AUSTRALIAN-AMERICAN HEALTH POLICY FELLOWSHIP 2016–17

APPLICATION DEADLINE:
October 2, 2015

The Australian-American Health Policy Fellowship is administered by the Centre for Health Economics Research and Evaluation at the University of Technology, Sydney, in partnership with 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. The Fellowship is funded by the Australian Government Department of Health.

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CONTENTS

AUSTRALIAN-AMERICAN HEALTH POLICY FELLOWSHIP, 2016–17

Overview

The Commonwealth Fund is pleased to announce the 2016–17 Australian-American Health Policy Fellowship. 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. One or more Fellowships may be awarded for 2016–17, subject to approval of funding from the Australian Department of Health.

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 Fellowship program is coordinated by the Centre for Health Economics Research and Evaluation (CHERE) at the University of Technology, Sydney. It is funded by the Australian Government Department of Health. Continuation of the Fellowship program for 2016–17 is subject to continuation of funding from the Australian Department of Health.

The aim of the program is 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.

The Australian-American Health Policy Fellowship is open to accomplished, mid-career health policy researchers and practitioners, including, academics, clinical leaders, decision-makers in health care delivery systems and health care plans, federal and state health officials, and journalists.

For a full 10-month stay in Australia, the fellowship awards up to $87,000 (AUD) which includes a living allowance, relocation expenses, research-related travel and conferences, etc. There is also a family supplement available (e.g., up to $26,000 for a partner and two children). Round-trip airfares to Australia are also covered.

The program for each Fellow is based on a research project which will focus on issues of common concern to Australian and U.S. policymakers, for example: safety and quality; coordination of care; meeting the needs of patients with complex chronic conditions; medical homes; long-term care and aged care; mental health; use of IT; patient-centered care; health care workforce; high-need/high-cost populations; innovations; health care financing; consumer copayments; retail pharmacy; pharmaceuticals; costs and quality; health in federal systems; performance reporting; activity-based funding; prevention; indigenous and minority health (see Fellowship Areas of Interest on page 8). The program also includes a structured series of briefings and seminars led by distinguished Australian researchers, and key policymakers.

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 are encouraged to indicate the organizations to which they would prefer to be attached, but final decisions on placements are subject to approval by the Fellowship program's director in Australia.

The deadline for receipt of applications for the 2016–17 Fellowship is October 2, 2015.

Applicants may obtain an application online at http://www.commonwealthfund.org/grants-and-fellowships/fellowships/australian-american-health-policy-fellowship.

Generally, one or two Fellows are selected annually. Depending on the nature of the project, Fellows will be based at academic institutions or other health agencies. The Program Advisory Committee will guide and assist Fellows in their projects. Fellows also will have a mentor at their host insti-

tution to supervise their research, provide technical expertise and guidance, and facilitate access to data, colleagues, and organizations.

The 2016–17 Australian-American Health Policy Fellows will arrive sometime between September 2016 and January 2017, 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(s) will participate along with selected Australian Health Policy Fellows, in a program of seminars and policy briefings. These may include engaging with 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 their tenure, Fellows are expected to produce a final report and/or a peer-reviewed journal article, and present project findings at a final reporting seminar to policy experts, scholars, and government officials. From the beginning of their fellowship, Fellows will be expected to identify further 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 CHERE and The Commonwealth Fund.

Throughout the fellowship and afterwards, Fellows 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, Canadian, Dutch, French, German, New Zealand, Norwegian, Swedish, 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 150 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 Health Care System and Reform in Australia

The Australian health care system provides universal access to a comprehensive range of services, largely publicly funded through general taxation. Medicare was introduced in 1984 and covers universal access to free treatment in public hospitals and subsidies for medical services; Medicare is now sometimes used to describe the Australian health care system though precisely it refers to access to hospitals (hospital Medicare) and medical care (medical Medicare). Health indicators are strong: for example, Australian life expectancy is the third-longest in the OECD. Nonetheless, there are concerns in common with many developed countries, such as the aging of the population, rising levels of obesity, the prevalence of mental illness, and the burden of chronic disease. There is a dramatic gap in the health indicators for the indigenous population compared with nonindigenous Australians. Health care expenditure represents approximately 9 percent GDP, close to the OECD median but much less than the U.S.

Australia has a federal system of government, with a national (Commonwealth) government and six States and two Territories. At Federation, health remained the responsibility of the States. However, the Commonwealth Government holds the greatest power to raise revenue, so States rely on financial transfers from the Commonwealth to support their health systems. This makes the Australian health care system a complex division of responsibilities and roles across levels of government. It is also marked by a complex interplay of the public and private sectors. The system is financed largely through general taxation. Although there is a specific income tax levy (the Medicare levy), it raises a small portion of total finance. There is also a high reliance on out-of-pocket payments, at 18 percent of total expenditure. Government dominates funding, with 41 percent of total expenditure provided through the Commonwealth, and 27 percent through other levels of government. This gives the Commonwealth the dominant role in policymaking.

The three major components of Medicare cover public hospitals, medical services, and pharmaceuticals. There is a strong and growing private hospital sector. There is government support (subsidies) for private health insurance which covers both hospital inpatient treatment and out-of-hospital services not covered by Medicare.

Public hospitals are owned and operated by the State and Territory Governments which also deliver a variety of mental health, dental, health promotion, school health, and community health programs. Under funding agreements with the Commonwealth, all Australians are entitled to free treatment as a public patient in a public hospital. Public hospitals can also admit private patients, who may face a range of out-of-pocket charges. Private patients have choice of doctor, i.e., the patient selects the doctor who is responsible for their care while the public patient has a treating doctor assigned by the hospital. In practice, these are the same doctors but the doctor charges the private patient directly for their medical care. In general, emergency departments are in public hospitals while teaching, education, and research are found in the larger public hospitals which also tend to a treat a more complex case-mix.

The private hospital sector is growing in size and complexity. There is an increasing presence of for-profit firms operating several hospitals. There is a strong focus on elective surgery, and many day-only facilities are private. Private patients benefit from subsidized insurance (if insured), and the Medicare subsidies for medical services in hospital.

