



South East Health
South Eastern Sydney Area Health Service

COMMUNICABLE DISEASES

STRATEGIC DIRECTIONS STATEMENT

1999 - 2002

Acknowledgement: The Steering committee and sub committee working groups were integral to the development of this plan however the efforts of a number of key personnel warrant individual mention. Ms Reta Creegan, Director, Nursing & Community Development, provided the leadership and vision to steer a population health approach to the development of the communicable diseases plan. A/Professor Sue Hanson, Area Manager Nursing Education Research and Development, undertook the complex task of synthesising the volumes of information into a coherent and well considered document. Ms Sue Stewart provided executive support to the committee. Their invaluable contributions are reflected in the high calibre of the document.

Foreword

The SESAHS *Communicable Diseases Strategic Directions Statement* represents a significant milestone in the planning, development and management of communicable disease services in the Area.

A comprehensive consultative approach was adopted for the development of the document, which involved numerous providers and consumers of services. This approach was time consuming though essential, as fundamental to the plan is a philosophical shift from service structures and inputs towards philosophies and outcomes of care. The results of this process are demonstrated by the quality of the document.

The *Communicable Diseases Strategic Directions Statement* was developed under the guidance of the Communicable Diseases Strategic Plan Steering Committee, who contributed considerable time and expertise. Thanks are extended to those involved.

The Communicable Diseases Strategic Directions Statement sets the framework for the future of communicable disease prevention and management in the Area. To achieve the goals and objectives outlined in the document will require on going commitment from all involved in the management and provision of services. I commend this document to you.



Deborah Green
Chief Executive Officer

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Executive Summary

Historically the South Eastern Sydney Area Health Service (SESAHS) has undertaken service planning for communicable diseases on an individual disease basis rather than through an integrated population needs approach. The strategic plan for the period 1999-2002 detailed here provides an integrated and coordinated response to the communicable disease threats to the community of the SESAHS. The scope of the Communicable Disease Strategic Directions Statement incorporates services provided to the resident population of the SESAHS with regard to surveillance, prevention, treatment and long term care of communicable diseases. Specifically, it seeks to integrate, where appropriate, programmes targeted at the needs of people at risk of, or suffering from HIV/AIDS, Hepatitis C and other blood borne infections, sexually transmitted diseases (STD), tuberculosis, vaccine preventable diseases and nosocomial infections. It has been developed within the broad context of national and state health service policies and strategic frameworks.

Integration at the strategic level will flow on to the development of integrated approaches to service planning and delivery, and improving the effectiveness and efficiency of targeted programmes. Integration of specific communicable disease programmes will establish closer planning and evaluation links between services providing care to similar groups of people. Adopting an integrated approach to the planning of services for the prevention, surveillance and where appropriate treatment of communicable diseases provides an opportunity for collaborative case management approaches between government and non-government services and care providers.

Epidemiology of Communicable Diseases in SESAHS

There is an estimated 10,000 persons living with HIV in NSW, of whom 60% or approximately 6,000 individuals live in the SESAHS. Approximately 40% of notifications of new cases of HIV infection in NSW are reported in residents of the SESAHS. Of the new cases in the SESAHS, 93% were males and 5% females. The notification rate for males in the SESAHS is more than three times greater than for males in NSW.

AIDS notifications in NSW appear to have peaked in 1994. Notification of AIDS by the SESAHS was almost 4 times that of the rest of NSW for males and twice as high for females. Crude AIDS notification rates between 1992-96 within SESAHS were highest for males aged between 30 and 34 years (142/100,000). Women aged between 25 and 29 years had the highest notification (4.6/100,000). NSW notification rates for AIDS averaged 7.0/100,000 over the same period.

There is an estimated 40,000 people living with Hepatitis C virus (HCV) in NSW of which an estimated 16% (6,500) live in the SESAHS. The notification rate for Hepatitis C in the LGA of South Sydney was 933.8/100,000 compared to 121/100,000 for NSW.

Notification rates for syphilis and gonorrhoea are both higher in SESAHS males when compared with NSW as a whole. The majority of notifications of gonorrhoea were in males aged between 20 and 39. Gonorrhoea notifications have continued to increase in 1997 and 1998.

Notifications of tuberculosis from SESAHS represent almost 20% of the total notifications in NSW. The notification rate for SESAHS overall is 11.4/100,000.

Strategic Directions

The aims of the SESAHS Communicable Disease Strategic Directions are to:

- Provide best practice standards of surveillance, health promotion, prevention, clinical care and treatment for communicable diseases to all patients.
- Ensure health care providers and the community are informed regarding the most effective available treatments and approaches.
- Ensure the cost-effective delivery of health promotion, prevention and treatment services.

The following goals and objectives have been identified as critical in achieving the goals established for these strategic directions.

1. To provide a framework for an integrated, coordinated and comprehensive approach to the planning, provision and evaluation of services in the field of communicable diseases.

- 1.1. Improve the integration and coordination of communicable disease services and programmes to enhance service effectiveness and to maximise the capacity to reach target or at risk populations.
- 1.2. Develop integrated practice partnerships where aspects of communicable disease have a clear and direct relationship with other policy or programme areas (eg. General Practitioners, Mental Health, Drug & Alcohol, Aboriginal and Torres Strait Islander, Housing)
- 1.3. Develop an integrated approach to the prevention of communicable disease that facilitates the development of partnerships between community based health promotion and communicable disease prevention programmes.
- 1.4. Develop a framework for the evaluation of communicable disease programmes that are population needs based and that incorporate measures of service effectiveness and efficiency.

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- 2. To establish a standard data set and comprehensive database for communicable diseases throughout the SESAHS.**
 - 2.1. Develop and implement a comprehensive Communicable Diseases database that is accessible to all health care services and practitioners; meets consumer and legislative requirements for confidentiality and privacy; provides timely, comprehensive and clinically useful reports and that is supported by a comprehensive structural and procedural framework..
 - 3. To reduce the burden of illness and to improve the quality of life of those already living with communicable diseases in the SESAHS.**
 - 3.1. Develop practice partnerships with consumers, non-Government Organisations and communities to facilitate effective, cooperative effort and joint decision making.
 - 3.2. Adopt an approach to the development of services that recognises the chronic nature of many communicable diseases and that is oriented toward assisting the community maintain optimal health status.
 - 4. To eliminate discrimination in health service planning and delivery and to ensure the protection of the human rights and dignity of people affected by or living with a communicable disease.**
 - 5. To affirm a systems wide commitment to excellence with the provision of communicable disease services.**
 - 6. To establish financial accountability in the allocation of resources within communicable disease services/programmes.**
 - 6.1. Ensure resource allocation is based on established measures of population need.

The implementation of the strategic goals and objectives set out in this document will be undertaken by a formal, accountable and participatory process with defined lines of accountability and communication. The Communicable Diseases Advisory Committee will provide the mechanism and structure for the integration and coordination of communicable diseases services across the area and will enable Area-wide analysis of trends, patient flows and service utilisation. The Communicable Diseases Advisory Committee will report to the SESAHS Health Outcomes Council.

Section 1: Introduction and Rationale

An Integrated Approach to Health Services

The development of the South Eastern Sydney Area Health Service Communicable Disease Strategic Directions Statement has taken place within the broad context of national and state health service policy and strategic frameworks.

NSW Health provides the strategic framework for the delivery of health care services in NSW, outlined in the document *Strategic Directions for Health 1998-2003*(NSWDH,1998) In achieving Better Health Good Health Care the document identifies four key goals of the health system:

- Healthier people
- Fairer access
- Quality health care
- Better value

The integration and coordination of care is seen to be critical to the achievement of these goals and is being pursued as a matter of urgency by NSW Health. A number of factors are driving the integration process. There has been, and will continue to be, an increase in the demand for health care services, particularly as the proportion of older people increases in our communities. At present it is estimated that 40% of the current health care budget is expended on the care of people aged over 65 years. (NSWDH, 1997)

This increase in demand is occurring in an environment of budgetary constraint that is also likely to continue. It is estimated that a move to the population based funding model currently being implemented by the state health department will result in overall reduction in the operating budget of the SESAHS in excess of \$30 million dollars by the year 2003. Alongside these challenges are the system-wide increased emphasis on effectiveness and the need to demonstrate this through the achievement of specific, pre-established outcome measures.

In spite of the policy rhetoric, barriers to integration have developed. Traditionally health care services have been separated into discrete programmes, frequently with different funding sources and lines of accountability. The consequent lack of integration results in a duplication of effort and contributes to difficulties in accurately establishing community need and demand for services. Increased specialisation has also tended to fragment health services, making communication between health services and other community services (government or non-government) difficult.

Impediments to the full integration of services have, in the main, occurred as a consequence of the failure of the Commonwealth-State relationship to fully integrate primary care services (eg general practitioners, community-based organisations, social services) at all levels and at all points in the continuum of care. The full integration and coordination of general practitioners and other primary care services in the community is critical to the achievement of improved outcomes for all people. The failure to acknowledge the central role that such services play in the overall management of the health of the population can contribute to disjointed and poorly coordinated services that are not optimally effective or efficient.

A health care system that lacks integration has a tendency to focus on short term, acute interventions and episodic care rather than on the longer term, ongoing care that is required for many of the communicable disease threats to the health of the population. Services that are not integrated tend to be inflexible, and over a period of time become poorly targeted, failing to accommodate newly emergent trends. Services developed

this way are less amenable to change and can resist attempts to substitute more effective and efficient alternatives for existing forms of care or structures. (*Centre for GP Integration Studies, 1996.*)

The capacity of communicable disease programmes to maintain a flexibility that allows services to respond to the needs of patients as they change due to changes in the incidence, spread and treatment of diseases is critical to their continuing effectiveness. Failure to develop integrated services also increases the possibility of duplication of effort and consequential wastage of resources. This is not to suggest that specialisation, particularly where it is focused on meeting the complex needs associated with some client groups, does not have value. Specialisation provides a focused approach to service delivery and development. The integration of health services needs to be balanced by appropriate specialised services to ensure continued “critical mass” of clinicians and expertise remains available.

The development of integrated care models requires a philosophical shift from the current emphasis on service structures and inputs towards philosophies of care focused on the needs of the individual and on improved outcomes of care. Well-coordinated services arise from a willingness to work cooperatively to achieve common goals for health improvement. Integrated health care services can be described as coordinated, comprehensive, accessible and compatible, and have been demonstrated to improve the effectiveness of health service delivery.

Review of National, State and Area Policies

A fundamental necessity when planning health services on a population needs basis is the availability of timely, comprehensive data that allows the detection of serious short and long term threats to the health of the community. The NSW Health Department issued a discussion document in December, 1997 that outlined its strategy for population health surveillance in NSW. This document makes recommendations for key surveillance areas based on identified gaps in current data collection. These recommendations focus on the improvement of information systems and increasing quantities of data available for surveillance (*NSW Health Strategy for Population Health Surveillance in New South Wales, Dec, 1997*)

The SESAHS has developed a guiding document that establishes the strategic programmes that will contribute to improved health for the residents of the South Eastern Sydney Area. The mission and goals of the SESAHS are defined and communicated through the *Corporate Directions Statement (1998)*. The statement is an overarching strategic framework for the provision of health care services within the SESAHS over the next three-year period until 2000.

Corporate Directions captures and expresses the mission of SESAHS in the slogan “*Good health care, better health*”. The statement establishes the core values and practices that are essential to the achievement of the mission, and describes them as,

- High ethical standards in clinical and business practices.
- Appropriate, accessible and efficiently managed services.
- Accountability and responsibility to the community we serve.
- Commitment to teaching and research.
- Emphasis on planning, evaluation and outcomes measurement.

Corporate Directions also establishes a commitment on an area basis to the:

- development of innovations in health service delivery and organisation,
- development of cooperative partnerships,
- achievement of efficient economic performance, and the
- demonstration of leadership and management.

As well as having been developed cognisant of the broad strategic directions in health care provided at a national and state level, specific communicable disease strategic and policy statements have also been taken into careful consideration in shaping the SESAHS Communicable Disease Strategic Directions Statement. These are briefly discussed here.

HIV/AIDS

The Third National strategy for HIV/AIDS was released in December 1996. It followed an evaluation of the previous strategy, the findings of which were published in a report *Valuing the past....investing in the future: Evaluation of the National HIV/AIDS Strategy 1993-94 to 1995-6*". This report is commonly referred to as the Feachem report.

The Feachem report found that although Australia had, to date, averted an epidemic of HIV/AIDS in injecting drug users, sex workers and heterosexuals, the rate of infection in homosexual men was still unacceptably high. The evaluation report also raised concerns of the possibility of an emerging epidemic in the Aboriginal or Torres Strait Islander (ATSI) population. The high rates of sexually transmitted infection, particularly in remote and rural ATSI communities was seen as both a communicable disease threat in itself and as an indicator of risk of HIV spread in these communities. A major recommendation of the Feachem report was the establishment of links between services targeting similar at risk populations. Specifically links between HIV, Hepatitis C and STD services were proposed.

The 3rd national strategy "*Partnerships in practice: National HIV/AIDS Strategy 1996-97 to 1998-99*" reflects the Commonwealth's commitment to integration of health care services. Specifically, the national strategic document states;

"It has become clear in recent years that the management and control of communicable disease cannot be dealt with in isolation on a problem by problem or disease by disease basis. For quite some time there has been an overlap between public health responses to HIV/AIDS and Hepatitis C..."

(3rd National Strategy, 1996, p3)

The 3rd National HIV/AIDS Strategy is built around the need to establish practice partnerships which reflect the wide ranging impact of HIV infection and the clinical similarities between at risk and target groups for related communicable diseases, most notably HIV/AIDS, hepatitis C and sexually transmitted diseases (STD).

The strategy emphasises that the greater integration of public health policies and services is, in no way, intended to detract from the focus that should be accorded separate HIV/AIDS, hepatitis, STD or other programmes. Indeed it warns that this would not be allowed. The purposes and benefits of the integration of communicable disease programmes, where this is appropriate, will be a strengthening of each program by drawing together and making use of the overlapping and complementary parts.

Specific recommendations of the National HIV/AIDS Strategy suggest that health government and non-government services work in partnership to:

- Reduce the overall number of HIV infections in Australia by reducing the level of HIV infection in established epidemics, minimising the level of infection in emerging epidemics, monitoring and responding to any changes in patterns of HIV infections and maintaining our current successful strategies.

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- Reduce the transmission of Hepatitis C and sexually transmitted diseases within the context of this strategy, focusing on the relationship between HIV/AIDS, Hepatitis C and sexually transmitted diseases generally.
 - Reduce the personal impacts of HIV infection, Hepatitis C and sexually transmitted diseases, including seeking a reduction in levels of discrimination, prejudice and violence directed at people living with and affected by these diseases.
 - Develop the capacity to respond at a community level to epidemics of HIV and Hepatitis C in an appropriate and effective manner, and to
 - Maintain awareness of HIV/AIDS, Hepatitis C and related sexually transmitted diseases within the community and to integrate the national response to these disease threats within an appropriate time frame.

(3rd National Strategy, 1996 p38/39)

Reference has also been made to the “*NSW HIV/AIDS Health Promotion Plan, 1994*”, and the “*Strategic Planning for HIV/AIDS Education in NSW, 1991*”

Hepatitis C

National guidelines for the planning and development of services for hepatitis were provided in the National Hepatitis C Action Plan. In 1994 these guidelines were endorsed by the Australian Health Ministers Advisory Council. The National Hepatitis C Action Plan is being reviewed during 1997/98. Links between hepatitis services and HIV/AIDS are acknowledged in the document and strategies that promote integration where there is obvious overlap are supported. These overlaps are most likely to occur in areas such as surveillance, epidemiology, education and prevention, and to a lesser degree in relation to treatment services.

It is reported that most Hepatitis C infection (HCV) will occur in injecting drug users and the 3rd National Strategy establishes links at a strategic level to the National Drug Strategy to ensure a coordinated approach to service development and delivery. Currently a number of initiatives have been taken up under the National Drug Strategy to address hepatitis risks in injecting drug users. The National Drug Strategy is also currently under review.

The NH&MRC developed a set of guidelines for the detection and management of HCV, which was outlined in a report “*A strategy for the detection and management of HCV in Australia*”. The NH&MRC guidelines were developed as a consequence of the National Hepatitis C Action Plan. The guidelines address several contentious issues, particularly the availability of costly drug therapies. It is hoped that they will provide for improved effectiveness of pre and post-test counselling and appropriate specialist referrals.

In 1995, NSW participated in a National Hepatitis C risk factor study. Data was collected on 5% of all notifications for hepatitis made in that year (n=325). Risk exposure was recorded for 158 of these cases. Risk factors included 65% that reported injecting drug use, 8% sexual contact, 7% blood transfusion before 1990, 7% skin penetration in a non-medical setting and 6% reported no risk exposure. Approximately 11% of cases were found to have evidence of acute infection. (*NSW Health, Public Health Bulletin, 1995, Vol.9 Supplement*)

The National Hepatitis C Councils Education Reference Group presented the following key findings of a study of the needs of people living with HCV (1996).

The study found that the diagnosis of HCV was traumatic and distressing to many people and that general practitioners had little knowledge or information to enable them to provide adequate counselling or support. Depression is reportedly common, and psychological concerns and fears were focused on the uncertainty of the prognosis and outcome. Hepatitis C can profoundly affect an individual's ability to undertake employment and can seriously damage relationships and social networks. Treatment options are limited and currently available treatments have in some cases unacceptable side effects. Treatments are not uniformly available to all HCV infected people. Stigmatisation and discrimination are also fairly widespread in relation to HCV infection. Discrimination may be institutionalised (e. through insurance or superannuation policies) or practiced by health professionals, employers and others. Counselling prior to testing is conducted in an ad hoc manner with too few practitioners spending time to provide information and support (*Hepatitis C Council, 1997*).

The National Coordinated Hepatitis C Education and Prevention Approach (1995) recommended the following strategies:

- an expansion of harm reduction programmes
- improved testing and availability of treatment
- the provision of training, education and information to health care workers
- the provision of training and information to drug user groups, drug and alcohol services, advocacy groups and health care services
- research into the related risk practices for HCV
- provision of drug treatment and substitution programmes

(National Hepatitis C Councils, Education Reference Group, 1997)

Sexually Transmitted Diseases

Sexually transmitted diseases (STD) have been used as markers of unsafe sexual practices that can result in HIV transmission and it is believed that some STD facilitate HIV transmission. The Aboriginal and Torres Strait Islander population has high rates of STD infection and there are concerns that this group is at risk of an HIV epidemic. The health of the Aboriginal and Torres Strait Islander community will be monitored through the Aboriginal and Torres Strait Islander Health Framework Agreements between the various Commonwealth, State and community representative groups.

