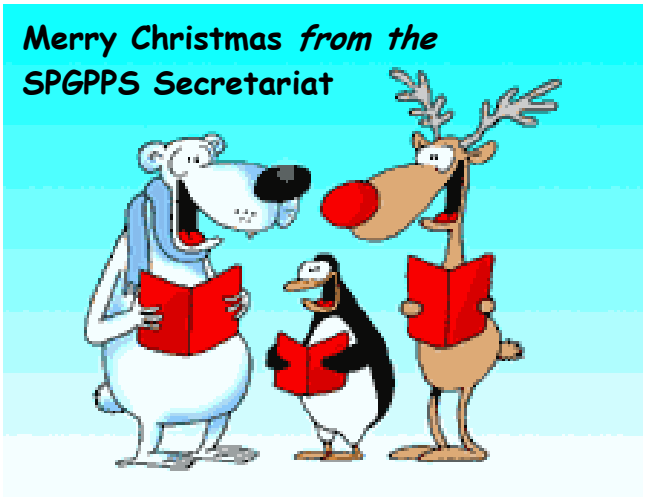
STRATEGIC PLANNING GROUP FOR

SPGPPS

PRIVATE PSYCHIATRIC SERVICES

News

Issue 20 | December 2004



Editor's Desk

Dr Bill Pring

This *SPGPPS News* will be our final edition for 2004 and the SPGPPS Secretariat would like to wish our readers a very Merry Christmas and a happy and safe New Year.

In this edition, we focus on the launch of our new website, the further development of our Centralised Data Management Service (CDMS), and the work of our two main SPGPPS Working Groups, the Innovative Models Working Group and the Information Strategy Working Group.

Innovative Models Working Group (IMWG)

Over the course of its 2004 Meetings, the SPGPPS, has listened to presentations from its stakeholders on their perspectives regarding innovative models of service delivery and funding. ***Health Funds*** gave a detailed analysis of methods of funding, both those in use and those theoretical. ***Psychiatrists*** followed up with the views of the clinician and an examination of the central question. Is innovation necessary?

Consumers and their Carer's produced an eminently practical wish list of the services they would like to receive, and finally ***Hospitals*** gave their perspective on innovative models at our last meeting of the SPGPPS for 2004. Our outgoing Hospital Representative, Ms Sue Williams, details that perspective in this edition and her replacement, Ms Carole Turnbull, outlines her experience of the innovative prospective payment model.

In February 2005, the IMWG will hold a face-to-face meeting in Canberra to consider the collated perspectives of SPGPPS stakeholders.

Information Strategy Working Group (ISWG)

This hard working group has adopted the habit of meeting face-to-face on the day preceding the SPGPPS meetings. It has been invaluable to the work of the group to be able to hold such relatively lengthy meetings, given the very complex tasks involved in improving the quality of information available to the private mental health sector. A short article in this Issue features the proposed changes to the reporting framework for the Standard Quarterly Reports produced for Hospitals and Health Funds by the SPGPPS Centralised Data Management Service.

New version of HSMdb to be distributed to Hospitals in February 2005

A new version of the Hospitals Standardised Measures database application, HSMdb version 1.6, will be distributed to Hospitals participating in the SPGPPS's National Model in February of 2005. This update of the software includes several significant changes:

- A more sophisticated statistical report on the Data Collection process. This report has been designed to assist Hospitals in improving and maintaining adherence to the data collection protocols. Graphs within the report will enable Hospitals to monitor month–to–month changes in collection rates and the timeliness of data entry.
- A new Clinical Review function. This function enables the user to select a set of records for review on the basis of a very wide range of administrative, clinical and service utilisation related attributes. Comprehensive aggregate statistics may then be reported for that set of records.
- A completely revised HCP import and linkage function, including a more user–friendly format for the 'Check links' report.
- Modifications to the data entry functions to enable repeated very brief overnight stays for same-day procedures to be more effectively handled.

These updates to the software are fully documented in an accompanying revision of the HSMdb System Users Guide. Both the Users Guide and a new Implementation Guide now also include a detailed explanation of and reference for the Data Collection Protocol.

