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PUBLICATIONS, PRESENTATIONS & COLLABORATORS 2009-10



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Peer-Reviewed Journals

- Ada L, **Sherrington C**, Canning CG, Dean CM, Scianni A. Computerized tracking to train dexterity after cerebellar tumour: a single-case experimental study. *Brain Injury*. 2009;23:702-6.
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Williams CM, Maher CG, Hancock MJ, McAuley JH, McLachlan AJ, Britt H, Fahridin S, Latimer J. Usual care of low back pain in primary care and a comparison to evidence-based guideline recommendations. Abstracts from the Australian Physiotherapy Association Conference Week: Musculoskeletal Physiotherapy Australia. Sydney, Australia, October 2009. *Journal of Physiotherapy*. 2009;55(4):43.

Conference Presentations

CRAIG ANDERSON

The rewards and challenges of research in China. Sleep and Circadian Research Meeting (Woolcock Institute). Sydney, Australia, April 2010.

Assessment and management of the non-physical components of stroke. Stroke Clinical Network Forum. Brisbane, Australia, April 2010.

Medical treatment of acute intracerebral hemorrhage. International Stroke Conference. San Antonio, USA, February 2010.

The second, main phase, of the Intensive Blood Pressure Reduction in Acute Cerebral Haemorrhage Trial (INTERACT2): progress update. International Stroke Conference. San Antonio, USA, February 2010.

Establishment of the new Australian Clinical Stroke Registry (AuSCR) Clinical Trials in stroke. 11th Statewide Stroke Clinical Network Forum. Brisbane, Australia, October 2009.

Collaborative International Research. Royal Prince Alfred Hospital Reunion Week. Sydney, Australia, August 2009.

Stroke as a medical emergency. Royal Prince Alfred Hospital Reunion Week. Sydney, Australia, August 2009.

Trials and tribulations of the conduct of academic clinical trials in China: experience in the area of stroke. 2nd Sino-Australian Symposium. Sydney, Australia, August 2009.

Disparities in secondary prevention between cardiac and stroke patients. Sanofi-Aventis Neuro Event. Sydney, Australia, July 2009.

HISATOMI ARIMA

Effects of blood pressure levels at presentation and those achieved during the first 24 hours on haematoma growth in acute intracerebral haemorrhage: the INTERACT trial. High Blood Pressure Research Council of Australia annual scientific meeting 2009. Sydney, Australia, December 2009.

Effects of early intensive blood pressure lowering on haematoma growth in acute intracerebral haemorrhage according to time from onset to treatment: the INTERACT study. The 32nd Annual Scientific Meeting of the Japanese Society of Hypertension. Otsu, Japan, October 2009.

LAURENT BILLOT

Clinical Management Online: Electronic Data Capture (EDC) and Management. eHealth – The Modern Age Healthcare. Sydney, Australia, November 2009.

SOUFIANE BOUFOUS

Ethnicity, risky driving behaviour and road traffic crashes: findings from the DRIVE Study. National Conference on Injury Prevention and Safety Promotion. Melbourne, Australia, July 2009.

ALAN CASS

Diabetic kidney disease: epidemiology and prevention. Endocrine Society of Australia Annual Scientific Meeting. Wollongong, Australia, May 2010.

Domestic and international research collaborations in chronic kidney disease. World Congress of Internal Medicine. Melbourne, Australia, March 2010.

Economics of home-based dialysis therapies. 3rd Australia and New Zealand Home Therapies Workshop. Brisbane, Australia, February 2010.

Diabetes, heart and kidney disease: the health reform challenge we must address. Australian Diabetes Educator Association ACT Branch Conference. Canberra, Australia, February 2010.

Public hospitals and medical research – Where now? St George Hospital Medical Research Symposium. Sydney, Australia, November 2009.

Intensity of Renal Replacement Therapy in Critically ill Patients: the Randomised Evaluation of Normal versus Augmented Level Renal Replacement Therapy (RENAL) study. Late-breaking Clinical Trials Plenary Session. Annual Scientific Meeting of the American Society of Nephrology. San Diego, USA, October/November 2009.

The RENAL study – Randomised Evaluation of Normal versus Augmented Levels of Renal Replacement Therapy in Severe Acute Kidney Injury. Kidney Health Australia Clinical Research Award Session. 45th Annual Scientific Meeting of the Australia and New Zealand Society of Nephrology. Hobart, Australia, September 2009.

Rationale and design of the ACTIVE Dialysis trial: a multi-centre, unblinded, randomised controlled trial of extended vs standard duration of dialysis in patients with end-stage kidney disease. 2nd Congress of the International Society for Haemodialysis. Hong Kong, August 2009.

Global challenges in the provision of renal care. 2nd Congress of the International Society for Haemodialysis. Hong Kong, August 2009.

Leadership in research and medicine in Aboriginal health and chronic disease. Sydney University Medical Society Leadership Forum. Sydney, Australia, August 2009.

Participation of Indigenous Australians in cardiovascular trials: Making it happen. Cardiac Society of Australia and New Zealand Annual Scientific Meeting. Sydney, Australia, August 2009.

JOHN CHALMERS

Optimal hypertension management with Preterax. Satellite Symposium on Maximizing Benefits in Hypertension Management with Preterax. 20th European Meeting on Hypertension, European Society of Hypertension (ESH). Oslo, Norway, June 2010.

The importance of blood pressure lowering in type 2 diabetes: focus on ADVANCE. 13th Annual Meeting of the Institute of Cardiovascular Medicine & Science. Hong Kong, December 2009.

Does blood glucose lowering reduce cardiovascular outcomes – a perspective on the trials. Asia Pacific Conference on the Metabolic Syndrome. Melbourne, Australia, November 2009.

New Results from ADVANCE. Mainline Symposium on Latest Clinical Trials. 20th World Diabetes Congress. Montreal, Canada, October 2009.

ADVANCE: new results of the intensive Diamicon MR-based strategy. Satellite Symposium to the 20th World Diabetes Congress. Montreal, Canada, October 2009.

Cognitive function and risk of cardiovascular disease and hypoglycaemia among patients with type 2 diabetes in ADVANCE. 19th International Association of Gerontology and Geriatrics World Congress. Paris, France, July 2009.

Older patients with type 2 diabetes derive substantial benefits from blood pressure lowering with perindopril-indapamide. 19th International Association of Gerontology and Geriatrics World Congress. Paris, France, July 2009.

TOM CHEN

Socioeconomic status and risk of car crash injury: results from the DRIVE study. Road Safety Research, Education and Policing Conference. Sydney, Australia, November 2009.

LEONARDO COSTA

Motor control exercise for chronic low back pain: a randomised, placebo-controlled trial. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

Prognostic factors in chronic low back pain patients: inception cohort study. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

Reproducibility of rehabilitative ultrasound imaging for the measurement of abdominal muscle activity: a systematic review. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

ZHAOHUI CUI

Community interventions for child obesity prevention. World Congress of Cardiology Scientific Sessions. Beijing, China, June 2010.

Temporal trends in overweight and obesity of children and adolescents from nine provinces in China from 1991 to 2006. 19th International Congress of Nutrition. Bangkok, Thailand, October 2009.

CANDICE DELCOURT

Determinants of quality of life after stroke in China. Combined Meeting of the 6th Asia Pacific Conference Against Stroke and the 20th Stroke Society of Australasia Annual Scientific Meeting. Cairns, Australia, September 2009.

The second intensive blood pressure reduction in acute intracerebral haemorrhage trial (INTERACT2) update. 6th Asia Pacific Conference Against Stroke. Cairns, Australia, September 2009.

JOANNA DIONG

Passive mechanical properties of gastrocnemius muscles of spinal cord injured patients with ankle contractures. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

XIN DU

Data presentation to develop a non-laboratory-based cardiovascular risk prediction model among Chinese population. World Congress of Cardiology Scientific Sessions. Beijing, China, June 2010.

Identifying barriers toward implementing absolute cardiovascular risk assessment tools in primary care setting. World Congress of Cardiology Scientific Sessions. Beijing, China, June 2010.

Monitoring of liver function in patients using statin and its consequences to therapy adherence. World Congress of Cardiology Scientific Sessions. Beijing, China, June 2010.

Treatment of atrial fibrillation during pregnancy. World Congress of Cardiology Scientific Sessions. Beijing, China, June 2010.

ELIZABETH DUNFORD

Monitoring sodium reduction in Australian processed foods. 8th International Food Databank Conference. Bangkok, Thailand, October 2009.

Progress with reducing salt in the Australian food supply. Emerging Health Policy Conference. Sydney, Australia, August 2009.

NICOLA FAIRHALL

Measurement of participation restriction in older people. 8th National Conference of Emerging Researchers in Ageing. Melbourne, Australia, October 2009.

Participation restriction: nature, extent and associated factors in frail, community-dwelling older people. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

MANUELA FERREIRA

Can we explain heterogeneity among exercise randomised clinical trials in chronic low back pain? A meta-regression of randomised controlled trials. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

Factors defining care-seeking in low back pain – a meta-analysis of population based surveys. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

Smallest worthwhile effect of interventions for low back pain. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

Patients beliefs and experiences. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

SIMON FINFER

My experience with H1N1. 30th International Symposium on Intensive Care and Emergency Medicine. Brussels, Belgium, March 2010.

Literature interpretation. 30th International Symposium on Intensive Care and Emergency Medicine. Brussels, Belgium, March 2010.

Subgroup analysis: used, abused, misunderstood. 30th International Symposium on Intensive Care and Emergency Medicine. Brussels, Belgium, March 2010.

International variation in the use of intravenous fluids. 30th International Symposium on Intensive Care and Emergency Medicine. Brussels, Belgium, March 2010.

Albumin in patients with sepsis and traumatic brain injury. 30th International Symposium on Intensive Care and Emergency Medicine. Brussels, Belgium, March 2010.

Hypoglycemia in the NICE-SUGAR study. 30th International Symposium on Intensive Care and Emergency Medicine. Brussels, Belgium, March 2010.

Corticosteroids in septic shock – why I don't use them. 30th International Symposium on Intensive Care and Emergency Medicine. Brussels, Belgium, March 2010.

How to know what "works" in sepsis: understanding strength and weakness in clinical research. 30th International Symposium on Intensive Care and Emergency Medicine. Brussels, Belgium, March 2010.

Glucose control in critical care. Canadian Critical Care Conference. Whistler, Canada, March 2010.

Papers that changed practice in 2010. Canadian Critical Care Conference. Whistler, Canada, March 2010.

Medicolegal issues in critical care – the expert witness view. Canadian Critical Care Conference. Whistler, Canada, March 2010.

The Gillian Hanson Lecture: ICU Research – A journey through the looking glass. Intensive Care Society State of the Art Meeting. London, UK, December 2009.

The Intensive Care Ashes: why Australia won. Intensive Care Society State of the Art Meeting. London, UK, December 2009.

The NICE-SUGAR study. Intensive Care Society State of the Art Meeting. London, UK, December 2009.

Update on clinical trials – the NICE-SUGAR study. Sepsis International Symposium. Amsterdam, the Netherlands, November 2009.

JAVIER GUZMAN

Global funding of innovation for neglected diseases (G-FINDER). Annual Forum of the Global Forum for Health Research. Havana, Cuba, November 2009.

Understanding the challenges of technology transfer from a country perspective. Annual Forum of the Global Forum for Health Research. Havana, Cuba, November 2009.

MAREE HACKETT

Single questions to screen for depression miss important negative cognitions. Combined Meeting of the 6th Asia Pacific Conference Against Stroke and the 20th Stroke Society of Australasia Annual Scientific Meeting. Cairns, Australia, September 2009.

ROB HERBERT

A pragmatic randomised trial of stretching before and after physical activity to prevent injury and soreness. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

STEPHANE HERITIER

Two-stage seamless adaptive designs: the Hemangioma study. Australian Biopharmaceutical Statistics Group Meeting. Sydney, Australia, December 2009.

Two-stage adaptive design with dose selection and non-inferiority comparison to a standard treatment. International Meeting on Recent Advances & Trends in Statistics Applied to Clinical Trials. Paris, France, September 2009.

GRAHAM HILLIS

Heart rate in heart failure. Australian Atherosclerosis Society/ International Society for Vascular Health Combined Scientific Session. Melbourne, Australia, October 2009.

Large artery disease: biomarkers and medication. Australian Atherosclerosis Society / International Society for Vascular Health Combined Scientific Session. Melbourne, Australia, October 2009.

REBECCA IVERS

Indigenous status and risk of motor vehicle crash: the DRIVE study. 9th National Conference on Injury Prevention and Safety Promotion. Melbourne, Australia, July 2009.

Motor vehicle crashes in Indigenous youth in New South Wales, Australia: the DRIVE study. 9th National Conference on Injury Prevention and Safety Promotion. Melbourne, Australia, July 2009.

STEPHEN JAN

The role of health insurance in addressing economic hardship following stroke in China. International Health Economics Association Conference. Beijing, China, July 2009.

Harmonising value of information methods with decision making in practice – organised session. International Health Economics Association Conference. Beijing, China, July 2009.

STEVE KAMPER

Low back pain and disability scores in 'completely recovered' patients. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

LIANG KE

Behavioral and clinical effectiveness of community-based individualised lifestyle intervention among diabetic and hypertensive Chinese adults. World Congress of Cardiology Scientific Sessions. Beijing, China, June 2010.

LISA KEAY

Urban and rural differences in older drivers – failure to stop at stop-signs. The Eye and the Auto. Detroit, USA, September 2009.

A multi-site study evaluating fungal keratitis in the US 2001-2007. International Society for Contact Lens Researchers Biennial Meeting. Crete, Greece, August 2009.

Driving errors influence an older drivers' decision to give up or restrict driving. 9th National Conference on Injury Prevention and Safety Promotion. Melbourne, Australia, July 2009.

LIKHIM KWAH

Passive mechanical properties of gastrocnemius muscle and tendon in stroke patients with contracture. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

JANE LATIMER

Conducting RCTs: real world considerations. American Physical Therapy Association Combined Sections Meeting. San Diego, USA, February 2010.

Yajilarra. To dream: Aboriginal women leading change in remote Australia. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

Indigenous health and the Fitzroy Valley. Rotary Combined Districts Conference. Sydney, Australia, October 2009.

Key issues for different older populations: working with Aboriginal women. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

Alcohol in Indigenous communities. University of NSW Indigenous Law Centre Open Forum. Sydney, Australia, September 2009.

NICOLE LI

Action on salt and health: an evidence-based advocacy approach to make salt reduction a national priority in China. World Hypertension Congress. Beijing, China, October 2009.

CHRISTINE LIN

Introducing PEDro: The Physiotherapy Evidence Database. 11th National Congress of the Chinese Society of Physical Medicine and Rehabilitation. Shenyang, China, November 2009.

Physiotherapy interventions for non-specific low back pain – value for money? Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

5 x 5 Session 4 – hip, knee, lower limb kinematics. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

Treatments for back pain: are they worthwhile? University of Sydney Early Career Research Showcase. Sydney, Australia, September 2009.

What do we use as our inclusion criteria when investigating insufficiencies and implementing interventions for subjects with chronic ankle instability (CAI)? The 4th International Ankle Symposium. Sydney, Australia, July 2009.

Predicting activity limitation after ankle fracture. The 4th International Ankle Symposium. Sydney, Australia, July 2009.

New dimensions in the Clinic Session 2. The 4th International Ankle Symposium. Sydney, Australia, July 2009.

MARILYN LYFORD

Safety promotion capacity building in Australian Indigenous communities – a partnership program. 9th National Conference on Injury Prevention and Safety Promotion. Melbourne, Australia, July 2009.

LUCIANA MACEDO

Graded activity and graded exposure for persistent non specific low back pain: a systematic review. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

CHRIS MAHER

Management of back pain in primary care. Pharmacy Expo 2010. Sydney, Australia, June 2010.

Diagnosis and prognosis of low back pain. Are current guidelines too simple? American Physical Therapy Association Combined Sections Meeting. San Diego, USA, February 2010.

How to design and conduct RCTs: real-world considerations. American Physical Therapy Association Combined Sections Meeting. San Diego, USA, February 2010.

STEPHEN MACMAHON

The role of academic health centres in developing global health priorities. John P. McGovern Award Lecture. Association of Academic Health Centers International Forum. Washington DC, USA, March 2010.

The global burden of chronic diseases. First Annual Beijing Forum on the Prevention and Management of Chronic Disease. Beijing, China, November 2009.

Effects of existing interventions for cardiovascular disease prevention and treatment. Global Alliance for Chronic Disease Scientific Meeting. New Delhi, India, November 2009.

Cardiovascular disease crisis in the developing world. The Chancellor's Lecture Series, Duke Medical Center. Durham, USA, September 2009.

Cardiovascular disease in the developing world. Symposium: Genetic Epidemiology and Cardiovascular Disease, the University of Oxford. Oxford, UK, July 2009.

ALEX MARTINIUK

Coordination of health aid in the Solomon Islands. Australian Association for the Advancement of Pacific Studies (AAAPS). Melbourne, Australia, April 2010.

Lightning talk and network walk. Annual Forum of the Global Forum for Health Research. Havana, Cuba, November 2009.

ALINA MCDONALD

Fighting neglected diseases with innovation – the past, present and future. Cambridge International Development Course, Cambridge, UK, May 2010

ZOE MICHALEFF

Design of a randomised clinical trial of a combined exercise treatment for chronic whiplash. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

MARY MORAN

G-FINDER and implications of US Funders. Global Health Technologies Coalition. Washington DC, USA, October 2009.

Global funding of R&D to treat neglected diseases and G-FINDER survey. Neglected Diseases Forum: Progress, Current Challenges and Promising Approaches. Washington DC, USA, October 2009.

ANNE MOSELEY

Reported quality of randomised controlled trials of physiotherapy interventions has improved over time. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

JOHN MYBURGH

The Crystalloid versus Hydroxyethyl Starch Trial (CHEST). Australian and New Zealand Intensive Care Society Clinical Trials Group Annual Meeting. Noosa, Australia, March 2010.

SAFE TBI II – results. Australian and New Zealand Intensive Care Society Clinical Trials Group Annual Meeting. Noosa, Australia, March 2010.

What fluid should I use for resuscitation? World Congress of Internal Medicine. Melbourne, Australia, March 2010.

Development of a clinical algorithm for intracranial hypertension: the Brain Trauma Foundation consensus process. Scottish Intensive Care Society Annual Scientific Meeting. St Andrews, UK, January 2010.

Evidence for the use of vasopressors in critically ill patients. Scottish Intensive Care Society Annual Scientific Meeting. St Andrews, UK, January 2010.

Optimising glycaemic control in critically ill patients. Annual Scientific Meeting in Anaesthesiology. Hong Kong College of Anaesthesiology and Society of Anaesthesia. Hong Kong, October 2009.

Determining the optimal dose of renal replacement therapy in critically ill patients. Annual Scientific Meeting in Anaesthesiology. Hong Kong College of Anaesthesiology and Society of Anaesthesia. Hong Kong, October 2009.

Evidence for the use of vasopressors in critically ill patients. Annual Scientific Meeting in Anaesthesiology. Hong Kong College of Anaesthesiology and Society of Anaesthesia. Hong Kong, October 2009.

Development of a clinical algorithm for intracranial hypertension: the Brain Trauma Foundation consensus process. Australian and New Zealand Intensive Care Society New South Wales Regional Meeting. Sydney, Australia, September 2009

Why we need the CHEST trial on the safety and efficacy of 6% hydroxyethyl starch 130/0.4. 4th International Congress of the German Sepsis Society. Weimar, Germany, September 2009.

Albumin in sepsis – an in depth analysis of the SAFE Study. 4th International Congress of the German Sepsis Society. Weimar, Germany, September 2009.

Vasoactive agents in critically ill patients. Combined Congress of the Critical Care Society of South Africa and the South African Thoracic Society. Sun City, South Africa, August 2009.

Large-scale studies on intensive insulin therapy in critically ill patients. Combined Congress of the Critical Care Society of South Africa and the South African Thoracic Society. Sun City, South Africa, August 2009.