Most medical practitioners are in private medical practice with fee-for-service payments. The Medical Benefits Schedule (MBS) sets a fee for each item or service covered by Medicare, for which the Government pays a fixed rebate. New items added to the MBS are generally assessed for safety, effectiveness and cost-effectiveness, and recommendations for public funding are made by an independent committee. The MBS covers all out-of-hospital medical services, and in-hospital medical services for private patients. However, medical practitioners are free to set their own fees above the MBS fee, thus exposing patients to out-of-pocket charges. Overall, around 70 percent of all medical services are bulk-billed (direct-billed to Medicare), in which case there is no out-of-pocket fee; bulk-billing rates are over 80 percent for primary care attendances, and vary by specialty. The out-of-pocket charges for out-of-hospital services cannot be covered by private insurance, and recent changes have introduced the Extended Medicare Safety Net to provide some protection against high levels of private expenses (though some services, such as cosmetic surgery, are excluded). There is a strong primary medical care sector, and general practitioners (primary care doctors) play a gatekeeping role, i.e., specialist treatment will be covered by Medicare only with a referral from a general practitioner. There is free choice of provider, with no enrollment or restrictions. Until recently MBS payments were limited to services delivered by medical practitioners, but a small number of services 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.

The Pharmaceutical Benefits Scheme (PBS) provides subsidized drugs at a set copayment (at a lower level for welfare recipients). It was established more than 50 years ago and now covers about 600 drugs in over 1,500 formulations. This comprises over 90 percent of all prescriptions written in Australia. Patients therefore pay the set copayment regardless of the cost of the drug they receive. There are safety-net provisions in place to limit total expenditure. There is direct negotiation on price between the Government and the pharmaceutical company. All new items added to the PBS must be recommended for listing by an independent committee, the Pharmaceutical Benefits Advisory Committee (PBAC), based on an assessment of safety, effectiveness, and cost-effectiveness. Australia was the first country to introduce a mandatory requirement for comparative effectiveness and economic evaluation.

Private health insurance funds (and there are many in Australia though the bulk of the market is covered by four funds) are highly regulated. Insurance can cover private treatment in hospital (duplicating the public coverage) and out-of-hospital services not covered by Medicare, for which the majority of services are dental care and physiotherapy. Since 1996, there have been incentives to encourage the purchase of insurance, often described as "carrots and sticks." The carrots comprise a 30 percent rebate on private insurance premiums, effectively reducing the cost. The sticks are an income tax surcharge for higher-income earners without private coverage. Since 2000, there has been a financial incentive to purchase insurance by the age of 30 and to stay with coverage. This is Lifetime Health Cover, an age-related premium based on the number of years after 30 without private insurance. Other than that, premiums are community-rated. From July 1, 2012, access to the rebate has been means-tested, with the full 30 percent applying only to individuals with an annual income less than $84,000 and families less than $168,000.

The improvement of information technology as means of supporting better communication and coordination of care has been widely accepted. There has been a Practice Incentives Program for primary care physicians to adopt IT strategies. Current efforts are focused on the implementation of a Personally Controlled Electronic Health Record and are under the auspices of the National E-Health Transition Authority.

Recent Trends

Although the Australian health system has performed well on many indicators, there are concerns shared with other developed nations about how to reshape the system to meet current and emerging challenges. The aging population and increasing prevalence of chronic conditions require more integrated and coordinated care. New technologies are likely to deliver improvements in many areas, but come at a substantial cost. At the same time, growing government expenditure generally is not matched by increasing revenue.

A broad set of reforms was established under the National Health Reform Agreement of 2011, as a result of lengthy negotiations between the Commonwealth and the States. This redefined respective responsibilities, established a new basis for cost-sharing of public hospitals, boosted public reporting of health system performance, and restructured the framework for primary care. While this was a long way from meeting all the challenges facing the Australian health system, to most informed observers it represented progress and a strong foundation for further reform. A new national government, elected in 2013, has initiated further review and further reform.

Currently, new Primary Health Care Networks are being established to increase the efficiency and effectiveness of medical services and to improve coordination of care, particularly for patients with multiple conditions and at risk of poor outcomes. There is a strong emphasis on supporting and assisting general practices, with the potential to purchase or commission services in areas of need. Selection is taking place through

a competitive tender process. The Primary Health Care Networks, or PHNs, replace a larger number of Medicare Locals which had been created as part of the 2011 reform agreement to coordinate and deliver services.

PHNs (and their predecessor Medicare Locals) should facilitate the delivery of more integrated care. However, the need for integration and coordination has been well recognized and there are programs across the country, though often these are in spite of rather than supported by existing funding and organizational structures. Several successful examples can be found in the Aboriginal health services sector.

The new PHNs will align more closely with the State and Territory organizational arrangements. Local Health Networks for managing and delivering public hospitals and other State health programs were also a feature of the 2011 reform agreement. Prior to this, the States generally had some form of regional structure for coordinating and administering public hospitals; and the new Local Health Networks, therefore, represented varying degrees of reorganization. Of course, reflecting State differences they have been given different names in different States. There has been an increasing emphasis on the States' responsibility as managers of the hospitals and related services.

Activity-based funding (ABF) had been in use across the States in different forms beginning with its introduction in Victoria in 1993. As part of the 2011 reform agreement, the Commonwealth's share of public hospital funding is determined on the basis of ABF. A new agency, the Independent Hospital Pricing Authority (IHPA) has responsibility for determining the nationally efficient price. From 2017–18, the Commonwealth will index its contribution to public hospital funding by the Consumer Price Index and population growth.

Public performance reporting is the responsibility of another new agency, the National Health Performance Authority (NHPA). The performance of public hospitals is reported through the myhospitals website; and the Authority has developed a series of other reports, commencing with primary care. There already is public performance reporting to varying degrees across the States. Again, the challenge is national consistency, and the extent to which this will establish new incentives.

Another important agency is the Australian Commission on Safety and Quality in Health Care. The Commonwealth Government has made clear its intention to reduce the number of agencies to eliminate duplication and secure administrative efficiencies. It is not yet clear how these will be reconfigured.

The health workforce is large and diverse. Historically there has been a maldistribution of the workforce, with rural and remote areas, and outer metropolitan areas being less well served than the cities. A number of strategies have been put in place to encourage building capacity in the rural workforce, particularly for medical practitioners. Health practitioners are trained separately for specific occupations, although many commentators argue that more flexibility in roles will be required in the future.

