MENZIES CENTRE FOR HEALTH POLICY SEMINAR

Day 2 – Thursday, 6th APRIL 2006

The Darlington Centre, The University of Sydney

BOB WELLS: Good Morning. I'm Bob Wells. For those of you who don't know me, I'm the other half, I suppose, perhaps the better half, of the Menzies Centre for Health Policy and I am based at the ANU! I don't want to recap what we talked about yesterday, but I think it was a great starter for a stimulating debate. The question time, I think, went for well over an hour and I don't think anyone was saying, "Oh dear, I hope there will not be any more questions?"

I would like, also, to add Steve's thanks. First of all, thanks to everybody for coming, thanks to our speakers for giving us their time and their valued insights. I want also to thank particularly the Menzies Foundation for their support and generosity in giving the grant which set up this Centre.

As some of you know, I have had a long-term involvement in public administration in health. I was reflecting on this yesterday when John Deeble said, "Well, really, essentially, the system hasn't changed much. Despite all the activity, in its essentials it's still the same." Then we had the perspective from a practitioner in a system, in a hospital, which has changed enormously. He said "I now can do only one surgical theatre session a week and I used to do five!" This reminds me of a famous musical in the 70s called "Oh What a Lovely War." It had two perspectives. There was one that the soldiers had, out fighting the war in the mud and there were the one that staff officers had sitting in a garden somewhere, sipping gins and tonic and jumping over each other's back. I had a feeling that I was in the garden and that the real health system – the front line - was actually out there and never the twain did meet. So I guess this is an opportunity for us to bring some of those two perspectives together.

This morning we're going to start by considering the public/private aspect of health and Mary Ann O'Loughlin is director of the Allan Consulting Group, an economics and public policy consulting firm. She joined the then Allan Consulting Group from her position as General Manager Corporate Affairs at Mayne Nickless, where she was responsible for government relations and health policy analysis. Prior to that, between 1992 and 1996, Mary Ann was Senior Adviser in Social Policy to the former Prime Minister, Paul Keating, providing policy advice and analysis across the areas of health and community services, employment, education and training and social welfare. So, Mary Ann, over to you.

MARY ANN O'LOUGHLIN: Good morning, everyone. I think I'm on the gin and tonic side of health policy, given we're talking about the private sector.

My topic today is reforming public/private relations, but at the beginning, I need to acknowledge that I'm only going to be speaking about a very small part of the private sector world and that's private health insurance. Most of the health service world is private, in the sense of medical practitioners and diagnostics and as well as the private hospitals, but private health insurance is quite small. But you could be forgiven for thinking that it was a very big part of the Australian healthcare system from listening to the government and the associated public and policy debate around the issues. We have to remind ourselves that private health insurance only pays for acute care - so we're on Dan Fox's old model - and very unrelated ancillaries like your teeth and your eyes.

So I'm going to look, today, at how government has reformed the public/private relations in healthcare, through reform to private health insurance. Now, I realise that "reform" is a loaded word, so I'm going say from the start that I'm looking it from the government's perspective. The government had an objective, they wanted reform in this area — they wanted to increase membership of private health insurance, which had really gone into freefall, from 45 per cent at the beginning of the 1990s, to a low of 31 per cent at the end of the 90s.

The government believes that a sustainable private health insurance industry offers people greater choice in healthcare between public and private provision, and it also believes it takes pressure off the public system, which may not be what other people think. But, again, it's from the government's perspective that I'm looking at this.

The government has been successful, I would suggest, beyond their wildest dreams. Membership increased from 31 per cent to a high of 45 per cent in 2001. Coverage increased by about 3 million people. The funds' reserves increased, following a period of decline in reserves. But even more impressively, coverage appears to be reasonably stable, at about 43 per cent for the last three years, and despite very large premium increases above AWE. As the Minister for Health, Tony Abbott, said: "For its part the Howard Government has rescued the private health insurance system." My question is, how did they do it?

We know there has been a raft of policies, in particular the Medicare levy surcharge, the 30 per cent rebate on premiums and lifetime health cover. There are different views in the debates on the success of these policies. Jim Butler's infamous phrase, I think, is that, "The cheapest policy" — lifetime health cover — "did the trick." John Deeble, yesterday, suggested that people were frightened into taking out private health insurance. What I'm going to do is take an industry perspective and look at the policies more like what I think they should be best conceived of — as part of an industry assistance plan, very like the car plan for South Australian manufacturers of cars that the government put in place.

So from this industry perspective, this begs the broader question — what makes an industry sustainable? I'll use here Michael Porter's work on the Competitive Structure of Industries, which people might be familiar with. It's a framework for analysing the reasons why some industries are more profitable and sustainable than others.

According to Michael Porter, industry profitability is determined by five factors:

- The customer's buying power — how strong is the position of buyers. For example, are buyers very price sensitive to the industry's product.
- Supplier's bargaining power — how strong is the position of sellers of key inputs.
- The threat of substitutes — how easily can the product or service be substituted by another one, particularly by less expensive ones.
- The threat of entry of new competitors — how easy or difficult is it for new entrants to start to compete; and
- The strength of rivalry among existing competitors.

The collective strength of these forces determines the profitability of firms and of the industry because they influence the prices, the costs and the required investment of firms. For instance, customer's buying power influences the prices the firms can charge, the bargaining power of suppliers determines the cost of inputs. The more powerful the force is in an industry, the lower the potential profits and the harder it is for the industry to be sustainable in the long run.

The strength of these five forces varies across industries. I'm actually only going to talk about one of the five in detail, you might be pleased to hear, but just very quickly to cover the other four — for private health insurance we know that:

- the customers are very price sensitive;
- that the suppliers of the key inputs — the private hospitals and the doctors — have quite a lot of bargaining power;
- the threat of entry by new competitors isn't very high, given there is so much regulation and you need quite a lot of reserves and a membership base; and
- there is low to medium rivalry amongst the competitors.

But I'm going to focus on the threat of substitutes. A substitute product threatens profitability when it can perform the same function as the product of the industry. Medicare, as the provider of universal public health insurance, is the substitute for private health insurance. I argue that the government was so successful in its policies to reform private health insurance because its raft of policies targeted, intentionally or not, the main factor that determines the sustainability of private health insurance, which is the threat of the substitute of Medicare.

I begin by looking at conditions under which the threat of any substitute is high and then look at the relevance to Medicare as a substitute. The threat of a substitute is high if:

- Buyers have a propensity to substitute. They want to do it. This is certainly true for Medicare. More than 50 per cent of people don't take up private health insurance and many people drop private health insurance to rely on Medicare.

- The price is lower: Again, very true. Medicare is free for lower income people. Other people pay for it through taxation, but private health insurance actually isn't a substitute for Medicare, it is just an additional cost.

- There is little perceived level of product differentiation between the substitute and the product. This is true to some extent. The major product difference offered by private health insurance is access to elective surgery more quickly, and higher accommodation service in private hospitals. But its coverage of services is very similar to Medicare.

- The relative value of the substitute is high: I think this is true for Medicare, which funds public hospitals which provide very good care. Medicare also funds many other things than acute care. Also, the same doctors, by and large, treat patients in public hospitals as in private hospitals, so you can't really say that the private hospitals can differentiate on clinical care.

- The fifth one is that switching costs are low. That is, it doesn't cost much to switch to the substitute. This is true. Many people would save money by dropping private health insurance and relying only on Medicare.

So, in summary, Medicare is a particularly threatening substitute to private health insurance from an industry perspective. It provides hospital insurance for all Australians. It's free for poorer people, it's paid for by general revenue and it's compulsory, so you can't get out of it, and it gives access to fairly good treatment in public hospitals, and then it's free at point of use. So if you're a private health insurer and what you want to do is be sustainable and you want to make profits and you want to sell your product, you've got a huge task. You have to sell insurance to people who are not only already covered by medical insurance from Medicare, but they actually can't drop their existing cover to take up private health insurance. They can only buy additional insurance, which, for much of its offering, duplicates the insurance they already have.

So to counter this situation is a very big ask for an industry assistance plan. When you summarise it like that, it doesn't actually sound extraordinary that we saw private health insurance drop so greatly in the 90s because it is a really big challenge to have a sustainable private health insurance industry when we've got such a good Medicare system.

Now, I want to argue that the fact that Medicare is a substitute for private health insurance is the most powerful influence on its long-run sustainability. I'm going to illustrate this point qualitatively by using this figure that maps the fortunes of the private health insurance industry as reflected in the percentage of the population with hospital coverage.

The graph is a familiar one. You've seen it a million times. But it shows starkly that the fortunes, up or down, of private health insurance, seem to be significantly affected only when the relationship changes with its substitute of public hospital insurance. Over the past 35 years there have been five points when membership of private health insurance either greatly increased or decreased. All of them were linked with a fundamental shift in the relationship with private health insurance and its substitute product of public health insurance.

- When Medibank was introduced, in July 1975, providing universal public health insurance, membership of private health insurance fell by about 18 percentage points over a year.

- In 1976 the Fraser Government introduced a contingent 2.5 per cent levy on taxable income for access to free public care, which was waived if a person had private health insurance. This increased membership by about 5 percentage points in a year.
- When Medibank was abolished in 1981, membership increased by about 11 percentage points in a year.
- When Medicare was introduced, in 1984, bringing back the universal public health insurance system, membership fell by about 14 per cent a year.
- When lifetime health cover was introduced in 2000, membership increased by about 14 percentage points over the year.

At other times, when much less significant structural changes were introduced, the impact on membership has been much smaller. This includes policies that decreased the cost of private health insurance:

- An income-tested rebate was introduced for private health insurance in 1997, which had a negligible impact on membership.
- The 30 per cent rebate, in 1999, had about a 1 percentage point increase in membership over a year.
- Contracting between health funds and private hospitals was introduced in 1995 and had no impact.

The other takeout from the figure is that the long running trend for private health insurance has been steadily pretty well downwards, even though punctuated by significant recoveries at points in time. Perhaps, though, you'd have to say that is, until the period we're in now, when, amazingly, given what has happened in the past, membership seems fairly stable.

But the message of the story of the ups and downs in the fortunes of private health insurance is that a major shift is required with the substitute of public health insurance to significantly interrupt this downward trend.

So the question is, you're a government, you want to increase membership, that's your objective. So how do you shift this relationship between private health insurance and its substitute of Medicare?

The threat of a substitute is a function of three factors:

- First is its relative value/price compared to the industry product. A substitute is valuable if it lowers buyer costs or improves buyer performance relative to the industry product.
- Second, the cost of switching to the substitute. The higher the switching cost, the more difficult substitution would be.
- Third, the buyer's propensity to substitute. This varies among buyers because of differences in their characteristics, including how they use a product, the value they attach to it, their incomes and their risk profiles. For example, with private health insurance, there are differences between younger and older people in their attachment to private health insurance.

Strategies against a substitute target these factors.

So the first possible strategy is to improve the relative value/price of private health insurance. The product's value/price is the value it provides to the buyer, compared to the price that the buyer pays for it. But when faced with a substitute, it's the *relative* value/price equation that's important to buyers. So the industry product must seek to differentiate itself from the substitute in terms of either the price or value, related to customers' needs and wants.

What I want to look at here is the possible sources of differentiation for private health insurance if they wanted to take advantage of this.

The first is price. Well, price is never going to be an advantage for private health insurance. Now, the government improved the relative price through the 30 and 40 per cent rebate, but as noted earlier, strategies based on price alone have not been very successful to increase membership. They only work to reduce the huge price disadvantage faced by private health insurance relative to Medicare.

Strategies to improve the value of private health insurance relative to Medicare are potentially more promising. Currently the main value is that you get access to elective surgery more quickly. This is valued very highly by people, especially older people and people in poor health, but it's difficult for a government to directly target the issue, particularly the Commonwealth Government, to deliberately increase waiting lists.

In terms of coverage, Medicare funded access to public hospitals has an advantage. It covers accident and emergency and a number of very complex procedures that you can't get in public hospitals. Now, in principle, the quality of services could be a potential source of value differentiation for private health insurance. As I said before, it might be true for accommodation services, where private hospitals have a clear advantage, but there is not a lot of room for the important differentiation according to the quality of clinical services, because, as I said, the doctors work in both sectors.

In terms of ease of use, again Medicare has the advantage, and although the government is encouraging the industry to improve gap cover and simplified billing - and they're useful policies for people who have private health insurance - but you'd have to say they're more like defensive strategies to reduce the disadvantages of some of the features of private health insurance, rather than positively increasing the value relative to Medicare.

The second possible strategy is to raise switching costs, the costs incurred in shifting to the substitute. People save money from dropping or not taking up private health insurance, but both lifetime health cover and the Medicare levy surcharge have, in effect, introduced costs for switching to total reliance on Medicare, whereas previously there were none. Now, higher income earners who drop or don't take up private health insurance face a 1 per cent Medicare levy surcharge, and older people who drop or don't take up their private health insurance face increased premiums if they wish to join or rejoin at a later stage.

The focus of the much of the commentary about the recent increases in membership of private health insurance has been on the impact of lifetime healthcover. Certainly its introduction had a major impact associated with a big increase in membership in a couple of years. But I think that the Medicare levy surcharge must also be a major factor, particularly now, in keeping the level of membership of private health insurance so high and so stable.

As the Minister for Health, Tony Abbott, said, "Thanks to the Medicare surcharge, private cover is more or less mandatory for people earning more than $50,000 a year and families earning more than $100,000 a year." The surcharge was introduced in 1997, which is quite a long time ago now, and the thresholds haven't been indexed, so more and more people are being captured in this net.