Priorities in management of traumatic brain injury. Combined Congress of the Critical Care Society of South Africa and the South African Thoracic Society. Sun City, South Africa, August 2009.

BRUCE NEAL

Treatment and prevention of cardiovascular diseases in developed and developing country settings – health transition in rural India. Surfer's Medical Association Australia 17th Multi-Focused Indian Ocean Medical Symposium. Exchanging Knowledge and Experiences. Providing Aid to Those in Need. Chaaya Island, Maldives, April 2010.

Can you do what you want to do? AstraZeneca Cardiovascular Specialist Symposium. Sydney, Australia, February 2010.

Making and interpreting blood pressure measurements. Philippine Society of Hypertension (PSH) & Asian Pacific Society of Atherosclerosis and Vascular Diseases (APSVD). Manila, the Philippines, February 2010.

The strengths and weaknesses of blood pressure monitoring. Malaysian Society of Hypertension. Kuala Lumpur, Malaysia, January 2010.

How should women at risk be managed? Malaysian Society of Hypertension. Kuala Lumpur, Malaysia, January 2010.

National sodium reduction strategies and policies: experience from Australia. Global Cardiovascular Health Division for Heart Disease and Stroke Prevention. National Center for Chronic Disease Prevention and Health Promotion Meetings. Atlanta, USA, December 2009.

Should you be eating that much s**t? (salt). Wollongong Branch of the Nutrition Society of Australia dinner. Wollongong, Australia, October 2009.

Should you be eating that much s**t? (salt). Australian Academy of Science Symposium. Sydney, Australia, August 2009.

Tight glycaemic control and cardiovascular death in diabetes. 57th Annual Scientific Meeting of the Cardiac Society of Australia and New Zealand. Sydney, Australia, August 2009.

Why we should reduce dietary salt. The George Institute, India. Hyderabad, India, August 2009.

Salt substitution in China. Harvard Initiative for Global Health. Chronic and Cardiovascular Diseases Working Group Meeting. Boston, USA, July 2009.

Setting the scene – salt and ill health. International Life Sciences Institute, Southeast Asia Region – Australasia Symposium. The Science of Salt: Industry, Innovation and Best Practice in Reducing Salt in Foods. Sydney, Australia, July 2009.

BP measurement. Cardiovascular Disease in Developing Countries – Moving Forward. Boston, USA, July 2009.

ROBYN NORTON

ICMR, University of Sydney and George Institute – scope for collaboration. Workshop on Adolescent Obesity and Diabetes. Indian Council of Medical Research, Ministry of Health & Family Welfare, Government of India, & the University of Sydney and The George Institute. Hyderabad, India, February 2010.

Road Traffic Injuries Research Network multi-country study on motorcycle helmets: capacity building for research. Building and Road Research Institute and Road Traffic Injuries Research Network. Accra, Ghana, December 2009.

Providing evidence to guide the health care reform agenda: international experience. Health Policy Roundtable. Ministry of Health Bureau of Disease Control and The George Institute, China. Beijing, China, November 2009.

Chronic diseases and injuries: a major but neglected component of the global health agenda. Global Health Day, the University of Sydney. Sydney, Australia, August 2009.

ANUSHKA PATEL

Impact of glucose control on macrovascular and microvascular diseases: insights from ADVANCE. American Heart Association Scientific Sessions. Orlando, USA, November 2009.

Cardiovascular risk in Australians and Indians: lessons from comparative studies. 6th Indo-Australian Biotechnology Conference. Hyderabad, India, September 2009.

Co-morbidities and risk factors for coronary disease in Indigenous populations. Cardiac Society of Australia and New Zealand Indigenous Cardiovascular Health Conference. Sydney, Australia, August 2009.

Update on polypill trials. 57th Annual Scientific Meeting of the Cardiac Society of Australia and New Zealand. Sydney, Australia, August 2009.

Time to ditch blinded endpoint adjudication? 57th Annual Scientific Meeting of the Cardiac Society of Australia and New Zealand. Sydney, Australia, August 2009.

Blood pressure and blood glucose control in diabetes. 57th Annual Scientific Meeting of the Cardiac Society of Australia and New Zealand. Sydney, Australia, August 2009.

Dr PS Rao Annual Oration – Implementing new paradigms for cardiovascular disease prevention. XIV Annual Meeting of the Cardiologists Society of India (Andhra Pradesh Chapter). Vijayawada, India, July 2009.

DAVID PEIRIS

Monitoring and clinical systems in primary care. Aboriginal Health & Medical Research Council Action for Health Conference. Sydney, Australia, September 2009.

Chronic care in the primary health sector – will COAG help? Cardiac Society of Australia and New Zealand Indigenous Cardiovascular Health Conference. Sydney, Australia, August 2009.

VLADO PERKOVIC

Blood pressure management in dialysis patients. Canadian Society of Nephrology Annual Meeting. Montreal, Canada, May 2010.

Recent clinical trials in home and extended hours haemodialysis. 3rd Australia and New Zealand Home Therapies Workshop. Brisbane, Australia, February 2010.

Which marker, what risk? Australasian Clinical Nephrology Symposium. Melbourne, Australia, August 2009.

JULIE REDFERN

A national framework for ongoing cardiovascular disease risk reduction. 6th Health Services and Research Policy Conference. Brisbane, Australia, November 2009.

Implementation science. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

Cardiac rehabilitation – moving forward. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

Community care is better than hospital management – debate. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

Cardiac rehabilitation by CHOICE. Victorian Cardiac Rehabilitation Coordinators Conference. Melbourne, Australia, August 2009.

Secondary prevention and patient choices. Cardiac Society of Australia and New Zealand Annual Scientific Meeting. Sydney, Australia, August 2009.

Exercise prescription for cardiac patients. Australian Cardiac Rehabilitation Association Conference. Sydney, Australia, August 2009.

KATHARINE SCRIVENER

An observational study of mobility outcomes for 100 stroke survivors. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

TERESA SENSERRICK

Driver education in the community. Road Safety Research, Policing & Education Conference. Sydney, Australia, November 2009.

CATHIE SHERRINGTON

Development of the Prediction of Falls In Rehabilitation Settings Tool (Predict-FIRST): a prospective cohort study. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

Hip fracture rehabilitation: update on the evidence and next steps. Enhancing Mobility after Hip Fracture Symposium. Vancouver, Canada, October 2009.

What works in exercise to prevent falls and injuries? Australian Osteopathy Association Conference Week. Sydney, Australia, October 2009.

Physical activity in people aged 40-65: implications for an ageing population. Queensland Department of Health. Talk to clinicians and health promotion staff. Brisbane, Australia, June 2010.

MARK STEVENSON

Validation of the Vietnam mortality study. Statistics New Zealand and the Australasian Mortality Data Interest Group Combined Meeting. Wellington, New Zealand, December 2009.

Driven to distraction: road safety research for 2020. Australasian College of Road Safety National Conference. Perth, Australia, November 2009.

Road safety 2020: smart solutions, sustainability, vision. Australasian College of Road Safety National Conference. Perth, Australia, November 2009.

COLMAN TAYLOR

Research in progress – the cost and benefit of helicopter emergency medical services. Emerging Health Policy Conference. Sydney, Australia, August 2009.

Helicopters – cost effective? South West Area Network XVII Trauma Conference. Liverpool Hospital. Sydney, Australia, July 2009.

ANNE TIEDEMANN

The development of a brief performance-based fall risk assessment tool (QuickScreen) for community-dwelling older people. Australian Physiotherapy Association Conference Week. Sydney, Australia, October 2009.

Predictors of adherence to a supervised exercise program in older community dwelling people. 7th National Physical Activity Conference. Brisbane, Australia, October 2009.

FIONA TURNBULL

Lowering blood pressure to protect against cardiovascular disease: does baseline blood pressure matter? 31st Annual Scientific Meeting of the High Blood Pressure Research Council of Australia. Sydney, Australia, December 2009.

Hospital quality improvement initiatives in the management of acute coronary syndromes: the CPACS experience. 20th Great Wall International Congress of Cardiology. Beijing, China, October 2009.

Cardiovascular risk management among female and male patients in Australian General Practice: the AusHEART study. 57th Annual Scientific Meeting of the Cardiac Society of Australia and New Zealand. Sydney, Australia, August 2009.

JACQUI WEBSTER

Getting serious about salt in the Pacific. World Health Organization Pacific Island Non-communicable Disease Forum. Nadi, Fiji, June 2010.

Salt reduction in the Western Pacific Region: baseline situational assessment. World Health Organization Western Pacific Regional Office Forum on Salt Reduction in the Region. Singapore, June 2010.

Getting the labeling right for salt. Salt in the diet: the elephant in the room: why health professionals needs a shake-up. Symposium hosted by the Australian Academy of Science and the Nutrition Society of Australia. Sydney, Australia, August 2009.

A novel electronic decision support system to assist GPs in cardiovascular disease risk management. Pfizer Cardiovascular Lipid Forum. Sydney, Australia, July 2009.

JADE WEI

Genetics of ICH in INTERACT2. 7th International Stroke Genetics Consortium Workshop. Edinburgh, UK, June 2010.

Comparison of recovery trajectories and prognostic indicators for ischemic and hemorrhagic stroke in China: the ChinaQUEST registry study. XVIII European Stroke Conference. Barcelona, Spain, May 2010.

Secondary prevention of ischemic stroke in urban China. XVIII European Stroke Conference. Barcelona, Spain, May 2010.

MARK WOODWARD

Cardiovascular epidemiology in Asia and Australasia. Columbia University Seminar. New York, USA, October 2009.

The Asia Pacific Cohort Studies Collaboration and its relevance to public health. The Hong Kong Public Health Forum. Hong Kong, September 2009.

From risk factor to prognostic factor: when association is not enough. University of Glasgow Seminar. Glasgow, UK, September 2009.

Current role of hsCRP in cardiovascular risk prevention. 3rd East Meets West Cardiology. Pattaya, Thailand, August 2009.

JUPITER: extra gravity or spin? 3rd East Meets West Cardiology. Pattaya, Thailand, August 2009.

We don't have the tools to accurately deal with CVD in women. 3rd East Meets West Cardiology. Pattaya, Thailand, August 2009.

Where to draw the line for abdominal obesity: evidence from international data. Joint Statistical Meeting of the American Statistical Association. Washington DC, USA, August 2009.

Interpreting studies of predictor variables and clinical outcomes: what does having a risk factor really mean? XXII Congress of the International Society on Thrombosis and Haemostasis. Boston, USA, July 2009.

YANGFENG WU

Long term benefit of salt substitution. World Congress of Cardiology Scientific Sessions. Beijing, China, June 2010.

A randomized controlled trial on effect and cost-effectiveness of low cost, simplified, primary healthcare provider-based cardiovascular disease prevention and management program in rural China. World Congress of Cardiology Scientific Sessions. Beijing, China, June 2010.

The rising burden of cardiovascular diseases in China. World Congress of Cardiology Scientific Sessions. Beijing, China, June 2010.

Salt reduction in China. World Congress of Cardiology Scientific Sessions. Beijing, China, June 2010.

Utility of subclinical CVD measures in stratifying CVD risk. World Congress of Cardiology Scientific Sessions. Beijing, China, June 2010.

LIJING YAN

Use of polypill in community for primary prevention of CVD. World Congress of Cardiology Scientific Sessions. Beijing, China, June 2010.

SOPHIA ZOUNGAS

Association of glycaemic exposure with macrovascular and microvascular complications of type 2 diabetes: ADVANCE prospective observational analyses. 20th World Diabetes Congress. Montreal, Canada, October 2009.

How to read a report of a randomized controlled trial. Australian Atherosclerosis Society. Melbourne, Australia, October 2009.

The efficacy of lowering HbA1c with a gliclazide modified release-based intensive glucose lowering regimen in the ADVANCE trial. 20th World Diabetes Congress. Montreal, Canada, October 2009.

Arterial function: metabolic influences and therapies. International Society for Vascular Health. Melbourne, Australia, October 2009.

ADVANCE-ON: a post-trial observational study. 20th World Diabetes Congress. Montreal, Canada, October 2009.

Targeting lipid fractions other than LDL to improve cardiovascular risk in diabetes: what does the evidence say. World Congress on Oils and Fats and the 28th International Society of Fat Research Congress. Sydney, Australia, September 2009.

Glycaemic exposure and the risks of vascular complications and death in patients with type 2 diabetes: ADVANCE prospective observational analyses. Annual Scientific Meeting of the Australian Diabetes Society. Adelaide, Australia, August 2009.

COLLABORATORS

AUSTRALIA & NEW ZEALAND

- Aboriginal Medical Service Western Sydney
- Adelaide Institute for Sleep Health
- Ambulance Service of New South Wales
- Auckland City Hospital
- Auckland MRI Research Group
- Austin Hospital
- Australasian College of Road Safety
- Australasian Faculty of Public Health Medicine
- Australasian Kidney Trials Network
- Australasian Sleep Trials Network
- Australian Academy of Science
- Australian and New Zealand Dialysis and Transplant Registry
- Australian and New Zealand Intensive Care Research Centre, Monash University
- Australian and New Zealand Intensive Care Society Clinical Trials Group
- Australian and New Zealand Society of Nephrology
- Australian Commission on Safety and Quality in Health Care
- Australian Food and Grocery Council
- Australian National University
- Australian Red Cross Blood Service
- Australian Stroke Trials Network
- Baker IDI Heart and Diabetes Institute
- Bakers Delight
- Bankstown-Lidcombe Hospital
- Bendigo Health Care Group
- Bendigo Hospital
- Boden Institute of Obesity, Nutrition and Exercise
- Bourke Aboriginal Community Working Party
- Brain and Mind Research Institute
- Cairns Base Hospital
- Canberra Hospital
- Canberra Institute of Technology
- Cancer Council NSW
- CARl Guidelines
- Central Australian Aboriginal Congress
- Centre for Brain & Mental Health Research (CBMHR), The University of Newcastle
- Centre for Health Economics Research and Evaluation (CHERE), University of Technology Sydney
- Centre of National Research on Disability and Rehabilitation Medicine (CONROD), The University of Queensland
- CHOICE
- Christchurch Public Hospital
- Clinical Excellence Commission
- Coalition for Research to Improve Aboriginal Health
- Coles Supermarkets
- Concord Hospital
- Cooperative Research Centre for Aboriginal Health
- CoRE Research Group Pty Ltd
- Corporate Nutrition Melbourne
- CSIRO Human Nutrition NSW
- Deakin University
- Diabetes Australia – NSW
- Dietitians Association of Australia (DAA)
- Domino's Pizza
- Double Bay Physiotherapy
- Dunedin Hospital
- Epilepsy Action Australia
- Flinders Medical Centre
- Flinders University, Department of Medicine
- Florey Neurosciences Institutes
- Food Media Club
- Food Standards Australia New Zealand
- Freedom Foods
- Fremantle Hospital
- Garvan Institute of Medical Research
- Geelong Hospital
- George Weston Foods
- Gold Coast Hospital
- Goodman Fielder
- Gosford Hospital
- HJ Heinz Co Australia Ltd
- Healthy Kids School Canteen Association NSW
- Heart Foundation
- High Blood Pressure Research Council of Australia
- Hornsby Ku-ring-gai Hospital
- Hunter Medical Research Institute
- Inala Indigenous Health Service
- James Cook University
- John Hunter Hospital
- Kellogg's, Australia and New Zealand
- Kidney Health Australia
- Kids and Traffic – Early Childhood Road Safety Education Program, Macquarie University
- Kolling Institute of Medical Research
- Launceston General Hospital
- Liverpool Hospital, Australia
- Maari Ma Aboriginal Health
- Macquarie University, Department of Psychology
- Marninwarntikura Women's Resource Centre
- McCain
- McDonald's
- Melbourne Renal Research Group
- Ménière's Support Group of NSW Inc
- Menzies Centre for Health Policy, the University of Sydney
- Menzies Research Institute Tasmania
- Menzies School of Health Research
- Middlemore Hospital
- Monash Medical Centre
- Monash University Accident Research Centre (MUARC)
- Monash University, Department of Epidemiology & Preventive Medicine
- Monster Muesli
- Nambour General Hospital
- National Heart Foundation of Australia
- National Stroke Foundation
- National Stroke Research Institute
- National Transport Commission
- Nepean Hospital

- Neuroscience Research Australia
- New England Hunter Valley Mental Health Services
- New South Wales Food Authority
- New South Wales Health
- New Zealand Food Safety Authority
- Ngaanyatjarra Health Service
- Nganampa Health Council
- Nindilingarri Cultural Health Services
- North Ryde Physiotherapy
- North Shore Heart Research Foundation
- North Shore Hypertension Service
- Nutrition and Wellbeing Clinic
- Oporto Australasia
- Pain Management and Research Institute, the University of Sydney
- Physiotherapy Research Foundation
- Pine Rivers Renal Clinic
- Prince of Wales Hospital
- Princess Alexandra Hospital
- Renal Research
- Research Australia
- Roads and Traffic Authority, NSW
- Rotary Sydney Cove
- Royal Adelaide Hospital
- Royal Brisbane Hospital
- Royal Children's Hospital, Queensland
- Royal Hobart Hospital
- Royal Melbourne Hospital
- Royal North Shore Hospital
- Royal Perth Hospital
- Royal Prince Alfred Hospital
- Ryde Hospital, Department of Physiotherapy
- Ryde Rehabilitation Centre Sydney
- SaltMatters
- Sanitarium
- Sax Institute
- Sir Charles Gairdner Hospital
- Specialist Magnetic Resonance Imaging
- St George Hospital
- St Vincent's Public Hospital, Department of Physiotherapy, Sydney
- St Vincent's Hospital, Melbourne
- Stroke Society of Australasia
- Subway Systems Australia
- Sydney Adventist Hospital
- Sydney Children's Hospital
- Sydney Health Projects Group, the University of Sydney
- Sydney South West Area Health Service
- Sydney Specialist Physiotherapy Centre
- Sydney Spine Physio
- Tangentyere Council
- Tharawal Aboriginal Corporation
- The Alfred Hospital
- The Centre of Clinical Research Excellence in Spinal Pain Injury and Health
- The Children's Hospital at Westmead
- The Food Group
- The Heart Research Institute

- The Parents Jury
- The Queen Elizabeth Hospital
- The Royal Australasian College of General Practitioners
- The Smith's Snackfood Company
- The Sydney University Nutrition Research Foundation
- The Townsville Hospital
- The University of Adelaide
- The University of Auckland
- The University of Melbourne
- The University of New South Wales
- The University of Queensland
- The University of Sydney
- The University of Western Australia
- The Woolcock Institute
- Unilever Australasia
- University of Ballarat, School of Human Movement and Sports Sciences
- University of South Australia, Nutritional Physiology Research Centre
- University of Technology, Sydney
- University of Wollongong
- Urapuntja Health Service
- Waikato Hospital
- Wellington Hospital
- Western Desert Nganampa
- Westmead Hospital
- Wollongong Hospital
- Wuchopperen Health Service
- Yum! Restaurants Australia

BELGIUM

- Erasme Hospital
- Liege University Hospital
- University Hospital Gasthuisberg
- University of Leuven

BRAZIL

- Universidade Cidade de São Paulo
- Universidade Federal de Minas Gerais

CANADA

- Canadian Critical Care Trials Group
- Centre for Hip Health and Mobility, University of British Columbia
- CLARITY Research Group, McMaster University
- Cochrane Back Review Group
- Hamilton Health Sciences
- McMaster University Health Centre
- MedPharmGene Inc
- Population Health Research Institute, Hamilton Health Sciences, McMaster University
- Prognomix Inc
- Queen's University
- Sunnybrook Research Institute
- University of Alberta
- University of Calgary
- University of Toronto
- Vancouver Coastal Health Research Institute