The Commonwealth Government also has made clear its encouragement for the use of stronger price signals throughout the system as a means of tempering demand. An initial proposal for mandated out-of-pocket payments in primary care was modified and then dropped in the face of extensive opposition. Although the government through Ministerial statements and other reports has reiterated that "doing nothing is not an option," what is to be done is not yet explicit. The Commonwealth Budget is brought down in May and that may provide more information.

The respective roles, responsibilities, and revenue capacities of different levels of government are again in the spotlight, with a review of Commonwealth–State relations under review. The Health Issues paper has posed a series of questions:

- What is the appropriate role of government, as well as nongovernment and private providers, in health care?
- What should we change in the allocation of roles and responsibilities between the Commonwealth and the States and Territories to improve the health of Australians? Why?
- Should any roles be shared? If so, which ones, and how can they be clarified and coordinated to minimize overlap, duplication, and blame-shifting and improve service delivery?
- What aspects of our health care arrangements involving the Commonwealth and the States and Territories are working well and should be maintained or extended?

The review will continue at least throughout 2015 and may lead to substantial change in the financing and organization of health care.

The National Disability Scheme is currently being rolled out through a series of pilot projects. This will provide individualized support to people with permanent and significant disability. It is intended to provide nationally consistent coverage for accommodation, treatment, and income support. However, the speed of implementation will be influenced by the fiscal position of the country.

At this stage, there is a lot of potential for change but also uncertainty about further change in the Australian system. Important work will continue in the development of integrated care, in improving incentives for primary care, in performance reporting, in use of electronic health records and other

information technologies, in promoting quality and safety, and overall in enhancing efficiency and productivity across the system.

For More Information

Recommended sources for more information about the Australian health care system and the current reforms:

Australian Institute of Health and Welfare. 2014. *Australia's Health 2014: The fourteenth biennial health report of the Australian Institute of Health and Welfare*. Australian Institute of Health and Welfare: Canberra.

Deeble JS. 2008. Medicare: Where have we been? Where are we going? *Australian and New Zealand Journal of Public Health* 23:1–7.

Duckett S, Willcox S. 2011. The Australian Health Care System. Oxford University Press.

Hall J. 1999. Incremental change in the Australian health care system. *Health Affairs* 18:95–110.

Hall, J Savage E. 2005. *The role of the private sector in the Australian health care system*, in *The Public–Private Mix for Health*, A. Maynard, ed. Nuffield Provincial Hospitals Trust: London.

The following websites also will be useful:

Commonwealth Department of Health
http://health.gov.au/internet/main/publishing.nsf/Content/Home

Independent Hospital Pricing Authority
http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/home-1

National Health Performance Agency
http://nhpa.gov.au/internet/nhpa/publishing.nsf

Australian Institute of Health and Welfare
http://www.aihw.gov.au/

Australian Commission on Quality and Safety in Health Care
http://www.safetyandquality.gov.au/

National E-Health Transition Authority
http://www.nehta.gov.au/

State and Territory Health Departments

http://www.health.act.gov.au

http://www.health.nsw.gov.au/

http://www.health.nt.gov.au/index.aspx

www.health.qld.gov.au/

www.health.sa.gov.au/

www.dhhs.tas.gov.au/

www.health.vic.gov.au/

www.health.wa.gov.au/

FELLOWSHIP AREAS OF INTEREST

The aim of the Fellowship is to enrich policy thinking. Many topics of interest, development, and the issues around health reform which are current in the United States are equally relevant in Australia. Applicants are invited to propose topics of interest to them that they believe will advance the policy agendas of the two countries. Studies which compare policy development, evaluate strategies, or compare aspects of health care practice are welcomed.

Some suggested broad topic areas are provided here.

Safety and quality
What strategies have been used in Australia to improve safety and quality? How do these compare with U.S. strategies? Have they been successful?

Coordination of care
What strategies have been used to improve coordination and integration of care? Which have been successful?

Medical homes
What lessons are there from the development of medical homes in the U.S. for Australia? How do experiences in managing comorbidities in primary care vary between Australia and the U.S.?

Long-term care and aged care
What are the problems and barriers to improved coordination of primary care and long-term care? Are there innovative programs that have successfully integrated primary care and support services?

Mental health
Is mental health care well coordinated with primary care? How successful are recent programs for reaching at-risk adolescents? What has been the impact of the National Mental Health Strategy?

Patients with complex chronic conditions
How are high-risk patients with chronic conditions identified and managed? To what extent are they cared for by multidisciplinary teams? What kinds of programs support patient self-management? What are the mechanisms for integrating health and social services?

Use of information technology (IT)
How has the Personally Controlled Electronic Health Record been implemented? What is its acceptability? What IT-based strategies have been successful in improving quality of care? To what extent can providers at different sites of care share patient information electronically?

Patient-centered care
What strategies have been successful in developing more patient-centered care? How has consumer feedback been used in improving quality of care? In what ways is IT enabling patient engagement?

Health care workforce
How effective are existing policy tools, financial incentives, and organizational arrangements for promoting the most efficient use of the health workforce or sectors of it? What flexibility is there for substitution across professional groups? How does this differ between Australia and the U.S.? What approaches could be adopted to align the distribution of medical practitioners more closely with patterns of need, especially in rural and remote communities?

High-need/high-cost populations
What approaches have been successfully employed to identify and design programs for high-need/high-cost population groups and vulnerable populations? Are there system approaches which integrate clinical, behavioral, social support, and long-term support services?

Innovations
How to identify breakthrough opportunities, i.e., disruptive innovations that will positively impact the health care system, such as the use of health information technologies to change the way patients are engaged and care is delivered, and how to foster successful development from concept to scale.

Health care financing
What are the challenges in developing payment models? What factors explain variation in health care costs across populations? Are pay-for-performance strategies likely to be effective in Australia? What other incentives should be considered?

Consumer copayments
How does the use of price signals for consumers differ between the U.S. and Australia? In which parts of the system are they used? What is the role for prices in the future? How transparent are the costs of pharmaceuticals and medical services to the consumer, in Australia compared with the U.S.? Does it make a difference to consumers?

Retail pharmacy
How do arrangements for retailing of pharmaceuticals differ between the U.S. and Australia? How are pharmacists developing new approaches to improving care for chronic conditions? For identifying at-risk patients?