The third possible strategy against a substitute is to change the buyer's propensity to substitute, which depends on the relative value/price of the product, which varies among buyers because of the differences in their characteristics. I think that the government's private health insurance policies have been reinforced in Australia by changes to the propensity of buyers of private health insurance to substitute away from private health insurance, back to total reliance on Medicare. There are two strong trends that are decreasing the propensity of people to shift back to Medicare — the ageing of the population and the increase in real household disposable incomes, which has been very high in Australia in the last decade. Both age and income are positively related with taking up and keeping private health insurance. The experience of the past three years, where we've actually had a flattening out of private health insurance membership and a stability at around 43 per cent, seems to suggest that buyers' propensity to shift from private health insurance is decreasing. Over this period the increase in private health insurance premiums far exceeded growth in earnings and the CPI, but membership fell only very marginally, and now seems, as I said, for the past three years, to have stabilised.

Now, you might like to ask what did we get for the private health insurance reforms? From the perspective of the government, they increased their expenditure on private health insurance from zero to $2.8 billion. The government now funds 35 per cent of expenditure in private hospitals, so more than a third, both through the rebate and the treatment of DVA patients. That's a lot of money. When you take on that level of expenditure, you take on a share of the problems — premium increases, the fights between the private health insurance funds and private hospitals, problems with gap payments, problems with private hospitals cherry picking.

From the perspective of the private hospitals they've significantly increased their throughput — they've had an increase in separations of 615,000 over this period, probably more now because the data is a couple of years old. They now have close to 40 per cent of separations, of all acute hospital separations, and they've had great increases in revenue.

From the perspective of the health funds, they have increased their members, but they are fighting the last war. They're absolutely terrified of cost increases feeding into premium increases, which will wipe out their membership gains. That's led them to be much more aggressive purchasers in contracting with private hospitals, and we've seen that with the example of Medibank Private in particular, which is the largest fund.

The trouble for health funds, though, is that utilisation is a much bigger problem than costs, but it's a problem that they can't target as it's controlled by the doctors. Here they're up against the AMA, who had this lovely quote when they feared that contracting might actually impact upon utilisation. The AMA said: "The treatment of an individual needs to be determined by their clinical condition, so for as long as it takes, they should be covered, and that's determined by the treating doctors. The role of the health fund is to provide cover for those episodes and not to determine who treats, how they treat, how long for and especially where."

The private hospitals, naturally, responded to the more aggressive contracting by the health funds through strategies of their own. They didn't just lie back and take it. One thing they have done is increased industry consolidation, which is a common response, in an industry, to buyers increasing their bargaining capacity. As well, of course, there is a high level of for-profit ownership in the private hospital industry. It's a good time to be in the private hospital industry, given there's been such a big increase in throughput and revenue, and this also encourages consolidation. Which is what we have seen happen. Over this period, so from about 1999 to 2005, the group for profit sector — that's for-profit groups which have five or more private hospitals —that sector has gone from seven large groups to only two: Ramsay and Healthscope. Together, these two groups own 44 per cent of all acute private hospitals beds. They own 80 per cent of total for profit beds.

So what's happening from the perspective of patients? Well, it depends, really, who you are — if you're a public or a private patient, if you're old or new to private health insurance. Certainly for those with private health insurance who are sick, they have gained increased access, through private hospitals, to elective surgery. But this raises equity issues for those who don't have private health insurance. In terms of affordability of private health insurance, it's gone up if you were already paying for it, so if you already had private health insurance the 30 per cent rebate was a nice gift. But for those who took up private health insurance due to the Medicare levy surcharge or lifetime healthcover, their affordability obviously went backwards, even with the rebate.

The million-dollar question is around appropriate care. Has all this additional throughput, additional hospital care, been, actually, good for us — for patients? We don't know. We know, though, there is huge variability in the access to and the appropriateness of care and potentially, probably, more so in the private than the public sector.

Finally, I just want to, in concluding, raise the question of what's the future for private health insurance. Again, from the government's perspective, what if the policies stopped working? What if the government wanted to further increase private health insurance membership? What are their options? I suggest a profound shift would be required in the relative value of private health insurance, based on greater differentiation of private health insurance compared to Medicare. Medicare would need to look less like a substitute. Currently, private health insurance in Australia has a duplicate role, as I said. It provides cover for health services already covered by public health insurance. Shifting private health insurance more towards a supplement to Medicare, so providing cover for additional services not covered by public insurance, would absolutely increase its relative value.

The question of what services Medicare should cover has been opened up recently by the Productivity Commission in the context of the challenges facing Medicare of the population ageing, rising patient expectations and the advances in medical technology. In the context of the ever-increasing demands of funding for governments, governments have competing fiscal demands and an aversion to raising taxes to pay for them. In its report on medical technology, the Productivity Commission mused:

"There is a pressing need to explore what overall level of subsided access to healthcare, and the technology it embodies, the community considers is appropriate... Inter alia, this means addressing the issue of what basic services a universal healthcare system should cover in the future."

If, in time, Medicare became a safety net, which one of the Productivity Commissioners suggested might happen, the relative value of private health insurance would dramatically shift. Private health insurance could provide more comprehensive cover for the hospital services not provided for under Medicare, but it would be at a price. Thanks very much.

BOB WELLS: Thank you, Mary Ann, for that stimulating and insightful analysis of private health insurance. I used to manage the private health insurance policy for the government It was a bit like being in a plane that is plunging to the ground. Your eye was focussed on the altimeter. As it's going down, down you'd pull a lever and suddenly you'd go up, but then you'd go back down again. So I think that graph sums it all up. I still think it will start to go down again before too long.

MARY ANN O'LOUGHLIN: A good recession would do it.

BOB WELLS: Yes, yes, it would. Or even just tightening up on some of the parameters.

Our next speaker is Andrew Podger and he will be commenting on the previous presentation. Andrew is National President of the Institute of Public Administration in Australia. He retired from the Australian Public Service, after 37 years, in 2005, and is now a consultant and also Adjunct Professor at The Australian National University. His most recent role in the Australian Public Service was to chair a task force for the Prime Minister on the delivery of health services in Australia. So, Andrew, over to you.?

ANDREW PODGER: Thanks, Bob. I suspect that, in part, going back to your remark about 'Oh what a lovely war', I might be the first staff officer jumping over the second staff officer's back.

Mary Ann's comments on the private health insurance debate, coming at it from an industry perspective, an industry assistance perspective, highlight five forces that might be affecting the membership of private health insurance: Customers' buying power, suppliers' bargaining power, the threat of substitutes, the threat of entry of new competitors, and rivalry amongst existing competitors. She focuses on the threat of Medicare as the main substitute, noting also that the relative value in price of private health insurance is important, and the increased switching costs, particularly from lifetime health cover and from the tax rebate.

Her conclusion is that the future role of private health insurance would be enhanced, if you were coming from the government's perspective about concern about the membership levels, if it were a supplement to Medicare, not a substitute. Alternatively, if Medicare became a safety net, the value of private health insurance would dramatically shift because it would not have a substitute for the majority of people, but would be the means of health insurance for most Australians.

Let me come at the private health insurance issue from a slightly different angle, almost in reverse. I want to start with some of the arguments about the appropriate role of private health insurance in a health system. Interestingly, when you come at it from that angle, private health insurance is one of the areas of most disagreement amongst advocates of healthcare financing reform. There are a lot of areas of common ground between the different

commentators on where the health system should go. But probably the biggest area of difference would be what is the role of private health insurance. The reasons for that difference are both philosophical and related to the evidence.

Let me start with the philosophical arguments. At one end of the spectrum on the philosophical line is the Canadian view. That is, if a service or product is covered by the universal, government-funded system, you are not allowed to buy that service or product privately. Everyone has to be subject to the national rationing process. This rationing takes into account individuals' health needs, but explicitly does not take into account the financial needs. Because there are always limits to government funding, there are queues, but everybody is in the queue, and that's the sense of what equity means. That's one particular philosophical view. Significantly different, but towards that end of the spectrum, is the UK view. That is, you may choose to buy services privately, but you must then pay the full price of that choice. You can't take some of the subsidy with you if you wish to take a choice.

Australia is a little bit further along this spectrum, because we've always had a view that if you choose to buy privately, through private health insurance as the main way, you may not only do so, but you also have the right to draw on some of the costs that Medicare would otherwise have borne. This is not a new philosophy in Australia, we've had that for many, many decades, not always through subsidies for private health. Previously we had bed subsidies for private hospitals.

If I leave you to think of the Scotton Managed Competition model, it's a little bit further down the spectrum, because it would allow everyone to direct a voucher, equal to their Medicare premium, to the insurer of their choice. So the amount you could take from Medicare, 100 per cent of it could be diverted if you wished to take a choice to be outside Medicare. You may supplement that with your own money, but you do have right to 100 per cent of what otherwise would have been spent by the Medicare system.

The US model is near the other end of the spectrum. Except for the aged and those on Medicaid, there is no universal Medicare system, but private health insurance, or similar schemes, are indirectly subsided, as Dan talked about yesterday, and there is a degree of choice at least by the employer, if not by the employee, but that private system is the means by which you get it. There isn't an alternative, unless you are aged or in Medicaid.

On this philosophical argument, let me put my colours on the mast: I guess this a philosophical view, a political view. I don't normally give a political view - at least I haven't for 37 years. But, personally, I find it hard to see why people should be forbidden from buying services privately. Interestingly, that point is starting to be argued in Canada, including in the Canadian courts. Indeed, I find it hard to deny people some of the cost they truly would have imposed on the Medicare system, and that debate is starting to occur in the UK.

We've long had that argument in Australia accepted in not only health, but in education, that some part of the subsidy might be able to be moved across. But I would be truly alarmed if opening up the system to more choice involved a significant lowering of the quality of our universal Medicare system or limiting access to that system. That is, I'm happy to have two classes of air travel, if you like, so long as the economy class is, in fact, high quality, safe, gets you there and is continuously improving, in contrast with the US arrangement.

Let me turn to the evidence side of it, away from the philosophical side, and about the performance of private health insurance. This is also relevant to your assessment about the appropriate role. The evidence is that competition between funds does not deliver nearly as much efficiency gains as competition between the providers. It is possible, however, that competition between funds may enhance competition between providers and thereby lead to some efficiency gains. But most of the evidence is that when you have got competing funds, you don't get a great deal of efficiencies out of that.

Secondly, as Mary Ann said, funds have substantial difficulty in managing what I would call moral hazard, in particular the interests of doctors. There is evidence of inefficient and less cost effective service patterns that are provided by private health insurance arrangements, than the patterns that you see in the publicly funded system. There is quite a lot of evidence of that, including in Australia.

In Australia the funds do not cover some key health services, as Mary Ann talked about. Private hospitals generally don't have A&E. There is A&E in a few hospitals, but it's not the A&E you see in a large public hospital, and you don't often get the high end of the most complex surgical procedures.

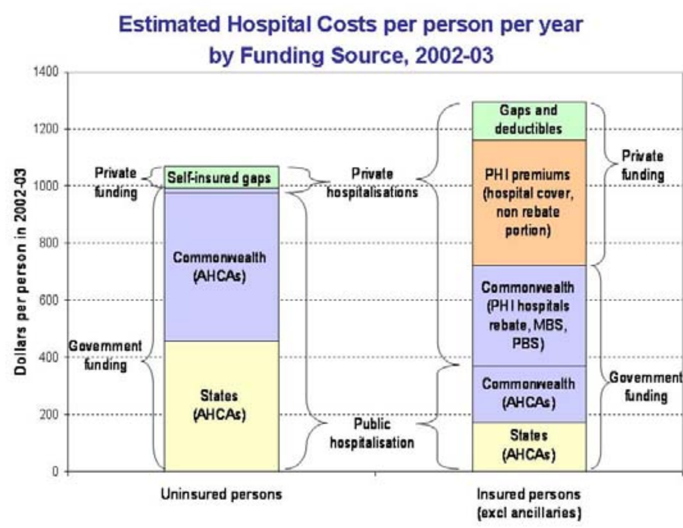
That said, it is hard to deny that insured people get better services overall than uninsured people. That's anecdotal, not great evidence, but I think the anecdotal stuff is reasonably

convincing. They get earlier access to elective surgery, which must mean they get their hip replacements earlier, and they get their cataracts and so on earlier than you would otherwise get. That's got to be a plus. They will have a wider range of diagnostics, meaning they're likely to discover things earlier than other people do. So I think, anecdotally, the chances are, overall, they're getting more effective, not necessarily more cost effective, care.

Again, what's my take on the evidence? My own take is that we shouldn't be denying consumer choice or removing all support for private health insurance. But what we should be doing is starting to address some of these weaknesses on the evidential side. In particular we should be looking at poor competition between funds, because we do not have a proper competition between our funds because of the way in which the reinsurance pool operates. The capacity of funds to contract with doctors needs to be looked at harder, and to apply cost effectiveness considerations. We need to look at the constraints on the funds to fund services outside the hospitals, a point that I think that John Deeble was close to talking about yesterday, and the ability of the funds and their members to double dip in strange ways with the Medicare public hospitals. It's a really odd way in which we manage that.

Now let me return to Mary Ann's focus on private health insurance and Medicare and the questions of substitution and of relative value in price.

This is an interesting little table I prepared a while back in the paper I gave to the Menzies Centre a couple of weeks ago.



If you look at this, we've got the uninsured people and the dollars per person for their hospital side of the costs. The vast majority, of course, is government money, but there is a bit of private expenditure because some uninsured people will do things out of their own pockets.