CHILE

- Clinica Alemana

CHINA

- Baotou Central Hospital
- Beijing Chinese-German Safe-Driving Technology Development Co Ltd
- Changzhi Medical College
- China Medical University
- Chinese Society of Cardiology
- Fu Wai Hospital
- Hebei Provincial Center for Disease Control and Prevention
- Ministry of Health
- Ningxia Medical University
- Peking University First Hospital
- Peking University Health Science Center
- Shanghai Institute of Hypertension
- The University of Hong Kong
- Xi'an Jiaotong University

COLOMBIA

- Hospital Pablo Tobon Uribe

FRANCE

- Biostatistics and Epidemiology Unit, Université Paris Descartes, Assistance Publique-Hôpitaux de Paris, Hôpital Cochin
- INSERM
- Lariboisiere Hospital

GERMANY

- Friedrich Schiller University of Jena
- Physio-Akademie des ZVK gGmbH
- University of Leipzig

INDIA

- All India Institute of Medical Sciences, New Delhi
- Apollo Hospital, Chennai
- Apollo Hospital, Hyderabad
- Arneja Heart Institute
- Asian Heart Institute and Research Centre
- Baby Memorial Hospital
- Bhagwan Mahavir Hospital
- B.L.Y. Nair Hospital
- Brain Waves
- Byrraju Foundation
- CARE Foundation
- CARE Hospital, Banjara Hills, Hyderabad
- CARE Hospital, Nampally, Hyderabad
- CARE Hospital, Ramnagar
- Centre for Cellular and Molecular Biology
- Centre for Chronic Disease Control
- Centre for Economic and Social Studies
- Christian Medical College and Hospital, Ludhiana
- Christian Medical College and Hospital, Vellore
- Deccan College of Medical Sciences
- Deenanath Mangeshkar Hospital & Research Centre
- Frontier Lifeline – Dr. K.M. Cherian Heart Foundation International Center for Thoracic and Vascular Diseases
- Gandhi Medical College Hospital
- G B Pant Hospital
- GKNM Hospital
- Global Hospitals, Hyderabad
- Indian Council of Medical Research

- Indian Institute of Health and Family Welfare
- Indian Institute of Public Health
- Jagadguru Sri Shivarathreeshwara Medical College and Hospital
- Jehangir hospital
- KEM Hospital, Mumbai
- KEM Hospital, Pune
- King George Hospital, Visakhapatnam
- Lalitha Super Specialty Hospital
- Mahavir Hospital and Research Centre
- Mediciti Hospital
- Medwin Hospital
- Narayana Hrudayala
- Nithra Institute of Sleep Sciences
- Nizams Institute of Medical Sciences
- Osmania Medical College and Hospital
- Post Graduate Institute, Chandigarh
- PSG Hospital
- Public Health Foundation of India
- Ramana Maharishi Rangammal Hospital
- Ruby Hall Clinic
- Seven Hills Hospital, Visakhapatnam
- Sher-I-Kashmir Institute of Medical Sciences
- Sir Ganga Ram Hospital
- Sri Chitra Institute
- Sri Ramakrishna Medical Center
- St. Johns' Hospital, Bangalore
- St. John's Medical College, Bangalore
- St. Theresa Hospital, Hyderabad
- The George Foundation, Bangalore
- University of Hyderabad
- Vijaya Health Clinic
- Vijayanagara Institute of Medical Sciences

IRAN

- Faculty of Rehabilitation, Tehran University of Medical Sciences

IRELAND

- University College Dublin

ITALY

- University of Rome

MALAYSIA

- Clinical Research Centre, Ministry of Health
- Hospital Ipoh
- Hospital Kuala Lumpur
- Hospital Kuala Terengganu
- Hospital Melaka
- Hospital Pulau Pinang
- Hospital Raja Perempuan Zainab II
- Hospital Selayang
- Hospital Sultanah Aminah II
- Hospital Taiping
- Hospital Tengku Ampuan Rahimah
- Hospital Tuanku Ja
- Hospital Umum Sarawak
- University Malaya Medical Centre

MEXICO

- Road Traffic Injuries Research Network

NORWAY

- Oslo University Hospital, Division for Neuroscience and Musculoskeletal Medicine

SAUDI ARABIA

- King Saud Bin Abdulaziz University for Health Sciences

SOUTH KOREA

- Yonsai University

SWITZERLAND

- World Health Organization

THAILAND

- Bhumibol Adulyadej (Royal Thai Air Force) Hospital
- King Chulalongkorn Memorial Hospital
- Rajavithi Hospital
- Ramathibodi Hospital
- Siriraj Hospital

THE NETHERLANDS

- Department of Public Health and Primary Care, Leiden University Medical Centre
- EMGO Institute for Health and Care Research, VU University Medical Centre
- Erasmus University Medical Center, Department of General Practice
- Groeninge University Medical Center
- Julius Center for Health Sciences and Primary Care, University Medical Center Utrecht
- Kwaliteitsinstituut voor de Gezondheidszorg CBO, Utrecht
- Maastricht University
- Utrecht University
- VU University, Department of Health Sciences, Faculty of Earth and Life Sciences

UNITED KINGDOM

- Arthritis Research UK Primary Care Centre, Keele University
- Cochrane Stroke Group
- Consensus Action on Salt and Health
- Food Standards Agency
- Imperial College London
- International Centre for Circulatory Health, Imperial College London
- Keele University
- Leeds Institute of Health Sciences
- London School of Hygiene and Tropical Medicine
- Oxford Centre for Diabetes, Endocrinology and Metabolism
- Queen Elizabeth Medical Centre
- University of Aberdeen, Department of Public Health
- University of Central Lancashire, Department of Central Nursing
- University of Oxford
- World Action on Salt and Health

UNITED STATES OF AMERICA

- Coordinating Centers for Biometric Research, University of Minnesota
- Dana Center for Preventative Ophthalmology, Johns Hopkins University
- Duke Global Health Institute
- Duke University
- Harvard University
- Institute of Health Metrics and Evaluation, University of Washington
- International Life Sciences Institute
- John Hopkins University
- Johns Hopkins School of Public Health
- Mayo Clinic
- MMRF Berman Center for Outcomes and Clinical Research
- Mount Sinai Medical School
- The University of Minnesota
- University of Michigan Transportation Research Institute
- University of Pittsburgh Medical Centre, Centre for Sports Medicine
- University of South Carolina
- University of Utah

VIETNAM

- Center for Injury Policy and Prevention Research
- Hanoi School of Public Health

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globally

locally

CHANGING LIVES

YEAR IN REVIEW 2009-10



THE GEORGE INSTITUTE
for Global Health

globally





locally



Our research is helping people,
to lead *healthier* lives...


George Institute research is helping people all over the world to lead healthier lives. Find out on page 16 how we are doing this in China through groundbreaking research on the use of motorcycle helmets.



Our research is improving
the delivery of health care...


George Institute research is improving the way health care is delivered in countries around the world. Find out on page 24 how our research into just one little pill has the potential to revolutionise the way health providers treat vascular diseases, such as heart disease and stroke, on a global scale.





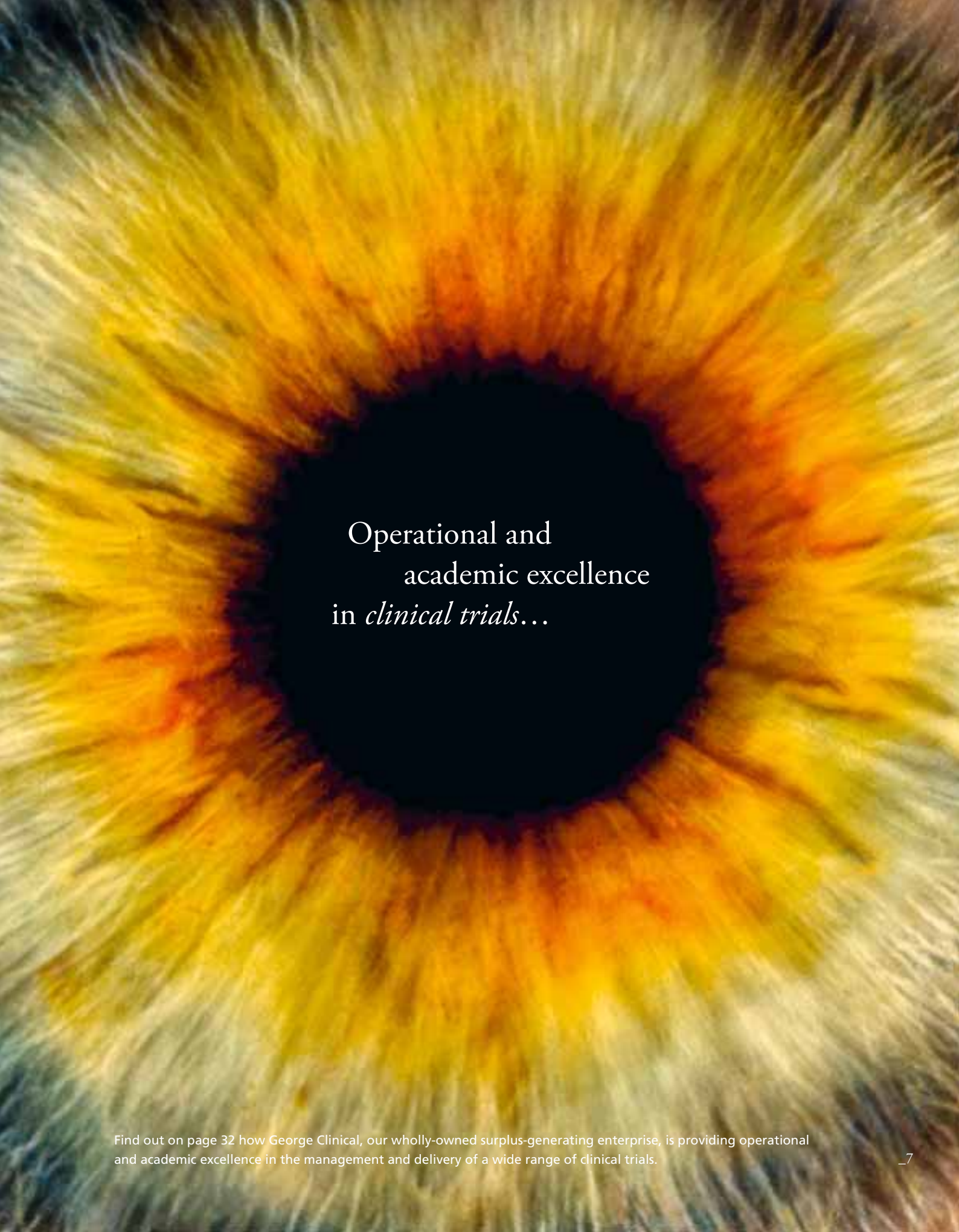
Our research is helping people
who are ill to *get better*...

George Institute research is helping people who are ill to get better. Read more on page 20 about how our researchers' analyses of 60 years of clinical trial data has provided critical evidence into the effectiveness of cholesterol lowering treatments.



Our research is *empowering*
disadvantaged people
to *overcome* barriers
to good health...

George Institute research is empowering disadvantaged people to overcome barriers to good health. On page 30 you'll find out how our research has identified the problem of high blood pressure in Tibet and how our research into a salt-substitute is providing a solution to this issue.



Operational and
academic excellence
in *clinical trials*...

Find out on page 32 how George Clinical, our wholly-owned surplus-generating enterprise, is providing operational and academic excellence in the management and delivery of a wide range of clinical trials.

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IBC	Publications, presentations and collaborators (separate insert)

Imagine an organisation where some of the world's leading minds are working together to achieve one purpose. One purpose, driven by a desire to improve the health of millions of people worldwide. One purpose, which has transformed us from an Australian-based institute, into one with offices in China, India and the United Kingdom. One purpose, where our research actually benefits people rather than just talking about the problems they face.

If you can imagine that then you're starting to get a good idea about *who we are*.

Our *Year in Review* tells you our story in 2009-10. Through this report you'll see how our research is helping people to lead healthier lives; how our research is helping people who are ill to get better; how we are helping to improve the delivery of health care; and how we are helping the most vulnerable communities to overcome barriers to a healthier life.

The George Institute for Global health has been undertaking health research of the highest scientific calibre for over a decade.

We conduct research that's tackling some of the world's biggest killers. Diseases like heart disease and kidney illness, diabetes, and stroke are all in our sights. We also undertake research aimed at identifying the causes of injury and the best approaches to prevention. We're carrying out groundbreaking research on musculoskeletal conditions as well as neurological and mental health issues. We run global studies to determine how clinicians can best manage and treat people who require intensive care, as well to determine how best to help these people recover and manage the consequences of their conditions. We're also working with some of the most disadvantaged populations around the world to overcome the barriers they face to better health.

If that wasn't enough, we're also producing innovative and groundbreaking research to help governments, organisations and people make evidence-based decisions on how best to improve systems and the delivery of health care around the globe.

Our research is not undertaken in laboratories. It doesn't take years and years to make a difference to people. We're all about conducting research that has the power to improve the health of people on a local level right now. 'Innovation', 'creativity' and 'high impact' are bywords for the work we do in our quest to improve the health of millions of people worldwide.

Mission and values

At The George Institute for Global Health our **mission** is simple.

We seek to **improve the health of millions of people worldwide.**

We do this by...

- Providing the best evidence to guide decisions about health.
- Talking to decision makers to help them achieve real change.
- Targeting our research at global health issues.
- Focusing on the most disadvantaged people throughout the globe.

Our **values** reflect how our research affects people across the globe:

- Our **humanitarian commitment** will spur us to tackle the health issues affecting high-risk and disadvantaged people worldwide.
- Our focus on **excellence** will produce scientific evidence that is ethical and of the highest quality.
- Our **creativity** will challenge traditional thinking and provide an impetus for new and innovative solutions to the world's leading health problems.
- Our **integrity** will underpin all our work and interactions, including our collaborations with partner organisations worldwide.
- Our **'can do'** approach will produce timely, effective action, even in the face of adversity or other barriers to implementation.
- Our emphasis on **impact** will ensure our work has real consequences for those who are most vulnerable to disease and injury.



We promised

We delivered

**1. HIGH-QUALITY,
HIGH-IMPACT
RESEARCH**

- > Significant research findings that received worldwide attention, such as the potential benefits of drinking coffee and tea to prevent type 2 diabetes, and highlighting the comparative ineffectiveness of commonly used treatments in intensive care units.
- > Research aimed at closing the gap in health care inequalities among disadvantaged populations in Australia and China.
- > The creation of The Chalmers Centre for Partnerships in Health Care Innovation to develop, implement and evaluate innovative approaches to health care delivery.

2. FINANCIAL STABILITY

- > A total of 14 awarded peer-reviewed grants.
- > A total of 13 awarded research fellowships, an increase of 15% on the previous year.
- > Consistent growth of our philanthropic capacity and activities, including a comprehensive fundraising strategy for Australia and China, and our first philanthropic event held in China.
- > Successful leveraging of philanthropic donations to engage and secure significant funds from government.
- > A seven-fold increase in funds from our strategic enterprise George Clinical.
- > Initial plans for the creation of two more strategic enterprises.

**3. ROBUST OPERATIONS
IN CHINA & INDIA**

- > Continual progress on our ongoing regionally specific research programs and the formulation of new projects, including a household health survey in India and a salt reduction initiative in China.
- > Establishment of a Memorandum of Understanding (MOU) with the Public Health Foundation of India.
- > Successful launch of the China International Center for Chronic Disease Prevention.
- > Appointment of a Head of Research and Development in India to increase management capacity and foster future research.
- > An increase in staff in India. One-third of our staff now work in our China, India and United Kingdom offices.
- > Research workshops in India to build research capacity and establish new projects.

**4. STRONGER
STAKEHOLDER
RELATIONSHIPS**

- > A strategic and specific list identifying our top stakeholders for each of our global offices.
- > Positive engagement and support from government ministers and officials in Australia, China and India in relation to improving food policy, road safety, and the health of Indigenous and rural peoples.
- > A high level of global media coverage growing our profile around the world.
- > A number of events to build our global profile, including a successful stakeholder event in China in conjunction with the Australian Chamber of Commerce in Beijing.
- > An international stakeholder event in the UK for medical innovation hosted in partnership with the Centre for Entrepreneurship and Innovation at the University of Oxford.

**5. GOVERNANCE
& APPROPRIATE
MANAGEMENT**

- > A constitutional review process to ensure the governance of our organisation is consistent across our global entities.
- > Successful roll-out of our global re-branding strategy to bring all our offices in line with our new global structure.
- > Completion of a global staff survey and focus groups to identify our areas of strength, and to provide focus for optimum employee satisfaction and retainment.

How we've performed

RESEARCH OUTPUT: ACADEMIC PUBLICATIONS AND PRESENTATIONS

To ensure maximum exposure of research findings, the Institute maintained its number of publications and presentations in 2009-10. During the year research findings were published in *The New England Journal of Medicine*, the *British Medical Journal*, the *Public Library of Science (PLOS)* and *The Lancet* among others. This publication record is extended and supported by our stakeholder engagement program, working with government and media.

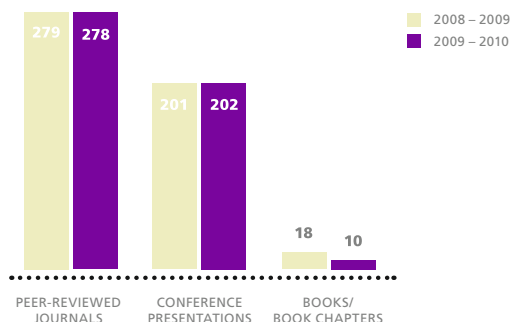
INSTITUTE FUNDING SOURCES

The George Institute is an independent not-for-profit organisation. A best practice funding model underpins the Institute's operations which makes the best use of donor funds, as well as producing self-generated income. Our strategic enterprise, George Clinical, generates a surplus from mission-related commercial activities which is re-invested into the main work of the Institute. See more on George Clinical (page 32) and our funding sources (page 51) later in the report.

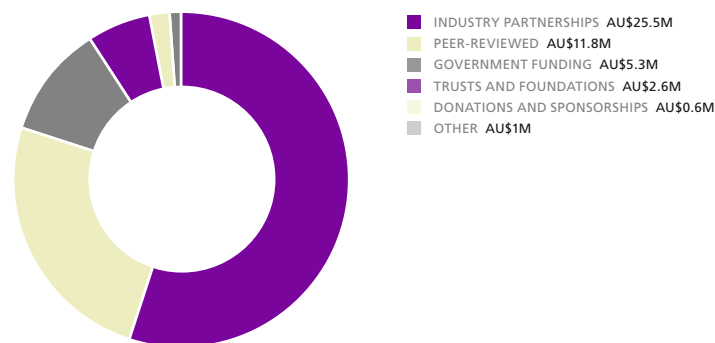
STAFF AT THE GEORGE INSTITUTE

A total of 341 (249.1 full time equivalent) staff were employed at the Institute as at 30 June 2010. Collectively, China, India and the UK represent one-third of the workforce.

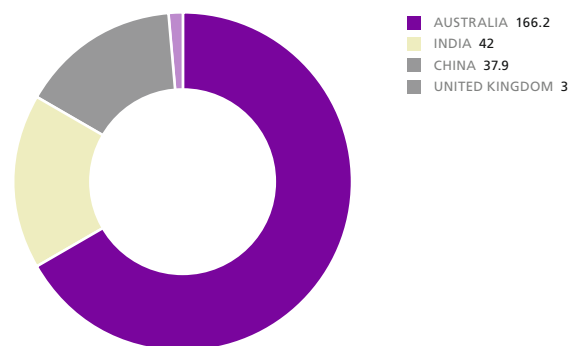
Academic publications and presentations



Income 2009-10



FTE staff numbers at The George Institute across the world as at 30 June 2010





Growth can be challenging in the development of any organisation. However, growth can also provide opportunities to strengthen an organisation and facilitate the achievement of organisational goals. Over the past year we have continued our growth towards becoming a global organisation – an organisation that is ‘Changing lives: Globally, locally’. Our activities, conducted from our offices in Australia, China, India and the United Kingdom, and involving partnerships and collaborations across many more countries, have contributed new evidence aimed at improving the health of millions of people worldwide. We are proud to share with you some of our achievements in our 2009-10 Year in Review.