Pharmaceuticals
How do approval processes for marketing and funding of pharmaceuticals differ between Australia and the U.S.? What role does comparative effectiveness research play? How are these systems responding to emerging new and expensive drugs and personalized medicines? What strategies are available to address the rising costs of pharmaceuticals?

Costs and quality
How have funding strategies affected attempts to improve quality and reduce costs?

Health in federal systems
What are the particular challenges of reform in a federal system? How are they being addressed? How have they been overcome? How will the review of federal arrangements in Australia affect the health sector? Are there lessons for the U.S.?

Performance reporting
How has performance reporting been implemented in the two countries? What are the levels of awareness in different target audiences for these reports? How useful have the performance measures been for policy development? How do the reports address disadvantaged groups (such as indigenous, low socio-economic groups)?

Activity-based funding
What are the challenges in developing a national payment model? How have incentives changed and what has been the impact? What factors explain variation in health care costs across populations?

Prevention
What strategies have been successful in encouraging preventive care in primary care? In hospitals? In aged care? How have health care systems coordinated with community-based services to improve preventive care? What is distinctive about Australia's approach to health promotion? How have programs addressed the needs of special groups?

Indigenous/Minority health
How effective are mainstream versus targeted services at addressing indigenous/minority health needs? How can differential approaches for under-serviced population groups, including addressing patients' social service and basic resource needs, 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?

SELECTING A HOST INSTITUTION

Applicants are encouraged to consider possible host institutions for their Fellowship program. This should be based on the work program of the institution, the availability of key staff, and the suitability of the selected mentor. The final decision regarding the most appropriate placement will be approved by the program director, with the advice of the Program Advisory Committee.

It is essential that the host institution agree to the publication of the Fellowship project report; this will include agreement to the release of aggregate data where required. The host institution also will be responsible for any approvals by Human Research Ethics Committees.

Most of the following groups are Australian Corporate Members of the Health Services Research Association of Australia and New Zealand. They have indicated their interest in hosting Fellows. Appropriate host institutions will not be limited to this list, but it may serve as an introduction to some of Australia's leading research groups and policy agencies.

Australian Centre for Health Services Innovation (AusHSI), Institute of Health and Biomedical Innovation, Queensland University of Technology, in Brisbane

AusHSI is building capacity for health services research amongst clinicians, and building a culture of cost-effectiveness within health services. AusHSI supports clinicians of all disciplines to do research in partnership with academics; we offer a range of training and skills development courses; and our large team of internal researchers undertakes consulting and advisory services alongside their own grant-funded research.

AusHSI's major research areas are:

- cost-effectiveness for decision-making
- economics
- decision modeling
- implementation science
- health policy development
- epidemiology
- mathematics
- evidence synthesis
- statistics
- funding models.

Key research staff include: Professor Nicholas Graves, Associate Professor Adrian Barnett, Dr. Kate Halton, Dr. Katie Page, Dr. Rosanna Norman, and Dr. Lisa Hall.

For further information see http://www.aushsi.org.au/, or contact Megan Campbell, centre manager, at +61 7 3138 0307, email: megan.campbell@qut.edu.au.

Australian Commission on Safety and Quality in Health Care (ACSQHC), in Sydney

ACSQHC was established in 2006 to lead and coordinate safety and quality improvements nationally. Its functions are specified in the National Health Reform Act 2011, and include:

- formulating, promoting, and monitoring the implementation of standards, guidelines, and indicators relating to health care safety and quality matters;
- advising health ministers on national clinical standards;
- formulating model national schemes that provide for the accreditation of organizations that deliver health care services and relate to health care safety and quality matters; and
- collecting, analyzing, interpreting, and disseminating information relating to health care safety and quality matters.

Key research staff include: Dr. Robert Herkes, Dr. Nicola Dunbar, Ms. Kathy Meleady, Dr. John Turnidge, Dr. Heather Buchan, Ms. Margaret Banks, Dr. Marilyn Cruickshank, Mr. Neville Board, Dr. Suellen Allen, Ms. Catherine Katz, and Ms. Rosio Cordova.

For further information see http://www.safetyandquality.gov.au/ or contact Mike Wallace, chief operating officer, at (02) 9126 3518; email mike.wallace@safetyandquality.gov.au.

Australian Health Services Research Institute (AHSRI), University of Wollongong

AHSRI is a major research facility at the University of Wollongong. AHSRI brings together eight research centres, and is part of the Faculty of Business.

AHSRI aims to improve the management and provision of health and community services in Australia by achieving greater equity in resource distribution, fairer access to services, better continuity within and across the health and community care sectors, and wider use of evidence to assist management decision-making.

In addition to producing robust academic output, the products of AHSRI include practical and expert advice to a variety of government and nongovernment agencies and interest groups.

AHSRI comprises the following eight research centres: Centre for Health Service Development (CHSD); Palliative Care Outcomes Collaboration (PCOC); Australasian Rehabilitation Outcomes Centre (AROC); National Casemix and Classification Centre (NCCC); Australasian Occupational Science Centre (AOSC); Australian Health Outcomes Collaboration (AHOC); Centre for Applied Statistics in Health

(CASiH); and electronic Persistent Pain Outcomes Collaboration (ePPOC).

Key research staff include: Professor Kathy Eagar, Associate Professor Rob Gordon, Professor Kathleen Clapham, Professor Ian Ring, Associate Professor Janette Green, Associate Professor Jan Sansoni, Dr. Malcolm Masso, Ms. Karen Quinsey, Ms. Frances Simmonds, Ms. Jenny McNamee, and Ms. Cristina Thompson.

For further information see http://ahsri.uow.edu.au or contact Elizabeth Cuthbert, business manager, at (02) 4221 5691; email cuthbert@uow.edu.au.

Research School of Population Health, Australian National University

The Research School of Population Health at the Australian National University comprises five centres with a strong track record of identifiable impact in improving health policy and practice.

The School's research and teaching draws on a wide range of disciplines and builds strong links with consumers, communities, practitioners, and policymakers.

The Australian Centre for Economic Research on Health is a multi-university research center focused is on applied health economics research in four main areas: health care financing and insurance; health costs and ageing; the economic burden of illness and injury; and the economics of compensation schemes.

The Australian Primary Health Care Research Institute is designed to provide leadership in improving the quality and effectiveness of primary health care by conducting quality research and promoting best practice. It focuses on important sectoral questions relating to the organization, financing, delivery, and performance of primary health care, including its interaction with public health and the secondary and tertiary health care sectors.