Now, if you look at the insured people, the extent to which they still use public hospitals means there is government money for that. They also draw directly on Commonwealth monies, in particular the rebate, but also MBS and PBS arrangements. So that's the government funding they get, and then of course they put in their premiums and they have got gaps and deductibles as private expenditures.

But if I look at the government funding as a percentage of the government funding that the uninsured get, I get 73 per cent. Not a trivial amount. But, most importantly, that doesn't take into account a number of items. It doesn't take into account the safety net that's been introduced on Medicare. I'm not too sure what that would add, but that would add something significant to 73. Most importantly, it doesn't take into account the exemption from the Medicare levy surcharge.

So if I put all of that together, we've got a large amount of money that goes to you from taxpayers if you are privately insured. What is the right amount? Well, as I said, Scotton would say that 100 per cent is fair, you should be able to market that and go to the insurer of your choice. My worry is that I'm not sure that the funds are ready for that and there might be some risks.

I am also worried that this is an average and there are some people who are getting a lot more because they're insured, than if they're uninsured. The areas that need to be looked at very closely are the Medicare levy surcharge, because I think there is a real problem with that these days. We now need to think carefully about limits to the PHI rebate. To take a stab at it; I wouldn't mind if the overall subsidy figure was about 75 per cent, so long as it really was 75 per cent and not, as I suspect, well over 100 per cent for some people.

So I think there is an agenda here to be looked at, not only to get a view of what is the right number that we all can say that's what we ought to be heading towards into the future, but also how do we get something that's sustainable more generally and is a bit more rational than shown in that complicated graph. This is a bit of a muddle and if we could sort it out, we'd not only get a more sensible and coherent policy, but you'd actually get better competition not only

among funds, but also better competition among hospitals, for both the public patients and private patients.,

My final comment is an aside about lifetime health cover. Now, like Bob, I was involved in the Department when we advised on lifetime cover, and it took a couple of years to get through. I think going back to our recommendations to the Productivity Commission, which the Productivity Commission then took up, and which we then we had to work it all through and then we had to be careful of the politics and hold it off for the 1998 election and do it afterwards because we thought we might come undone if we exposed the whole thing in an election campaign.

I remain a bit surprised by the continuing portrayal of lifetime cover as penalising people who take up private health at an older age, or drop out and come back in again, because that's not what lifetime cover is at all. Mary Ann is correct in saying that it has increased the switching costs. But that is primarily because the previous switching cost was totally uneconomic and unsustainable.

Under the old community rating, private health insurance premiums were uneconomic in terms of the price being paid by older people. They were paying far less than the actual costs for their private health insurance. Young people, of course, in turn, were paying far more than they would have been paying for the product they were receiving. All that lifetime cover did was to narrow that inequity.

Even now, under lifetime cover, young people pay too much and old people pay too little. It is still cross-subsiding from the young to the old, but not as much as we did in the past. Lifetime cover was designed to address a major problem we had with community rating and it has done so reasonably successfully. If anything, there is a case for going further on lifetime cover than we went. Thanks.

Bob Wells: Thanks, Andrew. We have some time for some questions and Diana has the magic microphone. So any questions? Yes, Richard.

RICHARD MADDEN: Thanks, Bob. Richard Madden, University of Sydney, but a casual observer of this system over many years. I'd love to debate and argue many of the issues that have been raised, but I was really struck by Mary Ann's analogy to the South Australian car

industry. I've just been thinking, as she talked; the health insurance product we have in Australia is the East German Travi. You can buy it from a few dealers, but you can only buy one brand and it's a bit of a problem. Now, the Travi is history, but health insurance is not history. So let's leave all that alone.

She put up a slide showing a few policies that had encouraged the take up of health insurance, but she left out one very crucial policy, which goes back to the Labor government. Maybe she had something to do with advising on it. That's the exclusion of other insurers. Now with all the subsidies that are available, lifetime health cover and all these other things, why do we still have to exclude other people competing for unsubsidised, offering unsubsidised health cover, to allow the Mercedes import to come in and compete with the Travi.

MARY ANN O'LOUGHLIN: I think that goes to what Andrew is saying — the importance of politics to private health insurance. Community rating is such an important part of the regulation of private health insurance and the cross subsidisation of the sick and elderly, that the government won't allow general insurers in because of that. Isn't that their issue?

RICHARD MADDEN: But it's now heavily subsided. I mean, lots of new policies have been layered on since that prohibition was put there. Why not now allow us a bit of a discipline for the unsubsidised alternatives to come back and see what happens.

MARY ANN O'LOUGHLIN: See what happens. I don't care.

RICHARD MADDEN: It's unlikely to swamp the system in the first year.

MARY ANN O'LOUGHLIN: It certainly would be unlikely to swamp the system because I think it would be hard to make money out of doing it. But I would have thought private health insurers would scream blue murder because of the regulations they face. That's the answer as to why they don't let it happen. Should it happen? I don't know.

ANDREW PODGER: Mary-Anne is right. The basic argument is that any other insurer coming in would only come in if they didn't have to abide by community rating. Your argument is that they should be allowed to do so if they're not subsided because the fact that they wouldn't be subsided would make up for the fact that they're --

RICHARD MADDEN: Not --

ANDREW PODGER: I understand the argument. I guess, in a sense, the Scotton model is an alternative way of looking at it. That is, you don't need community rating if you actually have a voucher which says your exact Medicare premium is available and can be marketed. If you went down that route, you allow anybody into the insurance market and they get the voucher if you choose to give it to them, and it doesn't matter how you handle that. So that's an alternative. Personally, I would like to see us think about how we move away from having that community rating if we could get to some way of identifying more clearly what the Medicare premium was and allowing, if not 100 per cent, 80 per cent or whatever that could be made available, then you could get rid of quite a lot of the regulation.

BOB WELLS: There were a couple of attempts to do that, I remember, and the government jumped on them very, very hard. It was in the late 90s, to get around it by some device, and the government threatened them and the threat was sufficient for those people to withdraw from the market.

UNIDENTIFIED MALE: Following the same question, I want to ask you if ever there has been a study of what those money, $2.8 billion, for subsiding private health insurance could have achieved if invested in public system?

BOB WELLS: John Deeble is going to answer that for us, is he?

JOHN DEEBLE: About twice as many admissions as it now does. The arithmetic is very simple; you subsidise everybody but you only gain a certain amount of extra admissions. There is no question at all that the same money would have bought much more treatment. That wasn't the purpose of the thing at all. It was an industry system support.

The term "lifetime health cover" is really a misnomer. It is not a level premium throughout your life. It's a level premium if you join at certain times, but it's not if you delay joining. So lifetime health cover, the term was a sting and is a sting, compared to a system that is based on Rawls' idea of equity, which is that it should be determined without knowledge of what your lifetime circumstances and experience is going to be. People who have done some political philosophy will remember that.

Then the Medicare arrangement, which doesn't discriminate according to what has happened to you, including ageing, is in fact more equitable than one that does discriminate. That's a philosophical argument. A practical argument says that you are allowing some risk related, insurance to enter the market.

In terms of what caused the private insurance rebate to be so successful, or the whole raft of policies and incentives, I agree almost entirely with what Mary Ann said. The biggest single thing was probably the [Medicare] surcharge [for those who chose not to take out private insurance], which was actually unanimously supported by the Opposition, for God's sake. Because the further that goes, the greater incentive there is for everybody on average weekly earnings and above to be privately insured. You can be a silly person like me and pay another $1,000 a year for something that I would avoid by paying $500, but as a matter of principle I wouldn't take it. But that's not a concern.

I still believe that it was the perception of the quality of the alternative, because the quality of the alternative made a big difference. Every newspaper article about problems with the public hospitals reinforces it, and every day that's reinforced.

I don't see private health insurance declining very rapidly, but I do think it's also a product of high incomes in the last 10 years. We need a recession to change that. [In times of prosperity] once the person has made a commitment to it, the price can vary a lot.

But on what Andrew was saying; I would have no concern and don't have any concerns about a rebate to private health. I don't see why it has to go through the health insurance funds, but I see no objection to a rebate to users of a private system. But it's based on a different argument altogether. It's based on the fact that the Medicare system inevitably has the rationing, and the government will meet 100 per cent of the cost of a rationed system. But will it meet 100 per cent of the cost of an unrationed system.? A 30 per cent rebate will be acceptable under those terms, from a philosophical point of view, saying, "As you've chosen not to have any limits on your use, you will pay a proportion of that." Now, Andrew says it actually is a good deal higher because of the Medicare component, the medical benefits component and so on.

The other argument I have against it, though, is that there was a great deal that goes through the AHCAs which is not for personal patient care, but the public hospitals do a whole lot of

things extra, and particularly the major ones. You can't unbundle that, but you try and take it away and see what happens. This includes all of the services that the hospitals provide that are not included in the personal patient episode of treatment. I remember doing hospital evaluations once in Brisbane and there was a little house down at the bottom of the campus. I asked, "What's that?" "That's a counselling service for women who have had stillborn children," they said, and I thought, "Yes, that's a very good public service, but where will private insurance find that?"

You can't just categorise the two systems as if they produce exactly the same product. More than 70 per cent of the recent increase in private hospital admissions was for same day procedures. The change in overnight procedures was very minimal indeed. Now, that tells you what sort of work was done.

BOB WELLS: Thanks, John. Steve, you had a question.

STEPHEN LEEDER: Let me quote from the Prime Ministerial Address at the celebrations in Canberra a couple of weeks ago for the 10th anniversary of the current government, and ask both Mary Ann and Andrew if they could help me interpret the future of both the public and the private system in the light of the Prime Ministerial vision. He says, and I quote: "When I think of the welfare safety net that we're committed to, I think of the enormous changes that we've made to strengthen the Medicare system. I mention that because one of the charges laid against us by our opponents, 10 years ago, was that we would rip out the safety net," I think he's there referring to Medicare as a safety net: "... that we would tax and axe Medicare. It's true that in my past, and it's all carefully documented because I said it in public, I was a critic of Medicare and I formed the view 10 and a half, or 11 years ago, but the public said to me, 'Well, John, we note what you say, but we want you to know what we believe, and we believe that Medicare, fundamentally, is a good system. It might have flaws, you might be able to make it better,' and we have made it better because we've given massive support to private health insurance and we now have, in this country, a real balance between the provision publicly and privately and assistance in the area of health. So we have preserved the safety net." So if that's not an interpretation of Medicare as the safety net, I'd like some help in understanding what it is?

MARY ANN O'LOUGHLIN: Yes, I think one of the points of looking at private health insurance from an *industry* perspective is because what we do, as health policy people, is look at it from a

health policy perspective, and whether we think it's efficient and equitable and appropriate and all those sorts of things. But when you look at it from an industry perspective, you see different drivers than if you look at it from a policy perspective.

What I think, what you just encapsulated there was, barring a recession — and I agree, if there was a recession, then the membership would go down — but if we stay reasonably economically healthy, given the policies that are in place, given the ageing population, given Australia's increasing incomes, given particularly the Medicare levy surcharge, is that you will get more and more people with private health insurance.

As I said, the Medicare levy surcharge already bites at AWE, for men, anyway, so you will get more and more people becoming members of private health insurance funds. What does this do to the health system over time, that great shift? Andrew could answer this question, but he probably wouldn't, but I honestly don't know how much this shift is intentional from the government's perspective. That quote from John Howard suggests that it is.

What John Deeble just said about what the public hospital system supports that you can't cost down into an episode of care, I also think that this applies on the private side, and that contracting between private health insurance funds and private hospitals, which is really getting more aggressive because there is so much more at stake, they are also trying to cost an individual episode of care. Well, any hospital can't cost an individual episode of care completely. Most particularly, I really think that this applies to some of our great not for profit private hospitals that make a huge contribution given their history and their culture and their place in the community far wider than a bed in an acute hospital. If you look what happened with Medibank Private last year, the pressure was on St Vincent's and Mater in Sydney and the Epworth in Melbourne. If funds want to say, "We're going to pay for that, but we're not paying for this and that and that," that's when I start to think that cost pressures will drive the system. But that's why, as much as it can sound not as interesting in some ways to look at the issues from an industry perspective, because private hospital companies also have so much money invested in this industry — as I said, 44 per cent of private hospital beds are owned by two for profit companies — where are their interests, how are they going to respond to the funds? Did they mean to do it, Andrew?

ANDREW PODGER: I'm not quite sure, when the Prime Minister says calls Medicare a safety net, what he actually has in mind. Is it because he knows we always think of safety nets

meaning means tested arrangements, a residual safety support for those who can't otherwise look after themselves in the general sense that people in social policy use? I don't think that's, actually, where the PM is coming from.

Interestingly, the Medicare levy surcharge arrangement — as John said, it was supported by Labor as well — has been a form of means testing. If you keep it as a means test, that's the main argument why you don't put it into my graph. If you think of it as being a tax expenditure, because you genuinely would expect most people to do what Crazy John does, and that is to pay his extra tax even though it's more than it would be to pay the premium, and therefore you add that as a tax expenditure, and we've brought it in here, all of a sudden this government subsidy is way over 100 per cent for all those insured people, it's inequitable. But, as a means test, you can explain that.

But, of course, it's a means test for a very small part of the system. John Howard and his government have, in fact, pumped a lot of money into the public system. The healthcare agreements, themselves, have grown very substantially since 1996. The most recent agreement, it being a much tighter one than the previous one, I think the indexation arrangement on the current agreement is, arguably, too low. But leaving that to one side, the money from the Commonwealth to public hospitals has gone up a great deal in real terms, certainly compared to the previous agreement, it was, Bob, but as I recall we had inflation, population, ageing, plus another 2 per cent increase each year for the purposes of more services per individual over and above ageing. So it was expanding, in very substantial, real terms, in that agreement from the Commonwealth.