HEALTHIER LIVES

Over the past year The George Institute has completed a number of studies and produced research findings that will enable people across the globe to lead healthier lives. In China and Vietnam our research has provided critical evidence to guide improvements relating to the use of motorcycle helmets by people in these fast developing countries. In China, road crashes are estimated to be the largest cause of death for those aged 45 years and below. Our work has resulted in suggested improvements in enforcement practices, while emphasising the continuing need for effective public education programs.

In India, opportunities to contribute new knowledge aimed at reducing the growing burden of child and adolescent obesity and the subsequent prevention of chronic disease are now on our agenda, more than ever before. During the year, we signed a Memorandum of Understanding with the Public Health Foundation of India and conducted a series of workshops in collaboration with the Indian Council of Medical Research, with a view to developing programs of research aimed at tackling these important issues.

OVERCOMING ILLNESS

Our research in 2009-10 has provided new evidence into the triggers for back pain; one in four Australian adults are currently living with this condition. Complementing these findings on the causes of back pain, we also examined general practitioner (GP) diagnoses of people seeking care for their back pain. As a result of this work, we were able to offer improved guidance for GPs while identifying the need to up-skill pharmacists in the fight against back pain. As part of the ongoing program of work into the management of back pain, we are now undertaking research examining the effects of paracetamol – the most effective treatment for early onset back pain – to determine whether taking paracetamol at set times of the day, as opposed to taking it on a pain responsive basis, provides better health outcomes.

During the year we also released findings from a project that assessed all the known studies that have examined the benefits of cholesterol medication for people at high risk of heart disease. The findings from this research – outlined in greater detail in this Review – have the potential to transform the lives of people at risk of cardiovascular illness, ensuring that people get the most effective and targeted treatment for one of the world's biggest killers.

IMPROVING HEALTH CARE

Our research is also addressing the big questions being asked by both providers and funders of health care; namely how best to ensure that care is safe and effective, even with limited resources. A significant amount of our research in 2009-10 has, therefore, focused on identifying innovative approaches, informed by a solid evidence base, that are likely to increase the quality of health care while getting the most value for money.

By way of example, our response to the AusHeart study findings that identified evidence-treatment gaps in the care provided by GPs for people with cardiovascular diseases, was the development of an ‘Electronic Decision Support Tool’ called

'HealthTracker' which aids doctors in identifying health risks to their patients. This tool will be rigorously assessed in the coming year, to determine whether it does indeed lead to improvements in health care for high-risk patients.

We've also been collaborating with colleagues across the globe in a series of studies examining the potential benefits of combining multiple medications into a once-a-day pill. Our 'polypill' research aims to improve the adherence to treatment by individuals who are at a high risk of cardiovascular disease. If these pills prove to be successful in increasing adherence, they have the potential to reduce cardiovascular disease worldwide, while slashing the costs associated with these illnesses.

In the UK, we co-hosted Medical Innovation 2010 – a conference involving international and UK contributors – with the University of Oxford's Saïd Business School. This conference provided a useful introduction to The George Centre for Health care Innovation at the University of Oxford which we plan to establish and launch in early 2011. The Centre is charged with developing innovative yet pragmatic evidence-based strategies and technologies to address the global health care challenges of the 21st century.

OVERCOMING HEALTH INEQUALITIES

In 2009-10, the Institute also continued to focus on research that empowers disadvantaged populations to overcome barriers to healthier lives. Our staff have been working with the Aboriginal communities in Fitzroy Crossing in Australia's rugged North West, understanding the effects of Fetal Alcohol Spectrum Disorder (FASD) in this community. Stage one of the two-stage 'Marulu: The Lililwan Project' has involved identifying and visiting the region's children born in 2002/2003 (7-8 years old), to assess the prevalence of this condition. The findings from this initial phase have been vital in informing stage two of the project, which hopefully will lead to recommendations about

the types of services and support the community will need in the future.

At the 'top of the world', staff from our China office have been working with communities in Tibet to determine the prevalence of high blood pressure in the local population and how best to reduce its prevalence. Specifically, our research has shown that the use of a salt substitute to reduce salt intake in the diet has the potential to have a very major positive effect in reducing high blood pressure in this population.

EXCELLENCE IN CLINICAL TRIALS

As in previous years, the activities of The George Institute have benefited enormously from both the operational support provided to our large-scale clinical trials and the financial support provided by George Clinical. Throughout the year we have strengthened our management and scientific teams at George Clinical in Sydney, China and India, to ensure that for the foreseeable future George Clinical will continue to provide a healthy financial surplus that can be invested into the work of the Institute.

MAINTAINING A SOLID ORGANISATION


Strengthening the Institute's operational and support services, as well as its management and governance arrangements, have been major focuses during the past year. We have been particularly mindful of the need to remould each of these areas, as the Institute transitions from being an Australian-based Institute with overseas offices, to that of a global organisation, as outlined in the Institute's 2009-2011 strategic plan.

We have also been mindful of the continuing need to rigorously manage our financial resources and as with many other research institutes continue to be thrilled, but challenged, by the successes of our research staff, in an environment where infrastructure funds to support our activities are static or declining. We were, however, pleased to be the recipients of major infrastructural support

from the New South Wales government in this financial year, in addition to the infrastructural support funds provided by the Australian Federal Government.

A WORD OF THANKS

Finally, our last word must be one of thanks to the members of the Board and its committees and especially to the staff and students of the Institute. This year, more than ever, the Board and its committees have contributed enormously to supporting the activities of the Institute. We are also very appreciative of the commitment of our staff to achieving the Institute's mission. They deserve our thanks for their determination, hard work and belief that the work that we do collectively is making a difference to the lives of millions of people worldwide.



DR JOHN YU AC
Chair



PROFESSOR STEPHEN MACMAHON
Principal Director



PROFESSOR ROBYN NORTON
Principal Director



On your bike, safely

On top of Associate Professor Rebecca Ivers' office bookcase sits a colourful collection of motorcycle helmets that she has picked up on visits to South East Asia. On inspection, it's obvious that most would not meet international safety standards. They are little more than plastic buckets lacking the shock-absorbing foam lining that protects the rider from serious head injury.

Professor Ivers, who leads The George Institute's Injury Division, says she has unsuccessfully spent hours combing shops in Southern China looking for motorcycle helmets that meet accepted standards. The problem is two-fold. "There's a huge black market and the cheap substandard helmets, which retail for AU\$2-4 often come complete with a forged safety standard sticker," she says. Good quality helmets cost closer to AU\$8. In addition, notes colleague Dr James Yu, many Chinese do not understand that the sun-protection and construction helmets sometimes worn are not suitable for motorcycle use.

Despite Chinese law stating that motorcyclists must wear helmets, previous studies have estimated only 30-60% do so. Helmet use has been mandatory for motorcycle riders since 1988, although mopeds, electric scooters and motor scooters with an engine size under 50cc are exempt. There are penalties for failing to comply but, until 2004, the fine was less than AU\$1. Now, motorcycle riders without helmets can be fined anywhere from AU\$3 to AU\$30.

There's no question that helmets save lives and decrease head injuries in a crash – the figures, produced by the Institute's Injury Division, are approximately 70% and 40% respectively. In 2008, the World Health Organization estimated that road collisions are the main cause of death in China for those aged 45 years and below. Dr Yu says that failure to protect oneself in China is partly about a lack of education about safety. In more developed regions drivers and passengers are more likely to wear helmets as police are more likely to enforce the mandatory helmet law.

Zhongsan is a city in Southern China with a population of around two and a half million people. By boat it's just over an hour from Hong Kong. Zhongsan has been growing rapidly over the last decade, attracting hi-tech business and increasingly becoming part of the tourism trail. One in seven citizens own a motorcycle, but there's been a moratorium on the registration of new bikes since 1999.

Given the shortage of helmet use data from Southern Chinese cities, Dr Yu and colleagues at The George Institute, China decided to assess the prevalence and correct use of motorcycle helmets in Zhongsan.

"We observed motorcyclists at 20 different sites across the city, which included rural and urban roads," says Dr Yu. The data, gathered in 2009, was obtained for 13,410 drivers and 4,498 passengers. Approximately three of every four drivers (72.6%) wore a helmet, but less than two in four wore a properly secured motorcycle helmet (43.2%). The data for pillion passengers was even more worrying. Approximately one in three wore a helmet (34.1%) and, of the total 4,498 passengers, only 940 (20.9%) wore a properly secured motorcycle helmet.

When the helmet usage data were analysed separately for the rural and urban streets, it was apparent that compliance was greater in the urban setting for both drivers and passengers. Even so, there's still a significant problem around the use of non-standard helmets.

Dr Yu says that to really make a difference in terms of reducing those killed or injured in road traffic accidents, visible enforcement programs which take into

account whether or not a helmet meets safety standards and is correctly fastened, need to be implemented.

"At the moment, if you are wearing a helmet it's ok; it doesn't matter that it's not good quality or that it's not being worn properly," says Dr Yu.

The George Institute researchers suggest that changes to the City bureaucratic structures could help to improve the situation. "Motorcycle helmet quality is the responsibility of the Bureau of Quality and Technical Supervision and the Administration for Industry and Commerce, rather than the traffic police. We believe joint action strategies on enforcement of helmet quality may help to improve the prevalence of helmet use and the quality of helmets worn in the region," explains Dr Yu.

"There's also a need for extensive public education programs around how to choose and wear a helmet; these need to target all riders and passengers," he says.

Vietnam is also struggling to boost helmet use among its motorcycle-riding population. However, unlike in China, where more than a hundred major cities have prohibited motorcycles due to traffic chaos, Vietnam's city streets are overrun with motorcyclists. There's rarely a break in the traffic, so to cross the road takes courage and some nifty navigational skills. On the dirt roads, widespread in rural Vietnam, there are fewer motorists, but often there's multiple passengers carried on the bikes. Indeed, families of four seem to have no trouble precariously perching on a small two-wheeler!

Vietnam does have helmet use legislation, but until 2007 it only applied on certain assigned routes and national roads. The George Institute's Dr Dang Hung, whose PhD thesis includes the first assessment of helmet use in Vietnam, reported that overall use was as low as 29.9% and that helmets are

often purchased to avoid penalties rather than to protect the riders' heads. Importantly, in the province where he carried out his 2005 observational study, compliance was almost 60% on the roads where helmet use was mandatory.

However, there are other barriers to helmet use. Ms Linh, a Sydney-based beautician, who was born and raised in Ho Chi Minh City, says that because it gets so hot and humid the helmets become very smelly, which is why she never wore one. Indeed, other prevalence studies in low and middle-income Asian countries have revealed there are seasonal changes in helmet use. But, as Professor Ivers' helmet collection reveals, there are models with vents in the top that better suit the Asian climate and would help to circumvent this problem.


According to Dr Hung, a good quality helmet may cost up to 28% of a Vietnamese person's monthly income, and many are reluctant to leave them on a parked bike. The alternative is to lug around the cumbersome headgear while shopping. When there's more than one passenger per bike, this problem is multiplied. Moreover, earlier this year, the government introduced new legislation that makes it mandatory for children over the age of six to wear a motorcycle helmet when riding as pillion passengers, meaning families will need to purchase even more helmets for their household.

"Given that a motorcyclist is approximately 20 times more likely than a car occupant to die in a motor vehicle crash, and serious injuries may be sustained by motorcyclists even when travelling at low speeds, it's essential that all motorcycle riders and passengers regardless of age are properly protected," says Professor Ivers.

In a recent George Institute research study commissioned by Unicef, it was found that over twenty Vietnamese children and adolescents die every

day from unintentional injuries: more than the number of children who die from infectious diseases. The second most common cause of these injury-related deaths is road traffic accidents; the first is drowning.

Both the children and adults who survive a road traffic crash may have to spend the rest of their lives coping with an injury-related disability, perhaps needing constant care. Given the existing demands on the current health system and Vietnam's increasing motorisation, it's perhaps not surprising that the government announced a National Policy on Accidents and Injury Prevention in 2001, setting a target of reducing road traffic deaths from 14 to 9 per 10,000 vehicles by the year 2010. Whether that target has been met is as of yet unknown, but The George Institute's research has helped to define measures to make that life-saving goal a reality.



The number of
motorcycles produced
in China this year
exceeds the population
of Australia.

Taking aim at back pain

Bending down to brush your teeth or twisting awkwardly may be the last thing you remember doing before you started experiencing back pain, but Professor Chris Maher, who leads the Institute's Musculoskeletal Division, says it's unlikely this movement caused the problem.

Approximately one in four Australian adults live with back pain, and in about 60% of cases the pain comes on suddenly.

"People often recall the last thing they were doing just before the back pain started, but these are often trivial activities that they carry out every day. When it comes to pinpointing a cause, they may be red herrings," says Professor Maher. He explains that unless you consider what people were doing over a longer period, you can't reliably identify what triggers an acute, recent onset back pain. "There are currently no studies that have examined all the events in a period prior to the beginning of back pain, but this is the information you need before drawing any conclusions about what triggers an episode," he says.

Professor Maher's George Institute researchers are currently planning such a study where they will interview participants who have just experienced sudden onset back pain. The new study will link in with other projects in his research team, including one that has examined how GPs respond to people who seek treatment for back pain.

The George Institute scientists analysed data from an ongoing Australia-wide doctors' survey that, for over a decade, has been documenting what GPs report they do for their patients. "We found that approximately one in four people with back pain who visit a GP are sent for further diagnostic tests that include an X-ray, CT scan or MRI," says Professor Maher.

Yet Professor Maher knows 90% of back pain is non-specific and less than one in a hundred people who see their GP for their back pain will be found to have a serious disease, like cancer, or a fracture or infection. "We'd expect the referral rate for imaging to be substantially lower," he remarks. "Imaging also has downsides. It is costly, and for X-ray's and CT scans there's the exposure to radiation to consider," he says.

Of perhaps more concern is the types of medicines given out by doctors. "We also found that many people aren't being prescribed the appropriate medicines at the appropriate doses. Often GPs are recommending a course of non-steroidal anti-inflammatory drugs or opioid drugs which have a greater potential for harm, than something simple and cheap like paracetamol," explains Professor Maher.

There are clear government guidelines from the Australian National Health and Medical Research Council for the treatment of recent onset back pain that came into effect in 1995. However, the research team also found that, if anything, there has been greater divergence in prescribed courses of treatment by doctors since the guidelines were introduced. Professor Maher and colleagues are interested in why this is so and have a couple of possible answers. "One is that people expect to be referred for further testing and can fixate on having a diagnosis. Another is that GPs don't necessarily have the time to explain the options and the risks of the various medicines. Perhaps most importantly, we don't believe GPs have ready access to the correct information."

Indeed when the researchers looked at the material from the National Prescribing Service they found some of it was 20 years out of date. "It included recommending bed rest, which is a big no-no," exclaims Professor Maher.

To redress the current situation, George Institute researchers are taking several approaches. They include holding workshops for the National Divisions of General Practice, writing up-to-date material for the National Prescribing Service, and working with colleagues to develop decision support tools that integrate into the GP's practice software.

Professor Maher says it's essential to need to chip away at all the different ways health professionals get information. With the trend in health care for pharmacists to become more than just a prescriber, he also believes that initiating a new health care pathway involving pharmacists may be a way to help solve the problem. "There are things pharmacists can't do – such as ordering medical imaging – but we can capitalise on the depth of their knowledge about individual medicines, including potential side effects and dosing."

Together with Professor Andrew McLachlan, Chair of Pharmacy at Concord Hospital in Sydney, The George Institute is setting up a program to up-skill pharmacists. The pilot study will teach pharmacists how to verbally screen for serious disease to determine which of their clients should see a GP and, for the remainder, how to best deliver simple, safe and effective treatments for back pain.

This includes administering paracetamol as a first-line treatment for people to get better from back pain. "Our previous research has shown that paracetamol, if used correctly, is extremely effective for new episodes of back pain. The problem is that most people try and 'tough out' the pain until it gets unbearable. Then they take a couple of paracetamols, find they are still in pain, and then head for the doctor to get something stronger," says Professor Maher. This phenomenon is called 'under-dosing'. According to Professor Maher between 60% and

80% of people who self-medicate use the wrong dose. "We believe one of the most important steps is to get people to take simple medicines properly; this will give the medicines a fair chance to work."

Professor Maher says they are also testing the best way to get back pain under control. The George Institute is currently part-way through running a trial, which will compare the effectiveness of 'time-contingent' (taken at set times of the day) paracetamol with 'as-required' paracetamol.

Incidents of back pain increase as you get older. While the direct costs of this health problem in Australia are estimated at AU\$1 billion, the indirect costs from lost labour are eight times that figure. Hence treatment programs that aid return to work and help reduce the rates of recurrence are likely to have significant cost savings.

"Treatments for back pain that require one-on-one therapy are unlikely to be cost-effective solutions, given the extent of the problem in the population. We are, therefore, examining resources available at the community level, and are proposing to evaluate wellness programs such as Tai Chi, which have been shown to work for a range of conditions, including falls prevention in the elderly," says Professor Maher.

arrghhhh!





CHANGING LIVES: GLOBALLY, LOCALLY

Our research is helping people who are ill to get better

Cholesterol is often painted as a villain that must be defeated if we are to avoid a heart attack or stroke. Yet, like every character in a complicated saga, cholesterol can not be completely vanquished because it has an essential role in the body. It is the key ingredient used to make vitamin D and steroid hormones, such as oestrogen, and it is a vital component of a cell's membrane.

The sixty-year fibrate story

Cholesterol is a white waxy fat synthesised mainly in the liver. It is circulated throughout the body via the blood. Our genes partly dictate the levels of cholesterol in our body by regulating the rates of cholesterol synthesis and breakdown. As most of us know, diet can also have a significant effect on a person's cholesterol level.

Cholesterol levels are assessed according to the proteins in the bloodstream that transport them: high-density lipoprotein (HDL) and low-density lipoprotein (LDL). HDL is the Dr Jekyll to LDL's Mr Hyde. The high and low-density naming refers to the size of the particles and the proportion of protein they contain: the LDLs are larger and heavier. They can travel into cells and stick to the inside of blood vessels, which can reduce the speed of blood flow. HDLs tend to be more compact, picking up cholesterol and returning it to the liver for recycling or to specific tissues for hormone synthesis.

Some of us manage to lead healthier lives by reducing the amount of LDL-associated cholesterol in our blood, and thus the chance of developing cardiovascular disease, through dietary modification. However, reduction of most LDLs requires specific medication of which there are several different types, sometimes used in combination. Levels of triglycerides, the main dietary fats, must also be kept in check. Triglycerides come from vegetable oils and animal products, and serve as an energy source. A high LDL cholesterol level is often associated with a high triglyceride level and triglycerides are also components of LDLs.

The first cholesterol lowering drug, clofibrate, was discovered in an Imperial Chemistry Industries (ICI) laboratory in London in the 1950s, through a methodical process that involved synthesising hundreds of compounds

in an effort to find one that would alter cholesterol levels in rats. It then progressed through clinical trials in the 1960s. Clofibrate was, however, phased out in the mid-1980s due to its side effects. By then a number of clofibrate analogues that were safer and better tolerated had been developed. Some of these are still used today.

Associate Professor Vlado Perkovic, a co-director of The George Institute's Renal and Metabolic Division, says it wasn't until the 1990s that researchers began to piece together how fibrates exert their physiological effect. "We know now that fibrates trigger a cell-signalling pathway that leads to more triglycerides being broken down and secreted, and less total cholesterol in circulation," he says. Notably, they raise the levels of good cholesterol while lowering the bad, as well as lowering overall triglyceride levels.

Statins, which were discovered in the 1970s, also lower cholesterol levels, but they do so by slowing an enzyme in the liver involved in cholesterol synthesis. They don't have much effect on HDL levels, but substantially lower LDLs. There is clear evidence that statins considerably reduce the risks of coronary heart disease, stroke, and cardiovascular disease (CVD)-related mortality.