The Centre for Research on Ageing, Health & Wellbeing conducts high-quality, innovative research to develop strategies to optimize wellness over the life course. The focus of the centre's research is concerned with physical, mental, and cognitive well-being, and the social and interpersonal context of population health.

The National Centre for Epidemiology & Population Health aims to improve the population's health through discovery, training, and the development of health policy that promotes equity, a healthy future, and environmental sustainability. The centre's research builds on the disciplines of epidemiology, biostatistics, sociology, anthropology, demography, and integration and implementation sciences.

The National Institute for Mental Health Research aims to improve the mental health of Australians through research, education, and policy development, focusing primarily on depression, anxiety disorders, substance abuse, and bipolar disorder.

For further information see http://rsph.anu.edu.au or contact Ms. Laura Vitler, rsph.executive.support@anu.edu.au.

Bureau of Health Information, in Sydney

The Bureau is a board-governed statutory health organization established to provide independent reports to government, the community, and health care professionals on the performance of the New South Wales public health system. It has project teams of researchers and analysts.

The major research themes are:

- assessing performance in health care systems and organizations;
- methods for measuring variation in hospital and system outcomes;
- patient survey development, analysis, and reporting; and
- the use of linked data in performance assessment and reporting.

Key research staff include: Dr. Jean-Frederic Levesque, Ms. Kim Browne, Dr. Kim Sutherland, Mr. Jason Boyd, Dr. Diane Hindmarsh, and Ms. Lisa Corscadden.

For further information see www.bhi.nsw.gov.au or contact Ms. Kim Browne at + 61 2 9464 4447; email: kim.browne@bhi.nsw.gov.au.

Centre for Health Economics at Monash University, in Melbourne

The major research themes are:

- health outcomes, including the construction of a utility instrument, discrete choice experiments, and life satisfaction measurement;
- the causal determinants of health and life satisfaction;
- priority-setting, particularly in public hospital services;
- evaluation of health programs using experimental and observational data; and
- policy analysis, particularly of pharmaceutical, dental, and medical service public insurance coverage.

There are over 25 research staff and doctoral students.

For further information see http://www.buseco.monash.edu.au/centres/che/, or contact Lynette McGowan at +61 3 9905 0733; email: Lynette.McGowan@monash.edu.

Centre for Health Economics Research and Evaluation at the University of Technology, Sydney

There are a number of research programs under way in the Centre. There is a strong program in economic evaluation (comparative effectiveness research) including assessment for the Pharmaceutical Benefits Advisory Committee and the Medical Services Advisory Committee. A major research theme covers the financing and economics of primary health care, including the use of financial incentives for providers, the impact of out-of-pocket payments, consumer experiences and the issues of consumer choice of provider, and the development of integrated care. The Centre has a major program around the support of cancer clinical trial groups to include economic evaluations in clinical trials. Several other topics cross health services research and applied microeconomics.

Proposals are particularly welcome in the following areas:

- quantitative evaluation of health care policy
- comparative health policy
- use of financial incentives in primary care
- health workforce
- understanding both provider and patient preferences, and the use of discrete choice modeling
- health status measurement
- economic evaluation of pharmaceuticals
- economic evaluation of medical technologies and procedures
- the use of economic analysis in clinical decision-making.

Key research staff include: Professor Jane Hall, Professor Marion Haas, Professor Rosalie Viney, Associate Professor Stephen Goodall, and Associate Professor Kees van Gool.

For further information see www.chere.uts.edu.au, or contact Jane Hall, email: jane.hall@chere.uts.edu.au.

Centre for Health Policy at the University of Melbourne

The major research themes are:

- programs, implementation science, and evaluation
- health economics
- health systems and workforce
- law and public health.

Key research staff include: Associate Professor Margaret Kelaher, Professor Gary Freed, Professor David Dunt, Professor Philip Clarke, and Dr. Marie Bismark.

For further information see http://www.peu.unimelb.edu.au/, or contact Margaret Kelaher at +61 3 8344 0648; email: mkelaher@unimelb.edu.au.

Department of Health Care Management, School of Medicine, Flinders University, in Adelaide

The major research themes are:

- Aboriginal health services and policy;
- patient flow—the modeling and simulation of patient movement within health systems, especially hospitals;
- governance, accountability, and contracting with third-sector organizations, particularly Aboriginal health services;
- cancer survivorship and care;
- hospital care for Aboriginal and Torres Strait Islander people;
- primary health care for Aboriginal and Torres Strait Islander people and other marginalized populations; and
- social health—observational research relating to alcohol use.

Key research staff include: Professor Judith Dwyer, Dr. Mark Mackay, Dr. Angelita Martini, Ms. Kim O'Donnell, and Ms. Janny Maddern.

For further information see http://flinders.edu.au/medicine/sites/health-care-management/, or contact Professor Judith Dwyer at +61 4 0953 0725; email: judith.dwyer@flinders.edu.au.

Health Services and Practice, Faculty of Health, University of Technology, Sydney

The major research themes are aimed at improving health outcomes and health service practice:

- health services management
- maternal and child health
- health workforce and service delivery
- primary health care
- sports and exercise science.

There are also five Centres conducting a broad range of health services research and consultancy projects nationally and internationally:

- Centre for Cardiovascular and Chronic Care
- Centre for Health Services Management
- Centre for Midwifery, Child and Family Health
- WHO Collaborating Centre for Nursing, Midwifery and Health Development
- Australian Research Centre in Complementary and Integrative Medicine.

Key research staff include: Professor John Daly, Professor Elizabeth Sullivan, Professor Christine Duffield, Professor John Adams, Professor Doug Elliott, Professor Caroline Homer, and Professor Aaron Coutts.

For further information see http://www.hsp.uts.edu.au/, or contact Elizabeth Sullivan at +61 2 9514 4835; email: Elizabeth.sullivan@uts.edu.au.

Independent Hospital Pricing Authority, in Sydney

The Independent Hospital Pricing Authority (IHPA) is responsible for the development and implementation of activity-based funding for public hospital services in Australia.

It has no specific research staff. However, its staff are highly skilled in all aspects of activity-based funding of hospital services including ABF classification and coding, pricing models, hospital costing, data, and policy development.