Then if you look at MBS and PBS, those have been going through enormous increases. So the fact that we've got 9.7 per cent of GDP in total health, the public part of that has been keeping up in proportion. That means that if I was going to look at what is the effective premium for individuals from the public system, it, also, has been going faster than AWE. So it is true that the Howard Government has in fact put a lot of money into the universal Medicare system.

What he would argue was that the issue of choice, from his philosophical point of view, was a very strong issue, and he wanted to put that up front. He does not view the rebate as a subsidy to industry, he sees it as the right of people who choose not to be in Medicare to take some of that subsidy with them. He would argue that this was showing that the government is saving 27 per cent, which they'd otherwise pay here, and, moreover, he is drawing a whole lot

of private money into the system and getting better overall results. That would be his take on it I believe. He would not see this as an attack on Medicare, he would see this as enhancing the overall system for those who wished to go a little bit further than the public system. That would be my interpretation of what he's done over the years. I'm not giving a view of whether he's right or wrong, I'm just simply saying that that would be his take.

Mary Ann's comment; was some of this accidental? Yes, always. I haven't worked in government at any stage where some things have not followed because of something in the press. Everybody has had to respond, — you've done something and you look back and you say, "Well, was that rational," or, "How planned was it?" Well, it was sort of, in a sort of a way plodding forward. One step forward, two steps back, and then one time it's the other way.

BOB WELLS: I know there is more questions, but I think we should break. Let us resume on time please, at 10.25.

(Break)

BOB WELLS: This session is to do with policy reform in the face of the growing burden of chronic disease. The first speaker is Professor Stephen Leeder. Steve is Director of the Australian Health Policy Institute at the University of Sydney, and, as we've already said, a co-worker at the Menzies Centre for Health Policy. His research interests as a clinical epidemiologist include asthma and colorectal disease. He has served on both State and Federal committees oversaw the adoption of health goals and targets for Australia, and on the National Health and Medical Research Council and on numerous boards. In 2003 and 2004 Professor Leeder worked at Columbia University, developing policy in relation to the control of heart disease and stroke in developing economies. So, Steve, over to you.

STEVE LEEDER: Thank you very much, Bob.

In this presentation I want, first, to remind you that chronic diseases occur in people, and that keeping clearly in mind the need to do our best for sick people, it's a good place to start our discussions about policy for provision of their care. Second, I want to discuss a little about the nature of chronic illness and demonstrate why policy is especially important to manage prevention. The third thing I want to do is review the current favourable climate for chronic disease policy development in Australia and point to where we may make gains in the future

there. Fourth, I shall outline a five-year research program that's supported by the NHMRC that the Menzies Centre for Health Policy is planning to conduct in western Sydney and in the ACT, and invite you, not necessarily immediately, but in the longer term, to view the protocol for that study and to make some comments about it, and, if possible, find some points within it where you might wish to collaborate with us. So those are the four things that I have in mind to do.

To demonstrate to you the human face of a chronic disease, I introduce you to Neville, who is a 65-year-old man with chronic respiratory disease who lives in Mount Druitt in the west of Sydney. I visited him, with two nurses from the Blacktown Hospital Pulmonary Rehabilitation Clinic, to whom he was well-known. I interviewed him several weeks ago.

He lives in a Department of Housing property. The house is neat and tidy, his bedroom likewise, resembling a ship's cabin. Indeed, his chief pastime is building magnificent model boats from balsa. He uses continuous oxygen and a long, narrow plastic hose connects him to the oxygen, concentrated wherever he is in his home. He was a truck driver and has friends from those days, but is no longer able to get out to meet them. He relies on Meals on Wheels to deliver his food, along with the support of some neighbours. He also has bad teeth, and each day he scrambles over the edge of the bathtub to shower. Despite his disabilities, he's a happy man, connected to and valuing life.

It struck me, when I met him, that a few things might help Neville, handrails for the shower and dental care being the two most obvious. He lives in a government house and, because of that, an occupational therapist must assess his bathroom beforehand rails can be fitted. When I inquired, there was a 12-month waiting list for such a visit, unless he was admitted to hospital with a hip fracture following a fall in the shower, in which case the handrails would be fitted before he returned home, if he survived.

Federal cutbacks occurred about 10 years ago to the public dental scheme. Dentists have never wanted to participate in Medicare. The state declined to take up the slack fully for public dentistry when the Commonwealth moved its support for dentistry into private health insurance rebates, and apart from being admitted to hospital with a dental emphasis, dental care for this man would need to be paid for privately, which is a difficulty.

Neville's quality of life would be better if he could get out of the house. To do this he needs

assistance to carry a portable oxygen pack, but also assistance with the cost of cylinders. He would also need to pay for taxi fares because public transport is impossible for him. All these additional costs are hard to absorb on a pension.

Now, each of these relatively simple problems has the potential to derail this man. They can land him in hospital - not good for him and expensive for the rest of us - and significantly reduce his quality of life. This is why we should take an active interest in policy reform if we are concerned about chronic illness in our community, and we need, always, to recall the human face of it.

My second point relates to the nature of chronic illness. We mean, by chronic illness, those conditions that go on for a long time, and we refer to the long-term pain and problems of arthritis, the year in year out course of mental illness, to the days and nights of breathlessness and incapacity of the person suffering from emphysema and cardiovascular disease. To these we will now add the patient with enduring forms of cancer, chronic leukaemia for example. If we're thinking widely, we might include the patient with HIV AIDS, the patient with drug resistant tuberculosis, or people in African villages suffering from leprosy or river blindness. All those disorders contrast with the short time course of many infections, and with much, but not all, physical trauma under the dizziness of accident and emergency wards in hospitals.

The characteristic of these diseases is that they cannot be resolved with a single solution. There is no course of antibiotics, no vaccine and no amazing surgical breakthrough, like keyhole or transplant surgery, that can cure most chronic diseases. Instead, the person with a chronic disease will require new solutions to problems as they emerge throughout the course of the disease. Because people live with their chronic disease, problems, also, are not contained within the walls of the hospital, the jurisdictions related to the health portfolio, and Neville's problems, for example, traversed economic, welfare, health policy domains, making it a bit of a challenge for policy makers to adapt beyond working within their speciality or portfolio area to this broader challenge. Indeed, I assert that the policy problems associated with chronic disease can only be solved by carefully examining the experiences of people with these diseases and working out where, at present, our policies fail them, regardless of whether these are occurring in the health domain or not.

The third point I want to make is that the effective management of chronic disease is well and truly on the agenda for Australia at the moment. In recent months we've seen the release of

various reports that recognise its significance. The Mental Health Council of Australia's report on mental health services is entitled "Not for Service", which has, in the last two days, been accompanied by bold initiatives at a Federal level, announced by the Prime Minister, the Productivity Commissions' report on the Australia's health workforce, and, most recently, the Council of Australian Governments' attention has turned to health and chronic disease in particular. Policy makers, that is, politicians, health service managers, clinicians, have a growing interest in chronic disease in Australia and that every member of government will allow efforts to develop new policies for the prevention and treatment of these problems. We could spend a long time talking about why that has occurred, but the fact is that these things are now on an agenda. The time is right, in other words, for considering what should be done about it. The Council of Australian Governments, which brings together the chief ministers of all the states, territories and the Commonwealth, COAG, as it's been called, recently announced commitment to developing more effective policies for the management of patients with chronic diseases. That's particularly significant because it means chronic disease has caught the attention of the people who are the most powerful policy makers in the country.

We need to recall that some of the difficulties that attend Commonwealth/State relations are less likely to surface in that forum where people are working together. I'm not advancing it as an ultimate solution, but it does seem to me a better thing to have COAG than not to have it.

A lot of the focus at the moment is, interestingly, (indistinct) portfolio and it's focusing on enhancing "human capital", the response to the fact that, with an ageing workforce, we have a likely circumstance where there will be a shortage of medi skills within the workforce. Although focusing on human capital might be seen by some as, cynically, the invasion of economics into all aspects of life, nonetheless the human capital agenda does embrace health, education, training and work incentives. Its strength is its recognition that in an ageing population it's critically important to keep the working age population healthy and to extend the working age in the interests of the nation's economic health. The thesis behind it is that we'll need every worker we can get, to ensure that we're able to maintain the standard of healthcare in Australia and the other attributes of a flourishing economy that we've become used to.

Focusing on what COAG proposes in relation to health, we read that from 1 July 2006 governments will commence implementation of a four-year, 500 million national program called the Australian Better Health Initiative, which is not to be confused with the multimillion dollar Australian National Better Health Program that was active in the late 1980s. It's a different

thing altogether, although it shares some common features.

The broad brush strokes that underlie that are listed there, that there is going to be a quest in all governments to promote healthy lifestyles, to detect early those manifestations of risk and chronic disease which, if treated properly, can diminish the impact of those disorders later, to encourage active patient self-management as far as is feasible, and to improve integration and coordination of care. Now, these are statements of principle which I'm sure those who have an interest in health would say, "Yes, we could invest in those with likely gain." So right at the top there is a recognition of the power - the importance of chronic illness and the need to do things, not just within the health sector, but broadly to diminish its impact and diminish its incidence.

Because of the economic implications of chronic disease, it has also caught the attention of the Federal Treasury. The Federal Treasury, for those of you who may not be familiar with what it does these days, I think - and Andrew might say otherwise - but I believe it enjoys a degree of intellectual liberty that it does not have in the states when treasury and finance are linked. In other words, it's not as pressured to solve immediate financial problems, but it can take a long view of things. Some really great policy papers are emerging from the Federal Treasury. Indeed, recently a paper, entitled "Health Promotion" emerged from the Macroeconomic Policy Division of the Federal Treasury. A very thoughtful, considered paper written by Janine Murphy, a name that you'll need to remember in a moment, which has provided a data-based analysis, in conjunction with the Australian Institute of Health and Welfare's analyses of the current burden of chronic disease as experienced by Australians of all ages, all ages, based on data, as I said, principally from the OHW.

The three diseases that account for the greatest share of total health expenditure were heart disease, nervous system disorders, which included dementia, and musculoskeletal, the arthritides. Together, they cost a total of 15 billion and accounted for about a third of health expenditure.

Now, Janine Murphy looks around to say, "Well, what has been studied by way of the impact of chronic disease on the productivity people in working age groups." Rather remarkably, she finds little evidence that anybody has looked at that very seriously, at least in developed countries. This was the subject of my 18 months' work at Columbia University in developing countries, so I'm quite familiar with it there. But Janine Murphy found nothing in the Australian

literature, and with a surname like that, as you may expect, turned to the Irish literature for her inspiration. What that showed was that even in a society where unemployment was low, three quarters of people with severe limitations do not participate in work in the labour market, half of those with some limitations, and a third of those with no limitations do not participate in the labour market. Now, from her perspective, as a macroeconomist, this is pretty powerful stuff, and I must say I was surprised by the extent to which she found that this was the case.

This macroeconomic approach to chronic disease policy is really welcome and important, but can't solve many of Neville's problems in the short-term. As Professor Penny will tell us, the New South Wales Government has also been active, over the past five years, with projects designed to assist patients with chronic disease to avoid the flare-ups that can spell disaster and which, in any case, may lead to expensive and traumatic admissions to hospital for the sufferers. These are comprehensive programs which he will speak about more in a moment.

Dan Fox has written this: "I have never worked with or heard about a successful policy maker who asked, abstractly, what should be done to solve a particular health or social problem. Policy makers invariably try to understand a problem at the same time that they assess what it is feasible to do about it. They understand that politics determines whether it's feasible to solve a problem at a particular time and which policy alternatives do and do not have any chance of being adopted." So how do we respond to Dan? In Australia there is a political opportunity to improve policy in relation to the care and support of people with chronic illness. This is a really very good beginning. There is ample evidence that care for patients with chronic illness, during intervals of relatively good health, can pay huge dividends and help diminish the need for them to be admitted to hospital. The second economic argument is in favour of addressing the problems associated with chronic disease because of its utility in preserving and enhancing the productive workforce as part of the human capital strategy. This is unusual. But while policy makers outside of health are interested in chronic disease, the window of opportunity is definitely open to ensure the politics, the policies implemented, are not restricted to the health sector. Now is the time to enlist the help and support of experts in economic, social and welfare policy, so that we're able to tackle the more complex areas of policy that have a significant impact on the lives of patients and the country as a whole. I do not see it as the task of academia to develop that policy or to tell people how it should be done, it's far too intricate and complex a matter than that. But we need to understand about the evidential base that can be incorporated into policy, and academia can, from time to time, can help provide that in a timely fashion.

So there is a need to follow the Fox formula, understand the problem and find solutions simultaneously., Politics determines what's feasible in Australia, and we have propitious moments of political opportunity. We have a reasonable evidence base of what works, and there is a sound economic argument and it's time to entice those outside health into helping solve the problem.

With all of these things there is always a question about how is the policy to be judged and by whom, who will evaluate it and what happens next. It's within that context that the Menzies Centre intends to operate a five-year program of exploration into three chronic conditions; that is, diabetes, congestive heart failure and chronic obstructive pulmonary disease, or emphysema. The approach that we have proposed and which has found favour with the NHMRC, is that the formulation and implementation of the policies that help people with chronic diseases should begin with the people who are experiencing those problems at the moment, so we will be working with such people in the ACT and in western Sydney.