The NSW Health Department "Guidelines for the Development of Sexual Health Services in NSW" identifies the following aims for sexual health services in NSW:

- minimise transmission of STD
- minimise morbidity from STD
- minimise morbidity associated with sexuality, sexual function and relationship issues
- promote the maintenance and enhancement of sexual health; and
- increase access to services throughout NSW

The guidelines establish areas of responsibility for NSW and for Area Health Services, and identify strategies related to these principles.

Within the framework, Area Health Services are identified as having responsibility for planning and coordinating sexual health services, including assessing the community needs and identifying local priorities. This includes the development of services to Level 3 within each area.

Strategies included, but were not linked to the enhancement of training opportunities; the establishment of formal links between health services and relevant colleges to facilitate GP education; the development of best

practice guidelines, and the development of joint management approaches and service models that incorporate a broad sexual health approach.

Also identified was the need to enhance epidemiological surveillance and to develop information systems and databases that improve capacity to plan and administer sexual health services.

Priority target populations for sexual health services were identified as:

- men who have sex with men
- people living with HIV
- Aboriginal and Torres Strait Islanders
- injecting drug users
- sex workers

Tuberculosis

Strategic directions for the management of tuberculosis on a national level, are outlined in the NH&MRC document “*Towards Elimination of Tuberculosis II, Guidelines and Protocols for Controlling Tuberculosis in Australia*”. This document provides the framework for the development of national guidelines and protocols to assist the states and territories to achieve the long-term goal of the elimination of tuberculosis. This has been defined as less than 1 case of tuberculosis per 100,000 population per annum.

The key strategies for tuberculosis control in Australia have been identified as:

- Active screening among high risk groups to discover persons with tuberculosis infection who can be given preventative therapy, and persons with active tuberculosis for curative treatment.
- Early and accurate diagnosis of persons who present with signs and symptoms of tuberculosis
- Prompt and effective therapy in persons with active tuberculosis

National performance indicators, focused on the measurement and assessment of these goals have been developed.

In Australia, tuberculosis rates are among the lowest in the world. This has been brought about by the combination of the steady downward trend in tuberculosis incidence and the success of the post World War II national tuberculosis campaign. However, there remain high risk groups within our population, and consequently activities to control tuberculosis must be maintained and strengthened.

The main threats to the control of TB in Australia have been identified as:

- inappropriate or inadequate approach to tuberculosis control in overseas born persons, and
- an increase in the incidence of multi-drug resistant tuberculosis.

In New South Wales, the Health Department has produced a document “*Control of Tuberculosis in NSW 1993,1994*” that has guided the State in tuberculosis surveillance and control. The NSW Tuberculosis Advisory Committee (TBAC) has the continuing responsibility for identifying priorities in tuberculosis control and determining policy at a state level.

Within the SESAHS, a Tuberculosis Advisory Committee was established in response to recommendations from the TBAC.

Vaccine Preventable Diseases

The control and eradication of childhood vaccine preventable diseases has been of significant priority to health planners at a national and state level. In 1997 the Commonwealth Department of Health and Family Services produced its strategic framework for immunisation programmes on a national level. The document, “*Immunise Australia; The seven point plan (1997)*” establishes the key strategic initiatives aimed at improving the rates of childhood immunisation. These can be briefly summarised as,

- Establishing financial incentives for parents to immunise their children.
- Encouraging a bigger role for general practitioners.
- Monitoring and evaluating immunisation targets.
- Establishing strategies for improving coverage (eg immunisation days, measles control).
- Facilitating research and education activities to undertake epidemiological, social research and surveillance.
- Introduction of school entry requirements for immunisation.

The 1997 Performance Agreement between the Department of Health and the South Eastern Sydney Area Health Service established targets of:

- 90% immunisation coverage of children aged 1-6 years by 2000.
- 95% MMR immunisation coverage of children aged 10-16 years by 2000, and
- Annual decrease in new cases of congenital rubella syndrome.

Nosocomial Infections

A task force established by NSW Health to examine nosocomial and occupational health issues recommended the following strategic objectives in its report to the Minister (*NSW Nosocomial Taskforce Report , 1996*)

- Establish a Department sponsored nosocomial review team.
- Develop and pilot, through a consortium of public hospitals, appropriate indicators for monitoring nosocomial infection.
- Review the role and functions of infection control practitioners.
- Review and modify information technology systems and coding systems relevant to infection control.

Additionally, the NH&MRC prepared a set of guidelines in 1996 called “*Infection Control in Health Care Settings*”. The Australian Infection Control Association is also currently establishing National Standards for Infection Control.

These documents along with other related documents/reports have contributed to the development of the SESAHS Communicable Disease Strategic Directions Document.

Integrating Communicable Disease Strategies

Historically the SESAHS has undertaken service planning for communicable disease on an individual disease basis rather than through an integrated population needs approach. The strategic plan for the period 1999-2002 detailed here provides an integrated and coordinated response to the communicable disease threats to the community of the SESAHS, in line with recommendations at a national and state level. Specifically, it seeks

to integrate, where appropriate, programmes targeted at the needs of people at risk of, or suffering from HIV/AIDS, Hepatitis C and other blood borne infections, sexually transmitted diseases STD, tuberculosis, vaccine preventable diseases and nosocomial infections.

There are many similarities, as well as unique differences, in the challenges facing each of these discrete programme areas, particularly in relation to the identification of appropriate strategies for the closer integration of primary care services and non-government agencies. Of major concern to all programmes is the lack of comprehensive data collection and reporting mechanisms for the purposes of surveillance, prevention and evaluation.

Integration at the strategic level will flow on to the development of integrated approaches to service planning and delivery, improving the effectiveness and efficiency of targeted programmes. Integration of specific communicable disease programmes will establish closer planning and evaluation links between services providing care to similar groups of people. Adopting an integrated approach to the planning of services for the prevention, surveillance and where appropriate treatment of communicable diseases provides an opportunity for collaborative case management approaches between government and non-government services and care providers. Without integration at a strategic and planning level there are likely to remain inefficiencies and duplication of services at the direct care level.

Several working parties currently exist to develop operational strategies for the control of tuberculosis, nosocomial infections and childhood immunisation within the SESAHS. Where possible these working parties have been consulted and their recommendations incorporated in the development of this Strategic Directions document.

Section 2: Methodology

The Strategic Planning Approach

The scope of the SESAHS Communicable Disease Strategic Directions Statement incorporates services provided to the resident population of the SESAHS with regard to surveillance, prevention, treatment and long term care of communicable diseases. Some services within the SESAHS also provide service on a state-wide basis and this additional role is recognised and supported.

A variety of planning methodologies were utilised in the development of plan. These included:

- A fourth generation evaluation approach (*Guba & Lincoln, 1990*). The approach is particularly suited to the evaluation of services where there are likely to be competing perspectives or viewpoints to be considered. Fourth generation evaluation (*Guba & Lincoln, 1990*) explicitly recognises the need to empower the less powerful groups in order to provide an equivalent voice for them.
- The concept of social need approach (*Bradshaw 1972*). This approach introduced the concept of normative, comparative, expressed and felt need. These needs are defined as :

“normative” need is that which is set (by standardised ratios or benchmarks) by authoritative bodies, or that which is obvious from established trends of “best practice” eg legislated public health surveillance functions

“expressed” need is that which is demonstrated by the pressure of the amount of work which is referred, or which is counted as “current activity”

“comparative need” is that which is determined by comparison of similar characteristics with, say, another Area Health Service or another hospital and

“felt” need is that which is expressed by consumers, staff or politicians.

Utilising this variety of planning techniques provided the opportunity to collaboratively determine direction and focus for the delivery of communicable disease services in SESAHS.

The Strategic Development Process

The need to develop a comprehensive, integrated strategic directions statement for communicable diseases required that a diverse group of health care providers and practitioners, consumer representatives and health service administrators work collaboratively to develop the strategic framework for the area.

A key feature of the utilisation-focused approach used in the first stages of the strategic development process was the wide consultation undertaken with key representatives and interest groups. A workshop was facilitated by an external consultant in June, 1997. Participants at the workshop were asked to contribute their perspective on the gaps in current services, unmet needs in the community or service planning issues, and were also asked to identify strategies to meet these needs. A summary of the report of the workshop is included here and a report of the conclusions and recommendations was produced and distributed (*Cotton, 1997*).

Gaps and Overlaps

The workshop participants identified several areas where gaps or overlaps in services currently exist. These have been grouped according to the phase of intervention (Surveillance, Prevention, Treatment and Long Term Issues), and are briefly summarised here.

1. Surveillance and Data.

- Quality of data suspect - inconsistent definitions
- underestimate of some conditions, compromised, incomplete.
- Lack of regular local data analysis and feedback
- Overlaps in reporting requirements
- Delays in notifications
- Passive vs active surveillance
- Compliance with some notification areas poor (eg nosocomial)
- Linkages to GP's inadequate/incomplete
- Inadequate resources for follow up of high risk client

2. Prevention and Education.

- Lack of comprehensive prevention strategy
- Require improved education of health care workers
- Information accessible relevant to NESB groups
- Services need better integration, clearly defined rolls
- Widespread community education programmes needed
- Some potential for overlap - as yet undefined
- Closer integration with HIV community in planning prevention
- Age/Gender specific programming
- Inconsistent application of guidelines
- Lack of Area wide immunisation strategy
- Inconsistent education/ prevention messages
- Inadequate screening (eg TB)

3. Treatment.

- Inadequate data related to surveillance, Prevention and planning
- Require improved Health care worker education programmes
- Require improved community education programmes (attitudes, treatment options)
- Develop expanded treatment options for specific at risk groups
- Dissemination of information re services
- Greater integration of services, including GP's
- Inadequate support/ counselling services (esp Hep C)
- Issues related to funding - casemix implications, RDF impact and cost of therapy.
- Inadequate integration - especially GP's
- Poor compliance with some patients
- Inadequate services for people with HIV Dementia, Mental health
- Inadequate immunisation programmes (especially Hepatitis)
- Overlap between services (HIV, TB, STD)
- Statewide role for some services
- Inadequate prison services
- Duplication of some services" (HCV/TB/STD)
- Over-use of antibiotics.

4. Long Term Issues.

- require needs assessment of specific groups/communities
- Specific, dedicated funding arrangements
- Services for HIV Dementia
- Education for health care workers, community
- Require rehabilitation/ retraining services
- Better integration
- Ambulatory care/community care focused
- Some competition between service providers
- Adequate resources allocated for future demand (especially Hep)
- Capacity to follow up at risk groups limited.

Key Strategies

The workshop participants also identified key strategies to address the identified gaps or overlaps in services.

1. Surveillance and Data.

Key gap: Compliance /Quality of Data

Strategies: System definition and review
Improve notification/ communication
Review policy for notification
Consider patient (self) notification
Compliance with statutory obligations
Improve capacity to follow up cases

Undertake collaborative analysis.

2. Prevention and Education

Key Gap: Sexual health and related conditions strategy

Strategies: Improve presence of Community Based Organisations(CBO's)
Encourage and support representation of community
Encourage cultural sensitivity/appropriateness
Provide timely/meaningful data
Ensure consistency of message/content
Facilitate interagency cooperation

Key Gap: Lack of Information

Strategies: Establish a central clearing house
Establish a database network
Establish a website directory
Standardise surveillance across the area
Improve information to NESB groups.

Key Gap: Overlap in existing services.

Strategies: Convene working party to define appropriate roles for all agencies/services.

3. Treatment

Key gap: Standardisation of practices/policies

Strategies: Continue to refine protocols
Improve dissemination of information
Develop broadbased data collection

Key gap: Education (Clients/ Health care Workers)

Strategies: Adopt active vs passive approach
Isolate resources (financial/human)
Develop cooperative programmes

Key Gap Communication

Strategies: Review and define appropriate roles/boundaries for all providers.

Key gap: Immunisation/Prophylaxis/Screening

Strategies: Develop area wide policy
Identify target groups
Select appropriate immunisation protocols
Measure outcomes (uptake rate/failure rate/adverse effects).

Key gap: **Delineate Area/Corrections Health Roles**

Strategies: Improve education to prison inmates
Improve voluntary screening programmes
Coordinated care for diagnosis/management
Follow-up liaison
Expanded condom provision/needle exchange

Key gap: **Professional education.**

Strategies: Define core knowledge (evidence based)
Develop consensus approach to treatment services
Develop and disseminate directory of information

Key Gap: **Ambulatory care**

Strategies: determine requirements for ambulatory care for chronic infection.

4. Long Term Issues.

Key gap: **Education for health care workers**

Strategies: Review current knowledge base of HCV
Identify deficiencies in knowledge
Develop programmes based on evaluation
Develop cooperative education programmes

Key gap: **HIV related mental health strategy**

Strategies: Undertake needs assessment
Develop model of best practice
Identify possible sources of funding
Develop training package

Following the consultative workshop, a Communicable Diseases Strategic Directions Steering Committee was established to drive the process of developing a Strategic Directions Statement for the Area. The membership of the steering committee included representatives from the related clinical areas, consumer representatives, Public Health Unit representatives and Area Health service staff. (Appendix 1)

Four clinical working parties were established, each convened by an appropriately experienced nominated member of the Steering Committee. A final group was convened to develop an evaluation framework for the Strategic Directions document. These working parties were organised around generic, continuum based groups, in line with the commitment to establish an integrated Strategic Directions Statement.

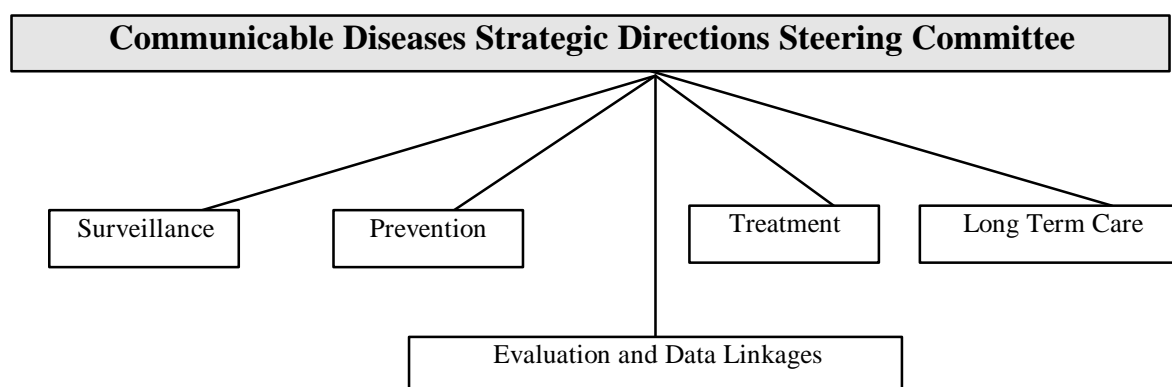
The working parties were:

- Surveillance Working Group
- Prevention Working Group
- Treatment Working Group
- Long Term Issues Working Group
- Evaluation

Each group addressed issues related to each of the major disease related programmes (that is HIV/AIDS, tuberculosis, nosocomial infections, sexually transmitted diseases and vaccine preventable diseases) within their allocated phases of either surveillance, prevention, treatment and long term issues.

The convenors of these working parties reported back to the Communicable Disease Strategic Directions Steering Committee. (Diagram 1)

Diagram 1: Communicable Diseases Strategic Plan Working Parties



A framework for the development of the Strategic Directions Statement was developed and the major recommendations of the working parties were incorporated into the final Strategic Directions Statement document. The Strategic Directions document has been organised by disease/programme to enable a clear transition from strategic planning to operational/business planning at the service level. The triangulation of the perspective used in the planning phase highlighted the areas of commonality and the opportunities for integration and collaboration. (Appendix 2)

Section 3: Population Profile

Demography

Population of the SESAHS

The SESAHS encompasses the Local Government Areas of Botany, Hurstville, Kogarah, Randwick, Rockdale Sutherland, Waverley, Woollahra and approximately 60% of South Sydney and Sydney. (SESAHS Population Profile, 1997)

The estimated resident population of the SESAHS as at 30 June 1996 was 722,117, which represented approximately 12% of the NSW population. Additionally, the area has a significant daily inflow of people to the Central Business District, Kings Cross and Darlinghurst Areas and the industrial areas of South Sydney and Botany. The provision of services to the non-resident population that flows into the Area is a major consideration in the planning of health care services. (ESAHS, HIV/AIDS Strategic Plan, 1993)

Almost 27% of the total population of the area reside in the Sutherland Shire. Sutherland has the lowest population density with 523 persons per sq.kilometre. Randwick with 16.5% of the area population and Rockdale at 11.8% are the next most populous LGA in the area (Table 1). Across the area the population density is highest in the LGA of Waverley (6,860 per km²) and South Sydney (part) (4663 km²). (SESAHS Pop Profile, 1997)

Table 1: The 1996 Census Enumerated Population by LGA

LGA	Males	Females	Persons	%total population
Botany	17267	17435	34702	4.8
Hurstville	31846	33546	65392	9.1
Kogarah	23154	24464	47618	6.6
Randwick	58573	60332	118905	16.5
Rockdale	41040	43807	84847	11.8
Sth Sydney(part)	26820	22956	49776	6.9
Sutherland	95720	98385	194105	26.9
Sydney (part)	8221	6708	14929	2.1
Waverley	29706	31968	61674	8.5
Woollahra	23453	26716	50169	7.0
SESAHS	355800	366317	722117	100.0

Source: SESAHS, Population Health Profile (1997)

Children accounted for 16% of the total population of the SESAHS. In comparison with NSW as a whole, SESAHS has a higher proportion of people aged over 65 years

Table 2: Estimated population 1997 by Age and Sex, SESAHS

Age Group	Male		Female		Person	
	No.	%	No.	%	No.	%
0-4	21064	5.9	19928	5.4	40992	5.7
5-9	18931	5.3	19058	5.2	37989	5.3
10-14	32577	5.4	18478	5.0	37711	5.2
15-19	30480	6.0	20528	5.6	41939	5.8
20-24	33451	9.4	32879	9.0	66330	9.2
25-29	32533	9.1	33538	9.2	66071	9.1
30-34	32577	9.1	32697	8.9	65274	9.0
35-39	30480	8.6	28264	7.7	58744	8.1
40-44	25454	7.1	25612	7.0	51066	7.1
45-49	26090	7.3	25748	7.0	51838	7.2
50-54	22938	6.4	22047	6.0	44985	6.2
55-59	17009	4.8	16510	4.5	33519	4.6
60-64	13091	3.7	12902	3.5	25993	3.6
65-69	13348	3.7	14494	4.0	27842	3.9
70-74	12372	3.5	15468	4.2	27840	3.9
75-79	8283	2.3	11569	3.2	19852	2.7
80-84	5082	1.4	9434	2.6	14516	2.0
85 and more	2874	0.8	7204	2.0	10078	1.4
All ages	356221	100.0	366358	100.0	722579	100.0

Source: SESAHS Population Health Profile (1997)

The greatest growth in population has occurred in the Sydney, Sutherland and South Sydney areas. On an age basis the growth has been greater in the proportion of the population aged over 65 years. The proportion of children has declined over the same period. (Table 2)

Approximately one third of residents of SESAHS were born overseas. Twenty three percent of SESAHS residents were born in non-English speaking countries, higher than NSW average of 16% of residents of NESB. The most common non-English speaking countries of birth were China, Greece, Hong Kong, Italy and Lebanon. About 20% of people in the SESAHS cannot speak English well or cannot speak English at all, and this is similar to the NSW average (20%). (Table 3).

