed care?

Interested applicants are encouraged to check the Australian Government Department of Health and Ageing website (<http://www.health.gov.au/>), as well as related website links, for further information on current health care policy initiatives and programs.

The following documents will be of particular assistance in gaining an appreciation of the structure and operation of the Australian health system, as well as the demographic, social, economic, and cultural context in which it operates. These documents also provide an analysis of current issues.

Department of Health and Ageing Occasional Papers

<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-publicat.htm>

Health Care Systems in Transition Australia <http://www.euro.who.int/observatory/Hits/TopPage>.

Fellowship Award

The basic fellowship award is not intended to match fellows' U.S. salaries. Candidates are encouraged, when possible, to obtain paid leave from their home institution. Fellows who receive full salary leave from their home institution will receive a supplemental allowance of \$725/month (AUD). Those on partial salary leave from their home institution will receive a supplemental allowance of \$2,450 (AUD), and those unable to obtain paid leave will receive a

living allowance of \$5,800/month (AUD), which is intended to cover the basic expenses of residence and any tax liability in Australia.0

All fellows, regardless of their salary arrangements, will be eligible for:

- Travel to and from Australia: roundtrip travel from the United States for a fellow.
- Setting-up allowance: \$1,250 (AUD) will be provided for household goods and relocation expenses.
- Baggage allowance: \$1250 (AUD) for a fellow will be provided to cover excess baggage/shipping costs to and from Australia.
- A pool of money will be set aside for project related conferences and seminars. The Fellow **must** obtain the approval of his/her Departmental Advisory Group to attend relevant conferences and seminars, and also travel undertaken in relation to the project. The Fellowship Officer in the Department of Health and Ageing will administer and coordinate this money as required.

Family allowances and travel entitlements are subject to the family member(s) accompanying the fellow for no less than 80 per cent of the Fellowship.

In addition to the above entitlements, fellows with family will be eligible for:

- Travel to and from Australia: roundtrip travel from the United States for a partner and 2 children (only) up to 18 years old.
- Family allowances: an allowance of \$1,500 (AUD) per month is available for a partner to accompany a fellow. (Partners who are employed or who receive a grant or fellowship would not be eligible for the allowance). Further allowances of \$250 (AUD) per month per child are available for children up to 18 years of age.
- Baggage allowance: \$150 (AUD) for a partner and \$250 (AUD) for a partner and children will be provided to cover excess baggage/shipping costs to and from Australia.

Fellows are liable and responsible for payment of income tax in Australia and are strongly advised to check their liability for U.S. income tax payable on their fellowship income. The U.S. Internal Revenue Service does not treat fellowship income as tax-exempt.

Fellows are advised to ensure that they have U.S. health insurance that will cover them and their families for medical care in Australia during the period of their tenure or take out appropriate health insurance coverage in Australia. The Australian Government Department of Health and Ageing and The Commonwealth Fund have no responsibility for insurance against sickness, accident, or death, either for candidates in the United States or for fellows traveling to or from, or residing in, Australia. Fellows are also advised to arrange adequate insurance coverage of their personal possessions when traveling to or from, or residing in, Australia.

Eligibility

The Australian-American Health Policy Fellowship is designed for U.S. health policy researchers and practitioners who are committed to improving health care policy and practice. Successful candidates will demonstrate exceptional personal and intellectual qualities, a high standard of professional achievement, and significant potential to influence health policy in Australia and the United States. There are no formal age limits; however, the focus of the fellowship is on mid-career development, so successful candidates are likely to be in their late-20s to mid-40s.

Candidates should propose research studies that respond to the 2010-11 Fellowship Areas of Interest (see page 7).

All applicants must also meet the following criteria:

- be a citizen of the United States;
- be a mid-career health services researcher or practitioner (e.g., a physician, decision maker in a managed care organization or other private health care organization, government official or policy analyst, or journalist);
- have a demonstrated expertise in health policy issues and track record of informing health policy through research, policy analysis, health services, or clinical leadership;
- have completed a master's degree or doctorate (or the equivalent thereof) in health services research, health administration, health policy, or a related discipline, such as economics or political science; and
- if academically based, be at a mid-career level (e.g., research fellow to associate professor).

Fellowships are not awarded to support basic research or study for an academic degree.

Applications are welcome equally from men and women and members of any ethnic group, regardless of physical abilities.

Application Process

All candidates must complete a formal application, available online at www.commonwealthfund.org/fellowships

The deadline for receipt of applications for 2010-11 fellowship is August 15, 2009. In fairness to all candidates, applications received after the August 15th deadline will not be eligible for consideration in the 2010-11 fellowships cycle.

The application includes:

- an applicant summary sheet;
- statement of professional objectives;

- preliminary research proposal for a policy-oriented research project that fits within the program's priority areas;
- curriculum vitae;
- institutional letter of reference from the director of the applicant's institution or organization;
- two other professional references from senior health policymakers, managers, or researchers who can comment on the applicant's past work and the potential contribution of his or her proposed project; and
- samples of up to 3 published articles or reports.

Information and application materials can be obtained at:
www.commonwealthfund.org/fellowships

For further questions regarding eligibility, the research proposal, or the application process, please contact:

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Review and Selection Criteria

Candidates are selected based on their qualifications and leadership potential; their commitment to improving health care through research and practice; the quality of their research proposal; the relevance of their proposed research to health policy in Australia and the United States; and the strength of their supporting letters.

Applications are reviewed by a screening committee. A limited number of applicants are then shortlisted and invited for interviews with the Australian-American Health Policy Fellowships Selection Committee. Travel expenses to New York City for applicants will be reimbursed by The Commonwealth Fund.

The Fund does not provide critiques of applications that are declined.

Fellowship Conditions

Approval of all fellowship awards is contingent upon: meeting normal Australian immigration and visa requirements; possession of a valid U.S. passport and Australian academic visa; a satisfactory medical examination; and agreement with the Australian Government Department of Health and Ageing on the starting date, length of tenure, mentor and placement, and the fellowship project to be undertaken.

While on tenure, fellows may not perform services for an employer for whom they are on paid or unpaid leave of absence.

As a condition of the fellowship appointment, fellows must agree not to seek permanent appointment or residence in Australia for at least two years following their fellowship.

Timetable

August 15, 2009	Deadline for receipt of applications
October 20, 2009	Notification of short listing for interviews
November 7, 2009	Selection of 2010-11 Fellow
July 1, 2010	Starting date for 2010-11 Fellowship

Whom to Contact for More Information

In the United States:

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