The implementation of activity-based funding for public hospital services across Australia will be progressively advanced over the next few years. This offers excellent opportunities within the research environment to study outcomes associated with national health policy. Data access and analysis forms a key part of the work of IHPA.

For further information see www.ihpa.gov.au, or contact Dr. Tony Sherbon, chief executive officer, at +61 2 8215 1101; email tony.sherbon@ihpa.gov.au.

National Health Performance Authority, in Sydney and Canberra

The National Health Performance Authority is an independent organization set up as part of national health reform in Australia with the role of reporting on the performance of the Australian health care system. Staff at the Authority are responsible for the development of 48 indicators of primary and secondary care, adding contextual information around each indicator to assist in understanding it and using it to improve services.

The major research themes are:

- performance of the Australian health care system, including public and private hospitals, primary care, and population health;
- indicator development for measuring the performance of the health system; and
- research into how information can help improve service delivery.

For further information see http://www.nhpa.gov.au, or contact Michael Frost at +61 2 9186 9253; email: michael.frost@health.gov.au.

DATA SOURCES

It can be difficult in developing a research proposal to understand what data are available. This description is not exhaustive, but is intended to provide an introduction to data sets which are generally available. However, access to many data sets requires approval of your specific project by the data custodians and their relevant ethics committees, so it is important to assess the extent to which the data will be ready to use at the start of your Fellowship. Many host institutions will have data sets or access to data as part of their existing programs of work; therefore, becoming part of an existing program can facilitate getting the data you need for your project.

AUSTRALIAN NATIONAL SURVEYS

Australian Bureau of Statistics (ABS)

www.abs.gov.au

List of Microdata available through the ABS can be found at: http://www.abs.gov.au/websitedbs/D3310114.nsf/home/Expected+and+available+Microdata.

ABS conducts the Australian health surveys program which includes the National Health Survey (NHS) and the National Aboriginal and Torre Strait Islander Survey (NATSIHS). Details of survey content and summary statistics are available on the website. Data from both surveys is publicly available for further analysis in the form of two confidential unit record data files (CURFs). A Basic CURF is available on CD-ROM and through the ABS website, while an Expanded CURF (containing more detailed information than on the Basic CURF) is accessible through the ABS Remote Access Data Laboratory (RADL) system only. Further information about these files, including details of how they can be obtained, and conditions of use, is available on the ABS website. Further information about the most recently available survey data is provided below.

Australian Health Survey

The 2011–13 Australian Health Survey expanded on the previous National Health Survey (NHS) program by adding two new components to the National Health Survey series: a National Nutrition and Physical Activity Survey (NNPAS) and a biomedical collection, which is called the National Health Measures Survey (NHMS). This involved an interview covering demographics, risk factors, health status, medications, chronic diseases, use of health services, and nutrition and physical activity habits. It also included a biomedical component where blood and urine samples were tested for markers of chronic disease. The most recent NHS survey was conducted in 2011–12 (seven previous surveys were conducted in 1977–78, 1983, 1989–90, 1995, 2001, 2004–05 and 2007–08). The 2011–12 survey sampled 20,426 people from 15,565 households from all states and territories and across all age groups. The survey collected information about health status (including long-term medical conditions), health-related aspects of people's lifestyles (such as smoking, diet, exercise, and alcohol consumption), use of health services (such as consultations with health practitioners and actions people have recently taken for their health), and demographic and socioeconomic characteristics.

More detailed information can be found at http://www.abs.gov.au/australianhealthsurvey.

National Aboriginal and Torres Strait Islander Health Survey

The Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) 2012–13 collected information from the Aboriginal and Torres Strait Islander population as part of the Australian Health Survey. It combined the existing ABS National Aboriginal and Torres Strait Islander Health Survey (NATSIHS, previously conducted in 2004–05) together with two new elements—a National Aboriginal and Torres Strait Islander Nutrition and Physical Activity Survey (NATSINPAS) and a National Aboriginal and Torres Strait Islander Health Measures Survey (NATSIHMS). The 2004–05 expanded CURF is currently available via the RADL and the 2012–13 expanded CURF is expected to be available by mid-2015.

More detailed information can be found at http://www.abs.gov.au/australianhealthsurvey.

Patient Experiences in Australia

The ABS Patient Experience Survey is conducted annually and collects data on access and barriers to a range of health care services, including general practitioners (GPs), medical specialists, dental professionals, imaging and pathology tests, hospital admissions, and emergency department visits. It includes data from people who did—and did not—access health services in the previous 12 months, and enables analysis of health service information in relation to particular population groups. Data also are collected on aspects of communication between patients and health professionals. The survey commenced in 2010–11 and has been conducted annually, with the most recent available from 2013–14.

Data are available via the online Tablebuilder. Details of the survey's content and results tables can be found at: http://www.abs.gov.au/ausstats/abs@.nsf/mf/4839.0.

Disability, Aging and Carers Australia

The most recent survey was conducted in 2012 (previously conducted in 1998, 2003, and 2009). The survey is designed to measure the prevalence of disability in Australia, measure the need for support of older people and those with disability,

provide a demographic and socioeconomic profile of people with disability, older people, and carers compared with the general population and to estimate the number of and provide information about people who provide care to people with disability, long-term health conditions, and older people. The survey included people living in private and nonprivate dwellings.

The unit record data are available as a basic CURF on CD-ROM or via the RADL system. For further information go to http://www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0.

Household Expenditure Survey and Survey of Income and Housing, Australia, 2009–10

This survey covers detailed household expenditure including health insurance and health care expenditure. The unit record data are available as a CURF or expanded CURF via the RADL system.

See http://www.abs.gov.au/ausstats/abs@.nsf/mf/6503.0 (user guide).

General Social Survey, Australia, 2010

This survey covers a wide range of social issues including health, disability, and well-being. It includes some questions about community and social support, as well as access to services (including medical) and delays in health care or medicine access because of cost. Over 15,000 households were surveyed. The survey is conducted every four years (since 2002). CURF data is available via the RADL system.

For more information see http://www.abs.gov.au/ausstats/abs@.nsf/mf/4159.0.

National Aboriginal and Torres Strait Islander Social Survey, 2008

The survey collected information from approximately 13,300 indigenous Australians living in private dwellings in remote and nonremote areas, including discrete communities. It provides information on a range of demographic, social, environmental, and economic indicators, including: personal and household characteristics, geography, language and cultural activities, social networks and support, health and disability, education, employment, financial stress, income; transport, personal safety, and housing. CURF data is available via the RADL system.