Until now, the evidence that fibrates also lead to better cardiovascular results, has been thin on the ground. George Institute researchers, therefore, decided to draw on their methodological expertise to assess all the published fibrate clinical trials to see if they could draw any conclusions as to their overall clinical benefit.

The team had access to sixty years of data to sift through. "Of the 1,195 unique studies, most were excluded because the study design wasn't robust enough," says Professor Perkovic. In the end there were eighteen published fibrate trials that contained enough detail for Professor Perkovic and

colleagues to include in their meta-analysis. In total, they collectively had information on 45,058 patients.

"We found that fibrate therapy does decrease the risk of cardiovascular events, but the effect is more moderate than that ascribed to statins," he says. Indeed the size of the effect has meant that previous studies, all of which were smaller, came to differing conclusions over the relative benefits of fibrate use as none were large enough. This includes a recent study (the ACCORD trial), where patients received both fibrates and statins. "The ACCORD trial was unable to show that fibrates had a clear and additional benefit to statins, but that study didn't have the statistical power to show a separate effect," he says.

Because of the constant uncertainty as to whether fibrates protect against adverse effects, they are not widely prescribed and, according to Professor Perkovic, some doctors don't use them at all. However, the team hope that the trend will change, based on the further findings of their meta-analysis.

"Despite fibrates having an overall moderate benefit, there are two groups of people for whom their use is likely to be particularly beneficial when taken in addition to statins. This includes those who've already had a heart attack and are thus at an increased risk of having another cardiac event, and those who have high levels of triglycerides," says Professor Perkovic.

The conclusions of the fibrate meta-analysis will no doubt influence current treatment practice, ensuring fibrates are prescribed only to those who will derive benefit. However, what could not be determined from the study is whether one fibrate is better than another, but Professor Perkovic believes those that have the largest effects on triglyceride levels are likely to be the most effective.

Charting a course through cardiovascular risk

Sir Ernest Shackleton died of a massive heart attack during his fourth voyage to Antarctica in 1922. He was just 47 years old. Reports from 1919 reveal he was drinking heavily, smoking and eating too much. In addition to gaining weight, Shackleton was apparently run down with constant colds and fevers, and suffered from bouts of severe pains across his shoulder blades. And, despite never allowing a doctor to listen to his heart, there are suggestions that the heart attack which killed him was likely not his first.

By the time Shackleton died, he obviously had established heart disease. We also now know that his lifestyle would have placed him at a higher risk of having a major cardiovascular event. However, although the blood and cholesterol pressure lowering medicines available today weren't around in Shackleton's time, it's possible that he'd still have been under-treated and that the outcome would have been the same.

Earlier this year, Dr Emma Heeley and colleagues published findings from a George Institute study called AusHeart that revealed a significant proportion of people at risk of cardiovascular disease, which includes both heart and blood vessel disease and stroke, were not being prescribed the best possible combination of drugs.


There are a number of medicines used to reduce the risk of a major cardiovascular disease. They include blood pressure lowering medicines of which there are many – the best known being perhaps beta blockers and cholesterol lowering, for example statin compounds.

Specifically, the researchers found that half of the people with established cardiovascular diseases were not receiving the recommended combination of a blood pressure lowering medicine, a statin and anti-platelet (blood-thinning) therapy. They also found that two-thirds of people at the highest risk of developing a first cardiovascular disease or illness, were not being prescribed a blood pressure lowering medication together with a statin.

"There's a significant under-treatment of certain subgroups of people, and a gap between the evidence base and what is actually happening in terms of the medicines being prescribed," says Dr Heeley. All of the 300 or so GPs who participated in the study were given feedback on how their prescribing practices measured up against the AusHeart study. "We plan to follow up with these GPs soon to see if this feedback has made a difference to their clinical practice," says Dr Heeley.

Cardiovascular disease is the leading cause of death in Australia and accounts for approximately half a million hospital admissions per year. Over 1.4 million Australians live with a cardiovascular-related disability. Dr Heeley explains that early identification of those at risk, together with appropriate intervention, could reduce the number of people affected by cardiovascular disease. "There's been a tendency to concentrate on a single risk factor, such as high cholesterol or high blood pressure, but there's a substantial number of people with smaller changes to several risk factors which, in combination, substantially increase their risk of cardiovascular diseases. These are people who are currently flying under the radar," says Dr Heeley.

Cardiovascular risk is based on age, gender, smoking, as well as blood pressure and lipid (fat) levels. But existing health problems, such as diabetes or kidney disease, mean a doctor has had to refer to different sets of guidelines to assess an individual's absolute cardiovascular risk. "The sheer number of guidelines was



overwhelming,” says Dr Heeley, adding that this was just for cardiovascular diseases, just one of many health problems doctors have to cover.

Last year, the National Vascular Disease Prevention Alliance (NVDPA) released a single set of guidelines that will make it easier for GPs to assess absolute cardiovascular risk in adults aged 45-74 years (35 years and above for Aboriginal or Torres Strait Islander adults), including those who are overweight or obese, who have diabetes or chronic kidney disease, or are without known cardiovascular diseases.

“The National Stroke Foundation, the National Heart Foundation of Australia, Diabetes Australia and Kidney Health Australia, who make up the NVDPA, previously all had their own guidelines; now they have a clear consistent message,” says Dr Heeley. “It’s a great step forward.”

These new guidelines also underpin The George Institute’s Electronic Decision Support (EDS) Tool, which has been named HealthTracker. For those who are computer-literate, it’s a bit like a widget that sits on your desktop. The beauty of the system is that it’s designed to work with all the main patient record keeping software programs. For example, it can automatically draw in the relevant data stored on the GP’s computer.

HealthTracker uses a complex mathematical equation to calculate a person’s absolute risk of having a heart attack or stroke in the next five years. However, HealthTracker is more than just a fancy risk calculator. The doctor can change one or more of a patient’s cardiovascular disease risk factors and demonstrate graphically how these modifications will reduce that person’s five-year risk of a major cardiac event like stroke or heart attack. HealthTracker is also unique in that it provides the GP with tailored treatment advice. This includes suggesting lifestyle changes, such as quitting smoking, and therapies,

such as a blood pressure and cholesterol lowering medicines.

“George Institute researchers had to collate all the treatment guidelines, because there’s currently no standardised course of treatment,” says Dr Heeley. She adds: “However, the EDS won’t take all the guesswork away, because GPs will still need to recognise those people who need to be assessed.”

“What is particularly rewarding is seeing how our various research projects are coming together to make a real difference to people’s lives through the delivery of better health care. In theory HealthTracker will address the two main problems highlighted by our AusHeart study: the need to consider a patient’s absolute cardiovascular disease risk and the need to properly prescribe evidence-based treatment options,” says Dr Heeley. Notably, these treatment options usually include several medications in combination, which is where The George Institute’s polypill study fits in.

HealthTracker has been tested by a group of doctors at several locations in Sydney. It’s now being tweaked and a larger trial across the state of New South Wales, Australia will begin in 2011. This will include measuring whether using HealthTracker changes the prescribing behaviour of GPs, which is the ultimate goal.

Every day, almost
130 Australians die
of cardiovascular
diseases.

The George Institute's Kanyini GAP study fits into a larger body of work called the Kanyini Vascular Collaboration (KVC), formally established in 2006. It is a health services project with an overarching goal of reducing the treatment gap between Indigenous and non-Indigenous Australians for major diseases such as diabetes, stroke, kidney and cardiovascular disease. The KVC brings together a cross-section of researchers, policy-makers, clinicians, and communities from different backgrounds.

Polypill – The potential of just one pill

Several trials are being conducted around the world that aim to assess whether combining multiple medications into a once-a-day pill may help those at high risk of cardiovascular diseases, such as heart attack and stroke, adhere to their treatment plan.

In Australia, the polypill protocol is being used in a George Institute study called the Kanyini GAP study which involves 1,000 Indigenous and non-Indigenous Australians. In New Zealand, the study is named IMPACT and in the United Kingdom (which has trial sites in England, Ireland, the Netherlands and India) it's UMPIRE. The secretariat for the collaboration (known as SPACE: Single Pill to Avert Cardiovascular Events) is housed at The George Institute in Sydney.

There are countless acronyms in this research arena, all of which are meaningful, but the four component polypills being trialled are simply known as Dr Reddy's red heart pills after an Indian company working with The George Institute to support the project. There are two versions of the pill. Both contain low-dose aspirin, a statin (simvastatin) and an ACE-inhibitor, which lowers blood pressure (lisinopril). Version one also contains a beta-blocker (atenolol), a standard type of medicine given to people who have already had a heart attack. Version two contains a diuretic (hydrochlorothiazide), which is an additional type of blood pressure lowering medicine often administered to those who have had a stroke.

The polypills being used in the SPACE trials are based on what was available in generic (off-patent) form at the time of their formulation, because they need to be cheap. The once-a-day requirement meant only long-lasting drugs could be included. "It was a technically challenging step and it took several years to produce these polypills," says

Associate Professor Anushka Patel, who has a lead role in the trials.

Professor Patel explains that the current goal is not to prove the treatments work, nor is it to determine what to include in a polypill. Rather, they are proof of concept studies. "We are testing the effectiveness of combining medicines for ease of use and for delivery to those most in need – these are people who are often economically disadvantaged. We believe the polypill will increase compliance due to the lower cost to the patient and the convenience of not having to take multiple pills," she hypothesises.

Because health services vary between countries, there are some minor differences in the trial protocols, but the overall focus is on participants with the highest risk of cardiovascular events. In Australia, this includes Aboriginal and Torres Strait Islander Australians who suffer excessively from premature morbidity and mortality from chronic diseases. Indigenous communities are also particularly vulnerable to the effects of medication non-adherence and under-usage.

Since its inception, the Kanyini GAP study has recruited more than 200 patients who have been randomised to receive either a polypill or usual care strategy (usually multiple medications). Professor Patel says that they hope to finish recruitment in Australia by April 2011. By then, the aim is to have approximately 1,000 participants, half of whom will be Indigenous.

"We will monitor each person until the average follow-up period is eighteen months. So, some of our volunteers will be followed for six months, others for 2.5 years. At each visit we ask the patients what medicines they are taking. We expect those receiving usual care to say they are taking some combination of three medicines: aspirin, blood pressure lowering and cholesterol lowering drugs. But because self-reporting is not

always reliable, we will also measure the patient's blood pressure and cholesterol levels," she explains.

"At the end of the study we will compare the proportion of usual care trial participants who say they are taking all three standard medications with those taking the polypill. If the availability of the polypill lives up to its potential, we expect that the polypill group will be more adherent and that their cholesterol and blood pressure measurements will therefore be lower," says Professor Patel. A similar finding is also expected for the UMPIRE and IMPACT studies, which are currently ongoing.

Heart disease kills more people than cancer and about 10% of the population fall into the high cardiovascular disease risk category. According to Professor Patel, approximately 40% of all major cardiovascular events occur in this group. "This means the other 60% occur in the rest of the population who are at lower risk," she says.

It is this 60% who are the subject of another polypill trial run by Professor Patel's colleague Professor Anthony Rodgers. Professor Rodgers and his international collaborators have just finished a 12-week pilot study in 400 people likely to be prone to cardiovascular diseases to assess how they would respond to a polypill. They are assessing side effects and the pill's effectiveness by measuring blood pressure and cholesterol levels. Results are due to be published shortly.

Given the huge global health burden from cardiovascular diseases, there's much to be gained by a targeted approach to reduction. This is particularly true in developing countries' health care delivery systems. Moreover, if a polypill proves to be a cost-effective health strategy, future versions could be specifically formulated for subgroups of a population who have differing cardiovascular disease risks.

Innovation across the nations

A map of the ancient scholar-city of Oxford sits on Professor Robyn Norton's desk; a reminder of the journey that the Principal Director of The George Institute has taken in establishing The George Institute's UK flagship centre dedicated towards furthering innovation in health care.

There's plenty of time to reflect during the 17,037 kilometre journey from Sydney. The plane flies above many of the countries that The George Centre for Health care Innovation, affiliated with the Oxford Martin School and the Nuffield Department of Medicine at the University of Oxford, has in its focus, and with which the Centre will conduct cutting-edge research in partnership with in-country collaborators.

"Given the scale of the emerging 21st century epidemics of chronic and complex diseases, particularly in countries with insufficient infrastructure or resources available to tackle them effectively, even a small change in access to quality health care, could result in large numbers of people avoiding premature death. Identifying and evaluating innovative ways of providing improved access to care, through the development of more effective pathways of care or through the development of more affordable drugs and devices, will be the focus of research activities within The George Centre for Health care Innovation," outlines Professor Norton.

The cost-effectiveness of programs for the management of the world's largest killers like stroke, kidney disease, diabetes and other 'non-communicable' conditions are well established. Perhaps surprisingly, access to such programs remains limited in both high and low-income countries, largely because of a lack of reliable evidence about how best to deliver these programs effectively and affordably. A recent

World Health Organization report on health inequalities revealed that male life expectancy in some areas of Glasgow, UK was as low as 54 years, the same as the Republic of the Congo. Identifying innovative ways in which health care delivery systems can best improve the health of the poorest citizens in high-income countries is, therefore, an equally important focus for the Centre as identifying improvements in health care delivery in low-income countries.

"The George Centre for Health care Innovation will focus on the conditions that are causing the greatest burden in disadvantaged populations in the UK, as well as in low to middle-income countries," explains Professor Norton. "The Centre's major emphasis is to develop innovative yet pragmatic evidence-based strategies and technologies that can be implemented widely, quickly and at a reasonable cost. Engagement with those organisations delivering health care, such as government health services, multilateral organisations and commissioners of health care is an overarching commitment," she adds.

So what will these programs look like? "Several are in the pipeline for 2011," says Professor Norton. "In India, one of the projects we plan to establish involves working across a number of Indian hospitals to determine whether the management of acute coronary syndromes, such as angina (severe chest pains), is consistent with local and international clinical guidelines. If evidence-practice gaps are identified, then we will implement improvements in the management of care based on these guidelines that should lead to significant improvements in the way people with these conditions are managed. We've had success with this approach already in China, so the modification and extension of this approach in India has the potential to be equally successful," says Professor Norton.

"We are also planning to develop an exciting project aimed at improving the management of hip fracture in China," she continues. "There are currently eight million 80-year-olds in China. This figure will increase to 100 million by 2050. The implications of this huge increase in the numbers of older Chinese will undoubtedly place significant pressure on health services in China, so it is clearly important that innovative ways of managing their health care needs are identified," she says.

China is a huge country with significant challenges in access to health care in both rural and urban settings. The rapid ageing in China has led to an aged population with only 8% of the average income compared to that in the UK or Australia. In addition, research undertaken by The George Institute on the cost of stroke has demonstrated that these catastrophic causes of disability are very costly for patients and families in China, so much so that stroke has huge financial consequences for 70% of affected families.

"The health impacts of hip fracture costs are likely to be very similar to the disabling costs of stroke and we are determined to work with our colleagues in China to minimise these financial impacts," says Professor Norton resolutely.

The George Centre for Healthcare Innovation aims to work with health care providers, funders, consumer groups and researchers, in the spirit of collaboration, to beat the would-be plagues of the 21st century. These illnesses cross national borders just as easily as the plague rats of the 14th century did. Like then, innovation is required if we are to overcome the barriers that stand in the way of a healthier future. This is the type of innovation that The George Centre for Health care Innovation at the University of Oxford promises to deliver.





Taking care of all the little ones

The temperature was over 40°C when two Aboriginal women left their remote Australian community and boarded a plane bound for New York. It was March 2009, and Emily Carter and June Oscar were on their way to a United Nations Forum on the Status of Women. They arrived in Manhattan to be greeted by snow-covered skyscrapers. The contrast in surroundings could not have been starker.

The George Institute's Associate Professor Jane Latimer accompanied them. "We didn't fully realise how stressful this trip must have been coming from outback Australia to a concrete jungle," she says. Professor Latimer and her twin sister, Elizabeth Broderick, who is Australia's Sex Discrimination Commissioner, were part of the reason the women had made the journey.

The story begins several years prior, when Elizabeth Broderick told her sister about a community in the Fitzroy Valley in North Western Australia where a group of Indigenous women lobbied the liquor licensing board to restrict alcohol sales in their town in an effort to curb alcohol-related violence and fatalities, and to reduce the number of children being born with Fetal Alcohol Spectrum Disorders (FASD), a range of irreversible conditions caused by the toxic effect of alcohol on the brain of an unborn child.

Fitzroy Crossing is the main town in the rugged Fitzroy Valley region, which includes forty-nine outlying communities spread across several hundred square kilometres. Three and a half thousand people who come from one of four Aboriginal language groups reside in the area, more than half of whom are in Fitzroy Crossing.

The only takeaway alcohol you can now buy in Fitzroy Crossing is light beer. Domestic violence and hospital admissions for alcohol-related incidents have almost halved, down by 43% and 55% respectively, and the police report fewer fights and street drinking.

Professor Latimer says she and her sister discussed what they could do to raise awareness of the benefits of alcohol restrictions, as well as demonstrating the courage of the local women who drove this initiative despite facing considerable opposition and verbal abuse.

The result was a short film that was subsequently introduced by June Oscar at the UN meeting. Representatives from 192 nations took home 'agreed conclusions' containing language informed by Aboriginal women June Oscar and Emily Carter, which are now being used to formulate women's policy right around the world.

Pictured above: Marminge Hand, Carer and FASD Leadership Team Member, Fitzroy Crossing, with her foster son, Tristan.

While there were some immediate and obvious changes that resulted from the alcohol restrictions, it won't be possible to measure the effect on future generations for several years. "To be able to assess whether the incidence of FASD is declining, we need a starting point or baseline," says Professor Latimer. Indeed the prevalence of FASD in an Australian population has never been properly measured and FASD can be hard to diagnose because other factors such as poor nutrition and severe infections can cause developmental problems similar to those caused by alcohol. At one end of the spectrum is Fetal Alcohol Syndrome (FAS). "These are the children who have distinctive facial features such as a thin upper lip and small eye openings, but for every child with FAS, there are probably nine others who have emotional, learning and behavioural problems that are characteristic of FASD."

FASD is not unique to Indigenous populations; it is seen in non-Indigenous children as well. "It is a delicate issue and we suspect that the Australia-wide proportion of children with FASD is significantly under-estimated. Those affected often end up unemployed or in jail – we'd love to be able to change that," she says.

Providentially, June Oscar and Emily Carter, with whom Professor Latimer had now formed a strong bond based on mutual respect and trust, invited her to bring a research team, including Professor Elizabeth Elliott, Dr James Fitzpatrick and Dr Manuela Ferreira from The Children's Hospital at Westmead and the University of Sydney, back to the community to assess the prevalence of FASD among children born prior to the alcohol restrictions. For the first time, researchers would have access to prevalence data on a whole population that might be generalised to other similar communities.

The study is named Marulu: The Lililwan Project. Marulu means 'precious, worth nurturing' in the Bunuba language, while Lililwan means 'all the little ones' in Kriol, another of the languages spoken in the region. The study has been divided into two stages and is part of an overall community strategy to address FASD.

The first stage, completed this year, involved identifying the entire region's children born in 2002/2003 (7-8 years old). It meant visiting all the parents and carers of those children, taking a very detailed history about what happened during pregnancy, and recording any problems that the children had at birth and as they were growing up.

Remarkably, of the 134 children identified, the research team has been able to access 134, of whom 95% agreed to participate in the project. "This speaks to the fact that the community is driving this research. That's what's critically different about this work," she notes.

They chose this age group because 7-8 year olds are easier to test than younger children, and they are at the point in their schooling where an intervention program is likely to have the greatest success. The community hopes that the children affected by FASD will go on to develop vocational skills and find ways to work within the community. Stage 2 will involve comprehensive health and developmental checks of all children.

"We see diagnosis of FASD as just a small part of the study. It's largely about getting support and care for these children, so that as adults they are given the opportunity to be the best they can be. When we leave this community we want to have changed lives," explains Professor Latimer passionately. "That's the central mission of The George Institute," she concludes.