National Network

Our National Network of Private Sector Psychiatric Consumers and Carers (National Network) has developed a comprehensive new *Strategic Plan 2004 – 2006*. Copies of the Plan may be downloaded from their own new sub-website at *www.spgpps.com.au*. Further details will be forthcoming in the Network's own newsletter. We anticipate that in 2005, the Network will be working on the trial of a Perceptions of Care Outcome Measure for use in private hospital-based settings.

The Better Outcomes in Mental Health Initiative

At the 26 November 2004 SPGPPS Meeting, Australian Government representatives reported that, the Australian Government had agreed to expand the Better Outcomes in Mental Health Initiative. The election commitment was additional funding of $30 million dollars over four years to address new issues and allow a greater focus on rural and remote primary mental health care.

SPGPPS Meeting Dates and National Forum 2005

The SPGPPS has finalised the dates of it's 2005 Meetings as follows.

1.	39th	SPGPPS Meeting	18 March	Adelaide
2.	40th	SPGPPS Meeting	24 June	Brisbane
3.	41st	SPGPPS Meeting	7 October	Melbourne
4.	42nd	SPGPPS Meeting	2 December	Canberra

Dr Bill Pring is the Editor of SPGPPS News, the official observer for the AMA on the SPGPPS, and Chair of the ISWG.

SPGPPS Website Launch

www.spgpps.com.au

Dr Yvonne White

With the decision to fund the SPGPPS, its Centralised Data Management Service (CDMS) and the National Network of Private Psychiatric Sector Consumers and Carers (National Network) for a further three years, the SPGPPS decided to make the presence of all three entities felt on the World Wide Web.

The new SPGPPS website was launched in December 2004, after eighth months of re-development. The SPGPPS, its CDMS and the National Network can now be found on the Internet at http://www.spgpps.com.au.

The new website has been clearly structured to provide the SPGPPS, CDMS and National Network with their own unique sub-sites (or channels) within the one domain.

SPGPPS sub-site

This channel provides access to valuable information on this unique *Private Mental Health Alliance*, which is dedicated to improving the quality of the mental health services provided by the Australian private health care sector. The sub-site acknowledges the alliance partners that make up SPGPPS, namely:

- Australian Medical Association (AMA)
- The Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- Royal Australia College of General Practitioner;
- Mental health Consumers, and their Carers
- Australian Private Hospitals Association (APHA)
- Australian Health Insurance Association (AHIA)
- Australian Government Department of Health and Ageing
- Australian Government Department of Veterans' Affairs

CDMS sub-site

This channel showcases the SPGPPS's *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Psychiatric Services (National Model).*

The majority of Australian private psychiatric hospitals have implemented the National Model for the purpose of obtaining information to support improvement in the quality, effectiveness and efficiency of the services they provide.

The de-identified data submitted by these hospitals to the CDMS forms the basis for Standard Quarterly Reports that are prepared and distributed to participating hospitals and private health insurance funds. The CDMS sub-site provides a secure log-in for participating hospitals to access the latest versions of all operating manuals, training materials, and data collection protocols.

National Network sub-site

In this channel, the AMA, RANZCP, APHA, AHIA and beyondblue acknowledge and support the integral role played by privately insured consumers and their carers in the improvement of mental health services in the Australian private health care sector.

Co-ordinators have been appointed and committees established in each State and the Australian Capital Territory with valuable work being done through their activities. The National Network is dedicated to effective consumer and carer participation as the driving force in all elements of change in private sector mental health services.

SPGPPS Home Page

The Home Page provides direct links to all participating organisations and other relevant organisations can now easily establish a link on their websites to spgpps.com.au (see home page).

Email addresses

To coincide with the launch of the new website, the email addresses for the SPGPPS Secretariat Staff, that are located in Canberra, have changed to be consistent with the new domain name. They are now as follows.