Table 3: Census Enumerated Population by Language spoken at home. SESAHS, 1996

Language	No of People	% total SESAHS population	% total NSW population
English only	469371	68.9	10.7
Chinese language	30383	4.5	19.2
Greek	29346	4.3	32.9
Arabic	14456	2.1	12.6
Italian	12069	1.8	12.1
Macedonian	8706	1.3	30.5
Spanish	8325	1.2	18.0
Russian	5793	0.9	46.4
Indonesian	4637	0.7	38.2
German	3984	0.6	13.9
Tagalog/Filipino	3899	0.6	10.7
Croatian	3761	0.6	14.9
French	3152	0.5	22.6
Hungarian	2776	0.4	29.2
Portuguese	2607	0.4	20.1
Polish	2118	0.3	12.0
Vietnamese	1793	0.3	3.5
Maltese	1718	0.3	9.8
Turkish	1682	0.2	10.4
Serbian	1605	0.2	10.3
Dutch	1030	0.2	10.6
Malay	534	0.1	32.7
Aboriginal languages	92	0.0	8.8
Other	24484	3.6	12.5
Not stated	29899	4.4	17.3
Overseas visitors	13027	1.9	30.9
Total	681248	100.0	12.1

Source: SESAHS Population Health Profile (1997)

According to the 1996 census there were 5,151 Aboriginal and Torres Strait Islander (ATSI) people living in the SESAHS, constituting 0.7% of the total population. Approximately 5% of the ATSI people in NSW reside in the SESAHS and are distributed across all LGA with the largest proportions in the LGA of Randwick and South Sydney. There are identifiable Aboriginal communities in the SESAHS, the largest of which are located at La Perouse and Woolloomooloo, with a smaller transient population located at Kings Cross (Table 4). In the 10-year period from 1981 to 1991 the size of the ATSI population increased by 74%. This is a larger than expected growth that cannot be explained by natural increase. (SESAHS, Aboriginal Health Strategic Plan, 1996-2000)

Table 4: Aboriginal and Torres Strait Islander population. SESAHS 1996

LGA	Aboriginal and Torres Strait Islander population	Total Population	Aboriginal & Torres Strait Islander people as % of the total LGA pop.
Botany	488	34702	1.4
Hurstville	335	65392	0.5
Kogarah	159	47618	0.3
Randwick	1379	118905	1.2
Rockdale	352	84847	0.4
Sth Sydney (part)	1012	49776	2.0
Sutherland	965	194105	0.5
Sydney (part)	97	14930	0.6
Waverley	242	61674	0.4
Woollahra	122	50169	0.2
SESAHS Total	5151	722117	0.7

Source: SESAHS Population Health Profile (1997)

Socio-economic Characteristics

Social Indicators are not consistent across all LGA in the area and there are several key differences between some LGA in relation to socio-economic status. The SESAHS includes suburbs that are affluent as well as some that are relatively deprived. The residents of the more affluent suburbs located in the LGA of Woollahra, for example, have average income double that of the rest of NSW and are almost twice as likely to have private health insurance. Almost half of all residents are employed as managers/professionals and only one third as many are poor English speakers. At the other end of the socio-economic scale the residents of the LGA of Botany, and Sydney (part) are more likely to be labourers/machine operators, renting public housing. They are less likely than other NSW residents to have private insurance and have higher levels of unemployment than the rest of the state (Table 5)

In the LGA of Sydney there are significantly more frail aged (>75yrs) people living alone when compared with either the rest of SESAHS or the state.

In the southern sector of the SESAHS residents of Rockdale LGA have a higher proportion of poor English speakers, more people employed as labourers/machine operators and less private health insurance than NSW on average. (Table 5)

According to the 1996 Census, SESAHS residents in general had higher levels of education, income and lower unemployment rates than NSW on average. SESAHS residents also had higher than state average private sector rental and lower public housing rates. SESAHS also has higher level of private health insurance than the NSW average.

When compared to the rest of NSW, overall income is slightly higher in SESAHS, as are the number of privately insured residents. SESAHS has more people renting privately (another indicator of socio-economic status) and less renting public housing than the NSW average. (Table 5).

Aboriginal and Torres Strait Islander people or poor English speakers were the two most disadvantaged groups in SESAHS in terms of employment, income and occupation.

Table 5: Selected socio-economic indicators SESAHS, 1991 &1996.

	Botany	Hurstville	Kogarah	Randwick	Rockdale	South Sydney	Sutherland	Sydney	Waverley	Woollahra ^a	SESAHS	NSW
% aged ≥ 75 ^a	5	7	8	6	8	4	5	2	7	7	6	5
% aged ≥ 65 ^a	13	16	16	13	16	11	12	6	14	15	13	13
% aged < 5 ^a	6	6	6	5	6	3	7	2	5	4	6	7
% 15-64 years unemployed ^b	14	9	11	9	10	13	9	17	8	7	10	11
% aged ≥ 15 without post-school qualifications ^b	50	45	40	35	45	50	40	50	35	32	48	50
% poor English speakers (aged ≥ 5) ^a	9	5	5	4	8	5	1	5	3	1	4	3
Median family income of family with dependent offspring ^b	\$35,001-\$40,000	\$35,001-\$40,000	\$40,001-\$50,000	\$35,001-\$40,000	\$35,001-\$40,000	\$30,001-\$35,000	\$40,001-\$50,000		\$40,001-\$50,000	\$70,001-\$80,000	\$40,001-\$50,000	\$35,001-\$40,000
% > 75 living alone ^b	34	32	30	27	32	35	30	45	31	36	34	31
% employed as Laborers /Machine Operators ^b	31	17	14	15	23	16	13	14	12	6	15	19
% employed as Managers /Professionals ^b	12	23	27	26	18	32	26	32	31	46	27	25
% hospital episodes with private health insurance	18	27	31	27	20	17	37	22	39	58	31	27
% renting privately ^b	24	16	19	29	21	34	11	12	36	31	22	17
% renting public housing ^b	11	4	1	7	3	7	2	10	2	1	4	7

- a. 1996 Census
b. 1991 Census

Source: SESAHS Population Health Profile (1997)

The positioning of health care services across the area needs to be guided by these differences, ensuring that resources are equitably placed where the need is greatest.

Residents of the SESAHS of non-English speaking background are more likely to be unemployed, have lower income levels than residents born in Australia or other English speaking countries. Residents of non-English speaking background are also less likely to be employed in a managerial/professional occupation or to have private health insurance. Those residents of NESB who are aged over 60 are also more likely to be living alone than other elderly people in the SESAHS or in NSW.

It is estimated that there were 990 first-degree homeless persons in SESAHS as at 6th January 1998, although this is an underestimate as non-government funded accommodations were not taken into account. First degree homelessness is categorised as those using refuges, hostels or other types of accommodation specifically for homeless people. According to the DOCS the average occupancy rate is approximately 100% and on occasions some people are turned away because there are no available places. The majority of these people reside in the South Sydney/Sydney LGA.

A further 3,350 people were classified as second degree homeless in 1997. This includes those living temporarily with others and those living in boarding houses, rooming houses and private hotels. The estimate is based on the number of beds in boarding/rooming houses, as the numbers of those living with others cannot be estimated. Of these, the majority (n=1867) are in the South Sydney/Sydney LGA

There are significant populations of sex workers living and working within the Inner and Eastern Sydney areas of the SESAHS. This population includes both male and female sex workers.

Epidemiology

Until 1995, the data for infectious disease notifications were collected in two public health areas, Southern Sydney Area (SSA) and Eastern Sydney Area (ESA). Following the amalgamation of the Southern and Eastern Sydney Area Health Services' the data are now reported for both areas combined.

Notification rates for the following communicable diseases were reported for the combined SESAHS in 1997. (Table 6).

Table 6: Infectious Disease Notifications in SESAHS Public Health Unit Area, NSW, 1997

Condition	SESAHS	NSW
	n	n
AIDS	53	271
Arboviral infection	39	1829
Food borne illness	14	168
Gastrointestinal (institutional)	319	966
Gonorrhoea	294	624
Hepatitis A (acute viral)	216	1444
Hepatitis B (acute viral)	15	50
Hepatitis B (other - lab only)	522	3834
Hepatitis C (acute viral)	3	21
Hepatitis C (other - lab only)	1410	8416
Hepatitis D (unspecified)	2	12
Hepatitis E	2	6
HIV	-	211
Listeria	-	22
Legionnaires	5	34
Malaria	26	168
Measles	18	262
Meningococcal Infection	24	220
Tuberculosis	69	426
Pertussis	519	4286
Syphilis	154	570

Source: Public Health Update Vol 9/No's 1 & 2

HIV/AIDS in the SESAHS

Much of the data here is based on HIV/AIDS notification data or service activity reporting. It is clear however that the true prevalence of HIV may be greater than the data suggest. Notification depends upon the person attending some form of health or community service to be tested. Many people, particularly those in the high-risk groups, may not present for testing and consequently may be invisible to data such as this. These, to date unidentified, HIV infected people can be expected to present at some time and consequently must be taken into account in any prediction of future service needs. Notifications for both AIDS and HIV have declined steadily since 1994. (Table 7)

Table 7: AIDS/HIV Notifications in SESAHS 1992-1996

Condition	1992	1993	1994	1995	1996
AIDS	107	229	284	209	157
HIV	ND	220	185	190	ND

Source: Public Health Unit, 1997

In NSW between the five years, 1992-1996, there were 2,446 notifications of new cases of HIV infection. Of these notifications, 968 were for residents of the SESAHS. This represents 39.6% of the total NSW notifications. (Table 8) The notification rate for males in the SESAHS is more than three times greater than for males in NSW.

Table 8: HIV Notifications by gender. Comparison of SESAHS and NSW, 1992-1996.

Gender	SESAHS		NSW		% NSW
	No.	Rate ^a	No.	Rate ^a	
Male	902	48.8	2211	14.4	40.8
Female	52	2.8	181	1.2	28.7
Transgender	4	ND	4	ND	100.0
Unknown	10	ND	50	ND	20.0
Total	968	26.0	2446	7.9	39.6

Rate per 100,000 population

Source: Public Health Unit, 1997

There is an estimated 10,000 persons living with HIV in NSW, of whom 60% or approximately 6,000 individuals live in the SESAHS. Of the new cases in the SESAHS, 93.2% were males and 5.4% females. The SESAHS HIV notifications for males represented 40.8% of NSW total notifications, however only 28.7% of all HIV notifications in NSW for females occurred in the SESAHS. (Table 8)

In both HIV and AIDS notifications there was a small number of people who identified as transgender, all of whom were resident in the SESAHS.

The most common risk factor for notified HIV cases was unprotected male/male sex, which accounted for 81.3% (n=787) of all cases either alone or combined with other risk factors (e.g. injecting drug use). Thirty-five cases in SESAHS occurred through unprotected male/female sex (3.4%) and 19 cases in heterosexuals reporting injecting drug use (2%). (Table 9)

Table 9: HIV Notifications by Risk Factors, 1992-1996

Risk Factors	NSW	SESAHS	% NSW notifications in SESAHS
Bisexual	149	58	38.9%
Haem/Coag Disorder	1	0	0.0%
Heterosexual at risk	112	35	31.3%
Heterosexual NOS	168	47	28.0%
Heterosexual + IDU	36	10	27.8%
Homo/Bisexual + IDU	73	44	60.3%
Homosexual	1407	685	48.7%
IDU	43	9	20.9%
Not Stated	380	56	14.7%
Other	41	19	46.3%
Transfusion	22	3	13.6%
Vertical	14	2	14.3%
Total	2,446	968	39.6%

Source: Public Health Unit, 1997

Medical modes of transmission accounted for less than 0.5% (n=3) of SESAHS notifications. Vertical transmission (mother-child) resulted in two cases of HIV infection in SESAHS and fourteen cases in NSW as a whole. (Table 9)

In the five-year period, 1992-1996, there were 986 AIDS notifications in SESAHS. Over the same period there were 2,162 AIDS notifications in NSW, 97% of whom were male and 2.4% female (Table 10)

Table 10: AIDS Notifications by Gender, 1992-1996

Gender	SESAHS		NSW		%NSW
	No.	CNR*	No.	CNR*	
Male	956	51.7	2068	13.5	46.2
Female	24	1.3	87	0.6	27.6
Transgender/Unknown	6	ND	7	ND	85.7
Total	986	26.5	2162	7.0	45.6

*CNR - Crude Notification Rate.

Source: Public Health Unit, 1997

AIDS notifications in NSW appear to have peaked in 1994. Almost half of all cases of AIDS in SESAHS are resident in the LGA of South Sydney (part) (n=460, 46.7%). This includes the suburbs of Darlinghurst and Surry Hills, the centre of the largest gay community in Australia. The next largest group are residents in the Randwick, Woollahra, Waverley area (n=251, 25.5%). Only a relatively small number of AIDS notifications were for residents of the Southern Sector of the SESAHS. A total of 56 AIDS notifications were for residents of the Hurstville, Kogarah, Rockdale and Sutherland LGA (5.7%). There were 16 notifications in the Botany area (1.6%). (Table 11)

Table 11: AIDS Notifications by LGA of residence, SESAHS 1992-1996

LGA	No.	CNR	%
Botany	16	8.9	1.62
Hurstville	9	2.6	0.91
Kogarah	3	1.2	0.30
Randwick	96	15.6	9.74
Rockdale	13	2.9	1.32
South Sydney(part)	460	193.0	46.65
Sutherland	31	3.0	3.14
Sydney(part)	0	0.00	0.00
Waverley	97	29.8	9.84
Woollahra	58	21.7	5.89
Non SESAHS Residents	203	N/A	20.59
Total	986	26.5	100.00

Source: Public Health Unit, 1997

Crude notification rates, a measure of the number of notifications per 100,000 population demonstrate the significantly higher proportion of ‘at risk’ people living within the SESAHS boundaries.

The HIV notification rate for the period 1992-1996 for SESAHS was more than three times greater than for NSW for males and twice as high for females. Notification of AIDS was almost 4 times that of the rest of NSW for males and twice as high for females.

Crude AIDS notification rates between 1992-96 within SESAHS were highest for males aged between 30 and 34 years (142/100,000) with rates for males 35-40 also high at 132.2/100,000. Women aged between 25 and 29 years had the highest notification (4.6/100,000) followed by those aged 45-49 (3.1/100,000). NSW notification rates for AIDS averaged 7.0/100,000 between 1992-1996.

The majority of AIDS notifications were for people who were aged between 30-50 years old, with almost 25% aged between 30 and 34 years. A small number of notifications occurred for people aged over 50 years (n=95, 9.6%) (Figure 1). 2.7% of AIDS notifications occurred for people aged between 15 and 25 years. There was one notification of AIDS infection in a child aged under 10 years between 1992-1996.

Figure 1: AIDS Notifications SESAHS by Age and Gender, 1984-1996

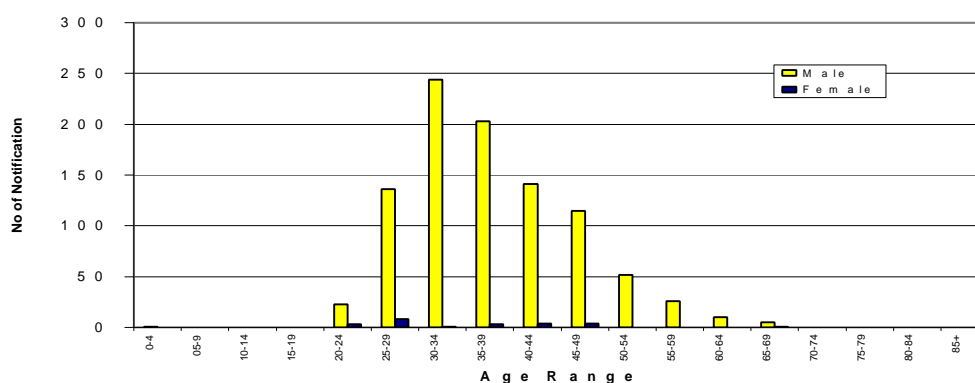


Table 12: AIDS Notifications in SESAHS by Country of Birth, 1992 -1996

Country	No.	Notification Rate*
Australia	696	30.6
New Zealand	32	40.8
UK	25	13.7
USA	18	114.9
Sudan	11	ND
Germany	10	51.8
France	8	ND
Thailand	7	ND
Malaysia	6	26.1
Netherlands	6	60.6
Ireland	5	27.2
Lebanon	5	16.3
Poland	5	33.1
Other (<5cases)	119	ND
Unknown	33	ND
SESAHS	986	26.5
NSW	2,162	7.0

*Average Annual Notification Rate per 100,000 population

Source: Public Health Unit, 1997

Table 13: AIDS Notifications by Language Spoken, 1992-1996

Language	No.	Notification Rate*
English	869	37.0
Spanish	7	16.8
Arabic	5	6.9
Other (<5 Cases)	25	ND
Unknown	80	ND
SESAHS	986	26.5
NSW	2,162	7.0

*Average Annual Notification Rate per 100,000 population

Source: Public Health Unit, 1997

The majority of patients with AIDS were English speaking (n=986, 88.1%) and were born in Australia (n=696,70.6%). Notifications also included people from New Zealand, UK, USA, Africa,Asia , European and Arabic countries. (Table 12-13)

There were five notifications for Aboriginal people, however, there were a large number of cases in the data where the Aboriginality of the person was not known or stated, suggesting caution in the interpretation of this data. (Table 14)

Table 14: AIDS Notifications by Aboriginality, 1992-1996

ATSI	No.	Notification Rate*
Yes	5	19.4
No	719	
Other/Unknown	262	ND
SESAHS	986	26.5
NSW	2,162	7.0

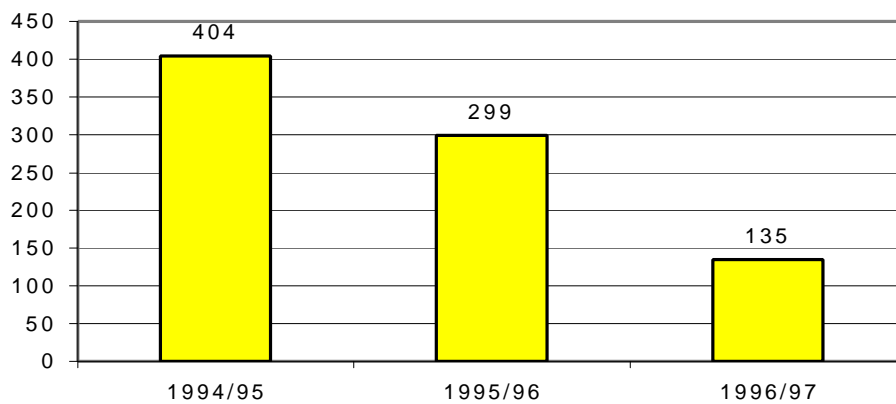
*Average Annual Notification Rate per 100,000 population

Source: Public Health Unit, 1997

The number of deaths from AIDS has declined over the past few years (Figure 2) and this has been attributed in part to the effectiveness of new combination therapies. Mortality in NSW from HIV/AIDS has declined from 404 deaths in 1994/95 to 135 deaths in 1996/97. Mortality within the SESAHS for the same period also declined.