For more information see http://www.abs.gov.au/ausstats/abs@.nsf/mf/4714.0/.

Other Cross-Sectional Surveys

BEACH

Bettering the Evaluation and Care of Health (BEACH) study is a continuous cross-sectional survey of Australian GPs, collecting clinical information on patients seen in Australian general practice.

BEACH study recruits around 1,000 GPs per year who each record clinical information on 100 consecutive GP–patient encounters. The BEACH study commenced in 1998 and now includes more than 1,300,000 GP–patient encounter records.

Data collected include: characteristics of the GPs, characteristics of patients seen, reasons people seek medical care, problems managed, and for each problem managed (direct link) medications prescribed, advised, provided, clinical treatments and procedures provided, referrals to specialists and allied health services, and test orders including pathology and imaging.

Access to data: The BEACH study is administered by the Family Medicine Research Centre (FMRC) at the University of Sydney. The line records are not available for outside researchers; FMRC staff will undertake a range of analyses and standard reports.

For more information see: http://sydney.edu.au/medicine/fmrc/beach/index.php.

New South Wales Population Health Surveys

The following population health surveys provide ongoing information on health behaviors, health status, and other factors that influence the health of the people of New South Wales.

- The NSW Adult Health Survey is collected through a telephone survey of about 15,000 people from all over NSW. This survey is conducted between February and December each year (since 2002).
- The NSW School Students Health Behaviors Survey is conducted in NSW schools every three years to provide information about the health behaviors and attitudes of secondary school students.
- The NSW Child Health Survey is collected through a telephone survey of about 15,000 people from all over NSW. This survey is conducted between February and December each year.

These data might be available upon request. Further information is available at: http://www.health.nsw.gov.au/surveys/adult/Pages/overview_of_survey.aspx.

Victorian Population Health Survey

The survey was last conducted in 2011–12. Information is collected via computer-assisted telephone interviews on overall self-rated health status, level of psychological distress, body mass index, the presence of chronic diseases, nutrition, physical activity, smoking, and alcohol consumption. Information is also collected on participation in screening for bowel cancer, cervical cancer, breast cancer, high blood pressure, cholesterol, and high blood sugar in addition to community

participation, levels of social support, and connections with others. These data might be available upon request.

For more information see: http://www.health.vic.gov.au/healthstatus/survey/vphs.htm.

Queensland Health Surveys

Since 2009 annual health surveys have been conducted by Queensland Health using computer-assisted relephone interviewing (CATI) methods. Surveys include questions on body mass index, exercise, nutrition, smoking, alcohol consumption, and sun exposure. Questions vary across years. These data might be available upon request.

Further information is available at: http://www.health.qld.gov.au/epidemiology/publications/phs.asp.

South Australian Monitoring and Surveillance System (SAMSS)

SAMSS collects information on health risk factors and chronic diseases. Data collection started in July 2002. Approximately 7,200 interviews have been conducted annually in South Australia across all ages. The survey is conducted by telephone utilizing the CATI (computer-assisted telephone interviewing) system.

For further information see: http://health.adelaide.edu.au/pros/data/samss/.

South Australian Aboriginal Health Survey

In 2012, SA Health completed its first-ever specialized population health survey of Aboriginal people. The main objectives included:

- determining the prevalence of chronic disease and risk factors in the South Australian Aboriginal and Torres Strait Islander population;
- identifying and describing the protective factors for health and well-being; and
- identifying and describing barriers to accessing health services.

For further information see: http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/health+statistics/aboriginal+health+outcome+statistics/south+australian+aboriginal+health+survey.

PANEL SURVEYS

Household Income and Labor Dynamics in Australia (HILDA)

This study collects a broad range of information about family, work, income and economics, and health and well-being. A sample of over 19,000 Australian adults was recruited in 2001; participants complete interviews and self-completed surveys annually. The annual survey includes information about chronic conditions, SF-36 Health Survey, and Kessler-10 Psychological Distress Scale. An additional health module was included in the survey in 2009 and 2013. A module on health insurance and health care utilization was included in 2004, and as part of the health modules in the 2009 and 2013 surveys.

Data access is by application for an individual license or through an institutional license. For further information see: http://www.melbourneinstitute.com/hilda/.

Australian Longitudinal Study on Women's Health

The Australian Longitudinal Study on Women's Health is a longitudinal population-based survey, which began in 1996 and is scheduled to continue until 2016 to examine the health of over 40,000 Australian women over a 20-year period. Participants are surveyed every three years. The surveys cover physical and emotional health (including major diagnoses and SF-36), use of health services, health behaviors and risk factors, time use (including paid and unpaid work), sociodemographic factors, life stages, and key events. There is also the capacity for the survey data to be linked to administrative data.

Data may be made available to collaborating researchers where there is a formal request to make use of the material. Permission to use the data must be obtained from the Publications, Analyses and Substudies (PSA) Committee of the ALSWH. For further information see: http://www.alswh.org.au/.

45 and Up Study

This is a cohort of over 260,000 men and women aged 45 and over who are resident in New South Wales. A wide range of health and health risk information is collected by a mailed survey every five years (commencing in 2006). Additional surveys are sometimes conducted on special topics. The study also has the capacity to link the survey data to administrative data sets including the use of medical services (MBS data), pharmaceuticals purchased (PBS data), use of hospital services (NSW admitted and emergency department), cancer registry, and death records. External researchers may apply for access to the data and will be charged. Access to the linked administrative data is likely to require an application for ethics committee approval, as well as application to the Centre for Health Record Linkage and will involve further charges.

For further information see: https://www.saxinstitute.org.au/our-work/45-up-study/.

The Longitudinal Study of Australian Children

The study involves a representative sample of children from urban and rural areas of all states and territories of Australia. It collects information about a broad range of educational, social, economic, health, development, and family information using self-completed questionnaires and interviews. Data are collected from two cohorts every two years. The first cohort of 5,000 children was aged 0–1 years in 2003–04, and the second cohort of 5,000 children was aged 4–5 years in 2003–04. Study informants include the child (when of an appropriate age) and parents (both resident and nonresident), carers, and teachers. In addition, the study links to administrative databases including: Medicare (medical services used), childcare and literacy, and numeracy data. Researchers can access the unit record data through an individual or institutional license. The current data set includes five waves of follow-up to 2012 (spanning eight years).