The program is divided into four stages: First, to gain a clearer understanding of the experience of patients and carers, and second to work with them and their immediate care providers and the managers of care, and we have good linkages with the ACT Health Authority and with the New South Wales Department of Health in this. Third, to implement and evaluate these new models of care and to consider implications for system change. This is a five-year program.

It's not our intention that we should steadily unfold our wisdom over half a decade and then deliver it, like Mosaic law, on two tablets of stone at the end of that time. This is to be an interactive program of research that informs the evolution of policy. So we hope that by doing that, we will be able to invite Dan Fox back in a few years and he'll be happy, and we' can say, "We've been developing policy along the lines that are suggested."

Those are the points that I wish to bring to your attention and to look forward to discussing them with you in a few moments.

STEVE LEEDER: Now, it's my great pleasure to welcome Ron Penny, who has an outstanding track record as a medical contributor to the development of national health policies, most visibly during the HIV/AIDS crisis but well beyond that. Ron is an honorary to several Sydney

hospitals, and a member of the editorial boards of several prestigious journals and has served on government and non-government committees, ranging from those concerned with HIV, through, I might say, to his current role as Senior Clinical Adviser and Co-Chair of the New South Wales State Government's Chronic and Complex Implementation Group. He's also Chairman of the Corrections Health Services Board, so watch your step. Ron, welcome. Thank you very much.

RON PENNY: Thank you very much indeed, and it's a great pleasure to talk to you. I should say that when I took on the Chronic Care project, in 2000, most people in the room here and most people around the country hadn't used the term "chronic disease." I've been a clinician working in immunology for decades and the patients I saw with chronic disease did not think of themselves as having a chronic disease and did not describe themselves in that way.

Much has happened in the past five years, internationally and locally. The term "chronic disease" is now ingrained and policy and implementation in relation to these disorders are valuable.

As Stephen mentioned, I was deeply involved in HIV/AIDS. At that time we did two things simultaneously. That is, we set the policies and implemented it simultaneously and learnt as we went – more or less as Dan Fox suggested yesterday. In relation to chronic disease we are doing the same thing. The alternative – a sequential strategy of developing a policy, which may or may not end up on a desk or in a drawer or actually take place, and then taking action was not appropriate. In HIV/AIDS we learnt and set policy almost through a collaborative and simultaneous process, and learnt as we went.

Now I believe that is better to have a short cycle turn around, shorter even than a five-year cycle. If I thought, five years ago, I'd be talking now about what I'm doing, I would have been wrong.

The Health Department has aggregated chronic illness into a Chronic Aged and Community Health Priority Task Force of which I am a Co-chair.
In 2000, when we were asked to look at chronic disease, the driving force was to reduce the demand for emergency department's beds. Why do people with chronic disease, who were consuming 70 per cent of the health budget, clog up the emergency departments and acute beds?

The second reason, of course, was to reduce the crisis events that devastate the quality of life of chronic disease sufferers and lead to hospital admissions, and improve the quality of healthcare provision. They were the briefs that we were given.

So how did we do it? Steve actually made the point, and that is, get input of what people are already doing that may be of value. So Steve Boyages and I were the co-chairs of Chronic and Complex Care Program. We sent out what was essentially a model of NHMRC grants to all 18 Area Health Services (AHSs), and invited them to make submissions as to how they could tackle the problems. We said, "These are the principles. We want to save emergency department beds, we want to have better links between the community and the acute sector, we want to reduce hospital bed days, and we're going to do it only in three diseases that occupy 16 per cent of bed days and some 30 per cent of ED admissions, being heart disease, primarily heart failure, chronic obstructive lung disease, primarily, and cancer. We then set up Expert Reference Groups for the major chronic diseases.

For the task we had “peanuts” for money, $45 million, that had to be distributed across 18 AHSs and it had to run for three years. But it catalysed action. We settled on three primary end points in phase 1. (1)That is, we would set up programs which were like NHMRC program grants, with not much money; (2) because electronic health record was delayed, that we would develop a personal, handheld record called My Health Record, of which we would distribute to people with chronic disease that they could actually carry around with them: What drugs they're on, what they're allergic to, all the things that lead to mismanagement and end up in hospital. They carried it with them. If they went on holidays, they would take it with them, if they went to another doctor they would take it with them. Uptake was slow, but that was essentially a model. (3) The last thing we'd do would be to develop clinical service frameworks along the NHS model what are the principles of what you want to do, what are your standards, what are your targets and what's your time line.

At the end of three years we had some 42,000 people involved, which we estimated was under 10 per cent of the target population. We probably saved about 56,000 bed days over the three years. We had great difficulty measuring how we avoided ED admissions, but we obtained anecdotal evidence of quality improvement. These were simple summaries of the clinical service framework document, which is available off the website under the chronic disease/care website of New South Wales Health.

The biggest problem was actually getting uptake, getting the message out, doing site visits. It was a policy setting and it was enacting implementation and we were all hands on. We visited every area. We actually found that at these meetings, it was the first time in living memory of most of the people round the room, the general practitioners, primary healthcare workers and area health service personnel got together.

At the end of three years of Phase 1, it was confirmed, that the funding would now be recurrent, so that was an achievement. We had already engaged GPs in a program, through the divisions and through general practices that would develop in the next three years, a strategy for self-management support, which were run through workshops with an extremely high uptake and success.

Two areas that show the least uptake and least availability in managing chronic lung and heart disease are cardiac and pulmonary rehabilitation. In 2000 and 2001, under 10 per cent of the people who needed rehabilitation could access it. If they did, it was like waiting for the handrails; they might wait three to six months. So we looked at strategies of how we could improve that.

The next strategy to engender greater uptake and utilisation of our program was to run the Chronic Care Collaborative in 2004 which was at the end of Phase 2 , to implement the clinical service frameworks. After the election in 2003, cancer was placed in the cancer portfolio of Minister Frank Sartor, and we handed over the cancer clinic service framework implementation to The Cancer Institute.

What did we aim to do in the collaborative? We wanted to make sure the diagnosis was right. Physiotherapists were telling us that they were having patients referred to them with chronic obstructive pulmonary disease who didn't have it, and people with heart failure who didn't have it, and so we felt we needed to build in better diagnostic and management services. We then had to make sure we could disseminate effective strategies. We had 22 collaborative teams to engage GPs

The outcomes? There were certainly improved communication, understanding of chronic care principles, capacity for clinic or practice care, and some 25,000 bed days saved in the one year of the collaborative. Bed savings occurred in those AHSs that participated in the collaborative.

An additional outcome was the publication of a practical toolkit. It's for individual providers in the community. We were aware of the inequity of service provision for the Aboriginal community of New South Wales. We funded, through our Chronic Care Program the management and early detection, of Aboriginal patients with chronic diseases. Part of the strategy in our clinical service framework focussed not only on management, but on prevention and the end of life decisions especially advance care directives.

What of the current Phase 3 program? We aim to develop a generic care model for chronic diseases. Ongoing remains the prevention and early detection of progression of chronic disease. Reduced progression and complications improve the quality of life of individuals, families and carers, avoid hospital admissions and presentations to ED and improve the capacity of the system to deal with it.

Clinical Service Frameworks will be developed in two specific and seriously prevalent diseases, which will be diabetes and musculoskeletal diseases, for reasons that have been outlined by Steve Leeder. The principles of the generic model of chronic disease is the model that occurs in an emergency or acute care setting whatever is wrong with them, the system moves around them in the emergency department, whether it's orthopaedic, gastro intestinal, cancer, or stroke. The patient in the community has to do all the manoeuvring and they don't always get the services they need. We're looking at a model where the patient will either virtually or actually be provided with coordinated and integrated community primary care.

One of the strategies to be released shortly is the support for integrated primary care centres, which is the model that most Divisions of General Practice have been looking at through the General Practice Council of New South Wales, where we will provide an integrated service delivery in a site, which will also be able to go off site and provide home and ambulatory care. Essentially, the principle is patient centred - again, what Steve spoke about - with strong principles of self management. Prevention should go across a continuum of care, from primary, secondary and tertiary. We need to be sure that the models include timely and equitable access. There has to be multidisciplinary care where it's needed. Often it's not needed, but should be available at a community level. There needs to be proper care, coordination and planning. The chronic disease management Medicare items are there, but they've not been taken up at the rate that they should be. Effective organisation and service delivery systems are a real problem.

A major problem is the media - as we all know someone just needs to be shuttled from one hospital to another with an acute sector problem, and that takes primary and community care off the page and off the financial support and government response is to the acute sector. Chronic disease policy and implementation certainly need leadership and governance, partnerships and commitment to monitoring and outcomes. Our model is a variation of the Kaiser Permanente model.

What are some of the key additional messages? The first is that after five years of working hard, we have not been able to engage the health insurers in this health strategy, or those involved in the private hospital sector, who receive the benefits of the strategy, but they don't actually participate financially.

The second is engaging the acute sector of the health system to try and address this area. That is a problem.

The third area is the corporate work force, that is health risk assessments, not only through the executive level, such as the St Vincent's Health Assessment Centre, which has been there for some 13 or 14 years but going into the workplace and doing health risk assessments primarily for chronic disease. It's interesting, again, the message is there, that this has been very successfully and taken up by the corporate sector, but by governments? No. If you work for government, they aren't interested, although they should be concerned about the health risk assessment for chronic disease, its effect on workforce, absenteeism, so forth. The private sector sees the effective return on investment, and yet most of us here are probably involved in the public sector and I'm sure that none of us have had our sector worry about our health, about whether we're at risk of chronic disease unless we initiate our own care.

I welcome the NHMRC grant, which will actually address how we can still do much better in the area of chronic disease prevention and management. Thank you very much.

BOB WELLS: Thank you, Ron, and also thank you, Steve, for those presentations. I'll turn, first, to Bill Coote, who has a question which he assures me will link the chronic disease with the private public debate.

BILL COOTE: Thank you, Bob. That was actually a question I was going to ask in the last session, but I'll try it.

I thank Professor Penny for that very interesting presentation. There are two issues. I was wondering, you mentioned the role of general practice. That's been an issue that I've been close to for years and am always interested in it. I was just wondering how popular the chronic care programs are, and I mean in the Divisions themselves rather to individual practitioners? and so on, in getting the initiative up? That's my first question.

RON PENNY: If we didn't have the Divisions of General Practice on side, it wouldn't have happened. I'd say the Divisions of General Practice generally welcomed the fact that, for once, the AHSs were seriously looking at engaging them effectively. We worked very closely with the General Practice Council. Di O'Halloran has been on our team from the beginning and I think that if we didn't have general practice and relied exclusively on our public sector AHS staff, I'd say it wouldn't have happened.

BILL COOTE: Thanks very much. My second question: linking, as Bob said, to private health insurance, you mentioned just briefly that you have not been able to engage the private health insurance industry. I was just wondering what you mean? Just as an anecdote, I remember, it was quite a few years ago now, going down to the health fund that's based in Wollongong to engage the contributors with chronic health problems. But there is a bigger strategic issue namely that they really couldn't put resources into doing it because that would put their prices up in the market.

RON PENNY: We met Dan Cook at the very beginning, who is part of the Wollongong group which is now Australian Healthcare . It's primarily New South Wales based, and it is a relatively small company. Dan Cook was very effective in driving that company to initiate a whole range of lifestyle issues very early on, and to set programs for members of that health fund .He has shown that if you have one risk factor, you have a certain cost impost on an insurer. If you've got five or six risk factors; overweight, blood pressure, smoke and so on, you might have five, six or eight times the impost. So he was actually able to show that by the insurer putting money into those areas benefits follow. I should say he's the only insurer who has done it. MBF, when Gavin Frost was there - and we talked with him - actually had a policy in which they encouraged their members who had diabetes, to go three monthly and have their haemoglobin H1C done and sent follow-up calls for them. So, yes, it's been done, but not globally, and, I'd

have to say, imperfectly.

STEVE LEEDER: I just wanted to tell Bill that the two nodes of the NHMRC program that I spoke about in western Sydney and the ACT have a very strong emphasis on working with general practitioners. We have Nick Glasgow in Canberra and Tim Usherwood in Sydney as principal investigators on the ground. So that's part of what we're into.

Just in comment to support Ron's view: If you look at private insurers such as Kaiser Permanente, you'll see many opportunities that are taken up there for engaging and preventive work, and in the fullness of time that might come to Australia.

BRUCE BARRACLOUGH: My question to both of you is about successful implementation of policy. You've used chronic disease as a model, you've identified implementation plans that use the IHI breakthrough collaborative as a methodology for implementing policy. Now, at the Australian Council on Quality and Safety we also did a major collaborative involving 100 hospitals. We did a similar collaborative in acute care, through the Clinical Excellence Commission and a toolkit is available.

The problem is this. Around the world, including in this country, once the extra little bit of funding that goes to the AHSs to support these collaborative initiatives stops, even though there are isolated pockets of leadership, and even though there are isolated area doctors, this doesn't become generalised and sustainable as an effective end point of policy. So would you care to comment on that?

STEVE LEEDER: Bruce's point is well made, that often these things start with a flush of enthusiasm and then, three years later, they've disappeared without a trace, as though it's all been an alien invasion. The advantage, I guess, that we have with the research program, which liberates us a little from this is that we have defined geographic areas where we will be testing out these things, and no money or resourcing for it! So the success of the program will depend on the extent to which we can negotiate with existing AHSs and existing providers of general practice care and so forth, to come on board.

So in a sense, assuming that generalisable approaches and policies emerge from it, they will be very much related to the process and much less about what you would do if you had extra money. So I think we have a chance to match the policy and implementation as Ron suggested

without, any magic pudding to fix it, and we've got a better chance of avoiding some of the flash-in-the-pan stuff.