Figure 2: AIDS Deaths NSW 1994/95 - 1996/97

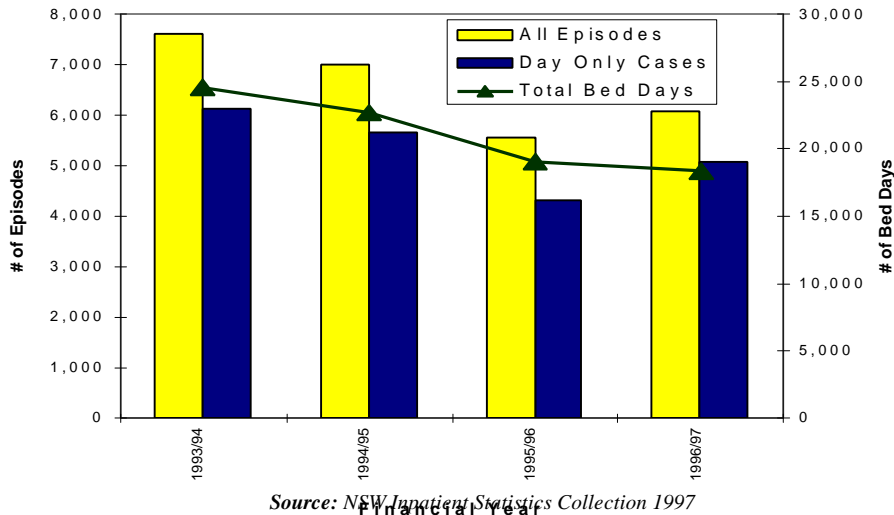
No of AIDS Deaths in NSW



HIV/AIDS Inpatient Episodes

Inpatient service demand has been declining since 1994/95 when HIV/AIDS notifications peaked, however there was a slight increase in the total number of inpatient episodes in 1996/97. Total number of bed days continued to decline. When day only cases are excluded from the estimate of average length of stay there is a slight increase in 1996/7 when compared with the previous years.

Figure 3: Inpatient Episodes HIV/AIDS, 1993/94 - 1996/97



Within the SESAHS a total of 6,080 inpatient episodes were provided in 1996/97 for patients admitted with a primary diagnosis of HIV/AIDS. These accounted for 18,339 bed days with an average LOS of 3.02 days (including day only cases). Of these episodes the greater proportion were day only admissions (83.3%). The proportion of day only cases has remained relatively stable since 1993/4. Average LOS, excluding day only cases, was 13.1 days in 1996/97 and 12.4 days in 1993/94. (Figure 3)

Of the total number of inpatient episodes provided during the period 1993-1997, 29.6% (n=7,787) were provided for residents of other health services areas. Day only admissions accounted for 6012 (77.2%) of the inflows in this period. (Table 15)

Table 15: HIV/AIDS Inpatient Episodes in SESAHS Hospitals, 1/7/93 - 30/6/97

HIV/AIDS Admissions	1993/94	1994/95	1995/96	1996/97	Total
SESAHS Residents					
All Episodes	5,183	5,003	3,815	4,459	18,460
Day Only cases	4,246	4,096	3,027	3,786	15,155
Total Bed days	16,064	15,506	11,824	13,105	56,499
Average Length of Stay (including Day Only cases)	3.1	3.1	3.1	2.9	3.1
Average Length of Stay (excluding Day only Cases)	12.6	12.6	11.2	13.9	12.5
Inflows					
All Episodes	2,427	1,996	1,743	1,621	7,787
Day Only Cases	1,879	1,558	1,294	1,281	6,012
Total Bed Days	8,521	7,220	7,239	5,234	28,214
Average Length of Stay (including Day Only cases)	3.5	3.6	4.2	3.2	3.6
Average Length of Stay (excluding Day only cases)	12.1	12.9	13.2	11.7	12.5
Total					
All Episodes	7,610	6,999	5,558	6,080	26,247
Day Only Cases	6,125	5,654	4,321	5,069	21,169
Total Bed days	24,580	22,726	19,063	18,339	84,708
Average length of Stay (including Day Only cases)	3.2	3.3	3.4	3.0	3.2
Average length of Stay (excluding Day Only Cases)	12.4	12.7	11.9	13.1	12.5

Source: NSW Inpatient Statistics Collection

More than two-thirds of HIV related patient inflows were for residents of Central Sydney Area Health Service (CSAHS). Residents of the CSAHS account for 20.5% of all inpatient HIV/AIDS episodes in the SESAHS. Just over 3% of inflows were from the Northern Sydney Area Health Service. These are considered natural flows and are not considered amenable to change. (Table 16).

A number of trends that have been reported indicate the need to reorientate HIV services to reflect changing service requirements.

Nearly half of persons with HIV are reporting improvements with current treatments. A re-orientation to a wellness and rehabilitation model is required for these persons. Key components of a rehabilitation model are accessible community based allied health services integrated with retaining programmes, especially counselling services to support rehabilitation and re-adjustment.

Treatment primarily occurs in the community through HIV GPs/prescribers (29 in SESAHS). Strategies will expand to ensure rapid and consistent information flow from HIV specialist services and communication exists to ensure the general practitioner is included in client management plan. General practitioners require outreach counsellors to visit practices to facilitate access to counselling services. In addition, strategies will be developed to improve access to community, allied and nursing services.

As current medications have a variable penetration into the brain, and preliminary data suggests that incidence prevalence figures have not changed recently, twenty percent of persons with AIDS are likely to have AIDS Dementia Complex (ADC), ie. 115 of the 574 residents with an AIDS defining illness. The AIDS Dementia HIV Psychiatry Service (ADAHPS), administered by SESAHS in cooperation with CSAHS, reports that

across NSW, HIV NGOs and HIV housing services are overburdened with clients with complex needs that are not fitting into an outpatient appointment model of care. ADAHPS, in partnership with area AIDS Coordinators, has identified the need for all Areas to reorientate services to ensure continuum of care and case management arrangements are in place for people with ADC, HIV psychiatric conditions and those with complex needs. Essential to the success of re-orientation of services are the availability of assessment and consultant advice from all health service streams, particularly mental health, drug and alcohol, palliative care, and neuropsychology services, in association with guardianship arrangements and backup respite, step-down and housing and social support. ADAHPS relies on paid supplementary care. Additional community staff will be re-orientated to assume a case management role.

Inner City Mental Health data indicate an HIV seroprevalence of 1-5% in the mental health population. There is an increasing trend of HIV mental health admissions (Caritas 1995/96 10 persons, ALOS 13.2, 1996/97 17 persons, ALOS 14.7). This figure is consistent with Rozelle Hospital admission data 1995/96 16; 1996/97 26 1997 to date 35. Foley House serviced 175 HIV positive persons from July to December 1997, 80% with a DSM diagnosis, one third with a mental illness, and two-thirds with a personality disorder. HIV general practitioners report difficulty in accessing mental health services for patients with HIV who have not been diagnosed with a mental illness, or are not known to mental health services. There is a need for accessible HIV mental health approaches to serve persons with an organic aetiology and for those with a personality disorder. In addition, HIV prevention strategies are required for the mentally ill.

The National Centre for Epidemiology indicates for 8% of persons with HIV overall and 3% in recent times, injecting drug use is one of the factors contributing to seroconversion. A three-year Centre study by Margaret MacDonald suggests 1-3% of injecting drug users are HIV positive, and this study is consistent with the ASOHAIDU study indicating 2-3%.

A need for accessible drug and alcohol services has been identified by a range of HIV treatment services including HIV GP prescribers, ADAHPS, HIV housing and support services, and by HIV counselling and treatment services. Services are required for non-opiate dependent drug users (i.e. cocaine, speed and ecstasy), alcohol users, assessment and treatment services for users with other dual diagnosis issues such as mental illness or dementia, and timely access to detoxification for the complex client.

Table 16: HIV/AIDS Inpatient Episodes in SESAHS Hospitals by Residence, 1/7/93-30/6/97

Locality of Residence	No.	% of Episodes
Botany	155	0.6%
Hurstville	312	1.2%
Kogarah	36	0.1%
Randwick	1,366	5.2%
Rockdale	170	0.6%
South Sydney (part)	9,417	35.9%
Sutherland	589	2.2%
Sydney (part)	1,673	6.4%
Waverley	1,716	6.5%
Woollahra	3,026	11.5%
SESAHS Total	18,460	70.3%
Central Sydney AHS	5,370	20.5%
Northern Sydney AHS	876	3.3%
South Western Sydney AHS	198	0.8%
Illawarra AHS	154	0.6%
Hunter AHS	130	0.5%
Western Sydney AHS	128	0.5%
Central Coast AHS	92	0.4%
Macquarie	38	0.1%
Mid North Coast	27	0.1%
Northern Rivers	26	0.1%
Other NSW	53	0.2%
Interstate	106	0.4%
Overseas	21	0.1%
Not Stated/Other	89	0.3%
Out of Area Total	7,308	27.8%
All Inpatient Episodes	26,253	100.0%

Source: NSW Inpatient Statistics Collection

Approximately 70.3% of HIV/AIDS hospital episodes in NSW occurred in the SESAHS. On average about 1,371: 100,000 males and 44: 100,000 females in SESAHS were admitted to hospital due to AIDS/HIV related conditions each year. (*SESAHS Population Health Profile, 1997*).

HIV/AIDS Non-Inpatient Episodes

Anecdotal evidence suggests that the utilisation of non-inpatient or ambulatory services has increased over the past few years, reflecting the change in the treatment of the disease and suggesting a change in the model of care. However, the activity data for non-inpatient episodes of care is considered to be highly unreliable, with concerns over both the adequacy of reporting mechanisms and the lack of standardised definitions for service

items. No data are available for General Practitioner utilisation for HIV/AIDS consultations although there are several large practices with significant HIV/AIDS focus in the Darlinghurst/Eastern Suburbs Area.

Paediatric HIV/AIDS Services

The Paediatric HIV/AIDS Service located within the SESAHS is the only designated Paediatric HIV/AIDS service in Australia. The team provides multidisciplinary services to all families living with HIV in New South Wales regardless of where the children receive their medical treatment. The Paediatric Unit also has established national and international links for consultation and information sharing.

The Unit has a strong role in the care of HIV positive pregnant women, focusing on the reduction in the transmission of HIV from mother to baby. A total of 20 families in the Sydney metropolitan area and a further 24 families nationally are cared for by the Paediatric HIV Unit. (Table 17)

The Unit is involved in the care of families with complex problems associated with a diagnosis of HIV or AIDS in an expectant mother or in a child. In many cases of infection in a child, either one or both parents are also infected, and there may also be infected siblings. The unit is currently staffed with three medical positions (one full time), a clinical nurse consultant and a social worker. A Family Support Officer is funded through ACON and is located at ACON's Sydney office. The service is provided by staff of the HIV Paediatric Unit currently at three metropolitan sites; Sydney Children's Hospital, Randwick, The New Children's Hospital, Westmead and at Liverpool Hospital.

Table 17: Paediatric HIV cases seen by HIV Paediatric Service (current 1997)

Area/State	No of Families	Characteristics of families				
		HIV +ve children	Other siblings	Unknown status	HIV +ve parents	Deceased parents
Sydney Metro	20	15	17	6	27	5
Country NSW	5	3	1	1	4	3
ACT	3	4	0	1	4	0
QLD	6	4	4	0	8	2
NT	1	2	0	0	2	0
Western Australia	3	3	3	0	5	0
South Australia	2	0	4	0	3	1
Victoria	3	1		0	4	1
TOTAL	43	32	29	8	57	12

Source: Paediatric HIV Service, SESAHS, 1997

The Paediatric service provides counselling support on a group and individual basis, case management for all children and their families affected by HIV/AIDS, assistance with school disclosure (which may take months or years to complete) and direct care to HIV/AIDS affected children and families. The Paediatric HIV Unit also coordinates a national Camp (Camp Goodtime) for families living with HIV/AIDS throughout Australia. The Unit provides medical and nursing services throughout the camp. Additionally the Unit has played a strong role in Paediatric HIV education for health professionals on a National and International basis. Research has focused on mother to baby transmission of HIV and has developed surveillance mechanisms to describe and monitor the impact of perinatal transmission.

Viral Hepatitis in the SESAHS

As at June 1996 it is estimated that up to 200,000 people have been infected with Hepatitis C Virus (HCV) in Australia (*Commonwealth of Australia, 1996*). Of these it can be estimated that up to 100,000 live in NSW. An estimated 8,000 to 10,000 new cases are diagnosed nationally each year (*Wodak, 1996*). Reported notifications of HCV across Australia now total around 90,000 (*Hepatitis C Council, 1997*)

Between 1990 and July 1997 there were 42,891 laboratory notifications of HCV in NSW, representing almost half of all notifications in Australia for this period (*NSW Health, Sept 1997*).

Data on risk factors are not routinely collected for HCV notification, however, there have been several studies conducted nationally and locally that have sought to identify behaviours that contribute to a high risk of HCV infection or transmission.

The primary risk factor identified for HCV infection in Australia is sharing needles and syringes amongst injecting drug users (IDU). In 1995, national surveillance data indicated that 91% of incident cases occurred in young IDU (*CDHFS, 1996*). Estimates of general prevalence amongst IDU range from 30% to 85% (*NH&MRC, 1997*). A study undertaken by the Kirketon Road Centre in Darlinghurst demonstrated an 89% incidence rate of HCV infection in injecting drug users under the age of 20 in inner Sydney between 1992 and 1995. Almost 90% of this group had become infected with HCV in the previous twelve months (*Dwyer & van Beek, 1997*). In the same study the incidence across all age groups was 17.6%.

Around 80 - 85% of all infections occur in IDU, however the other 15-20% of HCV infected people report the following routes of infection:

- blood and blood products received prior to the introduction of screening in 1990.
- contaminated tattooing and body piercing equipment
- clinical/surgical procedures in health care settings.
- blood to blood transmission in healthcare, hairdressing and household settings
- vertical transmission from mother to baby
- sexual transmission.

(Hepatitis C Council, September, 1997)

The natural course of Hepatitis C is not well understood. While the disease has been around for many years, prior to 1989 it was referred to as non-A non-B Hepatitis, most transmissions have occurred since the 1970's. Disease associated with infection progresses at variable rates, making individual prognosis difficult to determine. Approximately 85% of people exposed to the virus will develop chronic infection. Long term symptoms of illness, including signs of liver damage will occur in approximately 75% of those who develop chronic infection. It is estimated that approximately 20-25% of people with chronic infection will develop cirrhosis of the liver within 20 years of being infected and between 25-50% of these people will develop liver cell cancer or liver failure in a further five to ten years (*Hepatitis C Council of NSW, 1997*)

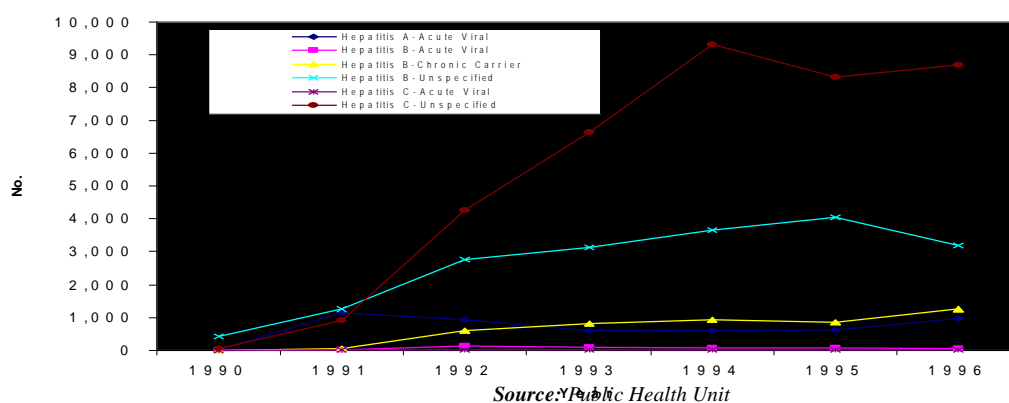
The increase in HCV notifications since late 1991 is related to the introduction of improved antibody testing. Initial infection with HCV is usually sub-clinical, although chronic infection can lead to serious health problems such as cirrhosis and hepatic cancer. Most HCV notifications are made via the laboratory, and the majority are considered to be a new diagnosis of HCV that had been acquired years ago, rather than new infections. Some of these infections may have occurred up to 20 years previously and mainly occurred through blood transfusion or injecting drug use. Males aged between 30 and 39 have the highest rate of notifications. (*Public Health Bulletin, Vol. 9 Supplement, 1995*). (Figure 4)

There is an estimated 40,000 people living with HCV in NSW of which an estimated 16% (6,500) live in the SESAHS.

There is some evidence that Hepatitis A behaves like a sexually transmitted disease with significantly higher rates among young urban-dwelling gay males than among the rest of the community. Data collected during epidemics in 1991-92 and 1995-96 by the SESAHS Public Health Unit revealed that adult males comprised 90% of all cases, and that of the 75% of cases where sexual preference was recorded, homosexual men accounted for 80-90% of all cases. The peak incidence during these epidemics was 500 cases per 100,000. (Ferson, 1998; Symons, 1998).

Recommendations included the proper surveillance and notification of Hepatitis A and vaccination for all people at high risk. (Ferson, 1998).