Ms Bronwen van der Wal
SPGPPS Administrative Officer
bvanderwal@spgpps.com.au

Mr Phillip Taylor
SPGPPS Executive Officer
ptaylor@spgpps.com.au

The email address for the Adelaide-based SPGPPS Principal Information Officer, Mr Allen Morris-Yates, will remain:

allen.yates@bigpond.com

Dr Yvonne White is Chair of the SPGPPS

Further Development of the CDMS Reporting Framework

Mr Allen Morris-Yates

The basic template for the provision of Standard Quarterly Reports (SQRs) by the SPGPPS Centralised Data Management Service (CDMS) was specified in the May 2000 edition of the *SPGPPS National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Psychiatric Services* (hereafter National Model). The content and format of the current SQRs provided to Hospitals and Payers is based on that template with some differences, related to the format of presentation rather than to the actual content of the reports.

Emerging limitations of the paper–based SQR format

As both Hospitals and Payers have begun to make greater use of the SQRs, two competing requirements have emerged.

Firstly, many users find the volume of data presented in the reports to be daunting. They would prefer to see a brief, easily and quickly understood set of numeric and graphical presentations of key performance indicators. Secondly, an increasing number of more sophisticated users have begun asking for more detailed statistics presented against a wider range of comparison groups presented in a manner that allows the close analysis of temporal trends in sub-groups of patients defined on the basis of certain clinical and service utilisation criteria.

These two requirements cannot be met using the same paper-based SQR format. The complexity and size of the current SQR format approaches the limits of what an application such as MS Access can be expected to handle. One solution might be to look for an alternative report engine, however, it is clear that the complexity and size of the current paper-based report format is also approaching the limit of its usefulness. Simply increasing the sophistication and volume of content within the paper-based SQRs is not a viable medium–term option. An alternative development path needs to be identified.

New requirements

During the last 18 months, through the process of preparation of SQRs, consultation with SPGPPS and other working groups, and liaison with Hospitals and Payers, a number of new requirements and issues have emerged. These include:

- A requirement for the MHQ-14 scoring algorithms to be re-developed so as to enable a single total score as well as clinically relevant summary scores to be derived from the 14 items.
- The inclusion of a number of summary statistical indicators as the first section of the SQRs. Each set of statistics are to be reported for both the current Quarter and the current Twelve months.
- The inclusion of additional comparison groups within SQRs. For Hospitals, these include the aggregation of statistics across the Hospital's corporate group, benchmarking partners, regional peers and type of facility (stand–alone or co–located). For Payers, these include the aggregation of member data across Payer groups (for AHSA and ARHG) within each Hospital, all Hospitals within each region and all Hospitals within Hospital corporate groups.
- The provision of reports in an electronic format that enables direct extraction of statistics. Such a facility would substantially enhance both Hospitals' and Payers' capacity to utilise the statistical data contained in the reports. However, for a number of reasons, it would be preferable to redevelop the report structure before proceeding with the development of electronic extracts.

Proposed new report generation model

In summary, whilst the current data warehouse is capable of reliably producing SQRs that meet most of the requirements outlined in the May 2000 edition of the SPGPPS's National Model, it needs substantial revision if we are to move forward. That requirement must be met within the context of reduced human and financial resources. The solution proposed is to redevelop the output side of the CDMS data model so that the limitations and new requirements identified above can be more easily and quickly addressed.

To begin with, the CDMS report structure will be extended so that it includes all the attributes required to represent the major dimensions of aggregation – Accounting periods (Twelve month periods, quarters, months); Casemix and Service classes; Hospitals and Hospital groups; Payers and Payer groups. For convenience these will be referred to as strata.

Within that framework, the major sections of the SQR would then each be represented as a specific data table capable of being conceptualised as a multi-dimensional data cube. (Combining the sections as a single table would be technically feasible but would be very difficult to conceptually and programmatically maintain due to the very large number of data elements it would contain.)

The report generation programmes for Hospitals and Payers would be combined into a single programme that creates a set of tables that contain

all possible strata. From these tables it will be possible to view any specified Hospital's or Payer's report for any required period for which submitted data was available without having to create a separate new set of statistical data tables. For each such report it will be possible to be print it as a paper-based SQR or extract it as an electronic database.

The principal benefits to be derived from the proposed changes are that:

- The maintenance and further development of the SQRs will be simplified.
- The inclusion of additional comparison groups in both Hospital and Payer reports will be simplified.
- The modification of existing content or inclusion of new statistical content in the SQRs will be simplified.
- The provision to Hospitals and Payers of appropriately selected subsets of the aggregate statistical data as an electronic database will be made possible.