RON PENNY: Bruce, there are a couple of messages. The first message is, the money that we got, the $45 million, was catalytic and still is catalytic now,. However, if they rolled that money into the common budget pool today then it will go to where the biggest pressure is on the health system is, which is the acute sector. So you've got to have money for the clinicians in the hospitals, as in general practice. Commonwealth funding of the model we have here is, essentially, uncapped for general practice, but capped for every other area So that's an area that sometime and somehow has to be addressed, and hopefully it will.

The other issue that I wanted to raise was setting performance targets for the person who receives the funding. The AHSs will now have, I believe, performance indicators that are going to be community and primary care based. COAG is now beginning to accept prevention as a goal and they might put the into prevention but will likely set performance measures

The problem with funding from governments is that the model of how it's funded and spent is a recipe for failure in the private sector, and that's why the private sector wouldn't fund whatever they're doing the same way. When you know something isn't working, private enterprise would shift its resources. But in the existing models that we have in funding through the public sector, it is counter-productive for initiating projects, particularly rolling out new ones, because the money has all gone on existing services however useless they may be. The benefits of prevention are not going to be seen within a three-year cycle. So the performance indicators don't allow you to initiate long-term projects that are going to make a big impact 2010, 2015.

BRUCE BARRACLOUGH: Thanks.

MARY HAINES: Mary Haines from the SAX Institute. Congratulations, Steve, on winning such a wonderful grant. It's fabulous to see such excellent health service research being supported by a body like the NHMRC. Second, it's wonderful to see it linking in so nicely to the policy that's going on in New South Wales and has been going on for such a while through Ron Penny's work. Finally, it's great to see it building on the already excellent health service research that goes on in the greater west.

My question really concerns Stages 2 and 3 of the project, which are developing the models of

care and implementing those models. I suppose that with Ron's work and the models of care trials in Australia, people have really been thinking about models of care and how one might implement it for quite a while. My question, what can we learn from other countries? We've heard about Kaiser, but Kaiser operates in a very different system r. Is there anything we can learn from other countries or do we actually have to reinvent the wheel ourselves here?

STEVE LEEDER: I am told that someone in Australia holds the patent for the wheel, so attempting to reinvent it has become quite a legal hazard! I'll respond to the question seriously and thank you for your kind remarks.

Clearly there are many models, and Ron has referred to the exploration that New South Wales Health has made of many of those as part of the front end of the project. We have that as one of our goals as well, but I guess the thing that would differentiate us is that we have the luxury, if you will, of two localised communities, ACT and western Sydney, to be able to do this without the intense service pressure that Ron is under, where if one AHS does it, then the others all have to follow. So we have space for experimentation. In developing those models, the philosophy that we wish to espouse is, yes, let's learn from everyone, everywhere what we can, and in addition from people who actually have got the problem. So there may be some novelty in deeper exploration of the models of care that suit the individuals that can be incorporated within the politics of an area health service in New South Wales and within the ACT Health Authority.

RON PENNY: Also, thank you for your kind comments. But, again, all effort is a team effort, there is no single person.

We reviewed the literature and I have travelled the world, looking primarily at the US and the UK models. The clinical service frameworks, I should say, were designed around the UK NHS model. The NHS Clinical Service Framework documents are excellent, but if anyone here is from the NHS, I apologise, but when I was there last year and I went through everywhere from Number 10 to their key policy advisers to the NHS and the Department of Health, they're not implementing them!

Secondly, you're quite correct that the US model is different. The US model is an incentive to put money up front because it's the same provider that's looking after the downstream effects.

We all know that a dollar spent in reducing weight, in improving eating habits, we put more money into smoking cessation, physical activity would be an excellent investment. So why hasn't it been done? Because two separate providers fund health and illness! One is the individual who provides for their own personal prevention, and the other is the government who pays for end of life care.

So we have looked at all the models - that's not to say there aren't better models, and I think you ask a very cogent question, that they do need to be revisited. But Ed Wagner, who has been a major international players in chronic disease for decades, runs, I think, Global Health Cooperative in Seattle and they have a large population. When he came out here as a guest of the Chronic Care Unit two years ago, he thought we had a remarkable opportunity in Australia to do things except in relationship to prevention, and in some ways he could learn more from us than we could learn from him. So it doesn't mean that we're always better, but I think we've got a lot to do on our own home front here, but we often underestimate our capacity in Australia.

STEVE LEEDER: Dan Fox made a very strong point yesterday about the evolution of services from a supply side dominated ethos, to one where the demand side is leading to a reconfiguring health services around the world. I'm very optimistic that that will happen in Australia, too. I'm confident that all the sources of information now available to people will raise health literacy to a very high level. If the community is energised and it wants an allocation of resources more in the direction of primary prevention or different models of care for people with chronic illness, then that will come about. One of our jobs, as research workers, is to listen carefully to what people are saying so that we can bring that in as evidence in terms of proposing new ways of doing things.

RON PENNY: May I make one other comment in regard to service delivery? We have an entrenched system of service delivery, which I think we have to change. Doctors oversee everything and then allocate work to everybody else. When you in the community, you realise that most people can self manage. The carers of somebody with a chronic disease are often better managers of chronic disease than any of the professionals who come and visit them. Pulmonary and cardiac rehab can be done in a community centre by a trained person, an exercise physiologist, for example, or even a person who is untrained, provided the person has been vetted

BOB WELLS: Time for one more question. Abby, did you have a question?

ABBY BLOOM: I'm both in the private sector as an executive director of the rehab company Recover, and I'm also an Adjunct Professor in health policy.

I wanted to express my gratitude to Ron Penny's group for pointing out musculoskeletal chronic conditions as important. It brings me around to stressing the importance, in macroeconomic analysis, á la Janine's work. Steve, I think you know what I'm going to say, which is that at any one time in a country of 20 million, you have up to a million people who are chronically unable to work. Many of those people have been injured at work and the majority of people who are injured suffer from musculoskeletal injury. We've been talking a lot about the private versus the public and I think it's important to note that there is a parallel health system in this country, one which controls or directs people who are injured at work, with each of the states having a different set up and all of those systems are evolving and improving over time.

Policy implementation is extremely complex when an injured worker finds himself or herself in a situation where he or she has to follow protocols. There seems to be a practice of delaying rehabilitation for 37 weeks, which, for many is palliative care, not really rehabilitation. So I suggest that we ought to have more discussion outside of this room. We certainly want to see the implementation of evidence based and protocols to improve those outcomes

JANE LLOYD: I'm Jane Lloyd and I am doing a PhD at Sydney Uni and the Menzies School of Health Research in Darwin. I am studying how Aboriginal health policy is implemented. One question I have is, what is implementation? When I first looked at it, I confined it to after policy development, but I have found that the process of development continues throughout. I give you the example of the preventable chronic disease strategy in Darwin. It started off looking at prevention, early detection and better management for the whole of the NT. We got funding from the S100 funds and that was tied to *remote* Aboriginal communities. So now the focus is on better management of chronic disease in *remote* Aboriginal communities. So that's an example of how the policy changed with implementation. It has been up and running for nine years and there is recurrent funding. It has continued. Maybe we need to know more about how implementation happens, rather than just getting frustrated that it doesn't, and that it is a process of collective negotiation. My question is in relation to governance. What do you mean? How could we, in health, learn more about governance initiative?

RON PENNY: I agree with your first comments. Implementation means that what you said in policy actually is happening on the ground. I'll give you a couple of examples of governance. An unnamed Area Health Service (AHS) was given about $1.7 million for their Chronic Care Program budget. The staff at that AHS were coming to me and saying, "There is no money. When we go to the Finance Officer and the CEO, they're telling us there is no money." So when I asked the Health Department, which then had an audit branch, to do an audit, they found that the money wasn't going to where it was supposed to go to. So there is the governance which is a financial responsibility to make sure that what money goes there goes for what its purpose was.

The second example is that people do what they say they do and there are standard principles for governance. The government puts out its own documentation, I think, Commonwealth - I know the state does - a Commonwealth document in terms of proper governance of entities. The NHMRC would have Steve under a very close scrutiny to make sure that he doesn't go on trips to the US as part of a holiday rather than - so they do monitor not only the trip, he has to give reports and so on. So the governance models are there, but they're only as good as what people put into them and how they're audited and monitored.

BOB WELLS: Thanks very much for that. Again, another very stimulating session. I'd like you to join with me in thanking Steve, and Ron, too. I'm now going to hand over to Jim Gillespie, who will take us through the next session. Thanks, Jim.

JIM GILLESPIE: I'm Jim Gillespie from the Menzies Centre. I'm Steve's deputy here at the Sydney end of it. I come from a political science background and I've been here for about a year. The next session, which we'll run right into - we had an optional coffee break which we always suspected we'd have to abandon after that session. But I've got a particular interest in this because I think what we've seen over the last 20 years or so a revolution in Australian government, mainly around changes in regulatory policies. The two next speakers have been major players in this, in various roles. The first of these is Bruce Barraclough. Bruce is Chair of the Board of the New South Wales Clinical Excellence Commission, he's President Elect of the International Society for Quality in Healthcare, and Medical Director of the Australian Cancer Network, and a member of multiple Federal and State government committees and health-related organisations. He's also had a long connection with organisations like the College of Surgeons, and I think he and Allan Fels have known each other for a long time through that regulatory process. So I'll hand over to Bruce.

BRUCE BARRACLOUGH: Jim, thank you very much for the introduction. Ladies and gentlemen, it's a great pleasure to be here this morning with my good friend, Allan Fels, and it's marvellous, for me, that the Menzies Centre has asked me to contribute to this program. So thank you for that.

Bob Wells used an analogy about "Oh What a Lovely War" and the fact that he and Andrew Podger were staff officers at a garden party, drinking gins and tonic. We've just heard from a couple of front line officers who have been moved up to staff grade and who are taking part in the G&T. I'd just like to say that I've been a front line officer in the trenches, leading the troops out of the trenches for the last 30 years and trying to relate and work with staff officers. It was interesting but my talk is really about creating public value and using good governance and regulatory reform as a basis for that. As an example, changing values and processes to improve safety and quality across the health system and showing how we can alter what is happening within the same hierarchical regionalism that Dan talked about. Within the same structure altering process and altering culture to make outcomes better. We need, I believe, continued significant systems change, culture change and regulatory change in order to continue to provide good, high quality, safe healthcare.

It's interesting, as "staff officers", both Bob and Andrew were responsible for writing the terms of reference for the Safety and Quality Council that they were required to monitor for the past six years. We had $55 million over that six years and we answered to all nine health ministers, all of whom changed at least once during that time. Being answerable to nine health ministers is really quite tricky. But it's been an interesting experience.

The whole of the world can be described as a pyramid or three circles and I plan to do both. These three circles I happened to stumble across. Allan Fels, a couple of years ago, asked me to speak to a class at the ANZ School of Government. I happened to wander in about 10 minutes early because I really wasn't quite sure of the situation. Alan was talking and he scribbled on a whiteboard these three circles from Mark Moore's work at the Kennedy School at Harvard, I thought, "well, this is a really great way of looking at what we do." Thanks to Alan, I've used it ever since, and I actually read Mark's book from 2003 and thought, "Well, you know, this is really an interesting way of understanding, not only about the safety and quality agenda, but in fact what we all do in healthcare in trying to provide better care for patients."

Creating public value can be about goods and services, but it is also about people's perceptions and desires. Jim alluded to the fact that Alan and I have known each other for some considerable time. I was President of the College of Surgeons when Alan started to say a few things in the newspapers about the College being a closed shop and having monopoly possession of the training of surgeons, which indeed we had for about 75 years. So I rang up and I said, "What's all this about?" He said, "Well you'd better come to Canberra and talk to me." So after a deal of interchange we decided to apply for authorisation to maintain the monopoly training position, and of course we were granted that authorisation, "in the public interest" with a number of conditions. That process and the conditions applied to the authorisation actually were designed by Alan and his team and I and my team, to create public value, to answer people's needs and perceptions, to answer people's desires and to involve current players.

The authorising environment: The ultimate authorising environment is our Parliament, our politicians, who are the people's representatives who represent the people's desire for certain public values and actually put the operational capacity in place in order to allow that public value to be created. So that is basically the idea behind those three circles. I guess many of us have varied between being part of the authorising environment and part of the operational capacity and in different models we might be in different circles. We all have our own needs and desires and perceptions in relation to the public value that we want.

It's somewhat different from private value, which is creating profits through products and services. Public value is more ambiguous. It's the desires and perceptions expressed through representative government. Sometimes it delivers goods and services that reflect collective and individual desires, but it answers perceptions as well.

How do you do that? That's what policy is all about. The policy needs to enable the delivering of public sector products and one of those might be high quality, safe healthcare. It might be by establishing and operating institutions to meet needs and desires through properly ordered and productive systems. So the policy needs to direct itself at doing those things because, as Mark Moore suggests, we may not be able to create the public value that the politicians and, therefore, the community want if we don't do these things.

We often don't look too closely at how to achieve managerial success in the public sector in order to create that value from the policies that are put in place. The public sector managers

need to create direction, change staff, reorganise to increase efficiency, effectiveness and fairness, establish new programs to respond to political aspiration, because that is, in effect, ultimately, a public aspiration, and use present capabilities to deliver new tasks, (In Danny Cass' question yesterday he was railing against that, because new tasks sometimes means that old tasks are no longer done.) building support and attracting resources. Many public sector managers don't see that as part of their task. Even if they were active there, if they followed the money trail and milked the money tree, they may be better able to perform their function. So just put all of that as a background.