Figure 4: Hepatitis Notifications NSW, 1990-1996



The number of notifications of Hepatitis A, B and C in the SESAHS from 1992 - 1996 was:

Table 18: Hepatitis notifications in SESAHS 1992-1996

Condition	1992	1993	1994	1995	1996
HAV	139	75	125	245	251
HBV	724	892	1,075	875	671
HCV	683	1,387	2,304	1,660	1,438

Source: Public Health Unit

The majority of Hepatitis A, B & C notifications between 1992 - 1996 occurred in males aged 30-34 (Figure 5/6/7)

Figure 5: Hepatitis A Notifications SESAHS by Age and Gender, 1992-1996

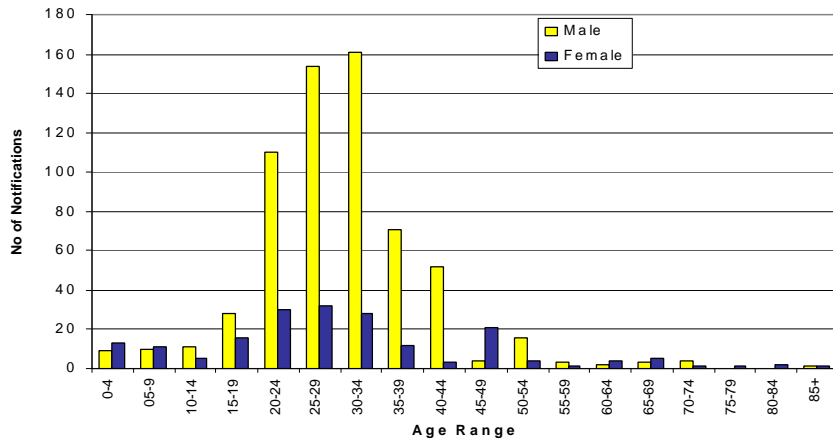
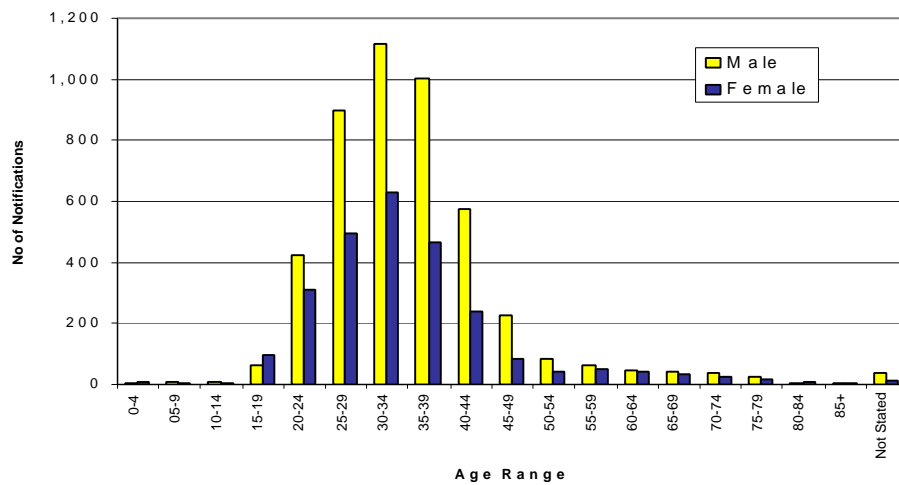
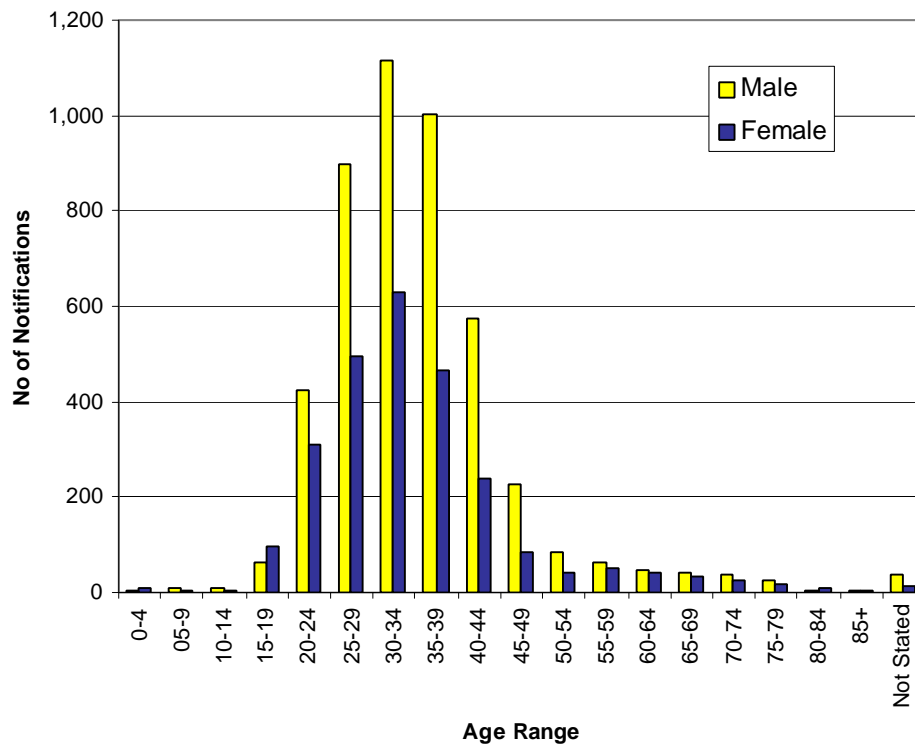


Figure 6: Hepatitis B Notifications SESAHS by Age and Gender, 1992-1996



Source: Public Health Unit

Figure 7: Hepatitis C Notifications SESAHs by Age and Gender, 1992-1996



Hepatitis E notification rates across the SESAHs ranged from 5.2/100,000 at Sutherland, to 128.8/100,000 at South Sydney (part). Notification rates for Hepatitis B and C were also highest in South Sydney (part) LGA and lower at Sutherland.

The notification rate for Hepatitis C in the LGA of South Sydney was 933.8/100,000 compared to 121/100,000 for NSW.

Table 19: Hepatitis Notifications by Gender, 1992-1996

Gender	NSW		SESAHS		% NSW Notifications in SESAHS
	No.	Notification Rate*	No.	Notification Rate*	
Hepatitis A					
Male	2,336	15.2	658	35.6	28.2%
Female	1,368	8.8	176	9.4	12.9%
Trans-gender / Unknown	23		3		17.4%
TOTAL	3,727	12.0	835	22.4	22.4%
Hepatitis B					
Male	11,581	75.4	2,333	126.2	20.1%
Female	9,620	61.8	1,742	92.8	18.1%
Trans-gender / Unknown	505		161		32.1%
TOTAL	21,706	70.2	4,237	113.7	19.5%
Hepatitis C					
Male	23,143	150.6	4,665	252.4	20.2%
Female	13,878	89.2	2,567	136.7	18.5%
Trans-gender / Unknown	397		240		60.5%
TOTAL	37,418	121.0	7,472	200.6	20.0%

*Average Annual Notification Rate per 100,000 population

Source: Public Health Unit

Notification rates for Hepatitis A, B and C were all higher in the SESAHS than in NSW. (Table 19) over the four-year period 1992-1996. The pattern of Hepatitis A in SESAHS has been characterised by a large epidemic in homosexual males and cases in IDU.

Hepatitis B epidemiology is characterised by low prevalence in the community and higher rates in high risk groups, including those born in high risk countries, injecting drug users and homosexual men. Males aged between 30-39 had the highest notification rate (188/100,000) on average in NSW.

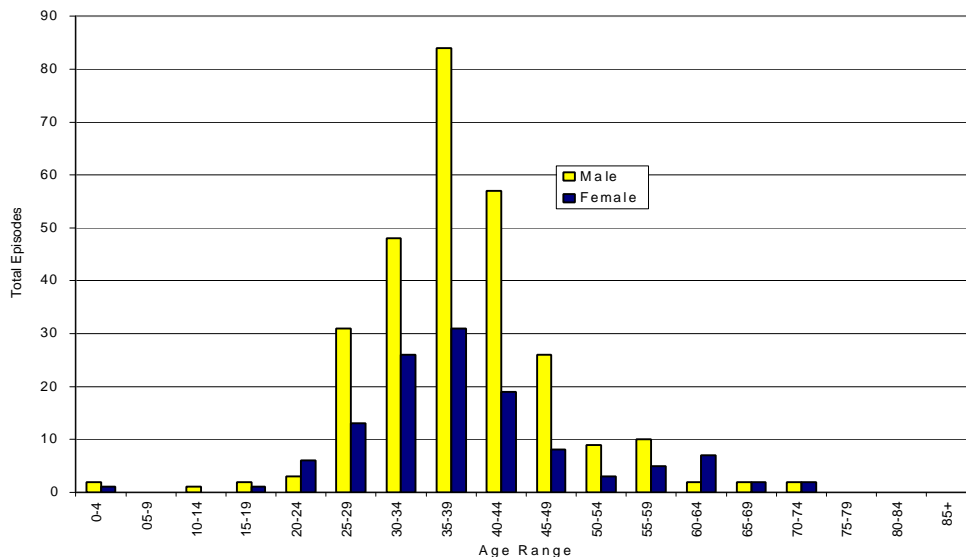
The incidence of Hepatitis C is also higher in specific high-risk groups. Prisons are of particular concern in the transmission of HCV. Estimates of the number of prison inmates who have a history of injecting drug use are generally around 60% (*Corrections Health Service*). Thirty-seven percent of males received into Long Bay Gaol in a 1994 study tested positive for HCV (*Butler et al, 1997*) and an equivalent number of women in Victoria were HCV positive (*Crofts et al, 1995*).

Viral Hepatitis Inpatient Episodes

Viral hepatitis is placed in miscellaneous ANDRGs (376-377) including non-infective hepatic disorders. Accordingly inpatient activity for 1996/1997 is described by ICD-9-CM codes summarised below. The

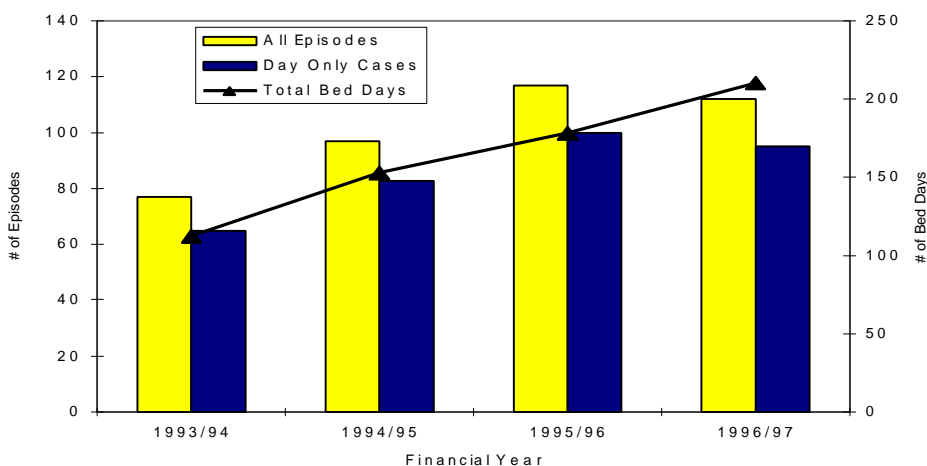
majority of admissions were for males aged between 25 and 49 years of age, with men aged 35-39 the largest single group. (Figure 8)

Figure 8: Hepatitis C Inpatient Episodes in SESAHS by Age and Gender, 1.7.1993-30.6.1997



There has been a steady increase in inpatient admissions for Hepatitis C between July 1993 and June 1996. Admissions declined slightly for both day only and all episodes in 1996/97. Total bed days continued to increase in 1996/97 despite the decrease in admissions. (Figure 9)

Figure 9: Hepatitis C Inpatient Episodes in SESAHS Hospitals, 1.7.1993-30.6.1997



Between approximately 15% and 36% of admissions during the four-year period 1993-1997 were for patients resident outside of the SESAHS. Most in-flows occurred from the Central Area Health Service. (Table 20)

Table 20: Hepatitis Inpatient Episodes in SESAHS by Residence, 1.7.1993-30.6.1997

Locality of Residence	Hepatitis A		Hepatitis B		Hepatitis C	
	n	%	n	%	n	%
South Sydney (part)	13	15.3	12	10.8	25	6.2
Waverley	5	5.9	-	-	18	4.5
Randwick	24	28.2	21	18.9	66	16.4
Sutherland	6	7.1	-	-	67	16.7
Rockdale	7	8.2	11	9.9	32	7.9
Kogarah	5	5.9	7	6.3	14	3.5
Woollahra	-	-	-	-	24	5.9
Hurstville	-	-	8	7.2	24	6.0
Botany	-	-	-	-	17	4.2
Other SESAHS	12	14.1	12	10.8	-	-
SESAHS TOTAL	72	84.7	71	64.0	289	71.7
Central AHS	8	9.4	19	17.1	48	11.9
Northern AHS	-	-	6	5.4	20	5.0
South Western AHS	-	-	-	-	20	5.0
Illawarra AHS	-	-	-	-	6	1.5
Wentworth AHS	-	-	-	-	7	1.7
Western Sydney AHS	-	-	7	6.3	-	-
Other NSW	5	5.9	7	6.3	13	3.2
Out of Area Total	13	15.3	40	36.0	114	28.3
All Inpatient Episodes	85	100.0	111	100.0	403	100.0

Source: NSW Inpatient Statistic Collection

Table 21: Hepatitis Inpatient Episodes in SESAHS Hospitals, 1/7/93 - 30/6/97

Hepatitis Admissions	1993/94	1994/95	1995/96	1996/97	Total
Hepatitis A					
All Episodes	11	15	13	46	85
Day Only Cases	0	1	0	3	4
Total Bed Days	34	84	46	190	354
Average Length of Stay/Days	3.4	5.6	3.5	4.1	4.2
Hepatitis B					
All Episodes	27	30	17	37	111
Day Only Cases	12	20	10	22	64
Total Bed Days	105	63	54	135	357
Average Length of Stay/Days	3.9	2.1	3.2	3.7	3.2
Hepatitis C					
All Episodes	77	97	117	112	403
Day Only Cases	65	83	100	95	343
Total Bed Days	112	153	178	210	653
Average Length of Stay/Days	1.5	1.6	1.5	1.9	1.6

Source: NSW Inpatient Statistics Collection

Average length of stay for patients with Hepatitis A was 4.2 days, compared with 1.6 days for patients with HCV. More patients with HBV and HCV were treated on a day only basis during the period 1993-1997. (Table 21)

Sexually Transmitted Diseases in SESAHS

Notification of syphilis and gonorrhoea are mandatory Public Health Unit notifications in NSW.

Population based data are not readily available on activity related to non-notifiable STD. Data on non-notifiable STD including genital herpes, genital warts and nongonococcal urethritis are provided to the SESAHS by Sydney Sexual Health Centre, Kirrketon Road Centre and Taylor Square Private Clinic.

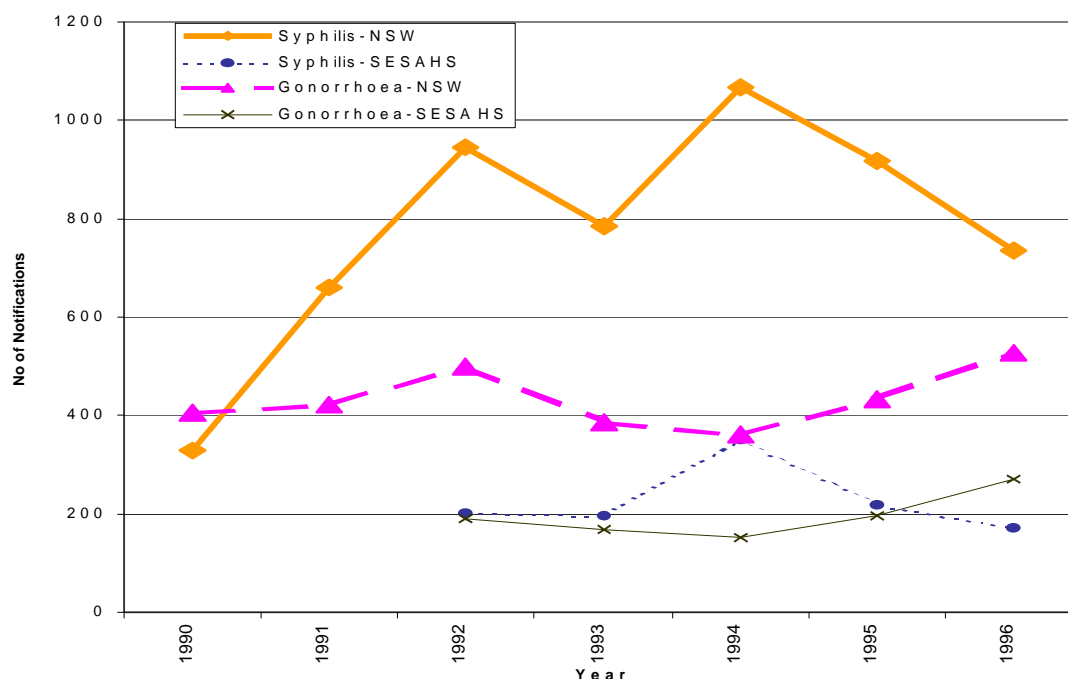
The number of notifications for syphilis and gonorrhoea from 1992-1996 were:

Table 22: STD Notifications in SESAHS, 1992-1996.