Once the community has the stage two diagnostic data, hopefully by the end of 2011, they will use it to lobby government for services and funds to deal with the terrible legacy of FASD.

The George Institute and the University of Sydney team are returning to Fitzroy Crossing for one week to test that they have all the systems in place to proceed with the second stage of the study: full diagnostic testing. A small number of children will undergo vision, hearing, speech, motor skills and psychological testing, and a full paediatric assessment. Allied health personnel who already live and work in the community will be 'up-skilled', so that they can carry out these assessments. In 2011, the team will then assess all of the children in the study.

"What we'll end up with is the number of children affected with FASD – so for some children we will have a definitive diagnosis. For others we will have a strong indication that their problems are caused by alcohol exposure but will be less certain. This will help us to develop an individual management plan that, with the consent of parents and carers, will be communicated to the schools and health services," says Professor Latimer.

It is hoped that if this study were to be repeated in five years time, the numbers of children with FASD would be greatly diminished. However, June Oscar and Emily Carter know that alcohol restrictions are not a complete solution, and that the Fitzroy Valley communities have only just begun a long and hard journey to change the lives of their people. Yet, the message is already spreading. "We know other communities around the Fitzroy Valley are asking to have alcohol restrictions extended to their area and, as far away as Bourke, our researchers are being asked about this study – that's a great feeling," Professor Latimer says with a deserved look of pride.

CHANGING LIVES: GLOBALLY, LOCALLY

*Our research is empowering disadvantaged people
to overcome barriers to good health*

Tibet is a place that is literally at 'the roof of the world'. Most of its inhabitants live more than 4,000 metres above sea level. In contrast, Australia, which is the lowest continent in the world, is on average just 330 metres above sea level. Tibet's altitude and cool conditions impact directly on the diet of its people and therefore on their health.

A life less salty

The Tibetan diet is based on grains and stews as the region's geography makes it difficult to grow fruit and vegetables. Yak, goat and mutton meat is often preserved through salting techniques. World famous yak tea is the drink of choice – made by adding yak butter and salt. While the British are generally thought to be large consumers of tea, the Tibetans arguably are much greater consumers – consuming up to seven litres of yak tea a day.

"The high dietary salt intake combined with the high altitude living conditions has given rise to a population with high blood pressure or hypertension," says Professor WU Yangfeng of The George Institute, China. Tibet is number one in the high blood pressure ratings in China. Approximately 40% of adults over the age of 40 have high blood pressure, according to a 2002 National Health and Nutrition Survey. The average prevalence across China is just under 20%, according to the same survey. "High blood pressure greatly increases the risk of a major cardiovascular event, such as a heart attack or stroke. It's also one of the most modifiable risk factors," says Professor WU.

Professor WU is overseeing the China Salt Substitute Study in Tibet, which aims to both confirm the prevalence of high blood pressure in Tibetan people and implement a program to reduce blood pressure in the population.

As the 2002 National Survey assessed urban Tibetan residents – those living in Lhasa – George Institute researchers decided to survey Tibetans living in pastoral areas, postulating they would be at greater risk of cardiovascular disease. They were right.

The team recruited residents of three villages in the Yangbajing township, 90 kilometres northwest of Lhasa at an altitude of 4,300 metres. Of the over 700 survey participants, 68.1% of men and 50.5% of women had high blood

pressure, but only one in five were aware of their problem, and only one in twenty were on medication. "The problem was much larger than we anticipated, and one that needs to be urgently addressed," says Professor WU. Thankfully, previous research by George Institute researchers has shown that a simple solution is likely to be the most effective: reducing salt intake through a salt substitute.

There are several different ways to substitute salt, but a salt substitution study in Northern China, conducted by The George Institute in 2008, showed that a compound of 68% pure salt (NaCl), 22% potassium chloride (KCl) and 10% magnesium sulfate heptahydrate (MgSO₄·7H₂O) was palatable and acceptable to the Chinese. "Medicating a large proportion of a population to decrease blood pressure would be a difficult and costly exercise, but our year-long study in rural Northern China conclusively showed that salt substitution leads to sustained and substantial blood pressure reduction," comments Professor WU.

The George Institute, China has now finished the first phase of the Tibet study. "We have baseline figures with respect to the prevalence of high blood pressure; we have calibrated our blood pressure meters, which is essential when you are working at high altitudes; and we have just completed a six-month trial of the salt substitute in combination with low-dose diuretics in almost 300 Tibetans," he says.

Diuretics are well-known for their blood pressure lowering effect. They act by increasing the amount of sodium excreted from the kidneys into the urine. At the same time, more water is removed from the blood. The net effect is a lower blood volume, which reduces pressure on the blood vessel walls. "Salt substitute on its own is effective but you reach a plateau after about three months – if you include diuretics, you will get a bigger reduction in blood pressure," adds Professor WU.

Blood pressure is measured in terms of

millimetres of mercury (Hg). High blood pressure is when the systolic reading (the peak pressure when blood is being expelled from the heart) is over 140 millimetres Hg. Normal systolic pressure is usually 90-120 mm Hg. "Salt substitutes can achieve a drop of around 8 mm Hg, but with diuretics you can achieve close to 20 mm Hg in this population," explains Professor WU. At AU\$0.50 (RMB2) a month, this is a very cheap and effective treatment combination that could save millions in health care costs.

The George Institute study has caught the attention of the Tibetan government who have recently commissioned the researchers to formulate a proposal to extend the project.

"We are also now thinking about how we can spread the salt substitution message," adds Professor WU. "At the moment there are two key obstacles: firstly we need to ensure the salt substitute is widely available throughout the province, not just in Lhasa, and secondly we have to make sure that it doesn't cost more than regular salt. One solution might be for the government to subsidise the cost difference between regular salt and salt substitutes. Once these first two problems are overcome, the third thing for us to do is to develop and spread health promotional messages, via a community-based health communication model for example," he says.

However, Professor WU is aware that Tibet is very different to other parts of China. "We don't know yet if the public engagement strategies we have used elsewhere can be extended, or if we need to come up with some innovative method that is better suited to the culture," he explains.

What The George Institute team does know is that unless large-scale blood pressure reduction measures are undertaken, the economic and social impact of having a sizeable population living under threat of, or with the consequences of, cardiovascular disease will be devastating to Tibetan society.

George Clinical: Operational & academic excellence in clinical trials

George Clinical is a wholly-owned surplus-generating enterprise of The George Institute for Global Health. Uniquely, for most not-for-profit research organisations, The George Institute is able to subsidise its infrastructure costs and fund shortfalls for research programs from revenue generated by George Clinical. This funding model is an incredible source of strength for The George Institute and helps to create stability in the often financially unstable world of health research.

For more than ten years, George Clinical, and its predecessor organisations, the contract research arm of The George Institute has been conducting and managing clinical trials. They include academic-initiated and large international pharmaceutical company-sponsored trials.

Over this period, George Clinical has shown that it has the skills and expertise to efficiently handle all of the logistical and operational components of a clinical trial. George Clinical has investigator contacts in 40 countries and over 300 sites under their management.

Associate Professor Vlado Perkovic, Executive Director of George Clinical, says that by being an extension of an academic organisation, they tend to communicate with site investigators on a peer-to-peer level. "We have a different approach to trial management. We tend to engage more deeply and collaboratively with site partners, which seems to result in better performance." Indeed, George Clinical consistently breaks expectations through rapid patient recruitment and start-up times.

George Clinical is currently engaged in eleven trials that are at different stages of activity. George Clinical has been involved in the recently published SHIFT trial. "The aim of the SHIFT trial was to determine whether a heart medication called ivabradine could reduce the number of hospitalisations and deaths due to heart failure when given in addition to optimal current care. People at risk of heart failure often have a raised heart rate and ivabradine acts by slowing the resting heart rate. Unlike other treatments, such as beta blockers, it lowers the number of heart beats per minute without reducing the strength with which the heart pumps (measured as blood pressure). This is a major benefit for people with heart failure as their hearts are already weakened," explains Professor Perkovic.

Of the total of about 6,500 SHIFT trial participants, George Clinical recruited and managed the Asia-Pacific region participants, of which there were over 1,000. The results revealed that ivabradine can reduce the risk of death or hospitalisation by 26%, and those people with a higher resting heart rate will receive a greater benefit. This means that 26 people would need treatment for one year to prevent one cardiovascular death or one hospital admission for heart failure.

"Ivabradine is the first new drug of this kind designed to come onto the market for decades. However, it's currently only used to treat angina and is not licensed for use in heart failure. This study suggests that ivabradine could prevent thousands of deaths around the world each year in people who experience heart failure," says Professor Perkovic.

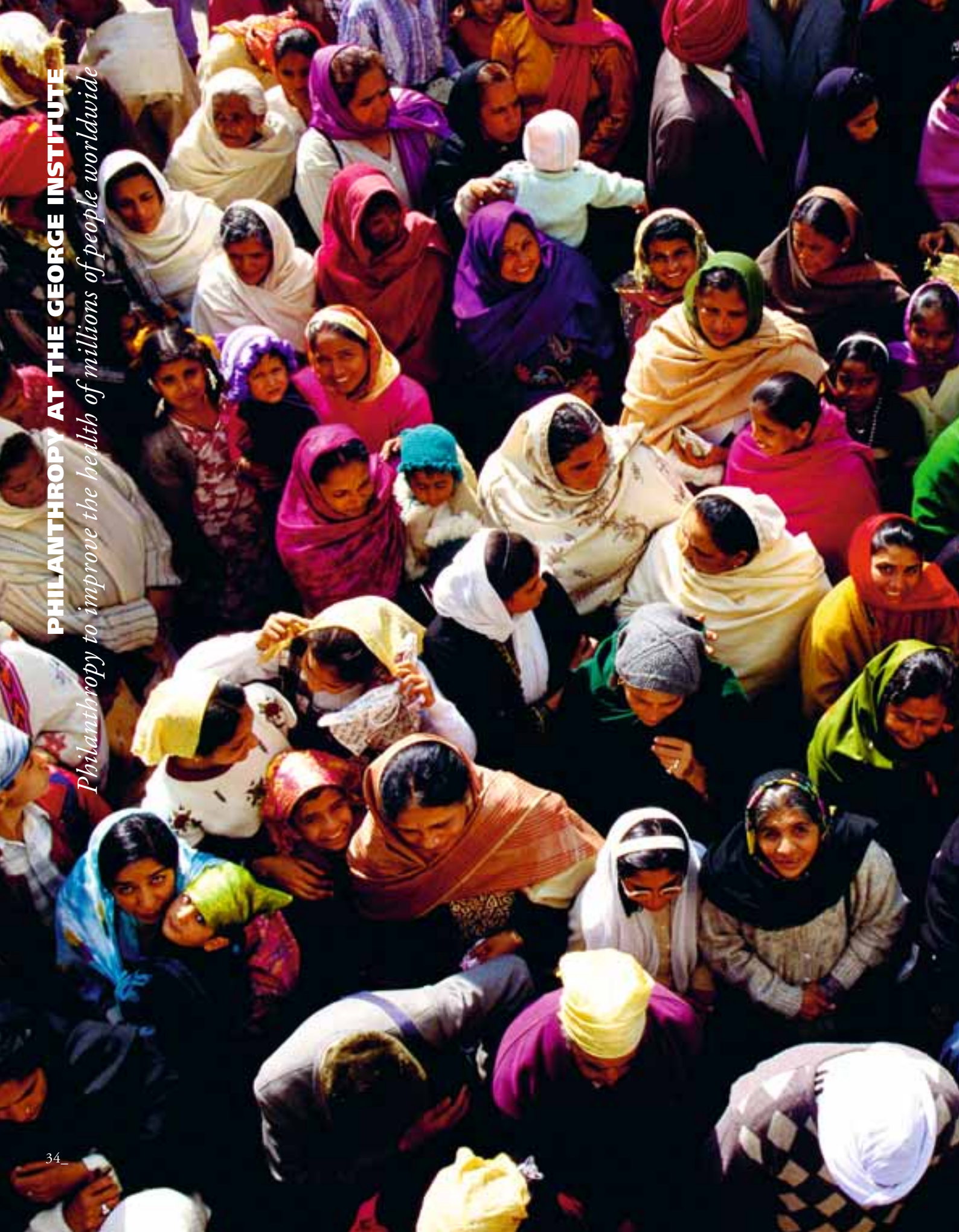
"Participating in and leading clinical trials on behalf of external investigators is a natural extension of The George Institute's raison d'être. We will continue to extend our networks so that we can further contribute to clinical research that will improve global health and change people's lives," he adds.

The George Clinical story

Every medicine on the market must first have been proven to be safe and effective in human clinical trials. Clinical trials are conducted in several stages or phases, with the latter phases involving potentially hundreds to thousands of people. There is variability in the ways individuals respond to a medicine: it depends on people's genetic makeup, their existing health problems and environmental factors. Thus, larger end-stage trials help researchers to identify potential side effects that may only be present in a small percentage of the population. Clinical trials are also conducted for the purpose of evaluating approaches and strategies to treatment and specific medicines, and to identify better and more cost-effective treatment and approaches.

The conduct of clinical trials requires substantial management. There are legal requirements, ethics requirements, and trial registration requirements. Every trial site, which is typically an individual clinic or hospital, must be approved, trained and prepared. That's before the recruitment of people even begins. Then there's monitoring those people involved in the trial, data collection and, finally, data analysis.





Our achievements in 2010 told on the preceding pages illustrate the story of The George Institute. In the broad spectrum of scientific research, with basic science and test tubes at one end, and health service delivery and policy research at the other, we operate at the latter end. In other words, we're about people, not test tubes. What this means is that our research almost always delivers an impact within three to five years, instead of fifteen to twenty. This is important for people who want to live and lead healthier lives right now.

For philanthropists, this is also important. In a relatively short period of time, they can see the impact their support is having. There is a global trend in philanthropy known as 'giving while living'.

Role of philanthropy

Philanthropy plays an important role in medical research, often providing support for the crucial, innovative projects not supported by government. That innovation informs and transforms public policies to create real change. Over the last year, The George Institute has begun to develop its philanthropic program, building on the results of our stakeholder research from the previous year. We've hosted a number of events and luncheons aimed at introducing our research to wider audiences. We've also developed a philanthropy strategy specifically to support our work in China.

Leveraging philanthropy

To attract significant, multi-source funding, such as government grants, researchers need to provide evidence that their project is viable and able to produce outcomes. Yet, how does one produce outcomes without funding to start the

project? To address this predicament, philanthropic seed funding often allows a pilot project to get off the ground and start producing the outcomes that can be presented to government and other funders. In effect, the philanthropic support has been leveraged to secure much larger amounts of funding.

A very clear example of where we've achieved this is through our consultation work with the community of Fitzroy Crossing, Western Australia (see page 28). Here, initial support by Bellberry Limited and an anonymous donor provided the funding impetus to begin the project. Initial results were then presented to the Australian Federal Government, who awarded the project over AU\$1 million. Additionally, the global creative agency, M&C Saatchi, has provided support to help us raise the remaining money for the project. This is a stunning example of how giving to The George Institute makes a difference to the lives of ordinary people.

Industry partnerships

Industry and corporate partners can play a vital role in helping us secure funding for research. The Australian National Health and Medical Research Council (NHMRC), through its 'Partnership Project Grant' scheme, supports partnerships between researchers, industry and government. Essentially, collaborating partners contribute about half the funding and the NHMRC will match it.

The George Institute, in partnership with the Australian Food and Grocery Council, New South Wales Food Authority and the New South Wales Department of Health, was awarded such a partnership grant to reduce people's consumption of salt. Through advocacy, we have been raising awareness that eating foods containing too much salt increases blood pressure – one of the biggest contributors to

heart disease and stroke throughout the world. This is particularly true for disadvantaged populations, whose consumption of fast and processed foods containing high levels of salt causes an increasing number of preventable deaths. We've had success already this year in persuading the Australian Government to set targets for salt levels in fast foods. We'll continue this in 2011.

Unique funding models

The George Institute is a not-for-profit organisation that includes a surplus-generating enterprise called George Clinical (see page 32). Profit generated by George Clinical is invested back into the main work of The George Institute to support current research projects and to pilot innovative new projects.

Proceeds from our enterprise division cover the Institute's fundraising costs. As such, all donations received by The George Institute go directly into our research and training.

Looking ahead

In 2011, we will continue to build on our successes to date. We'll forge closer relationships with the philanthropic sector, and host a variety of events to introduce new audiences to our work.

We will explore creative funding models, implement our philanthropy approach in China, and develop specific strategies to support our work in Aboriginal health, ageing and disability, and urban health in India. By doing so, The George Institute – and our partners – will continue our contribution to the rich narratives that have become the story of The George Institute.

To support our mission of transforming the lives of millions of people worldwide, contact Chris Ostendorf on +61 2 8238 2402 or e-mail

Our academic leaders

The George Institute provides a base for some of the leading minds in the field of health research. Staff have always had a strong sense of commitment to the Institute's mission and its values. Not only do we provide a base to many of the academic leaders of today, but we also pride ourselves that many academic leaders of the future are working at The George Institute's offices in Australia, China, India and the United Kingdom.



PRINCIPAL DIRECTOR
Professor Stephen MacMahon

Stephen MacMahon is Principal Director of The George Institute for Global Health and Professor of Cardiovascular Medicine at the University of Sydney. He is an international authority on the causes, prevention and treatment of common cardiovascular diseases. His special interest is the management of chronic and complex conditions in resource-poor settings, particularly in the Asia-Pacific region. In addition to his University and Institute appointments, Stephen holds several external appointments, including those as Chairman of the UK BioBank and Chairman of the Academic Alliance for Clinical Trials. He has published several hundred scientific papers and delivered many invited lectures. For his work in the field of cardiovascular disease, he has received numerous awards, fellowships and honours. He accepted the NHMRC Achievement Award for the Most Outstanding Program Grant on behalf of The George Institute in 2008.



PRINCIPAL DIRECTOR
Professor Robyn Norton

Robyn Norton is Principal Director of The George Institute for Global Health, Professor of Public Health and Associate Dean (Global Health) in the University of Sydney Medical School. She is an international authority on the causes and prevention of injuries, particularly road traffic injuries. Robyn was the inaugural Chair and is now Chair Emeritus of the Road Traffic Injuries Research Network, a global network, supported by the World Health Organization and the World Bank, aimed at increasing research and research capacity to address the current and growing burden of road traffic injuries in low and middle-income countries. She holds an Honorary Professorship at Peking University Health Science Center, and is an Honorary Consultant Epidemiologist at the Royal Prince Alfred Hospital.



EXECUTIVE DIRECTOR, THE GEORGE INSTITUTE, INDIA
Associate Professor Anushka Patel

Anushka Patel is Senior Director at The George Institute for Global Health, Associate Professor with the Faculty of Medicine at the University of Sydney, and a Staff Specialist in the Department of Cardiology at Royal Prince Alfred Hospital. Anushka completed her undergraduate medical training at The University of Queensland in December 1989, and her training in cardiology (leading to Fellowship of the Royal Australian College of Physicians) in 1998. She has a Master of Science degree in Epidemiology from Harvard University, and a PhD in Medicine from the University of Sydney. Anushka also holds a five-year National Heart Foundation of Australia Career Development Fellowship. She is currently Chair of the Chronic and Critical Conditions theme at The George Institute.



**EXECUTIVE DIRECTOR,
GEORGE CLINICAL**

*Associate Professor
Vlado Perkovic*

Vlado Perkovic is Executive Director of George Clinical, the clinical trials arm of The George Institute, and also plays a key role in the Institute's Renal and Metabolic Division. He is a Staff Specialist in Nephrology at the Royal North Shore Hospital, and Associate Professor at the University of Sydney. His major research interest is understanding both the cardiovascular risk associated with chronic kidney disease and the impact of interventions that might mitigate this risk mainly through the conduct of clinical trials and meta-analyses. He is Deputy Chair of the Scientific Committee of the Australasian Kidney Trials Network.