This approach also opens a range of new possibilities.

- Given the database version of the report, both Hospitals and Payers could, using basic MS Access query and reporting skills, generate their own graphical representations of the statistical information.
- Hard copy reports would then need only provide a summary view of the very much more detailed content available in the electronic tables. This would likely increase the utility of the SQRs for busy Hospital managers.
- In the longer term, such a set of tables could form the basis for moving the reporting process from its current fixed format to a more flexible model based on a simple web-based interface that allowed users to query the aggregate statistical data. This kind of access to the data could be securely hosted in a protected section of the SPGPPS's website with access only being made available via User ID and password to authenticated users.

Work plan for 2005

The work plan presented here encompasses the major tasks discussed in this article — redevelopment of the MHQ–14 scoring algorithms, the preparation and publication of a clinical reference manual, the redevelopment of the CDMS report generator and the development of a database output format.

Changed contact details - SPGPPS Information Officer

Allen now lives and works from Adelaide. His contact details are as follows:

Email: allen.yates@bigpond.com
Phone: 08 8278 5811
Mobile: 0417 268 386

As always, please do not hesitate to contact Allen if you have any questions about the SPGPPS's National Model, the collection of the HoNOS and MHQ-14, the use of the HSMdb database application, or the content and interpretation of your Standard Quarterly Reports.

Remember, an important part of Allen's job is to provide support for Hospital and Payer staff members in all aspects of the implementation of the SPGPPS's National Model. If you have a question, even if you feel like you should know the answer, it is unlikely you are the only person having trouble with that issue. So your questions also help us to understand what people are likely to need help with and often point to areas where the reports, software or manuals can be improved.

Mr Allen Morris-Yates is the SPGPPS Information Officer

Outline of the SPGPPS Information Officer's Workplan for 2005

Tasks	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Distribute new version of HSMdb (ver 1.6)		♦										
Develop new MHQ-14 scoring algorithms												
Prepare and publish clinical reference Manual						♦						
Redevelop CDMS report generator												
Develop database output format												

Alternative Models of Care

The Hospital Perspective

Ms Sue Williams

A major goal of the SPGPPS has been to promote the uptake of innovative models of care in the private sector. To that end, the SPGPPS established an Innovative Models Working Group (IMWG) to progress this issue. It soon became apparent, however, that there were markedly different views about the practicality, efficacy and feasibility of such services among the SPGPPS stakeholders.

In response, the IMWG has, over the course of 2004, invited providers, funders and consumers and their carers to put their perspectives on alternative models of mental health care and funding to the SPGPPS. At the November 2005 SPGPPS Meeting, private hospitals with psychiatric beds (Hospitals) presented their perspective.

The Hospital Perspective

In recent years, there has been a noticeable increase in the use of mental health services in the private sector due to a number of factors including the following.

1. The introduction of Life-time Health Cover in July 2000 has seen private health insurance rates rise from 30% to 42%, and Health Fund revenue increase by up to 40%.
2. Destigmatisation of mental health.
3. Reduced access to public sector psychiatric beds.

Changing Demographics

A review of AIHW data for the last four years reveals that separations in private psychiatric hospitals decreased by 4.5% whereas the number of bed days increased by 9%, this is considerably less than the increase predicted by Health Funds. There has been an increase in the average and median length of stay during the four-year period. This may be a reflection of increased severity of illness of patients admitted to the private sector. Severity of illness data could only be compared for 2002 and 2003. Both clinician and patients self-reporting measures (HONOS and MQH 14) indicate that patients admitted to private psychiatric hospitals have significant mental health problems.

The most substantial increase in service utilisation has been in the area of ambulatory care, with an overall increase of 24% in the last four years in same-day services. This has been driven by a number of factors including encouragement by Health Funds to substitute day programs for in-patient care, preference of consumers to be cared for in the community, and the preferences of psychiatrists wishing their patients to have access to day programs.

In terms of day programs being an add-on to in-patient care, analysis of one Hospital Group's data indicated that only 40% of in-patients are on referred to day programs.