Condition	1992	1993	1994	1995	1996
Syphilis	201	196	350	219	172
Gonorrhoea	192	168	153	196	272

Source: Public Health Unit

Figure 10: Syphilis and Gonorrhoea Notifications NSW, 1990-1996



Source: Public Health Unit

Between 1992 and 1996 there were 1,138 notifications of syphilis in SESAHS, and 981 notifications of gonorrhoea. (Table 22)

Notification rates for syphilis and gonorrhoea are both higher in SESAHS males when compared with NSW as a whole. Approximately 25% of syphilis notifications and 44% of gonorrhoea notifications in NSW occurred in SESAHS. (Table 23/24)

Table 23: Syphilis Notifications by Gender, 1992-1996

Gender	NSW		SESAHS		% NSW notifications in SESAHS
	No.	Notification Rate*	No.	Notification Rate*	
Male	2,467	16.1	778	42.1	31.5
Female	1,869	12.0	309	16.5	16.5
Transgender /Unknown	111	ND	51	ND	45.9
Total	4,450	14.4	1,138	30.5	25.6

*Average Annual Notification Rate per 100,000 population

Source: Public Health Unit

Table 24: Gonorrhoea Notifications by Gender, 1992-1996

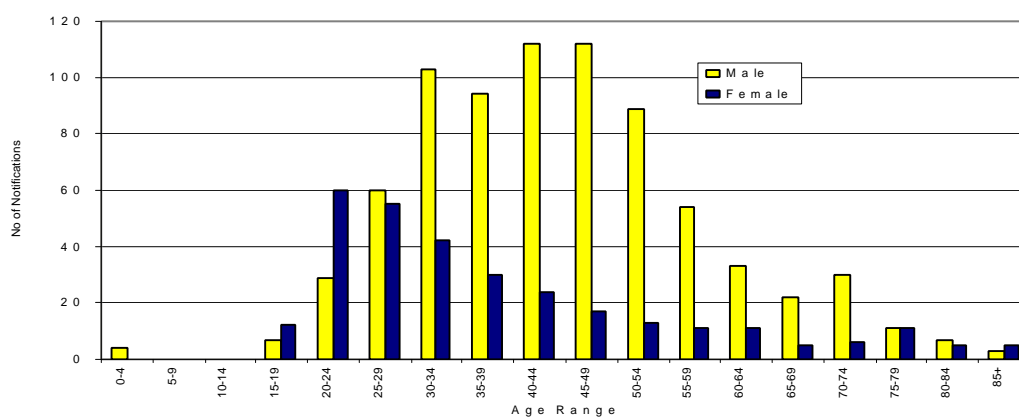
Gender	NSW		SESAHS		% NSW notifications in SESAHS
	No.	Notification Rate*	No.	Notification Rate*	
Male	1,852	12.1	889	48.1	48.0
Female	347	2.2	87	4.6	25.1
Transgender /Unknown	13	ND	5	ND	38.5
Total	2,212	7.2	981	26.3	44.3

*Average Annual Notification Rate per 100,000 population

Source: Public Health Unit

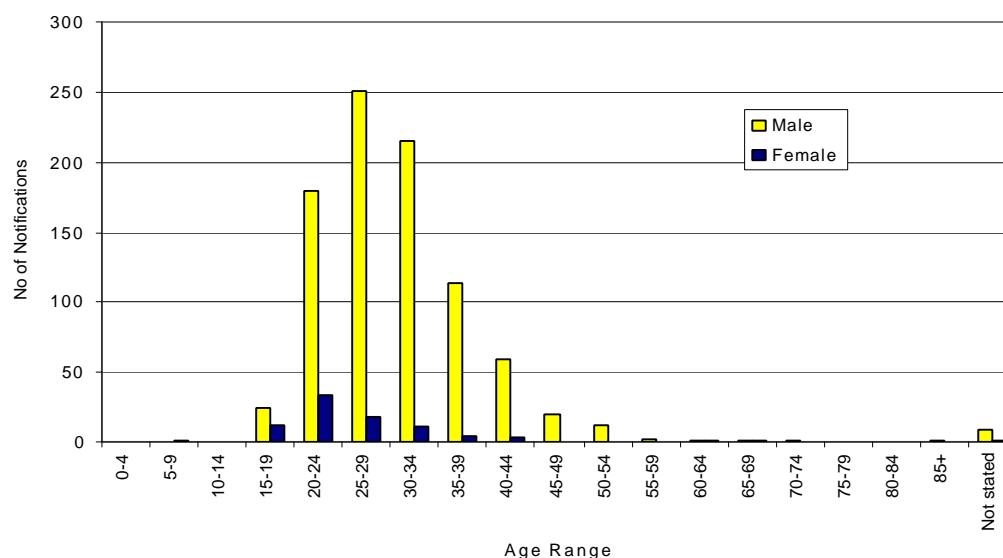
Notifications of syphilis were highest in males aged between 30 and 54 years and in females aged between 20 and 29 years. (Figure 11)

Figure 11: Syphilis Notifications SESAHS by Age and Gender, 1992-1996



The majority of notifications of gonorrhoea were in males aged between 20 and 39. Relatively few notifications were in people over 60 years. (Figure 12) High rates of gonorrhoea have been reported in gay men, contributing to the high rates in SESAHS. Gonorrhoea notifications have continued to increase in 1997 and 1998 (Sydney Sexual Health Centre).

Figure 12: Gonorrhoea Notifications SESAHS by Age and Gender, 1992-1996



Notifications for syphilis and gonorrhoea are often incomplete, and a proportion of unknown or incomplete data make interpretation difficult for both syphilis and gonorrhoea. Interpretation of Aboriginal status is also compromised by the lack of complete data. Almost one third of all notifications of both syphilis and gonorrhoea occurred for residents of the South Sydney (part) LGA. (Table 25)

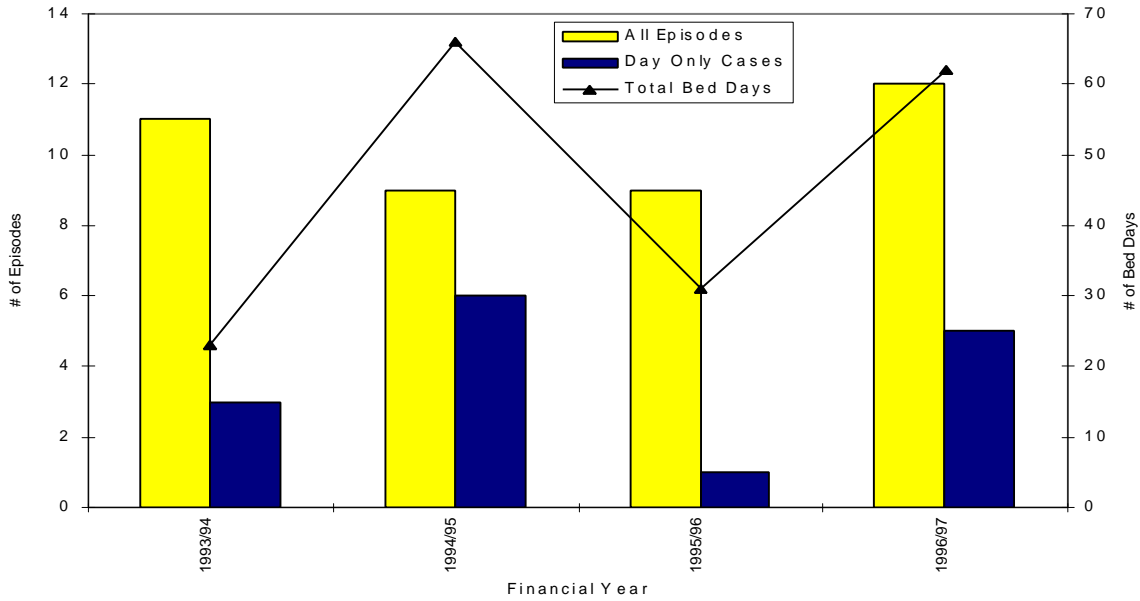
Table 25: Notifications for Syphilis and Gonorrhoea by LGA, 1992-1996

LGA	Syphilis		Gonorrhoea	
	No	CNR	No	CNR
Botany	47	26.2	21	11.7
Hurstville	25	7.3	18	5.3
Kogarah	28	11.2	5	2.0
Randwick	155	25.1	63	10.2
Rockdale	43	9.7	19	4.3
South Sydney (part)	393	164.9	501	210.2
Sutherland	55	5.4	31	3.0
Sydney (part)	0	0.0	0	0.0
Waverley	103	31.6	73	22.4
Woollahra	53	19.8	68	25.4
Other	236	-	182	-
TOTAL SESAHS	1,138	30.5	981	26.3
TOTAL NSW	4,450	14.4	2,212	7.2

Source: Public Health Unit

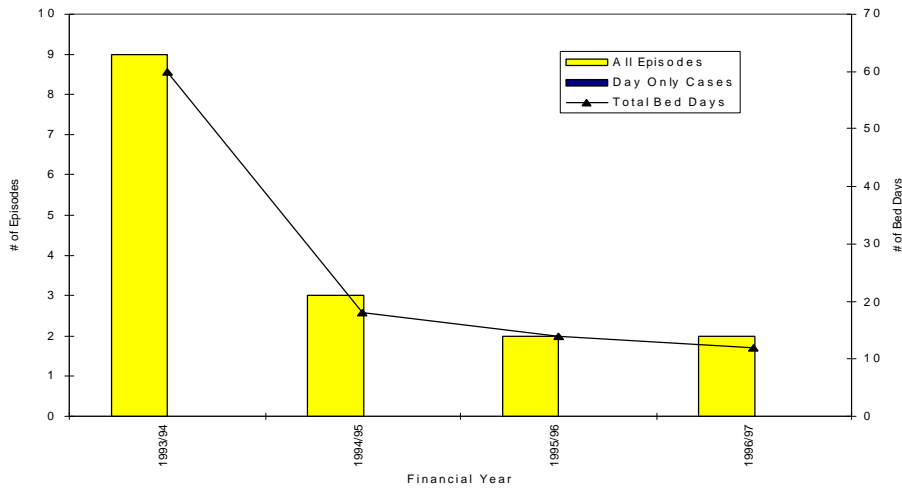
Inpatient actively related to STD is captured with a variety of AN-DRG and ICD-9-CM codes. Only primary STD diagnoses are recorded/coded. According to available data, both total episodes of care and total bed days for syphilis admissions have increased in the four years 1993-1997. (Figure 13)

Figure 13: Syphilis Inpatient Episodes in SESAHS Hospitals, 1.7.1993-30.6.1997



Inpatient episodes for the treatment/care of patients with gonorrhoea have declined significantly since 1993/94 along with total bed days. (Figure 14)

Figure 14: Gonorrhoea Inpatient Episodes in SESAHS Hospitals, 1.7.1993-30.6.1997



Approximately 26% of all inpatient episodes for syphilis were for residents of other health service areas. Only 6% (approximately) of patients with gonorrhoea resided outside the SESAHS. (Table 26)

Table 26: Inpatient Episodes for Syphilis and Gonorrhoea 1992-1996

Locality of Residence	Syphilis		Gonorrhoea	
	n	%	n	%
South Sydney (part)	8	19.5	-	-
Randwick	8	19.5	-	-
Other SESAHS	13	31.7	15	93.8
SESAHS Total	29	70.7	15	93.8
Central AHS	6	14.6	-	-
Other NSW	6	14.6	1	6.2
Out of Area Total	11	26.8	1	6.2
All Inpatient Episodes	41	100.0	16	100.0

Source: NSW Inpatient Statistics Collection

STD commonly result in serious conditions such as pelvic inflammatory disease, chronic pelvic pain, tubal factor infertility, ectopic pregnancy, cervical cancer and epididymitis. On currently available data it is not possible to determine the contribution that STD make to morbidity from these conditions within the SESAHS.

Tuberculosis in SESAHS

There were 424 notifications of TB in the SESAHS between the years 1992-1996. (Table 27)

Table 27: TB Notifications SESAHS, 1992-1996

Condition	1992	1993	1994	1995	1996
TB	90	97	88	86	63

Source: Public Health Unit

SESAHS notifications represent almost 20% of the total notifications in NSW. The notification rate for SESAHS overall is 11.4/100,000. Notification rates are much higher for some ethnic groups. Notification rates for Vietnamese are 177.4/100,000 and Chinese 120.9/100,000. Notification rate for Australian residents was 2.7/100,000. (Table 28)

Table 28: TB Notifications by Country of Birth, 1992-1996

Country	No.	Notification Rate*
Australia	62	2.7
China	52	80.1
Philippines	32	120.9
Vietnam	24	177.4
Korea	22	ND
India	16	96.8
Hong Kong	12	27.2
UK	12	6.6
Greece	11	17.5
Bangladesh	9	ND
Lebanon	7	22.8
Pakistan	6	ND
Malaysia	6	26.1
Yugoslavia	6	ND
Russia	5	ND
Fiji	5	34.0
Other (<5cases)	128	
Unknown	9	
SESAHS	424	11.4
NSW	2,126	6.9

*Average Annual Notification Rate per 100,000 population
Source: Public Health Unit

Table 29: TB Notifications by LGA, 1992-1996

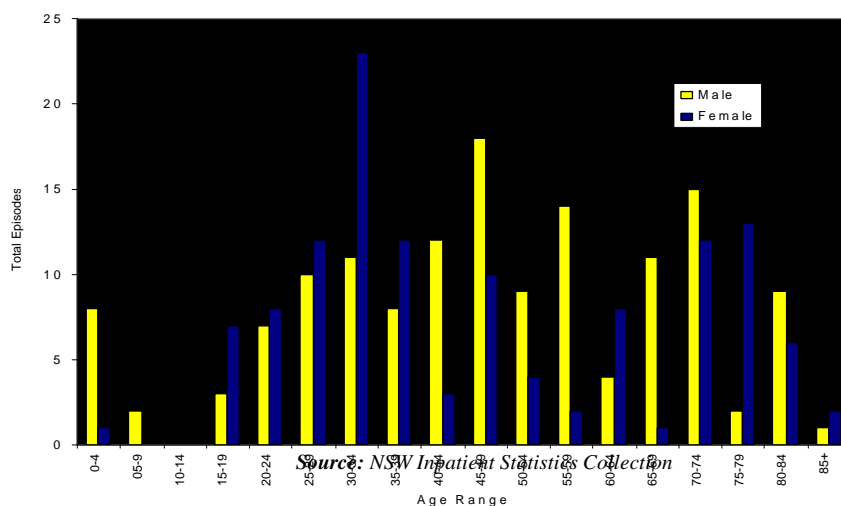
LGA of Residence	No.	Notification Rate*
Botany	40	22.3
Hurstville	36	10.5
Kogarah	29	11.6
Randwick	57	9.2
Rockdale	39	8.8
South Sydney (part)	31	13.0
Sutherland	31	3.0
Sydney (part)	0	0.0
Waverley	27	8.3
Woollahra	13	4.9
Other	95	
SESAHS	424	11.4
NSW	2,162	6.9

*Average Annual Notification Rate per 100,000 population
Source: Public Health Unit

Notification rates are highest in the LGA of Botany, South Sydney (part) and Kogarah. There are significant populations of newly migrated residents in these areas. (Table 29)

Admissions for TB accounted for a total of 3,806 bed days in SESAHS hospitals between 1993 - 1997. Average length of stay in 1997 was 14.6 days, reduced from 18.1 days in 1993. Day only admissions have remained stable over the four year period and total bed days have declined. The largest group of patients were women aged between 30-34. (Figure 15)

Figure 15: TB Inpatient Episodes in SESAHS by Age and Gender, 1.7.1993-30.6.1997



Almost 30% of admissions were for residents born in Australia even though they only represented 14% of all notifications. (Table 30)

Table 30: TB Inpatient Episodes in SESAHS Hospitals by Country of Birth, 1/7/93 –30/6/97

Country of Birth	No.	% of Episodes
Australia	78	29.2
Bangladesh	10	3.7
China	19	7.1
Hong Kong	6	2.2
India	5	1.9
Indonesia	16	6.0
Korea	7	2.6
Philippines	19	7.1
Thailand	9	3.4
UK	16	6.0
Vietnam	8	3.0
Other	46	17.2
Unknown/Not Known	28	10.5
All Inpatient Episodes	267	100.0

Source: NSW Inpatient Statistics Collection

There were 84 admissions for residents of other Area Health Services, representing 31.5% of all SESAHS inpatient episodes. (Table 31)

Table 31: Inpatient Episodes in SESAHS Hospitals by Residence, 1/7/93 –30/6/97

Locality of Residence	No.	% of Episodes
Botany	13	4.9
Hurstville	17	6.4
Kogarah	17	6.4
Randwick	43	16.1
Rockdale	32	12.0
South Sydney (part)	25	9.4
Sutherland	17	6.4
Sydney (part)	7	2.6
Waverley	10	3.7
Other SESAHS	2	0.7
SESAHS Total	183	68.5
Central Sydney AHS	40	15.0
Illawarra AHS	6	2.2
Northern Sydney AHS	9	3.4
South Western Sydney AHS	10	3.7
Other NSW	11	4.1
Interstate	3	1.1
Overseas	4	1.5
Not Stated/Other	1	0.4
Out of Area Total	84	31.5
All Inpatient Episodes	267	100.0

Source: NSW Inpatient Statistics Collection

Selected non-inpatient activity has been recorded for the major teaching hospitals within the Area. (Table 32)

Table 32: Selected TB Non-inpatient Activity SESAHS by Facility, 1996-1997

Activity	Sydney Hospital		St. Vincent's Hospital		Prince of Wales Hospital	
	1996	1997	1996	1997	1996	1997
Supervised TB Treatment (NIOOS)	1,092	936	468	624	1,219	1,131
Follow up & treatment (diagnosed as I/P)	1	3	11	10	15	18
Follow up & treatment (diagnosed as O/P)	5	4	7	3	17	13
Contacts Screening	284	276	171	164	227	259
Mantoux Test	151	192	119	108	269	270
BCG Vaccination	93	107	38	26	81	63

Nosocomial Infections in SESAHS

The findings of the NSW Nosocomial Infection Taskforce (*NSW Health Department, November 1996*) estimated that the current infection rate in NSW hospitals is 6.3%. It is expected that the incidence of nosocomial infections in hospitals in the SESAHS will increase as predisposing factors including age, co-morbidity, invasive procedures and immunosuppression become more prevalent in the hospitalised population. In addition to the absolute increase in nosocomial infections, the emergence of multiple drug resistance will contribute to greater morbidity and mortality from nosocomial infections.

Infection control is currently organised and provided on a facility basis and there is no area-wide infection control programme or framework. The service is practitioner driven with differences in policy and procedures between sites in the area. Consequently there are no consistent data available to describe service activity or patient acuity.

Vaccine Preventable Diseases in the SESAHS

Measles

Cases of measles are notifiable by medical practitioners, hospitals and laboratories. In 1997 there were 18 notifications in the SESAHS for measles (*SESAHS, Public Health Unit, Public Health Update, Vol.5[1]*). In the four-year period, 1992-1996, there were 550 notifications within the SESAHS and 5,484 in NSW.

Table 33: Measles Notifications, 1992-1996, SESAHS

Age	No.	CNR
0 - 4	140	66.2
5 - 9	194	96.2
10 - 14	105	52.6
15 - 19	51	22.1
20 - 24	31	9.2
25 - 29	11	3.1
30 - 34	9	2.7
35 - 39	2	0.7
40 - 44	4	1.5
45 - 49	3	1.1
50 - 85+	0	-
TOTAL SESAHS	550	14.8
TOTAL NSW	5,484	17.7

Source: Public Health Unit

Cases were evenly distributed in males and females, with more males afflicted in adolescence.