Michael Woolridge, as the representative of the nine health ministers of the day, in the December of 1999, when I was still President of the College of Surgeons, rang me and said, "We're going to get you to chair this council." I said, "What's it to do?" He said, "It's to fix the health system." I said, "Oh good." I said, "By Christmas?" and he said, "Not this one." They were our "riding instructions",. Bob put a few further items on the agenda and it was basically to take a systemic view of health in order to reduce adverse events and the effects of error. By any international standards we have a very good health system and it's a matter of trying to marginally fix that around the edges, to reduce the harm that comes from the best efforts of good people working in good places.

Many of you know all of these statistics, but some of you won't. Just look at the volume of activity that we and the policy makers needed to influence. Look at the number of hospitals, the number of admissions, the number of times we, as health professionals, attend various folk within the system. We've heard a lot about payment mechanisms, which I think are highly unimportant in this context, and I think that Dan Fox and John Deeble have both indicated that. Doctors are not the key feature of this, it's the systems in which doctors, nurses and everybody else who gives healthcare work. So this is about systems and not individuals, the organisational psychologists, and particularly one whom we've used a lot, James Reason from Manchester University. An adviser to many airline systems around the world, James would suggest that if we address the system, we address 90 per cent of the problems. If we address the individual, we address 10 per cent of the problems. So the 90/10 rule needs to apply when we're looking at policy.

Look at something else. One little measure: adverse event rates. Quite suspect methodology, but nevertheless it's been repeated on a number of occasions. You look at Australia and we have 16.6 per cent adverse event rate in acute care, back in 1995, based on events in 1992, so

what the relevance of that is right now, we're uncertain.

If you look at those numbers, we included in those numbers anything that met a two out of six scale, which was slight to modest evidence of healthcare management causation because we wanted to learn from the information, not because we necessarily wanted to quantify the adverse events. Whereas most of the others, except for New Zealand, have related their numbers to a four out of six scale. The early American studies, by Lucien Leape and others, didn't include some of the more minor adverse events such as urinary tract infections, and some of us would know that it is not a minor event if it's you. Now, even if there is only one adverse event that could be prevented, it's one too many, so let's not get too bogged down in the number.

Improvement continues to occur and a number of people have alluded to the increasing age at which we all die. Some of these bits of information are really quite significant. Overall mortality from heart attack fell by 34 per cent between 1991 and 2004. It's quite right that Ron Penny should include other than cardiovascular disease in his range of issues because we're getting, to a large extent, on top of cardiovascular disease.

So what was needed when we started to look at safety and quality in healthcare? We looked at the dimensions of quality as a way of defining it. We picked safety to attend to first, because everybody can grab hold of it and because Charles Vincent, another clinical psychologist in the UK, had suggested, following his research, "that safety is that dimension of quality that's most valued by patients and their families". We used that as the pointy end of a wedge to drag the rest of quality with it, so that if people grabbed hold of this concept, the rest would follow.

If we were going to actually achieve this, we needed health professionals of all types, with competencies to support this agenda. Otherwise, we're just wandering around with no leadership.

The Safety and Quality Council decided to think about this and to try and put some things in place to make it better. We wanted to have better focus for national efforts in safety and quality, to raise awareness, to bring consensus, to clarify priority issues and to stimulate activity. Because this was now the year 2000 and many of these words that we've used today that just drip off the tongue were not heard of in "clinical land" even five years ago. Council had no statutory and regulatory authority and it's very hard to make improvement and also to

answer to nine different sovereign governments. It would have taken years to provide that statutory or regulatory authority, and of course even the new Commission that we handed over to last December doesn't have that and shouldn't expect to. So we had leadership, persuasion, advice, example, development of strategies, frameworks, standards, tools and guidelines as the sort of levers that we could stomp on to produce change.

Where do we think we might get to and how will we measure what we've done? It wasn't by an adverse event rate because the acuity of hospital patients has changed, the age has changed, the methods of treatment change; and even over ten years there would be no realistic comparison with the 1992 number. So we thought that if new programs, processes and culture are accepted as a normal part of healthcare delivery, we'd be on the way to some success. That if there was quality improvement and a patient safety focus embedded across our really diverse and complex system and if there was a commitment at multiple levels to support improvement activities, we'd be on the winning side. While this isn't yet across every segment of the health sector, most members of Council would think that a lot of these are now in place that weren't in place five or six years ago but there are some glaring examples where that's not so.

The diverse nature and complexity of the health system is very important. Even Newt Gingrich, that highly respected leader of the House in the US suggests that health is 50 times more complex than defence, and he may have been underestimating it.

We put in place different processes and we were looking at systems, we were looking at processes, we weren't looking so much at structure, and we weren't necessarily. trying to adjust all the variables so that we could identify outcomes. So we did many things, including establishing a national system for collection, analysis, reporting and correcting causes of severe adverse events. It took two years to get six states and two territories to agree on the same eight-item sentinel event list, but they all also agreed to teach root cause analysis as the methodology of analysis of these events. That was a major step forward because we'd grappled with how to change culture. You change culture by process and methodology. So you change it not with one sector, but with all sectors of the health system. We taught 2,500 people in New South Wales, out of the 100,000 employed by New South Wales Health, the rudiments of root cause analysis and the understanding of human factors. We had a 30 fold increase in reporting of severe adverse events. We then convinced the states to agree to consistent incident monitoring and management systems, which have gradually been rolled out.

In the first 12 months in NSW - and this is after the teaching of root cause analysis, we had over 90,000 incident reports from 6 million people, in fact from the acute care processes of 6 million people. So this is a reporting culture that wasn't there before.

We are in the process of developing a national data set for patient safety and that's a task for the new Commission to complete, as is a report on the current status of the health system and we've done quite a lot of work in the background of that, but it will take some years to come to fruition. So we do now have a dramatic increase in the understanding of the vulnerabilities of the system so that they can be corrected. All states have agreed to report their sentinel events and two states have on more than one occasion reported publicly.

We developed numerous tools, and I won't go into those in great detail because some of those have been alluded to in relation to collaboratives. But these have been highly successful and very appropriate. We've developed some standards which I think, will provide a long-lasting effect. Policy, which doesn't include some standards that can be assessed and assured, rather than just assessed, is ineffective but with the assurance of the standards, policy becomes effective, and that is a very important issue. We've put together a standard for credentialing and defining the scope of clinical practice for senior clinicians, which can be adapted to all others. (All of our work, while it focused on the acute sector, can be adapted for other sectors).

The key issue is about one sentence in that standard, and that is that there needs to be performance agreements. There is no industry that has made an improvement in relation to defects in its products without some type of performance agreement. As an example, those performance agreements aren't necessarily about how I, as a surgeon, treat breast cancer but it might be how my variance analysis in relation to my use of evidence based guidelines is used. It might be about how I deal with the safety and quality agenda because that will have more effect on outcomes, than the individual techniques I use in the treatment of breast cancer.

We've empowered consumers by having all states to agree that before admission to public hospitals the "10 Tips" booklet, written by our consumers, is given to every patient, and we now have evidence that they ask more questions and actually take better charge of their disease if they get that little booklet. Questions answered, trust improved, outcomes improved.

Linkages and products to improve care by research and education: We've established a centre for research excellence in patient safety. It is to be a centre "without walls" based at Monash University and is working now. Medibank Private has picked up the agenda in its contracting of hospitals. The RACGP has been given half a million dollars to employ five project officers to customise five of our major issues for office practice. And so it goes on.

One of the keys, I think, to what Council will be remembered for is the National Patient Safety Education Framework. The vocational education and training sector is already using it extensively. Numerous people overseas have picked it up. It's totally evidence based, the bibliography is thicker than the framework. It was put together by Merrilyn Walton and Tim Shaw and others from Sydney University. They won the contract to do it. It identifies the competencies needed at multiple levels of the health system; i.e. for a lay person, a junior doc, junior nurse, senior nurse, senior doc, manager, etc. The competencies needed to meet the safety and quality agenda are in that framework and the Framework information is easily converted to a curriculum.

There are seven major learning topics, and even if our performance agreements only address those issues with performance being related to competencies required at the level of the health system in which people work, it would be a major step forward.

The new Australian Commission for Safety and Quality in Health care that is to continue this work now has a chief executive, who is Professor Dianna Horvath, a respected manager. She doesn't yet have a board or a chair and she does not yet have an inter-jurisdictional committee or a representative advisory committee, but there is enough money to set up the new Commission. One of the major advantages that she will have is that there will be members of AHMAC on her board. Because they are the leaders of the state health systems, they have the leadership that is required to implement most of the policy as it relates to safety and quality. Implementation has always been an accountability of the states and the private sector. It can't be by anybody who is doing a little catalytic work around the edges such as a Council or Commission who have no line management accountability.

Diana understands that the following are the functions for the new Commission: Identifying issues and policy directions, recommending priorities for action, disseminating knowledge, advocating for safety and quality, reporting publicly, recommending national data sets, providing strategic advice and recommending nationally agreed standards. There is a lot of

background with a big platform of reforms that she can build on, and I am sure that she will do that with the help of a very good board when it is announced.

One of the things we did on Council was to win an ARC grant as an industry partner, in combination with the Australian National University and ACT Health. It was approximately half a million dollars, to work on responsive regulation with RegNet at ANU, with John Braithwaite, Judith Healey and Catherine Dwan. Their first report to us was delivered to health ministers in 2005 and it is on the website, www.safetyandquality.org, in the list of things that were given to health ministers last July. The context is that healthcare is mostly a self-regulating profession in an otherwise strong regulatory environment, with a proliferation, currently, of regulators and regulations, with exploration of new external regulatory levers to improve performance within and by organisations, rather than depending on the voluntary behaviour of individuals.

Good governance is reflected in strong systems of leadership and accountability. Individuals and organisations need comprehensive systems of review, risk management and systems improvement. Do you realise that most public hospitals didn't have a risk management plan as it relates to safety and quality before we got ministers to agree that they should? There is a move from reliance on self regulation, to external regulatory levers. This is John Braithwaite's pyramid, his representation of the world as a pyramid. He doesn't talk about regulation as just the command and control issues in relation to regulation. He talks about the market mechanisms such as "pay for performance" and very many other things, as the basis of the regulatory pyramid. The self regulation and voluntary activity coming in at the next level, and we've got a lot of that. Not much at the bottom level. Lots at that middle level. Not much at the next level, which really is crying out for increase. If you think of any commercial firm out there, any corporation, it has metaregulation as far as its finance is concerned, where you have an internal audit group, or internal accountancy group that tells you where and how you've spent your money and what standards you've used to account for that. Then a well known accounting and audit firm coming once or twice a year to actually work with the accounting level people to take a joint statement to the board in an improvement context.

If we change the currency from money to safety and quality, and apply metaregulation ,i.e. external audit of internal audit, we've got a real way of influencing healthcare. Command and control activities at the top of the pyramid should be a last resort, particularly in the public sector, where it's very hard to shut things down.

John's thesis is that if you move inexorably from the soft regulatory environment to the hard regulatory environment, you drive the responses down the pyramid from the top to the bottom, and so you make improvements.

So we're moving to a metaregulatory environment, we're moving to networked governance, and the Council itself and the new Commission is a good example of that: Less reliance on top down government action and more on mobilised networks of power and influence. Responsive regulation is that escalation of sanctions, with complimentary mechanisms responsive to the conduct of those being regulated.

John would be very keen to mention restorative justice. If injustice is harmful, the application of justice should be healing. Our open disclosure policy does that. An apology takes the black anger out of medical litigation, as Lord Wolf referred to in his "Access to Justice" Report in 1995. Apology and forgiveness is part of the open disclosure process, but so also is root cause analysis in the fixing of the problem.

Much has been made of some of the failed hospitals around the place. Campbelltown Camden is a local example of problems that may have been avoided by a system with networked governance and metaregulation. The Macarthur strategy was conceived in good faith, where Campbelltown and Camden Hospitals were left by themselves, and yet they were asked to do, (except for cardiac and neurosurgery) everything teaching hospitals should do, with almost none of the resources to do that. Yet, the freeway is there, and 10 minutes down the track, by ambulance, you have Liverpool Hospital, which is tertiary referral, which is part of the same health area with the same governing board.

Let me just give you three examples. I was asked by the Director General to go into Camden and Campbelltown after the Healthcare Complaints Commission Report and look for opportunities for improvement.
Accident and emergency: Some difficulties because of lack of staffing, but no linkage with Liverpool, none whatever,.. Virtually no linkage with Camden. When Liverpool was on code red and Campbelltown were on code red, the ambulances no longer dropped there, ambulances took patients to Camden Hospital, where there was often only one doctor and no ability to triage the patients. Crazy! Lack of governance, lack of networked activity, lack of metaregulation because no-one was looking over their shoulder to see how the Macarthur Strategy was working. Of course, that particular problem was fixed very quickly.