For more information see: http://www.growingupinaustralia.gov.au/index.html.

ADMINISTRATIVE DATA

Medicare Australia (national data)

Medicare Benefits Schedule (MBS)

MBS data include all privately provided medical services reimbursed through the Medicare Benefits Scheme but do not include services provided as a public patient in a public hospital. The information collected includes type of service, type of provider, benefit paid by Medicare, and the patient out-of-pocket cost.

Pharmaceutical Benefits Schedule (PBS)

PBS data include all subsidized pharmaceuticals provided under the Pharmaceutical Benefits Scheme. They do not include drugs not listed on the PBS or drugs priced below the patient copayment (prior to 2012). The information collected includes the name of the drug, benefit paid, and patient out-of-pocket cost.

MBS and PBS data may be accessed online for simple data counts and some cross-tabulations at: http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp. Unit record data are generally only made available for studies collecting individual consent but studies which waive the requirement for consent may also be possible under some circumstances. For more information about accessing unit record MBS or PBS data contact statistics@humanservices.gov.au or go to: http://www.medicareaustralia.gov.au/about/stats/index.jsp. For information about studies linking multiple administrative data sets (including MBS and/or PBS) go to: http://statistical-data-integration.govspace.gov.au/.

Statewide administrative data sets

New South Wales

The unit record data from a number of NSW Health administrative data sets can be linked using the Centre for Health Record Linkage (CHeReL), including the following:

- NSW Admitted Patient Data Collection
- NSW Emergency Department Data Collection
- NSW Perinatal Data Collection
- NSW Central Cancer Registry
- NSW Registry of Births, Death, and Marriages death registration data
- ABS Mortality Data.

For more details on each of these data sets and data linkage using the CHeReL visit: http://www.cherel.org.au.

Western Australia

The Data Linkage Branch (DLB) links many data collections from the Department of Health Western Australia (DOHWA) and other agencies. The DLB maintains a set of "core' linkages which are updated on a regular basis.

For more information see: http://www.datalinkage-wa.org/data-linkage/data-collections.

Data sets include:

- Hospital Morbidity Data Collection
- Emergency Department Data Collection
- Mental Health Information System
- Western Australian Cancer Registry
- Midwives Notification System
- Death Registrations
- Birth Registrations
- WA Electoral Commission Records.

Other State-Based Data Linkage Facilities

Victoria
http://www.health.vic.gov.au/hosdata/index.htm

Queensland
http://www.health.qld.gov.au/hsu/

South Australia and Northern Territory
https://www.santdatalink.org.au/

SELECTED FELLOWSHIP HIGHLIGHTS

"The Commonwealth Fund Australian-American Health Policy Fellowship was one of the most rewarding professional experiences of my career. It provided an opportunity to work with and learn from a talented group of Australian researchers. My Fellowship project, based in the Centre for Health Policy at the University of Melbourne, evaluated an innovative strategy to enhance access to medications among Indigenous Australians. The findings have important implications for international efforts to address health disparities. On a personal level, my family and I made wonderful friendships and thoroughly enjoyed life in Melbourne. We can't wait to return some day!"

—Amal Trivedi, M.D., M.P.H.,
2013–14 Australian-American Health Policy Fellow,
Associate Professor, Department of Health Services,
Policy and Practice, Department of Medicine,
Brown University

"The Australian-American Health Policy Fellowship was an outstanding opportunity to learn about a different health care system and culture, as well as a wonderful family experience. I received excellent support from colleagues at the University of Sydney and the Australian Department of Health. Upon my return, the CDC commissioned me to perform a cost analysis of colon cancer screening in the U.S. based on the work I did during my Fellowship in Australia."

—Michael Pignone, M.D., M.P.H.,
2009–10 Packer Policy Fellow,
Division Chief, Division of General Medicine,
Associate Professor of Medicine,
University of North Carolina at Chapel Hill

"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

For profiles of all Australian-American Health Policy Fellows (2010–2015) and Packer Policy Fellows (2004–2009), please visit:
http://www.commonwealthfund.org/fellowships

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 $864/month (AUD). Those on partial salary leave from their home institution will receive a supplemental allowance of $2,920/month (AUD), and those unable to obtain paid leave will receive a living allowance of $6,910/month (AUD), which is intended to cover the basic expenses of residence and any tax liability in Australia.

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: $1,340 will be provided for household goods and relocation expenses.
- Short-term accommodation: $3,200 (AUD)
- Baggage allowance: $1,340 (AUD) for a Fellow will be provided to cover excess baggage/shipping costs to and from Australia.
- Up to $6,950 (AUD) for project-related conferences and seminars. The program for conference and other activities will be agreed between the Fellowship director and the Fellow and mentor at the beginning of the program. The Fellow **must** obtain the approval of the Fellowship director to attend relevant conferences and seminars, and also for travel and other expenses in relation to the project.

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 two children (only) up to 18 years of age.
- Family allowances: an allowance of $1,920 (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 $320 (AUD) per month per child are available for children up to 18 years of age.
- Baggage allowance: $160 (AUD) for a partner and $265 (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 University of Technology, Sydney, the Australian Government Department of Health, 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 Fellowship Areas of Interest on page 8.

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 apply online at: http://www.commonwealthfund.org/grants-and-fellowships/fellowships/australian-american-health-policy-fellowship.

The deadline for receipt of applications for the 2016–17 Fellowship is October 2, 2015.

In fairness to all candidates, applications received after the October 2nd deadline will not be eligible for consideration in the 2016–17 fellowship cycle.

The application includes:

- applicant summary information;
- 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 three published articles or reports.

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

Robin Osborn
Vice President and Director
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The Commonwealth Fund
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Tel: 212-606-3809
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Email: ro@cmwf.org

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 Fellowship Selection Committee. Travel expenses to Washington, D.C., for applicants to attend interviews 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 visa; a satisfactory medical examination; and agreement with the Fellowship director 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

October 2, 2015
Deadline for receipt of applications

November 15, 2015
Notification of short listing for interviews

December 9, 2015
Selection of 2016–17 Fellows

September 1, 2016
Starting date for 2016–17 Fellowship

WHOM TO CONTACT FOR MORE INFORMATION

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