Table 34: Measles Notification by LGA, 1992-1996

LGA of Residence	No.	Notification Rate*
Botany	50	27.8
Hurstville	54	15.8
Kogarah	21	8.4
Randwick	60	9.7
Rockdale	27	6.1
South Sydney (part)	27	11.3
Sutherland	87	8.5
Sydney (part)	0	0
Waverley	65	20.0
Woollahra	8	3.0
Other	151	-
SESAHS Total	550	14.8
NSW Total	5,484	17.7

Source: Public Health Unit

Pertussis

There were 5,747 notifications of pertussis across NSW between the years 1992 - 1996. Of these, 767 notifications occurred in the SESAHS. (Table 35)

Notifications for pertussis rose dramatically in 1992 across the state, from <200 cases a year between 1990 and 1992 to almost 1,600 cases in 1992. Since 1992 notifications have declined in NSW. Notifications in SESAHS are lower than for NSW.

Pertussis is often considered a disease of early childhood. Approximately 37% of cases occurred in adults between 25 and 59 years of age, and 12.5% of those aged over 60 years of age. Notifications are highest in children aged between 5 and 9 nine years (65.5/100,000). (Table 35 & Figure 16)

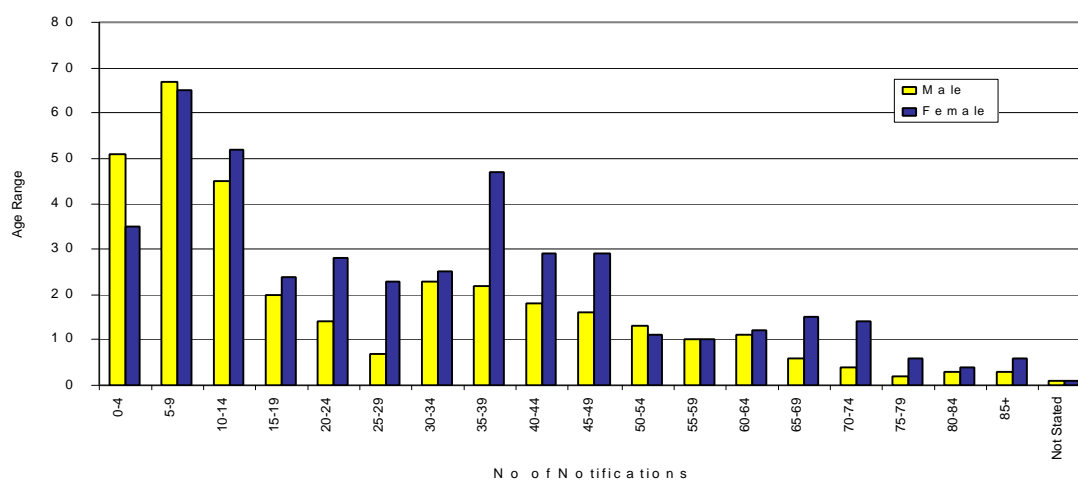
Table 35: Pertussis Notifications by Age, 1992-1996, SESAHs

Age	Male		Female		Total	
	No.	Notification Rate*	No.	Notification Rate*	No.	Notification Rate*
0-4	51	46.7	35	34.2	87	41.1
5-9	67	65.3	65	65.7	132	65.5
10-14	45	44.0	52	53.5	97	48.6
15-19	20	17.1	24	21.1	44	19.1
20-24	14	8.3	28	16.8	42	12.5
25-29	7	4.0	23	13.2	30	8.6
30-34	23	13.4	25	15.6	48	14.4
35-39	22	14.3	47	32.3	69	23.1
40-44	18	13.4	29	21.9	47	17.7
45-49	16	12.2	29	22.3	46	17.6
50-54	13	12.1	11	10.5	24	11.3
55-59	10	11.4	10	11.8	20	11.6
60-64	11	14.9	12	16.2	23	15.6
65-69	6	8.6	15	19.4	21	14.2
70-74	4	6.7	14	18.2	28	20.4
75-79	2	4.7	6	10.1	8	7.9
80-84	3	11.7	4	8.9	7	9.9
85+	3	20.9	6	17.3	9	18.4
Not Stated	1	ND	1	ND	2	ND
SESAHS	331	17.9	434	23.1	767	20.6
NSW					5,747	18.6

*Average Annual Notification Rate per 100,000 population

Source: Public Health Unit

Figure 16: Pertussis Notifications SESAHs by Age and Gender, 1992-1996



The large proportion (>14%) of cases where ethnicity was unknown, compromises the validity of conclusions drawn about ethnicity from notification data. Almost 60% of notifications were for people born in Australia, and 203 cases were reported for people not born in Australia. There were only three notifications for people of Aboriginal or Torres Strait Islander background, but again, the large number of “unknown” responses prohibit the drawing of reliable conclusions. Notification rate across the area was 20.6/100,000 compared with 18.6/100,000 for NSW.

Almost one third of cases of pertussis occurred within the Sutherland Shire, consistent with the age profile of the LGA. Notification rate in Sutherland was 24.8/100,000. The highest notification rates occurred in the LGA of Botany (32.3/100,000) and Waverley (31.6/100,000). The lowest rate of notification occurred in Rockdale (7.9/100,000). (Table 36)

Table 36: Pertussis Notifications by LGA, 1992-1996

LGA of Residence	No.	Notification Rate
Botany	58	32.3
Hurstville	44	12.8
Kogarah	58	23.2
Randwick	104	16.8
Rockdale	35	7.9
South Sydney (part)	27	11.3
Sutherland	253	24.8
Waverley	103	31.6
Woollahra	30	11.2
Other	55	ND
SESAHS	767	20.6
NSW	5,747	18.6

*Average Annual Notification Rate per 100,000 population

Source: Public Health Unit

Pertussis accounted for 69 inpatient episodes of care between 1993-1997, resulting in a total of 431 bed days with an average length of stay of 6.2 days per episode over the four year period. (Table 37)

Table 37: Pertussis Inpatient Episodes in SESAHS Hospitals, 1/7/93 - 30/6/97

Episodes	1993/94	1994/95	1995/96	1996/97	Total
All Episodes	25	8	8	28	69
Day Only Cases	0	0	0	2	2
Total Bed Days	119	46	61	205	431
Average Length of Stay	4.8	5.8	7.6	7.3	6.2

Source: NSW Inpatient Statistics

There was a significant increase in the number of admissions and total bed days in 1996/97.

Almost one third (n=23) of admissions were for residents of other area health services. Twenty percent of all admissions were for residents of Sutherland Shire. (Table 38)

Table 38: *Inpatient Episodes in SESAHS Hospitals by Residence, 1/7/93 –30/6/97*

Locality of Residence	No.	% of Episodes
Botany	5	7.2
Randwick	12	17.4
Rockdale	9	13.0
Sutherland	14	20.3
Other SESAHS	6	8.7
SESAHS Total	46	66.7
Central Sydney AHS	8	11.6
Other NSW	15	21.7
Out of Area Total	23	33.3
All Inpatient Episodes	69	100.0

Source: NSW Inpatient Statistics

Section 4: Current Service Profiles in Communicable Diseases

Description of Services and Programmes

HIV/AIDS Services

HIV/AIDS services are predominantly situated in the northern sector of the SESAHS although some services, particularly health promotion and education services are located in the southern sector. Historically, these have focused on the provision of tertiary and supra-regional inpatient services and tertiary and supra-regional ambulatory care services in line with the acute presentation of most patients and the efficacy of therapeutic interventions at that time. Treatment and prevention services are based at Sydney Sexual Health Centre, Kirketon Road Centre, Langton Centre, Albion Street Centre, Community Health Services and Programmes and Rankin Court (to a lesser degree) in the northern sector and Sutherland/Cronulla and St. George Hospital in the southern sector. Both St. Vincent's and Prince Henry/Prince of Wales Hospitals are designated level 5-6 facilities, and considerable inflows from other areas must be included in assessments of need. Inflows into the area between 1993/4 and 1996/7 accounted for 28,214 bed days, or 33.3% of the total bed days for HIV/AIDS patients. Palliative care services are provided at Sacred Heart Hospice and Calvary Hospital.

Support services for HIV/AIDS patients located within the SESAHS include accommodation services, ambulatory care services, counselling and dental services, education and information, home nursing and inpatient care services, legal services and other support services are provided by Government and non-Government services within the Area. General practitioners are also involved in the care of people living with HIV/AIDS with some large practices operating in the Darlinghurst area.

Hepatitis Services

Currently hepatitis services are provided at limited sites throughout the area. Health promotion/prevention services are provided at Kirketon Road Centre, Langton Centre, St. George Hospital, Rankin Court, Sydney Sexual Health Centre and Drug and Alcohol services within the area. General practitioners and community services are also involved in providing care to people with hepatitis. Treatment services are located in the major teaching hospitals and the Sydney Sexual Health Centre and Kirketon Road Centre. The Hepatitis C Council is also actively involved in the provision of support for people with Hepatitis C and to the community in general with regard to education and prevention programmes. The NSW Users and AIDS Association also provides a prevention, advocacy and information role for injecting drug users. A full list of services is attached (Appendix 3)

Neonatal immunisation for hepatitis B is available at St. George Hospital, Royal Hospital for Women, Hurstville Community Hospital, Sutherland Hospital, St. Margaret's Hospital and the Kareena Private Hospital.

Sexual Health Services

Sexual health services are located at the Sydney Sexual Health Centre, St. George Sexual Health Clinic, Kirketon Road Centre, Women's Health services and general practitioners throughout the area. Health promotion and prevention services and treatment services are available. A full list of services is attached. (Appendix 3)

Tuberculosis Services

Screening for tuberculosis is provided through the Sydney, Prince of Wales, St. Vincent's and St. George Hospitals as well as health promotion/prevention and treatment services. Inpatients are managed in all four teaching hospitals by Respiratory and Infectious Diseases physicians and Microbiologists.

Vaccine Preventable Disease Programmes

Over 90% of childhood immunisations are carried out by general practitioners. There are seven council immunisation clinics in operation within the SESAHS. Opportunistic immunisation is provided in children's wards and emergency departments throughout the area.

Nosocomial Infection Control Programmes

Infection control services are currently organised and provided on a facility basis. There is no current area-wide infection control programme or framework. The service is practitioner driven with considerable differences with policy and procedure.

Current Gaps and Opportunities for Programme Development

Current issues requiring resolution were identified at the June Airport Workshop and the subsequent consultation process. (*Cotton, 1997*)

Specialised HIV/AIDS Services

The reduction in inpatient activity has raised questions concerning the continuing level of specialist inpatient services. It is evident that the supply of inpatient services exceeds the current and anticipated short-term demand. However in considering the future of the inpatient services, it is important to assess their role as a function of the multidisciplinary teams that have been developed to deal with HIV/AIDS and not simply in terms of acute beds. It is essential that closing acute beds to reduce supply does not sacrifice the expertise and experience of these teams. It is also important to ensure continuation of patient choice and accessibility to care.

While the extent to which the reduction in demand for inpatient services will persist is unknown, there is already evidence that the duration of efficiency of current therapy is limited in patients with advanced immunodeficiency. Failure of this therapy will be followed by a resurgence of AIDS-related morbidity and renewed demand for inpatient care. It is imperative that the experienced teams endure to deal with this potential resurgence.

The multiple tertiary HIV/AIDS services in the SESAHS, however, raises a concern regarding the superfluity of services. Overall there is a need for a comprehensive range of services for persons with HIV/AIDS. This leads to an inevitable degree of similarity in the services provided by each facility. However, certain HIV related complications that are sufficiently complex to require specialised care occur

infrequently and are declining in incidence as AIDS incidence declines. It would be appropriate to consider consolidating the experience and expertise associated with uncommon complications.

The 3rd National Strategy predicts that the management of HIV will move more into the primary health care sector during the triennium. The successful outcome of this shift will depend on ensuring that there are adequate community health services to deal with the increased caseload. In addition, linkages between community and specialty services will be required. While the large public community centres should be able to adapt, the resources of the private sector are already extended.

Comprehensive Public Health Services for Patients with Chronic Hepatitis

Current services for patients with chronic viral hepatitis are widely distributed in the SESAHS and are primarily focused on medical care. Public hospital outpatient clinics and the private sector provide these services. The private sector however relies almost completely on the public sector to access virological tests and therapy. Currently there is little integration between the medical services and with other health care services. There is a perceived need for a comprehensive hepatitis treatment programme in the area.

Integration and Coordination of Services

Overall there is little integration or coordination of services relating to communicable disease in the SESAHS. While there has been some coordination of disease focused services e.g. HIV/AIDS and TB, there is no coordination of related communicable disease services.

Section 5: Strategic Directions

The following goals and objectives have been identified as critical in achieving the goals established for these strategic directions. These objectives should provide broad direction for the planning of services targeted towards specific communicable diseases, and should guide the formulation of Communicable Disease policy and programme responses.

The strategic aims of the SESAHS Communicable Disease Directions are to:

- **Provide best practice standards of surveillance, health promotion, prevention, clinical care and treatment for communicable diseases to all patients.**
- **Ensure health care providers and the community are informed regarding the most effective available treatments and approaches.**
- **Ensure the cost-effective delivery of health promotion, prevention and treatment services.**

In line with these aims, the guiding principles for the strategic directions set out in the document are as follows:

- **People living with communicable diseases have the same rights to comprehensive and appropriate health care as other members of the community, without fear of discrimination.**
- **The needs of groups of people, who may experience difficulty in gaining access to appropriate services, including aboriginal, ethnic and socially isolated groups are met. The cultural and social characteristics of special groups will be acknowledged and represented by the community in the planning of communicable disease services.**
- **The increasing complexity and cost of treatment for communicable diseases necessitates a commitment to an evidence based approach to treatment and care. Early intervention, prevention, health promotion, health maintenance and monitoring will be the basis of all guidelines.**
- **Proposed changes to clinical services will be developed within a health outcomes framework. Wherever possible, the indicators for assessing the effectiveness of a change will embrace multidisciplinary and multisectoral aspects of the service to ensure that the Area's progress as a whole is evaluated.**
- **The NSW Health Department Information Policy and Privacy guidelines will be uniformly applied to all situations relating to the use of data and information.**
- **The health and welfare of SESAHS staff will remain a high priority in these Strategic Directions.**

Goal 1

To provide a framework for an integrated, coordinated and comprehensive approach to the planning, provision and evaluation of services in the field of communicable diseases.

Objective 1.1:

Improve the integration and coordination of communicable disease services and programmes to enhance the effectiveness of such services and to maximise the capacity to reach target or at risk populations.

Strategies:

1.1.1 Appoint an Area Director for Communicable Diseases to facilitate implementation of these strategic directions.

1.1.2 Establish a SESAHS Communicable Diseases Advisory Committee that reports to the SESAHS Outcomes Council.

1.1.3 The terms of reference for the SESAHS Communicable Diseases Advisory Committee (CDAC) will demonstrate a population needs approach and will place a significant emphasis on people living with HIV/AIDS, men who have sex with men, Aboriginal, Multicultural, Drug Injecting, Adolescent and Commercial sex worker groups within the community.

1.1.4 The primary mandates of the CDAC will be to link the Area's performance agreement to service outcomes; to monitor outcomes and report to the Outcomes Council; to oversee the implementation of the Communicable Disease Strategic Directions and to determine research and development priorities.

Objective 1.2:

Develop integrated practice partnerships where aspects of communicable disease have a clear and direct relationship with other policy or programme areas (eg. General Practitioners, Mental Health, Drug & Alcohol, Aboriginal and Torres Strait Islander, Housing)

Strategies:

1.2.1 Develop a policy framework that facilitates and supports the integration of effective clinical and administrative partnerships between services and programmes

1.2.2 Develop funding mechanisms that support the integration of services where there is clear and direct relationship.

1.2.3 Maximise the efficiency of services by exploring opportunities for the establishment of practice partnerships with community support services, NGOs and other health care services on a local and supra regional basis.

1.2.4 Provide increased support to General Practitioners through the development of service partnerships with community and hospital based services.

Objective 1.3

Develop an integrated approach to the prevention of communicable disease that facilitates the development of partnerships between community based health promotion and communicable disease prevention programmes.

Strategies:

1.3.1 Develop a policy framework that facilitates and supports the integration of prevention programmes where there is a clear and obvious relationship between prevention/ education programmes.

1.3.2 Develop funding mechanisms that support the integration of prevention strategies/programmes and that reflect equitable financial distribution.

1.3.3. Maximise the opportunities to provide multifocused prevention/education programmes to target population groups.

1.3.4 Demonstrate efficient use of resources through the avoidance of duplication in the provision of education, prevention and treatment services and programmes.

1.3.5 Establish collaborative relationships with community based organisations and NGOs to facilitate coordinated and integrated education and prevention programmes.

Objective 1.4

Develop a framework for the evaluation of communicable disease programmes that are population needs based and that incorporate measures of service effectiveness and efficiency.

Strategies:

1.4.1 Identify, in consultation with key stakeholders, the key components of a model of effectiveness for communicable disease services programmes that captures the key performance measures and data required.

1.4.2 Identify the key performance indicators aligned with state/national performance measures or data required to support the use of the evaluation model.

1.4.3 Identify data sources and data collection structures required to collect the required information to support the evaluation.

1.4.4 Develop strategies to improve performance measures on an ongoing basis.

Goal 2

To establish a standard data set and comprehensive database for communicable diseases throughout the SESAHS.

Objective 2.1:

Develop and implement a comprehensive Communicable Diseases database that is accessible to all health care services and practitioners; meets consumer and legislative requirements for confidentiality and privacy; provides timely, comprehensive and clinically useful reports and that is supported by a comprehensive structural and procedural framework.

Strategies:

2.1.1 Adopt a population needs basis for the evaluation, planning and delivery of communicable disease services within the SESAHS.

2.1.2 Develop common data definitions and data sets and ensure uniform collection across the area.

2.1.3 Link the collection of communicable disease data to the Community Health Information System (CHIS) to improve data collection and minimise duplication of information collection.

2.1.4 Develop policies and procedures to direct access to the database for the purposes of surveillance, evaluation, research, government, non-government and community based organisation service planning.

Goal 3

To reduce the burden of illness and to improve the quality of life of those already living with communicable diseases in the SESAHS.

Objective 3.1:

Develop practice partnerships with consumers, non-Government Organisations and communities to facilitate effective, cooperative effort and joint decision making.

Strategies:

3.1.1 Establish linkages between the Area Health Service, NGOs, community support services and consumers and professional associations to ensure equitable representation and continuity of care.

3.1.2 Facilitate the equitable involvement and representation of consumer, community and NGO representatives in programme or service review activities.

3.1.3 Provide information/education to SESAHS staff on the role and availability of non-public sector services through appropriately funded partnerships.

3.1.4 Establish appropriate referral criteria and mechanisms to facilitate the smooth transfer of patients and support quality of care across the continuum, including rehabilitation and palliative care.