Along with increased emphasis on day programs, there has been a concerted push to extend the range of services available to consumers to include *outreach services*. The process has, however, been problematic. Feedback from Hospitals indicates that the obstacles to uptake of approved outreach services are as follows.

- ***Health fund approval***. None of the Health Funds in Western Australia have agreed to approve outreach services. Private psychiatric hospitals in Queensland have approved services but have limited number of agreements with Health Funds
- The current ***default rate*** is insufficient to make it viable for hospital operators to run an outreach service.
- ***Economies of scale*** are difficult to achieve in small hospitals.
- ***Access*** to suitably trained staff is difficult particularly in rural and remote areas.
- ***Philosophical differences*** of some clinicians who prefer to have their patients treated as either in-patients or day patients.

The cost of care of the public and private psychiatric sectors was also reviewed. While it was agreed that this data needed to be reviewed with caution. There were no DRG's where private hospital operators appeared to be providing care at excessively high cost. Most care could in fact be delivered at significantly lower cost than the public sector.

The Health of the Current System

Where Hospitals and Health Funds Agree

- Health Funds and hospital operators agree that the current system is not economically sustainable. Health Funds claim that they are finding it increasingly difficult to make a profit whilst Hospitals are argue that they are receiving insufficient funding to keep pace with increases in wages, consumables and drugs.
- There is a lack of incentives to substitute for inpatient care.
- Care needs to be linked to quality/outcomes

Where Hospitals and Health Funds Disagree

Hospitals and Health Funds disagree in several important areas.

- There is a perceived notion that inpatient care is unnecessary.
- That providers drive demand.
- Ambulatory care is not an add-on nor an absolute substitute for in-patient care
- Hospitals and Health Funds agree that quality measures are necessary, but they need to be within a hospital operator's control.
- Change cannot be implemented unilaterally by Health Funds
- Consumers, clinicians, Hospitals and Health Funds need to be part of the solution.

Models of Funding

The various models of funding presented by Health Funds have advantages and disadvantages from the Hospitals' perspective.

Capitation Model

Hospitals view this model as a mechanism for capping outlays. The model rewards substitution but has only been tested in a monopoly environment. Default rates would be an issue in other states where a patient or their clinician could choose to utilise another facility.

This model assumes operators have control over the way clinicians practise i.e; most of the medical staff in private hospitals are independent contractors and cannot be directed about how they should manage their patients, nor should hospital operators be telling expert clinicians how to manage their patients. The model would require indexation to handle unforeseen rises in costs. There is also a risk to Hospital operators that Health Funds may introduce discounting in future periods. The model is purely financially driven and does not address quality issues.

Pay for Performance (P4P's)

This model is based on block funding calculated on previous outlays with Hospitals competing for growth funding. This introduces an element of competition and rewards the most efficient provider. It is a legitimate way of distributing funds, encourages substitution, and makes an attempt to addresses quality, although hospital operators indicated that Key Performance Indicators (KPIs) attached to the model would need to be within the operator's control.

Case Payments

This model involves case payment for an entire episode of care based on the Average Length of stay (ALOS) in the program compared with clinical practice guidelines. The model rewards substitution but has a number of drawbacks. It does not take the severity of illness into account, ignores the inherent variations/subjectivity of diagnoses and does not address quality.

Per Diem

The perspective of Hospitals on the per diem model is similar to that presented by the psychiatrists. The model could be refined through the development of specific programs to improve the treatment of outliers and care of recidivist patients. This could include the following:

- Development of Dialectical Behavioural Therapy (DBT) programs for patient's personality disorder programs. These have proven to be very successful at keeping patients out of hospital, but are usually long-term programs.
- Improved monitoring and coordination of patients with requiring multiple admissions to hospital for addiction problems
- Early intervention programs for young people with mental health problems.
- Expansion of outreach services to include a crisis intervention service as a means of preventing readmissions to hospital.
- Purchase of private psychiatric beds by the public sector to address issues of excess demand in public mental health facilities. This has been successfully implemented in several private Queensland psychiatric hospitals.