**EXECUTIVE DIRECTOR, THE
GEORGE INSTITUTE, CHINA**

Professor WU Yangfeng

WU Yangfeng is the Executive Associate Director of the Clinical Research Institute at Peking University Health Science Center and Professor of Epidemiology in the Department of Epidemiology and Biostatistics at the Peking University School of Public Health. Yangfeng has made valuable contributions reducing the impact of cardiovascular disease in the region as a result of his previous work at the Cardiovascular Institute, Fu Wai Hospital, and the World Health Organization Collaboration Center in Cardiovascular Disease Prevention, Control and Research in China, and his current work at Peking University.



**SENIOR DIRECTOR,
NEUROLOGICAL AND
MENTAL HEALTH**

Professor Craig Anderson

Craig Anderson is Professor of Stroke Medicine and Clinical Neuroscience in the Sydney Medical School at the University of Sydney and the Institute of Neurosciences of the Royal Prince Alfred Hospital. Having led several major international stroke studies, Craig is widely acknowledged as a leader in his field. He was recently awarded the Royal Prince Alfred Research Medal for Excellence in Research. Craig is a member of several specialist societies, is an Editor for the Cochrane Stroke Group, and is currently President of the Stroke Society of Australasia. He has published widely on the clinical and epidemiological aspects of stroke, cardiovascular disease and aged care, and is on the steering committee for several large-scale research projects.



**SENIOR DIRECTOR, RENAL
AND METABOLIC**

Professor Alan Cass

Alan Cass trained as a nephrologist at the Royal Prince Alfred Hospital, in public health and health policy. He undertakes multi-centre clinical trials, collaborative research in Aboriginal health, studies of the economic burden of chronic disease, and is developing a program of implementation research focusing on translating research evidence into practice. Alan is Chair of the Scientific Committee of the Australasian Kidney Trials Network, and regularly consults for government to develop strategies for chronic kidney disease prevention and management, and plans for renal service provision.



SENIOR DIRECTOR

Professor John Chalmers

John Chalmers is Head of the Professorial Unit at The George Institute, and Emeritus Professor of Medicine at the University of Sydney and Flinders University. He is a world leader in research on the causes and treatment of high blood pressure. He has also served in many senior academic roles in Australia and internationally. John's work has been recognised through admission to the Australian Academy of Science, and awarding of the Wellcome Medal, the Volhard Medal of the International Society of Hypertension, and the Zanchetti Award of the European Society of Hypertension. He was appointed a Companion of the Order of Australia (AC) in 1991 and most recently, was made an Officer of the French National Order of Merit in 2010, in recognition of his contributions to enhancing Franco-Australian relations.



SENIOR DIRECTOR

Professor Bruce Neal

Bruce Neal is Professor of Medicine at the University of Sydney, Scientific Director of George Clinical, and Chair of the Australian Division of World Action on Salt and Health (AWASH). Bruce completed his medical training at Bristol University, UK and prior to joining the Institute in 1999, he worked as an epidemiologist at the Clinical Trials Research Unit in Auckland, New Zealand. Bruce is a Fellow of the Royal College of Physicians, UK and the American Heart Association. He is also a member of the Executive Council of the High Blood Pressure Research Council of Australia and the International Society of Cardiovascular Disease Epidemiology and Prevention.



SENIOR DIRECTOR

Professor Mark Stevenson

Mark Stevenson is Professor in the Sydney Medical School at the University of Sydney, a National Health and Medical Research Council Fellow and an Honorary Professor at the Peking University Health Science Center. A world leader in his field, Mark has extensive research experience in road trauma and public health. He regularly advises on issues such as driver distraction, childhood injury and road safety in low and middle-income countries, including advising World Health Organization, UNICEF and the Swedish International Development Agency. Mark is a member of the Australasian Trauma Society and a Lifetime Fellow of the Australasian College of Road Safety.



DIRECTOR, STATISTICS AND DATA MANAGEMENT

Laurent Billot

Laurent Billot manages a team of biostatisticians, statistical programmers and data managers responsible for the provision of statistical expertise to support the research undertaken at The George Institute. This includes clinical trials, meta-analyses, observational studies, as well as teaching and the development of new statistical methods. Laurent is a statistician with over ten years experience in the design, analysis, and reporting of health and medical studies, from public health surveys and epidemiological studies to multinational Phase III/IV clinical trials.



**DIRECTOR,
CARDIOVASCULAR**
*Associate Professor
Graham Hillis*

Graham Hillis is Associate Professor within the Faculty of Medicine at the University of Sydney, and a Consultant Cardiologist with clinical appointments at Concord Hospital, Royal Prince Alfred Hospital (honorary), Strathfield Private Hospital, and Central Sydney Cardiology. His current post is partly funded by a Life Sciences Research Award from the New South Wales Office for Science and Medical Research. His clinical and research interests include echocardiography, acute coronary syndromes, cardiac biomarkers, and the prediction and management of peri-operative cardiovascular complications in patients undergoing cardiac and major non-cardiac surgery.



DIRECTOR, INJURY
*Associate Professor
Rebecca Ivers*

Rebecca Ivers is Associate Professor at the University of Sydney, and directs a research program which is centred on injury prevention, with a strong focus on the prevention of road traffic injury. She has published widely in the field of road traffic injury, and has been awarded a NSW Young Tall Poppy Award in Science and an Achievement Award from the National Health and Medical Research Council of Australia for her road safety research. She is an investigator on studies in a diverse range of areas, including novice drivers, Indigenous road injury, heavy vehicle crashes, and motorcycle safety in Australia, as well as projects aimed at preventing injury in China, India and Vietnam.



**DIRECTOR,
MUSCULOSKELETAL**
Professor Chris Maher

Chris Maher is Professor in the Sydney Medical School at the University of Sydney. He also holds a National Health and Medical Research Council Senior Research Fellowship. Chris leads a program of research focusing on the management of musculoskeletal conditions in primary care and community settings. This research is characterised by innovation, an interdisciplinary approach and an emphasis on simple treatments delivered well. Particularly committed to knowledge translation and health literacy, Chris has worked with local and international colleagues to develop information technologies that deliver the best research evidence to clinicians and health consumers.



**DIRECTOR, CRITICAL CARE
AND TRAUMA**
Professor John Myburgh

John Myburgh is Professor of Medicine at The University of New South Wales, Honorary Adjunct Professor in the Department of Epidemiology and Preventive Medicine at Monash University, and Honorary Professor at the University of Sydney. He is lead clinician for research and Senior Staff Specialist in the Department of Intensive Care Medicine at the St George Hospital, Sydney. John is a foundation member and current Chairman of the Clinical Trials Group of the Australian and New Zealand Intensive Care Society. He is also President of the College of Intensive Care Medicine.



**DIRECTOR,
CARDIOVASCULAR**
Dr Fiona Turnbull

Fiona Turnbull is Senior Lecturer within the Sydney Medical School at the University of Sydney. She completed her undergraduate medical training at the University of Otago in 1992 and her training in public health medicine (leading to Fellowship of the Australasian Faculty of Public Health Medicine) in 2002. Fiona has an MPH (Hons) and a PhD in Medicine from the University of Sydney and she currently holds a National Heart Foundation of Australia Post-Doctoral Fellowship.



**HEAD OF RESEARCH
AND DEVELOPMENT, THE
GEORGE INSTITUTE, INDIA**
Dr Pallab K. Maulik

Pallab Maulik joined The George Institute, India as the Head of Research and Development in early 2010. Pallab brings a wealth of experience to the Institute, in particular expertise in mental health. Pallab has worked with the World Health Organization, Geneva on Project Atlas and other mental health programs, and clinically as a psychiatrist in India and Australia. His particular research interests include social determinants of health, especially mental health services, mental disorders, international mental health, and intellectual disability. After training as a psychiatrist at the All India Institute of Medical Sciences, New Delhi, he received training in public health at the London School of Hygiene and Tropical Medicine, and Johns Hopkins School of Public Health in Baltimore, where he completed his Masters and Doctoral level training.



**HEAD OF RESEARCH
AND DEVELOPMENT, THE
GEORGE INSTITUTE, CHINA**
Professor YAN Lijing

YAN Lijing is a cardiovascular epidemiologist with a background in epidemiology, demography and health economics. She is also Adjunct Associate Professor at the Department of Preventive Medicine, Feinberg School of Medicine, Northwestern University, Chicago, and the Health Economics and Management Institute, Guanghua School of Management, Peking University, Beijing. Lijing has worked extensively in the areas of chronic disease prevention and control, economic evaluations in health care, and integrated health management. She is also the principal investigator or co-investigator on several research projects funded by the National Institutes of Health, USA, the National Natural Sciences Foundation of China, and the Ford Foundation.



PROFESSORIAL FELLOW
Professor Simon Finfer

Simon Finfer is Professor in the Sydney Medical School at the University of Sydney and trained in internal medicine, anaesthesia and intensive care in London, Sydney, Toronto and Oxford. He settled in Sydney in 1993 and is a Senior Staff Specialist within the Intensive Care Unit at the Royal North Shore Hospital. He is a past Chair of the Australian and New Zealand Intensive Care Society Clinical Trials Group, and his major academic interest is the design and conduct of large-scale randomised controlled trials in critical care. Simon has played a pivotal role in some of the largest trials conducted in intensive care and was the lead investigator for The George Institute's SAFE and NICE-SUGAR studies.



PROFESSORIAL FELLOW
Professor Richard Lindley

Richard Lindley is Professorial Fellow in injury, frailty and disability, appointed in February 2010. After graduating in medicine in the United Kingdom, he trained in geriatric and general medicine in the UK and Australia, and was consultant and Senior Lecturer at the University of Edinburgh (1996-2003). In 2003 he was appointed Moran Foundation for Older Australians Professor of Geriatric Medicine at the University of Sydney, a post he continues to hold. Richard has collaborated with colleagues at the Institute for many years, and moved his research base to the Institute early in 2010. His main research themes have been the reliable assessment of new treatments for older people, especially in stroke and vascular disease. More recently he has focused on frailty and disability. He retains a clinical hospital appointment in the Sydney West Area Health Service (Westmead Hospital and now Blacktown Hospital). His research work at the Institute will build on the global theme of Frailty and Disability.



PROFESSORIAL FELLOW
Professor Anthony Rodgers

Anthony Rodgers is Professor of Global Health at the University of Sydney. After graduating in medicine in the United Kingdom, he trained in epidemiology and public health in New Zealand. He was the principal author of the 2002 World Health Report, the main annual publication for the World Health Organization. Since 2003, he has led a public-private partnership developing an affordable four-in-one cardiovascular combination pill ('polypill'), with a clinical trial program in economically developed and developing countries. His current work aims to foster similar developments designed to be 'fit for purpose' in low-income settings.

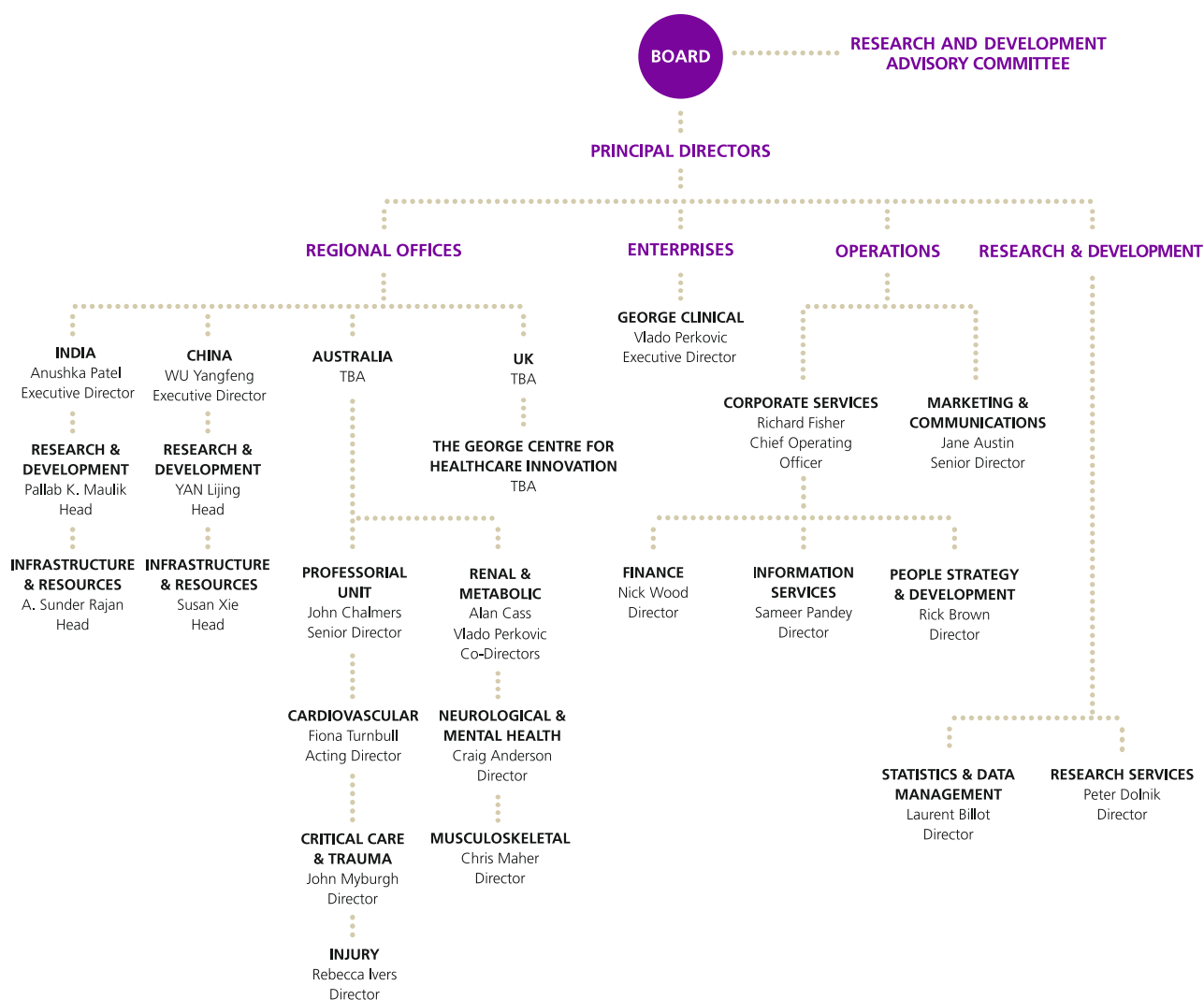


PROFESSORIAL FELLOW
Professor Mark Woodward

Mark Woodward is Professor of Biostatistics, at the University of Sydney and Adjunct Professor of Epidemiology at Johns Hopkins University in Baltimore. He also holds long-term honorary academic appointments at Mahidol University, Bangkok, and Glasgow and Dundee universities. Mark is Chair of the Asia Pacific Cohort Studies Collaboration and the senior statistician for several international collaborative studies. He has extensive experience of work in developing countries, including work for several aid agencies, such as developing a training package for the Millennium Development Goals on behalf of the United Nations.

We have 341 total staff
(249.1 full time equivalent
staff) based in offices in
Australia, China, India and
the United Kingdom.

*Organisation chart of The George Institute
for Global Health as of 30 June 2010*



Awards and achievements in 2009-10

- Anushka Patel** Awarded National Health and Medical Research Council (NHMRC) Senior Research Fellowship
- Bette Liu** Awarded NHMRC Training Fellowship
- Bruce Neal** Appointed Member of Scientific Advisory Board PepsiCo
- Bruce Neal Appointed Member of China Health Policy, China Studies Centre, the University of Sydney
- Cathie Sherrington** Awarded NHMRC Senior Research Fellowship
- Cathie Sherrington Awarded NHMRC Career Development Award
- Colman Taylor** Awarded Dora Lush Public Health Scholarship
- Craig Anderson** Awarded NHMRC Senior Principal Research Fellowship
- Elizabeth Clarke** Awarded NHMRC Training Fellowship
- Jane Latimer** Awarded Australian Research Council Future Fellowship
- John Chalmers** Appointed Officer of the French National Order of Merit
- John Myburgh** Elected President of the College of Intensive Care Medicine
- John Myburgh Awarded St George Clinical School Research Excellence Award
- Julie Redfern** Awarded NHMRC Training Fellowship
- Liz de Rome** Appointed Member of the US Transportation Research Board (TRB) Sub-Committee on Motorcycles and Mopeds (ANF30)
- Liz de Rome Launched her booklet, The Good Gear Guide for Motorcycle and Scooter Riders, at Parliament House, Canberra
- Lizzy Dunford** Awarded Medical Foundation Scholarship, the University of Sydney
- Luciana Machado** Won 2008 Peter Bancroft Prize for Research
- Maree Hackett** Awarded NHMRC Career Development Award
- Marilyn Lyford** Awarded Australian Injury Prevention Network (AIPN) Award for Excellence in Injury Prevention & Safety Promotion Practice
- Nicole Li** Awarded NHMRC Australia-China Exchange Fellowship
- Rebecca Ivers** Appointed Secretary of the AIPN
- Robyn Norton** Appointed Chair Emeritus, Road Traffic Injuries Research Network (RTIRN)
- Stephen MacMahon** Awarded 2010 John P. McGovern M.D. Award
- Teresa Senserrick** Awarded NHMRC Career Development Award
- Vlado Perkovic** Awarded Heart Foundation Career Development Fellowship

Role of The George Institute's Board

The George Institute is able to draw upon the skills and expertise of the Board to ensure that our governance and management are robust, dynamic and rigorous.

The Board's central duty is to protect and promote the objectives and interests of The George Institute. To achieve this, the Board considers the nature and range of Institute activities and makes sure that key stakeholder interests, including ethical, social and cultural considerations, are addressed.

The Board is responsible for the way the Institute is governed, our strategic direction, risk management, the monitoring of finances and other reporting.

The Board makes sure that the Institute complies with the Australian Commonwealth *Corporations Act 2001* and other obligations resulting from the Institute's charitable status. As a research and academic organisation, the Board values and promotes scholarship, academic freedom and scientific integrity.



Dr John Yu AC – Chair

John Yu has had a distinguished career in paediatric medicine and a strong commitment to community affairs. His previous positions include Chief Executive of the New Children's Hospital at Westmead, staff physician at the Royal Alexandra Hospital for Children, Chancellor of The University of New South Wales, and Deputy Chancellor of the University of Western Sydney. John has served on many management boards and charitable organisations, including chairmanship of both VisAsia at the Art Gallery of New South Wales, and the Centre for Asian Art and Archaeology at the University of Sydney. He was appointed a Member of the Order of Australia in 1989 for services to medicine. In 2001 he was awarded the Centenary Medal and made a Companion of the Order of Australia. He was named Australian of the Year in 1996. John joined the Board as Chair in September 2006.



Don Green – Deputy Chair

Don Green is a Fellow Chartered Accountant, a Fellow CPA, and a Senior Partner of Ernst & Young Australia, where he leads the Oceania Transaction Tax Practice. He has held Asia-Pacific leadership roles of his firm's Financial Markets and Japanese Business Programs, and is currently Chair of the Taxation Taskforce of Infrastructure Partnerships Australia. Over a number of years, Don has been Director or Committee Chair of the Friends of the Mater Foundation for the Mater Misericordiae Hospital, the Australian Council for Infrastructure Development, and the Institute of Chartered Accountants in Australia. Don joined the Board in May 2003.



Elsa Atkin

Elsa Atkin is a company director and a cultural management consultant. Previous roles include Executive Director of the National Trust of Australia (NSW), Deputy Director of the Evatt Foundation, and a Senior Manager at the Australian Broadcasting Corporation. Currently she sits on several boards, including the Library Council of NSW. She was made an Australia Day Ambassador (1998–2000) and Honorary Life Member of the National Trust in 2005. Elsa joined the Board in July 2007.