Objective 3.2:

Adopt an approach to the development of services that recognises the chronic nature of many communicable diseases and that is oriented toward assisting the community maintain optimal health status.

Strategies:

- 3.2.1** Ensure that programmes remain sensitive and responsive to the changing epidemiology and clinical spectrum of communicable disease in the SESAHS in manner that best meets the needs of the community.
- 3.2.2** Develop integrated treatment services that reflect the current needs of the community and that facilitate smooth transition between programmes of care.
- 3.2.3** Develop staff education programmes in collaboration with consumer groups that will encourage a therapeutic focus on rehabilitation and wellness.
- 3.2.4** Provide in consultation with community, NGOs and community based organisations, appropriate education and programmes for consumers and informal carers regarding risks and service availability.

Goal 4

To eliminate discrimination in health service planning and delivery and to ensure the protection of the human rights and dignity of people affected by or living with a communicable disease.

Strategies:

- 4.1** Ensure the dissemination of accurate information to health care workers and the community in general about communicable disease within the SESAHS.
- 4.2** Develop in consultation with community and other inter-agency representatives, comprehensive staff education programmes that focus on the values and attitudes surrounding many of the high-risk behaviours of communicable disease target groups.
- 4.3** Develop programmes, in consultation with community organisations and other interagency representatives, including professional associations, to increase community awareness about communicable disease threats to the community.
- 4.4** Establish policies and procedures that ensure unimpeded/prioritised access to housing and other community supports.

Goal 5

To affirm a systems wide commitment to excellence with the provision of communicable disease services.

Strategies:

- 5.1 Provide services that are population focused, and that recognise disease prevention and health promotion as key strategies.
- 5.2 Avoid inappropriate use of hospital services by the timely and appropriate development of community based services.
- 5.3 Provide services which embody the accepted tenets of accountability.
- 5.4 Develop and implement mechanisms to ensure continuity of care across service sites, disciplines and occasions of care.
- 5.5 Maintain the efficiency and effectiveness of state-wide referral services.

Goal 6

To establish financial accountability in the allocation of resources within communicable disease services/programmes.

Objective 6.1

Ensure resource allocation is based on established measures of population need.

Strategies:

- 6.1.1 Target priority and disadvantaged populations in resource distribution.
- 6.1.2 Ensure processes of financial management are transparent, accurate and timely.
- 6.1.3 Monitor the flexibility of the allocation of resources to ensure continued appropriateness.

Section 6: Implementation of Strategic Directions

The Strategic Directions Statement provides a broad framework to guide the changes identified by service providers, consumers and community representatives. The process adopted to support a full implementation will need to take into account local priorities Area and State led initiatives. It is anticipated that the development of specific, operational plans derived from this document will be undertaken, in consultation with the relevant services and consumer/community groups.

Clinical Networks and Accountability Structures

The implementation of the strategic goals and objectives set out in this document will be undertaken by a formal, accountable and participatory process with defined lines of accountability and communication.

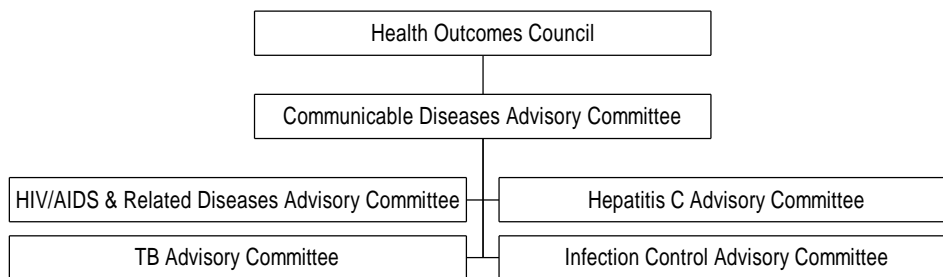


Diagram 2: Proposed Organisational Structure for Communicable Diseases Services

The Communicable Diseases Advisory Committee is to be convened by the Area Director, Communicable Diseases to provide the mechanisms and structures for the integration and coordination of communicable diseases services across the area and will enable Area-wide analysis of trends, patient flows and service utilisation. The Communicable Diseases Advisory Committee will report to the SESAHS Health Outcomes Council. (Diagram 2)

It is proposed that the Committee adopt a population needs based focus with particular emphasis on the needs of the following communities or minority groups; people living with HIV/AIDS, men who have sex with men, people of Aboriginal or Torres Strait Islander background, people of multi-cultural backgrounds, people who are drug injecting, sex workers and adolescents at risk. The committee should also focus on issues related to service barriers and quality of care across communicable disease programmes.

The Terms of Reference of the Communicable Diseases Advisory Committee are:

- To advise the Area Executive on health promotion and health care relating to Communicable Diseases for the population of SESAHS.
- To advise the Area Executive on health outcomes and relevant indicators to evaluate the appropriateness and effectiveness of Area services.
- To monitor health outcomes and indicators and report to the Health Outcomes Council.
- To provide timely advice to the Area Executive on developments in the epidemiology, clinical sequelae and treatment for Communicable Diseases which may affect health outcomes and service planning.

-
- To advise the Area Executive on policy development at an Area level and submissions to State and National policy initiatives.
 - To advise the Area Executive on research priorities to identify population needs and monitor health outcomes.

It is proposed to establish service networks based on compatible clinical priorities. These networks will provide a clinically focused and relevant forum to facilitate expert and informed planning and evaluation of services and therapies. The clinical networks are designed to enhance interagency communication and collaboration, thereby eliminating duplication of effort and enterprise.

Initial Steps in Implementation

Local priorities have been identified as those issues that require action within a short time frame. The development of those priorities is based on the opinions and beliefs expressed throughout the strategic directions development process. The following priorities apply to the **first year** of implementation:

6.1 HIV/AIDS and Related Diseases

6.1.1 Establish a point of leadership and coordination through the appointment of a Director, HIV/AIDS and Related Diseases to oversee the implementation of the strategic directions. This should be for a fixed term of one year in the first instance.

Person Responsible Area Director, Clinical Services

6.1.2 Commission a review of HIV/AIDS counselling services in all sectors (public and non-government), taking into account their appropriateness and relevance to current need.

Person Responsible Director, HIV/AIDS and Related Diseases Unit

6.1.3 Continue the costing study of HIV/AIDS funded clinical services. To include inpatient/day only, outpatient, home-based care services and community based care service.

Person Responsible Evaluation Officer, HIV/AIDS & Related Diseases Unit

6.1.4 Develop a funding distribution model to support better alignment between service need and service delivery, taking into account the need for better linkages and support to community based services, (eg. GPs).

Person Responsible Evaluation Officer, HIV/AIDS & Related Diseases Unit

6.1.5 Establish St. Vincent's Hospital as the centre for specialist HIV - related neuropsychiatric and oncology services. This is to be supported through cross appointments and shared outpatient services delivery.

Person Responsible Director, HIV/AIDS and Related Diseases Unit

6.1.6 Develop an operational strategy based on population need to guide the appropriate development of the HIV/AIDS dementia services, taking into account the need for neurology/neuropsychiatric assessment and diagnostic services.

Person Responsible Director, HIV/AIDS and Related Diseases Unit

6.1.7 Determine the feasibility of consolidating family support services at the Sydney Children's Hospital through the transfer of budget from A.C.O.N.

Person Responsible Executive Director, A.C.O.N.
Executive Director, Sydney Children's Hospital

6.2 Hepatitis C

6.2.1 Establish an Area-wide approach to hepatitis C services. Provide leadership in the development of a comprehensive public service across primary prevention, secondary intervention and tertiary level services.

Person Responsible Area Director, Communicable Diseases

6.2.2 Establish a point of coordination for hepatitis C services through the HIV/AIDS & Related Diseases Unit. To coordinate and facilitate a comprehensive approach to the management of hepatitis at a primary prevention and secondary intervention level.

Person Responsible Area Director, Communicable Diseases

6.2.3 Develop operational strategies based on population need to guide the development of a comprehensive approach to primary, secondary and tertiary level hepatitis service development.

Person Responsible Area Director, Communicable Diseases

6.3 Nosocomial Infections

6.3.1 Establish a point of leadership through the appointment of a Director, Infection Control to oversee the development of a cohesive approach to infection control surveillance, vaccine preventable diseases in health care workers and occupational health and safety as it relates to the clinical environment.

Person Responsible Area Director, Nursing and Community Development

6.3.2 Establish an Infection Control Advisory Committee that reports to the Communicable Disease Advisory Committee.

Person Responsible Director, Infection Control

6.4 Communicable Diseases (*all services*)

6.4.1 Re-assess the office productivity and community health information systems priorities for roll-out across the Area with a view to giving communicable disease services a high priority.

Person Responsible Sponsor, CHIS
CDAC

6.4.2 Install the necessary communication links across all communicable disease services to enable standardised data to be collected.

Person Responsible Area Director, Information Services
Area Director, Communicable Diseases

6.4.3 Establish a comprehensive database that is supported by standard data sets and standard data definitions taking into account the NSW Department of Health Community Health Information systems development.

Person Responsible Sponsor, CHIS

6.4.4 Develop an operational strategy to guide a systematic evaluation of services.

Person Responsible Evaluation Officer, HIV/AIDS & Related Diseases Unit

Section 7: Evaluation of Strategic Directions.

Evaluation of the implementation Communicable Disease Strategic Directions Statement will be undertaken both directly and indirectly. The Area Director, Communicable Diseases and the Communicable Diseases Advisory Committee will be responsible for the evaluation of the implementation of the Statement.

The evaluation will be undertaken in the following areas.

1. Evaluation of the implementation of the Strategic Directions.

Performance Measures:

- 1.1 Establishment of outcome council structure and process.
- 1.2 Evidence of integration of services where appropriate (*eg joint clinics, education, surveillance*)
- 1.3 Establishment of a Communicable Disease database and reporting mechanism
- 1.4 Plan for Hepatitis C services - linked to Drug and Alcohol Hepatology, HIV Services, Sexual Health Services and targeted primary care services.

2. Impact of the strategies on health services organisation.

Performance measures:

- 2.1 Evidence of greater integration of services at clinical, administrative and funding levels.
- 2.2 Integration reflected in the service and operational plans of the discrete communicable disease programmes.
- 2.3 Evidence of greater recognition and integration of general practitioners and community health organisations in planning, funding, delivery and evaluation of services.
- 2.4 Improve access, including access for community based organisations/NGOs to timely, accurate and clinically relevant communicable disease data for the purposes of service planning and evaluation of therapy.

3. Impact of the strategies on the health status of the community in relation to communicable diseases.

Performance Measures:

- 3.1 Specifically the following areas will be monitored in relation to the strategic directions:
 - HIV/AIDS
 - Hepatitis C
 - Measles
 - Whooping Cough
 - Syphilis, Chlamydia trachomatis, Gonorrhoea
 - Nosocomial Infection
 - Tuberculosis
 - Hepatitis A

Evaluation should include measure of incidence, prevalence, immunisation rates, general health assessment/measures, quality of life measures. Additional evaluation should include specific

measures of effectiveness of targeted therapies and of issues of access, especially for marginal or disadvantaged groups within the target populations.

4. Impact on access

Performance measures:

- 4.1 % NESB accessing services
- 4.2 % Aboriginals accessing services
- 4.3 Access for minority groups (MSM, young IDU)
- 4.4 Monitor specific related questions in SES Community Health Survey

5. Impact on appropriateness

Performance measures:

Right patients, right time, right cost, right approach.

6. Impact on social indicators

Performance measures:

- 6.1 Poverty
- 6.2 Homelessness/housing
- 6.3 Welfare recipients

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South Eastern Sydney Area Health Service. (1998) Corporate Directions Statement

Appendix 1: Communicable Diseases Strategic Plan - Steering Committee Members.

Ms Reta Creegan, Area Director, Nursing & Community Development, SESAHS (Chair)

Mr. Don Baxter, SESAHS Board Representative

Prof. Syd Bell, SEALS

Mr. Colin Clews, Acting HIV/AIDS Co-ordinator, SESAHS

Mr. Bernie Coates, ACON

Ms. Robyn Cook, ISD

Ms. Robyn Donnellan, CNC Infection Control

Dr. Mark Ferson, Director, Public Health Unit

Ms. Sue Hanson, Area Nurse Manager, Education, Research and Evaluation

Dr. Sylvia Jacobson, SESAHS GP Liaison Officer

Mr. Frank Jin, HIV/AIDS Services, SESAHS

Dr. Phillip Jones, Director, Department of Infectious Diseases, PHH

Ms. Elizabeth Koff, Service Planner, Clinical Services Unit, SESAHS

Dr. Lynette Lee, Director, Clinical Services Unit, SESAHS

Dr. Debbie Marriott, Australian Society for HIV Medicine, St. Vincent's Hospital

A/Professor Basil Donovan, Australasian College of Sexual Health Physicians

Mr. Stephen Davies, Australasian College of Sexual Health Physicians

Mr. Phillip Medcalf, People Living with HIV/AIDS

Dr. Ian Rewell, Executive Director, Sydney/Sydney Eye Hospitals

Ms. Sally Torr

Mr. Stuart Loveday, Hepatitis C Council.

Ms. Sue Stewart, Special Projects Officer, SESAHS.

Working Party Convenors

Surveillance Working Party
Prevention Working Party
Treatment Working Party
Long Term Issues Working Party

Dr. Mark Ferson
Mr. Colin Clews
Dr. Phillip Jones
Ms. Sally Torr

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St. Vincent's Hospital

Assoc. Professor Basil Donovan

Australasian College of Sexual Health Physicians
Sydney Sexual Health Centre, Sydney Hospital

Dr. Ingrid van Beek

Director, Kirketon Road Centre

Dr. Julian Gold

Director, Albion Street Centre

Dr. Richard Lawrence

Infectious Diseases
St. George Hospital

Dr. Debbie Marriot

Infectious Diseases/Microbiology
St. Vincent's Hospital

Dr. Pam Palasanthiran

Infectious Diseases
Sydney Children's Hospital

Dr. Peter Taylor

Microbiology/Infection Control
Prince of Wales Hospital

Mr. Philip Medcalf

People Living with HIV/AIDS, Darlinghurst

Ms. Deborah Thoms

Executive Officer
Royal Hospital for Women

Dr. Pauline Rumma

Medical Superintendent
Sutherland Hospital

Dr. Gerald Barold

Executive Director
Eastern Sydney Division of General Practice

Dr. Ana Singer

Co-ordinator
South Eastern Sydney Division of General Practice

Dr. Karen Flegg

Director, St. George District Division of General Practice

Dr. Phillip Lye

Chairman, Sutherland Division of General Practice

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Dr. David Baker

407 Bourke street, Taylor Square

Dr. Neil Bodsworth

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Mr. Bernie Coates

ACON

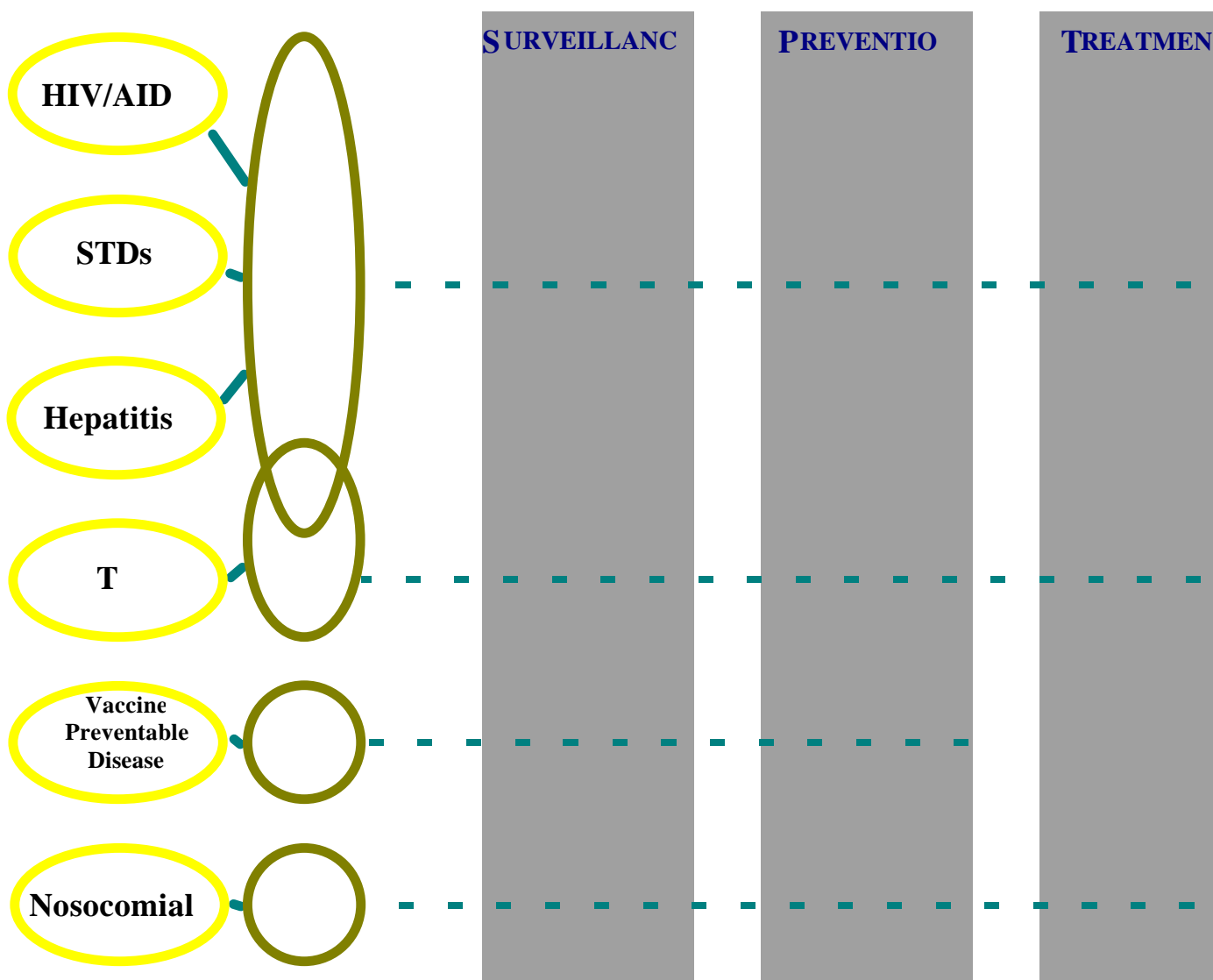
A/Prof. Ron Pirola

Gastroenterology
Prince of Wales Hospital

Dr. Sylvia Jacobsen

SESAHS GP Liaison Officer.

CONCEPTUAL



CONCEPTUAL FRAMEWORK