Conclusion

Hospitals concluded their perspective by highlighting the following.

- The private sector is performing well.
- Utilisation patterns are multi-factorial.
- Mental illness should not be treated differently from other chronic relapsing disorders.
- There is agreement that the current model is not economically sustainable. However change needs to be incremental and collaborative.
- Clinicians are part of the solution and quality measures are necessary to differentiate performance.

Future Directions

The Chair of the IMWG, Mr Phillip Taylor, will be convening a meeting of the IMWG at AMA House in Canberra on 7 February 2004 to consider the perspectives of all SPGPPS Stakeholders and determine what future work needs to be done.

Ms Sue Williams is the National Psychiatric Manager of Healthscope Limited and may be contacted at swilliams@healthscope.com.au

Alternative Models

Prospective Payment Model

Ms Carole Turnbull

Private mental health services in South Australia (SA) are unique in that Ramsay Healthcare SA (Ramsay Health) is the sole provider. There are three Ramsay Health sites in Adelaide, the Adelaide Clinic at Gilberton, Fullarton Private Hospital at Fullarton and Kahlyn Day Centre at Magill.

Ramsay Health has been involved with the prospective payment model (PPM) since 2000. Under this model of funding, a number of Health Funds have joined together, and based on costings over the previous two years, funding is allocated every month. With that amount of money, Ramsay Health looks after the Health Fund members needs.

The model has allowed for the creation of a broad range of services including the substitution of in-patient services where clinically appropriate.

Advantages of the Model

The relative lack of constraint on the types of services offered through this model has conferred a number of advantages to the service provider.

- A prospective payment system conferring the advantage of a known funding base.
- Payment provision of a full range of psychiatric services.
- Simplified administration.
- Increased choice of services for consumers.
- Greater options for clinicians. Psychiatrists have the option to admit a patient to a day program or community service first. They are not required to admit the patient for an assessment.
- Shift of focus to emphasis on quality, outcomes and benefits to members.
- Involvement of consumers and carers in a quality monitoring committee. The PPM model enhances consumer and carer involvement.

Program Trends

Since the inception of the model, there has been an overall trend downwards in in-patient days, though there has not been a huge change in average length of stay (ALOS). Regardless of the intervention, the ALOS hovers at 14 days.

Notably, the downward trend in the use of in-patient services is matched by the increasing use of ambulatory services. Kahlyn Day Centre was a small 40-bed Hospital with drug and alcohol patients and a few general psychiatric patients until October 2003, when Ramsay Health decided to convert the facility to a day-patient service exclusively

Options

The treatment options at Ramsay Health are wider, but remain clinically focused. The treating psychiatrist can choose an admission and assessment, admission directly into a day program or a community visit. Community visits have steadily increased since the inception of the model.

There has also been an increased use of multi-disciplinary teams. With the appropriate use of social workers, occupational therapists, physiotherapists, psychologists etc, it has been possible to devise programs suited to the individual patient. The increased use of multi-disciplinary teams is likely to continue.

The individualised, flexible delivery of day programs is expected to be a growth area.

New Programs

The Dialectical Behavioural Therapy (DBT) program for personality disorders, based on the Marsha Linehan Model, is currently being trialled. Patients attend this program once a week for 40 weeks. Ramsay Health is awaiting the outcome analysis for its first year of operation. It is hoped that admissions for this group would significantly decrease if not cease altogether.

Other Services

Ramsay Health would like to expand the use of telepsychiatry and community assessments. Both, however, are unfunded and therefore constitute a good-will gesture and a drain on staff and other resources.

Quality Measures

Ramsay Health has a number of quality measures in place to monitor the prospective payment model including the following.

- Consumer Carer Advisory Committee
- External Evaluation – 2002 Patient surveys
- Clinician surveys

There has been no increase in significant events.

Ms Carole Turnbull is CEO of Ramsay Healthcare SA and recently replaced Ms Sue Williams as one of the two Hospitals representatives on the SPGPPS.