Joanna Capon OAM

Joanna Capon is a member of the Australia-China Council, the Advisory Council of the Children's Hospital at Westmead, and the hospital's Health Care Quality Council and Governance Committee. She is also Chair of Operation Art, a board member of Museums and Galleries NSW, and a member of the Editorial Advisory Board of Art and Australia. Joanna is an art historian, industrial archaeologist, curator and writer. She was awarded the Medal of the Order of Australia in 2002 for services to the community. Joanna joined the Board in March 2007.



Peter Church OAM

Peter Church is Group Chairman of AFG Venture Group, a corporate advisory/ investment banking firm. Previously he was the Regional Managing Partner for Asia of the Australian law firm Freehills. His involvement in business relations between Australia and the South-East Asian region spans more than 35 years, for which he was awarded the Medal of the Order of Australia in 1994. His other current directorships include Special Counsel to the Australian law firm Blake Dawson, and Chairman of Bangkok International Associates Limited and Indonesia's Aksara Foundation. Peter joined the Board in June 2004.



Professor Stephen Garton

Stephen Garton is the Provost and Deputy Vice-Chancellor of the University of Sydney. He is a graduate of the University of Sydney and The University of NSW, and is a Fellow of the Australian Academy of the Humanities, the Academy of Social Sciences in Australia and the Royal Australian Historical Society. His area of research expertise is Australian history. He has also published in the fields of American and British history, psychiatry, crime, poverty, social policy, eugenics, policing, masculinity, and returned soldiers. Stephen has been a member of the Editorial Board of the Australian Dictionary of Biography, the Executive Committee of the Australian Historical Association, and a member of the Council of the Australian Academy of the Humanities. Stephen was appointed to the Board on September 2009.



Jason Yat-sen Li

Jason Yat-sen Li is Managing Director of Yatsen Associates Ltd, an investment banking and private equity firm based in Beijing. Previously he was Head of China Strategy and Senior Manager, Sustainable Development for Insurance Australia Group, and worked as a lawyer for the United Nations International Criminal Tribunal for the former Yugoslavia in The Hague, the Netherlands. He was a recipient of the Eisenhower Fellowship in 2002, as well as the Hauser Global Fellowship to New York University Law School in 2000. He is currently a Director of The Sydney Institute and a Governor of The Smith Family. Jason has been a member of the Board since June 2007.



Professor Stephen MacMahon

Stephen MacMahon is Professor of Cardiovascular Medicine at the University of Sydney and Principal Director of The George Institute for Global Health (see full biography on page 36).



Professor Robyn Norton

Robyn is Professor of Public Health and Associate Dean (Global Health) within the Sydney Medical School at the University of Sydney and Principal Director of The George Institute for Global Health (see full biography on page 36).

Board committees

To assist the Board with execution of its responsibilities, a number of Board committees have been established. The outcomes of Board committee meetings are reported to the Board of Directors following each committee meeting.

<i>Committee</i>	<i>Description</i>	<i>Membership</i>
Finance, Risk and Audit Committee	Oversees all financial matters, including budget, audit and risk management matters.	Don Green (Chair) David Clark Robyn Norton
Fundraising Committee	Provides strategic direction on philanthropic plans and activities.	Elsa Atkin (Chair) Jane Austin John Yu Stephen MacMahon Joanna Capon
Remuneration Committee	Reviews remuneration for senior employees of the Institute.	John Yu (Chair) Don Green
George Health Enterprises Committee	Provides strategic direction on enterprise plans and activities.	Peter Church (Chair) Don Green Bruce Neal Vlado Perkovic Jason Yat-sen Li Su-Ming Wong Stephen MacMahon

Research Committee

<i>Description</i>	<i>Membership</i>
The Institute's Constitution requires the establishment of a Research Committee with a minimum of five members, the majority of whom need to 'demonstrate the proven ability to direct a research program as evidenced by their academic qualifications and their professional appointments'.	John Yu (Chair) Don Green Stephen MacMahon Robyn Norton

Research and Development Advisory Committee

In order to provide the Institute with advice on future research directions, a Research and Development Advisory Committee (RADAC) has been established whose membership consists of international health research and development practitioners.

<i>Committee</i>	<i>Description</i>	<i>Membership</i>
Research and Development Advisory Committee (RADAC)	RADAC is an independent body which meets approximately every three years to provide an independent assessment of the scope, content and quality of The George Institute's research and development activities within the context of the Institute's mission and strategic plan. The Committee also issues advice in relation to current, medium and long-term issues facing The George Institute.	Terry Dwyer (Chair), Murdoch Childrens Research Institute, Australia Robert Black, Johns Hopkins University, USA Robert Califf, Duke University, USA Deborah Cook, McMaster University, Canada Paul Elliott, Imperial College, UK Wendy Hoy, The University of Queensland, Australia Garry Jennings, Baker IDI Heart and Diabetes Institute, Australia KE Yang, Peking University Health Science Center, China Michael Merson, Duke University, USA Terry Nolan, The University of Melbourne, Australia Don Nutbeam, University of Southampton, UK Vikram Patel, London School of Hygiene and Tropical Medicine, UK Srinath Reddy, Public Health Foundation of India Sally Redman, The Sax Institute, Australia Bruce Robinson, the University of Sydney, Australia

Institute management

The George Institute Principal Directors, Professor Stephen MacMahon and Professor Robyn Norton are responsible for overseeing the implementation of the Institute's strategic plan in consultation with the Senior Management Committee and the Institute Management Group. The Senior Management Committee has an Executive Group which oversees the day-to-day operation and administration of the Institute.

<i>Management Committee</i>	<i>Description</i>	<i>Membership</i>	
Senior Management Committee	Provides recommendations to the Principal Directors on matters of strategic or operational significance to the Institute.	Stephen MacMahon (Co-Chair) Robyn Norton (Co-Chair) Jane Austin	Richard Fisher Anushka Patel Vlado Perkovic WU Yangfeng
Executive Group	The Executive Group oversees the day-to-day operation and administration of the Institute.	Stephen MacMahon (Co-Chair) Robyn Norton (Co-Chair)	Jane Austin Richard Fisher
Institute Management Group	The Institute also consults widely with Institute Directors, who lead and manage major Institute programs. Members of the Senior Management Committee are also members of the Institute Management Group.	Craig Anderson Laurent Billot Rick Brown Alan Cass John Chalmers Denise Clarke-Hundley (from October 2009) Joanna Cole (until October 2009) Peter Dolnik Samantha Flynn (until January 2010) Javier Guzman Graham Hillis Rachel Kerry (until August 2009) Graham Lawrence (until October 2009) Richard Lindley (from February 2010) Chris Maher Pallab Maulik (from April 2010)	Mary Moran John Myburgh Bruce Neal Chris Ostendorf (from November 2009) Sameer Pandey Vinodvenkatesh Patel A Sunder Rajan Anthony Rodgers Mark Stevenson Cheryl Townsend (until October 2009) Fiona Turnbull WEI Liu Nick Wood (from October 2009) Mark Woodward (from January 2010) Susan Xie YAN Lijing

The financial year 2009-10 has been a period of consolidation of existing activities as well as investment in new projects and other initiatives.

Global revenues grew during the year by 16.4% to \$48.3M, with Australia continuing to be the main focus of activity but with growing contributions from our subsidiaries in China (\$7.4M) and India (\$1.3M). A consolidated surplus of \$0.2M was recorded for the year ended 30 June 2010, an improvement of \$1.9M over the previous year, due mainly to the better performance of the Institute's investment portfolio.

The financial strength of the consolidated group continues to be satisfactory, with net assets of \$5.3M. Total assets of \$31.2M included \$9.7M of cash, \$6.8M of liquid investments and \$14.7M of accounts receivable and other assets. This was offset by \$25.9M of liabilities and included \$19.9M of 'deferred income' (being commitments to research and other projects).

The period following the end of the financial year has seen continued growth in research activities, further investment in surplus generating activities and expansion of global programs.



Richard Fisher

CHIEF OPERATING OFFICER

OCTOBER 2010

Industry partnerships

A range of funding from industry partners supports our research projects, providing direct and indirect support for investigator-led research that identifies new approaches to the prevention and treatment of chronic disease and illness.

Industry partnerships also include research programs contracted to George Clinical for the provision of research services and the management of clinical trials. Profits from this wholly-owned enterprise are then invested back in to the work of The George Institute, and used to support current research projects and to pilot innovative new projects.

Peer-reviewed funding

The Institute has been highly successful in securing both Australian and non-Australian competitive peer-reviewed grants this year. Applications go through a rigorous selection process, based on the quality and significance of the initiative, and the track record of the researchers. The process involves review by committees of other 'peer' scientists who work in the same area.

Peer-reviewed funds are provided in Australia by the Federal Government through the National Health and Medical Research Council (NHMRC) and Australia Research Council (ARC). Peer-reviewed funds also come from health charities, such as the National Heart Foundation in Australia, as well the National Institutes of Health in the United States and the Wellcome Trust in the United Kingdom.

Government funding

Australian Federal Government and New South Wales Government grants support the Institute's infrastructure and administration

The Australian Federal, State and Territory Governments across a range of departments including Health, Families, Housing and Community Services, also provide support to a range of research projects undertaken within the Institute.

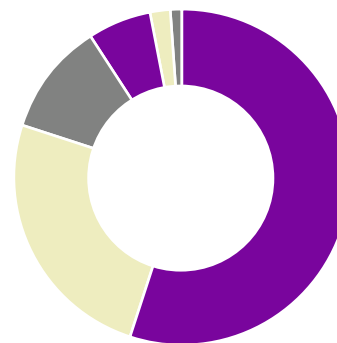
Trusts and foundations

Funds are also sourced from Australian foundations and research trusts, as well as international organisations such as the Bill & Melinda Gates Foundation in the USA.

Donations and sponsorships

Donations and philanthropic contributions have been received from a small but important number of individuals and companies. Additionally, sponsorship support has been received from associations such as the National Roads and Motoring Authority in Australia and for the support of activities such as our physiotherapy evidence database – PEDro – which is accessed by practitioners globally. Profits from our enterprise division cover the Institute's fundraising costs. As such, all donations received by The George Institute go directly to research and training.

Income 2009-10



INDUSTRY PARTNERSHIPS	AU\$25.5M
PEER-REVIEWED	AU\$11.8M
GOVERNMENT FUNDING	AU\$5.3M
TRUSTS AND FOUNDATIONS	AU\$2.6M
DONATIONS AND SPONSORSHIPS	AU\$0.6M
OTHER	AU\$1M

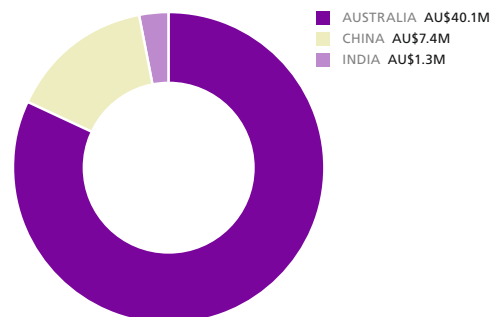
Balance Sheet

	2010
ASSETS	\$
CURRENT ASSETS	
Cash and cash equivalents	9,743,278
Trade and other receivables	12,695,079
Other assets	185,134
Investments	6,784,351
TOTAL CURRENT ASSETS	29,407,842
NON-CURRENT ASSETS	
Property, plant and equipment	1,750,522
Intangible assets	54,622
TOTAL NON-CURRENT ASSETS	1,805,144
TOTAL ASSETS	31,212,986

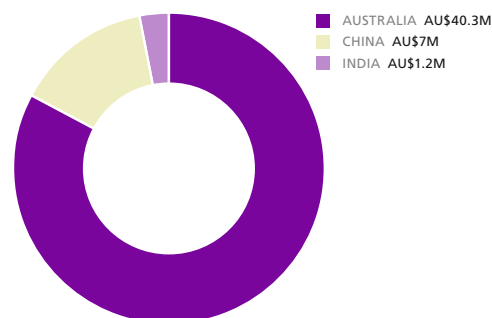
LIABILITIES	
CURRENT LIABILITIES	
Trade and other payables	3,864,164
Deferred Income	19,933,206
Provisions	1,792,528
TOTAL CURRENT LIABILITIES	25,589,898
NON-CURRENT LIABILITIES	
Provisions	345,636
TOTAL NON-CURRENT LIABILITIES	345,636
TOTAL LIABILITIES	25,935,534
NET ASSETS	5,277,452

EQUITY	
Foreign currency translation reserve	9,505
Retained earnings	5,267,947
TOTAL EQUITY	5,277,452

Income by region



Expenses by region



Income Statement

	2010
	\$
Operating revenue	46,787,585
Other income	1,545,141
Employee benefits expense	(18,967,691)
Depreciation and amortisation expense	(534,965)
Other expenses	(29,063,746)
LOSS FOR THE YEAR	(233,676)
OTHER COMPREHENSIVE INCOME	
Unrealised gain/(loss) on revaluation of financial assets	1,046,408
Realised gain/(loss) on disposal of financial assets	(591,058)
TOTAL COMPREHENSIVE INCOME	221,674

Cash Flow Statement

	2010
	\$
CASH FLOW FROM OPERATING ACTIVITIES	
Receipts of grants and contract revenue	40,967,643
Payments to suppliers and employees	(45,493,172)
Rental income	844,850
Dividends received	308,087
Interest received	142,278
NET CASH GENERATED FROM OPERATING ACTIVITIES	(3,230,314)
CASH FLOW FROM INVESTING ACTIVITIES	
Proceeds from sale of property, plant and equipment	12,000
Payment for property, plant and equipment	(514,096)
Proceeds from sale of available-for-sale investments	5,638,827
Payment for available-for-sale investments	(5,833,409)
Payment for held-to-maturity investments	101,599
NET CASH USED IN INVESTING ACTIVITIES	(595,079)
CASH FLOW FROM FINANCING ACTIVITIES	
Net increase in cash and cash equivalents held	(3,825,393)
Cash and cash equivalents at the beginning of the financial year	13,568,672
CASH AND CASH HELD EQUIVALENTS AT THE END OF THE FINANCIAL YEAR	9,743,278

Notes for full financial consolidated report are available. Contact The George Institute
Director of Finance on +61 2 9657 0300 or info@georgeinstitute.org.au

Independent Auditor's Report to the Members Of The George Institute for Global Health and Controlled Entities

We have audited the accompanying consolidated and company financial statements of The George Institute for Global Health (the entity), which comprises the statement of financial position as at 30 June 2010 and the statement of comprehensive income, statement of changes in equity, and statement of cash flows for the year ended on that date, a summary of significant accounting policies and the directors' declaration.

THE RESPONSIBILITY OF THE DIRECTORS FOR THE FINANCIAL STATEMENTS

The directors of the company are responsible for the preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the *Corporations Act 2001*. This responsibility includes designing, implementing and maintaining internal controls relevant to the preparation and fair presentation of the financial statements that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

AUDITOR'S RESPONSIBILITY

Our responsibility is to express an opinion on the financial statements based on our audit. We conducted our audit in accordance with Australian Auditing Standards. These Auditing Standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the directors, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

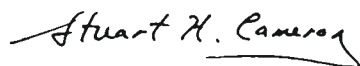
INDEPENDENCE

In conducting our audit, we have complied with the independence requirements of the *Corporations Act 2001*.

We confirm that the independence declaration required by the *Corporations Act 2001*, provided to the directors of The George Institute for Global Health on 30 June 2010, would be in the same terms if provided to the directors as at the date of this auditor's report.

AUDITOR'S OPINION

In our opinion, the consolidated and company financial statements present a true and fair view of the financial position of The George Institute for Global Health as of 30 June 2010, and their financial performance and cash flows for the year then ended in accordance with the *Corporations Act 2001* and the Australian Accounting Standards (including Australian Accounting Interpretations).



Stuart Cameron

PARTNER

K.S. Black & Co Chartered Accountants

Adelaide Institute for Sleep Health	Instituts de Formation en Pédiatrie- podologie, Ergothérapie et Masso- kinésithérapie de Rennes	Research Institute for Asia and the Pacific
Allergan Australia Pty Ltd	Intensive Care Foundation	ResMed Australia Ltd
American Physical Therapy Association	International Life Sciences Institute	Royal Prince Alfred Hospital Australia
Amgen Australia Pty Ltd	Australasia	Sanofi-Aventis Australia Pty Ltd
ANZICS Clinicals Trials Group	Irish Society of Chartered Physiotherapists	Servier Laboratories Australia
APTA Group Inc	James Cook University	Singapore Physiotherapy Association
Arcadia University	Johnson & Johnson Australia	Stroke Society of Australasia Inc.
Associação Espanola de Fisioterapeutas	Julius Clinical Research BV	Sunnybrook Health Sciences Centre
Associação Portuguesa de Fisioterapeutas	Kidney Health Australia	Suomen Fysioterapeutit-Finlands
Auckland Hospital New Zealand	Koninklijk Nederlands Genootschap voor Fysiotherapie	Fysioterapeuter
Australia – China Council	Laverty Pathology	Swedish Physiotherapy Association
Australia – India Council	Liverpool Hospital Australia	The Alliance of Girls Schools Australasia
Australian Commission on Safety and Quality in Health Care	McDonald's Australia	The Council of Health Research for Development
Australian Food and Grocery Council	Menzies School of Health Research	The Endocrine Society
Australian Kidney Trial Network	Merck Sharp & Dohme	The F Matthias Alexander Trust
Australian Physiotherapy Association	Motor Accident Insurance Commission	The Heart Research Institute
AUSTROADS Incorporated	National Heart Foundation of Australia	The Hong Kong College of Anaesthesiologists
Bill & Melinda Gates Foundation	National Stroke Research Institute	The Oxford Health Alliance
Cambia	New Zealand Society of Physiotherapists	The Royal Australian College of General Practitioners
Cardinal Systems	Northern Territory Government, Department of Education	The Sax Institute
Commonwealth Department of Families, Housing, Community Services & Indigenous Affairs	Northern Territory Government, Department of Lands & Planning	The University of Auckland, Auckland
Commonwealth Department of Health and Ageing	Northern Territory Government, Department of Planning & Infrastructure	Uniservices Ltd
Curtin University of Technology	Novartis	The University of Melbourne
Danske Fysioterapeuter	NRMA – ACT Road Safety Trust	The University of New South Wales
Deutscher Verband für Physiotherapie	NSW Department of Industry & Investment	The University of Oxford
Diabetes Australia Research Trust	NSW Food Authority	The University of Queensland
Diabetes Vaccine Development Centre	NSW Motor Accidents Authority	The University of Sydney
Dr Reddy's Laboratories Limited	NSW Office of Science and Medical Research	The Wellcome Trust
Drugs for Neglected Diseases Initiative	PeopleD Pty Ltd	Transport Accident Commission
Edwards LifeSciences LLC	Pfizer Australia Pty Ltd	Tufts Center for the Study of Drug Development
Eisai Global Clinical Development	PharmaKonsulting Pty Ltd	UK Department of Health
Eli Lilly and Company	Physio Austria	UNICEF
Elsevier Limited	Physioswiss	Universitair Medisch Centrum Utrecht
F. Hoffmann-La Roche AG	Physiotherapy Research Foundation	University of Cincinnati
Foundation for High Blood Pressure Research	Port Kembla Hospital	University of Oslo
Fresenius Medical Care	PriceWaterhouseCoopers	Vancouver General Hospital Canada
GlaxoSmithKline Australia Pty. Ltd	Prince of Wales Medical Research Institute	Victorian Government Department of Transport, Vic Roads
Global Alliance for Vaccines and Immunisation	Princess Alexandra Hospital	Wolters Kluwer Health
Global Forum for Health Research	Prognomix Inc	WorkSafe British Columbia
Government of Canada	PsycBITE	World Health Organization
Guild Insurance Limited	Queensland Cerebral Palsy and Rehabilitation Research Centre	Worldwide Clinical Trials UK Limited
Halfpennys Lawyers	Queensland Health	Yale School of Medicine
Hamilton Health Sciences	Reed Business Information Pty Ltd	
Imperial College London		
Injury Prevention Network of Aotearoa		

The George Institute for Global Health

POSTAL ADDRESS

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