How to Contact Your Representatives

National SPGPPS Secretariat

Mr Phillip Taylor
SPGPPS Executive Officer
42 Macquarie Street
BARTON ACT 2600
Phone: 02 6270 5438
Fax: 02 6273 5337
Email: ptaylor@spgpps.com.au

Mr Allen Morris-Yates
SPGPPS Principal Information Officer
42 Macquarie Street
BARTON ACT 2600
Phone: 02 6270 5438
Fax: 02 6273 5337
Email: allen.yates@bigpond.com

Ms Bronwen van der Wal
SPGPPS Administrative Officer
42 Macquarie Street
BARTON ACT 2600
Phone: 02 6270 5438
Fax: 02 6273 5337
Email: bvanderwal@spgpps.com.au

Australian Medical Association

Dr Martin Nothling
Suite 26 – 29
Level 2
101 Wickham Terrace
BRISBANE QLD 4000
Phone: 07 3839 7088
Fax: 07 3832 1629
Email: annyoung@mdeconsultants.com.au

Dr Bill Pring (Observer)
First Floor, Upton House
131Thames Street
BOX HILL VIC 3128
Phone: 03 9895 8000
Fax: 03 9890 1877
Email: bpring@ozemail.com.au

The Royal Australian and New Zealand College of Psychiatrists

Dr Yvonne White (Chair SPGPPS)
66 High Street
RANDWICK NSW 2031
Phone: 02 9399 8459
Fax: 02 9326 4461
Email: drywhite@bigpond.com

Dr Jo Lammersma
529 Port Road
WEST CROYDON SA 5008
Phone: 08 8340 0822
Fax: 08 8346 0252
Email: plammers@adam.com.au

Ms Sharon Brownie
Chief Executive Officer
The Royal Australian and New Zealand
College of Psychiatrists
309 La Trobe Street
MELBOURNE VIC 3000
Phone: 03 9640 0646
Fax: 03 9642 5652
Email: Sharon.brownie@ranzcp.org

The Royal Australian College of General Practitioners

Dr Brian Kable
Anzac Square Medical Centre
280 Ann Street
BRISBANE QLD 4000
Phone: 07 3229 1344
Fax: 07 3221 2694
Email: brian.kable@racgp.org.au

Australian Government

Ms Suzy Saw
Health Priorities and Suicide Prevention Branch
(Mail Drop 37), GPO Box 9848
CANBERRA CITY ACT 2601
Phone: 02 6289 7921
Fax: 02 6289 7703
Email: suzy.saw@health.gov.au

Mr Peter Callanan
Private Health Industry Branch
(Mail Drop 86), GPO Box 9848
CANBERRA CITY ACT 2601
Phone: 02 6289 7453
Fax: 02 6289 8750
Email: peter.callanan@health.gov.au

Mr David Morton
Department of Veterans' Affairs
PO Box 21
WODEN ACT 2606
Phone: 02 6289 6601
Fax: 02 6289 4702
Email: david.morton@dva.gov.au

Consumer Representative

Ms Janne McMahon
15 Samuel Place
FELXISTOW SA 5070
Phone: 08 8336 2378
Email: jmcmahon@senet.com.au

Carer Representative

Mrs Ruth Carson
PO Box 32
FOSTER VIC 3960
Phone: 03 5682 1303
Fax: 03 5682 1380
Email: k.carson@dcsi.net.au

Private Health Insurer Representatives

Mrs Judy Hardy
c/- PO Box 217
UNLEY SA 5061
Phone: 08 8272 7960
Fax: 08 8272 8236
Email: judyh@tne.net.au

Mr Brian Osborne
PO Box 14639
MELBOURNE CITY MC 8001
Phone: 03 9937 4462
Fax: 03 9937 4419
Email: brian.Osborne@hba.com.au

Private Hospitals Representatives

Ms Moira Munro (Deputy Chair SPGPPS)
The Perth Clinic
29 Havelock Street
WEST PERTH WA 6005
Phone: 08 9481 4888
Fax: 08 9278 2977
Email: moiram@perthclinic.com.au

Ms Carole Turnbull
Chief Executive Officer
Ramsay Healthcare SA
33-36 Park Terrace
GILBERTON SA
Phone: 08 8269 8100
Fax: 08 8269 7307
Email: turnbullc@ramsayhealth.com.au