The intensive care unit: Campbelltown had potentially five intensive care beds. They had a marvellous nurse running it but no doctors. They had been to South Africa to get five anaesthetists. None of them were in charge. There wasn't a doctor of any sort in charge. Magic nurse, no docs for her to refer to. They really couldn't manage complex patients or intubated patients. Full staff at Liverpool, 10 minutes down the track, on a contract that allowed them to spend one day a week in private practice, which they had to hunt around the country in order to do. They often went off for a month to do it somewhere else. It was suggested that they be employed at Campbelltown one day a week as VMOs, and Campbelltown then had a full service, with intensivists there every day of the week, with linkages to Liverpool so that the same protocols were applied and the really troublesome patients got to where they had the best care.
Radiology: It's a major hospital, Campbelltown. It's going to be even better. I chair the advice group for the University of Western Sydney's new medical school. We're planning to build Campbelltown up as a major teaching hospital. Marvellous buildings, marvellous equipment, all the top quality radiology equipment. No radiologists able to provide a service at night. But, worse, no networking that allowed the radiologists at Liverpool to get the information "over the ether" and then ring through the answers. Sick patients transferred, by ambulance, in the middle of the night to have a scan - just because the networked governance wasn't working.

So these are examples of how appropriate regulation, appropriate governance, a change in culture may actually influence things a lot. The future public debate, I think, needs to be about the provision of care where there is marginal capacity to deliver, whether that be at the periphery of the cities or in the bush. The public needs to understand that issue. We need effective networking and linking to deliver and to correct the marginal capacity to deliver.

Public discussion of the nature, limits and consequences of healthcare: There is a lot of magic pudding stuff out there at the moment. But we can't do what the public wants without definition of clear roles, clear responsibilities and clear accountability for care at each level of the system, and it's not just at the supply level. It needs to be at every level and particularly at the top level, because there is no firm that's improved its performance in terms of rising from one sigma to six sigma without the involvement of the CEO or the people on the board. A six-sigma organisation is where there are 3.4 defects per million product. A one sigma industry or organisation is where there is more than 100,000 defects per million product. Healthcare is one sigma - 10 per cent adverse event rate. I rest my case.

Where to now? We need to match the care needs to the human and physical resources so that there is equity of outcome irrespective of where care is accessed. Not equity of access necessarily, but equity of outcome irrespective of where care is accessed. We need to, then, publicly define some critical mass issues, some processes of control, which are often lacking, and determine what funding adequacy actually is. Networked governance and networked capabilities are essential if we're going to achieve any of that.

Cyril Chantler, who worked at the Kings Fund and Great Ormond Street and is almost a contemporary of many in this room, said two things: That "medicine used to be simple, ineffective and relatively safe. It is now complex, effective and potentially dangerous." The community thinks it is safe. At the back end of that, he said, "we need to recognise that we are mortal and that care can be more important than treatment at the end of life" and I guess we sometimes lose sight of that.

Thank you very much.

JIM GILLESPIE: I probably don't have to say very much to introduce the next speaker, Allan Fels, who is a little bit of a household name since his days at the Process Justification Tribunal, and then the man who really built the Australian Competition and Consumer Commission into a national and very independent organisation, and he will respond now to Bruce.

ALLAN FELS: Thanks very much. First of all, this morning all planes from Melbourne to Sydney are between two and three hours late this morning, so I wanted to comment on a couple of things that may have already been discussed. Also, I'm very glad to congratulate the Menzies Centre on holding this very worthwhile-looking seminar, and I'm very pleased to speak after Bruce, who is actually a Fellow of the Australia and New Zealand School of Government in recognition of his contributions to our teaching program. On his comments on regulation, I generally agreed with them and I tend to see the issues in a rather similar way.

I won't spend too much time on my own lack of knowledge because, well, for some reason you have asked me here, and the latest way of saying that you don't know too much about a subject is to say that you do not have domain-specific knowledge of an area. I lack some domain-specific knowledge of the health system, but I will give you, nevertheless, the full benefit of my less than fully informed opinions.

Now, a few brief comments on what Bruce said. He gave an excellent coverage of the safety and quality issues. I perceive a little bit of what is happening by virtue of being a member of the Bayside Health Board, which is three public hospitals in Melbourne. It seems to me that what is tremendously important now, and Bruce suggests this to a fair extent, is the importance of getting cultural change to bring about open disclosure about safety and quality. That includes a willingness to admit and report mistakes, to analyse their causes, to learn from them and to avoid a blame culture, and a recognition that, in the words of that famous American report, to err is human. I do see signs of progress in hospitals in this area. I think the scene is changing. Just to give you one terribly trivial example of how it works: On our board we certainly hear about every mistake that is reported and there is a root cause analysis. Recently there was a mistake and two patients in beds next to one another, one of them got the x-ray that was intended for the other. This was admitted and we had an analysis. What happened was that the nurse happened to get a phone call just as he was about to take the patient off for the x-ray and then he went and - the people had similar names and he took the wrong one off for x-ray.

Now, what emerged from that was actually the distraction of the phone call. The phone call was a business call on the mobile phone and the hospitals started thinking, "Well, let's bring in a policy where phone calls can't really be made to orderlies, except in very unusual circumstances, when they're doing jobs like that. That has slightly improved things, slightly reduced the chances of mistakes being made like that. As I said, a trivial example. There are millions of bigger ones, where the system is reacting to the new policy of open disclosure.

Well this increase litigation, again Bruce commented, I don't think we really know, but possibly it will increase litigation. When mistakes are admitted and explained to patients or their relatives, people are less likely to sue. On the other hand, when they are made aware of mistakes that they may not have been aware of or might never have found out about, when they become aware that there is substantial evidence, well maybe it does provide an opportunity to sue. Of course, in the end, this question of whether there will be more litigation or not shouldn't drive policy at all because the consequences for improved hospital performance and health system performance are improved so much by this policy of open disclosure that we have to press on nevertheless.

Now, the other point I wanted to make in this area is about performance monitoring in the

health system, including hospitals. My impression is that we need to do a great deal more about performance monitoring. We probably need a revolution here, and part of it is to make a lot more of the monitoring available publicly to anyone who wants to know. This calls for, in my view, essentially, a change in culture. Of course always a million reasons are given as to why performance outcomes should not be made public, but I do believe it's a cultural issue more than the reasons. There are huge benefits also from much more full disclosure. Let me give you a difficult example: Say you want to find out the number of deaths occurring in each hospital, you know, certainly in Victoria you will not find that out if you're a member of the public. Hospitals, themselves, I don't think, know. They are just starting, now, to compare the number of deaths in hospitals. Of course there is a massive set of problems, issues, challenges, difficulties in comparing performance, and also even more in making it public. Think what the media will do.

But, on the other hand, there are also very big benefits from doing these comparisons, trying to correct for them. There are ways of managing the press handling of them. In the end, my own underlying belief is that more performance monitoring and more public monitoring will actually trigger much better performance and outcomes.

If we turn away from such a difficult issue as deaths, to other forms of performance in the health system, then we find, again, that on the whole there is a lack of publicly available information and not much comparative across the system. There is not that much available on the comparative performance of individuals, that is individual doctors or health carers, of specialists, of hospitals, of other institutions, and if there were more so, I believe, on the whole, that that would trigger better performance. Just to give you one instance: In the United States, years and years and years ago, because of pretty special circumstances cystic fibrosis results were compared across all hospitals. That experiment led to a dramatic improvement in performance in the treatment of cystic fibrosis. Then when a further step was taken, the dramatic step of making that information publicly available so that patients and carers knew the performance of the hospitals, that led to further improvement and to acceptance by people who are being treated that maybe they were getting the best treatment in the country. Most of them actually stuck with their hospitals and got further improvement.

So I think, you know, in Australia, as I understand it, there is no information publicly available about cystic fibrosis performance across different hospitals or states, and if you're a consumer, then you have no idea. I don't know that there is much comparison across hospitals. I won't

spend time going through the many reasons that are given against having these comparisons in Australia.

I just want to say a word about mental health. There is a growing awareness of the seriousness of the problem in Australia and the extent of policy failure, and of course yesterday's statement by the Prime Minister was a very important public recognition by government and the steps were a significant step forward. Let me make a few qualifications: We await, now, a response from the states and territories. Even with a good response, there are really big issues concerning the adequacy of the coordination, the cooperation, the collaboration in our somewhat dysfunctional Federal/State way of handling things. There are huge implementation challenges in this mental health program. Even the best units of any kind that I know in Australia, whether you're talking about at the hospital end or the care end, the socio or psychological end or the medical or whatever, even the best fall a long way short of what's desirable. That's not taking a shot at them, it is just an accumulation of historical factors and neglect, inherent severe problems in dealing with mental illness problems and so on. So there will be terribly difficult implementation changes for years and years ahead.

Also, yesterday is a start, and if the states match the Commonwealth contribution, then this also is a step forward, but a huge amount more is needed by way of commitment. 30 lost years of caring for the mentally ill can't be made up with 1.5 billion from the Commonwealth or a matching amount from the states. There is a huge deficit of backlog to be addressed. On that subject I'd also just like to make a point, which I'm sure this audience won't misunderstand: Early intervention, very good. There seems to be evidence for it having some effectiveness. But let's not forget the lost generation, 30 years of people with mental illness who we already know have it and who have been neglected and need proper, decent treatment from here in.

I also have some fears that there will be a loss of political interest in this matter over the course of time. The mental health constituency is very, very weak, poorly organised, finds it difficult to get results, and, of course, I have fears that the governments will do a once and for all approach to dealing with this problem, but not deliver continual improvements and see it as a huge challenge that is at the fore of the weaknesses in our health system for the next 10 or 20 years.

I guess I've possibly been asked along to comment a bit on regulation and I just wanted to say

a few things about that. There are two views of professional regulation. One is that it's needed to protect quality, safety. The other view, there are two views - there is a bit of truth in each and there is also a bit of exaggeration in each. The other view is that regulation has really been captured to serve the interests of the professions. On that latter one, let me just say a couple of words about how one would look at that aspect from the economics or competition view. The issues are that by getting a monopoly through the exclusive reservation of work to the medical profession, and within that to certain categories of the medical profession, this generates a monopoly. The problems are accentuated by limited entry, including from outside the particular state or country or jurisdiction one is talking about, the problems are compounded by some history of anti-competitive practices, some of them sanctioned by governments, others are by professional associations, often, in the past, illegally. But there is one further truth between those two views, which also has to be said; that is that governments have, of course, played a huge role in limiting entry into the medical profession. This is for fear of supply-induced demand, for fear of causing cost blowouts, to save money anyway, possibly due to the influence of professions themselves on government policy, that symbiotic relationship with the profession.

Against that background there has been national competition and consumer policy in relation to health, especially the professions. There are two aspects, the Trade Practices Act. The other is the broader national competition policy. Now, regarding the Trade Practices Act, it now applies across all professions that are people who are self-employed. If you are an employee, if you're a doctor who is an employee of a hospital, you're not covered because employees are exempt. But it's had some effect, the enforcement, of the Act and the education of that, in reducing and largely perhaps eradicating unlawful, anti-competitive practices in terms of boycotts of hospitals that don't pay adequate salaries or price fixing agreements.

There are also - by the way, I should mention that a lot of very interesting, significant merger questions across the health sector are being dealt with under the Trade Practices Act now.

Just on the question of whether you should have competition law applied in these areas, after all they're questions of ethics and quality of service, I'll just briefly comment that most of the cases I've seen in Australia are, the ones in the US, they never involve higher questions about ethics, the fiduciary relationship of doctor to patient, or quality. They simply involve issues of the naked use of market power by a monopoly to extract benefit with no obvious public benefit. Secondly, if customers want quality, and that's what most people want from the medical

profession, then in a competitive market there will be competition to offer best quality service, rather than some kind of race to the bottom with prices, ignoring quality.

Now, the other bit, apart from anti-competitive practices, is the question of entry restrictions and exclusive work reservation. These are much deeper issues to face. The Trade Practices Act has limited application. As you know, the commission, in my term, dealt with the surgeons. Bruce, by the way, played a pretty constructive role in this matter, but I wanted to make a few points. The report by the Commission opened up issues. It went for some changes, transparency, a bit of opening up, somewhat better processes. I wanted to go further, but couldn't. All we could do was threaten that next time more would happen if things didn't improve.

The difficulties that we faced were, of course there was professional resistance, but the governments were a very big disappointment. They used to whisper in our ear that we should do something about it, so we did, and we had the authorisation and a public inquiry. But when that occurred we got virtually no help from governments. They weren't prepared to come forward with data and information, support policy ideas, any interest in helping with the policy problems, any interest in putting a bit of money into help maybe set alternative training schemes and so on. Again, we see some signs of improvement in government attitudes, but I found it terribly disappointing. I note, with great interest, the possibility, now, that universities will start offering specialist training.

Now, the final thing I am going to mention, is that there is much wider topic of health workforce issues. This is going to be a very important part of the health agenda in coming years. Clearly, there are major cost pressures through the ageing of the population, the rising cost of care per unit of population, so to speak, and, at the same time, general downward and competing budgetary pressures. So we then look to whether the health system can deliver results more efficiently, more cheaply, better results at the same time, and that inevitably leads to a huge focus on the workforce. The Productivity Commission Report has given us a very good general framework for looking at all of the health workforce issue. The one I wanted to mention is, of course, this question of the fact that the workforce seems to bee riddled with rigidities and inflexibilities, and that a vast change involving work redesign is needed. I say no more than the words "nurse practitioners" to give you an idea of the huge issues, including industrial relations issues, that have to be tackled that seem to me to be an enormous priority.

So it seems to me that these are some of the issues. We're moving into an era where consumers are much more important, they are becoming empowered, we need to have policies that will continue that trend. There are, as a result, big regulatory challenges, there is a vast amount of regulation that would be required. Everywhere there is deregulation, you'll find there is a need for re-regulation. My view of how that goes is something like Bruce's, in rather general terms, I'm across that kind of framework he was talking about. Thank you very much.

JIM GILLESPIE: We've move on to questions now. First of all, maybe some comments from Bruce would be good.

BRUCE BARRACLOUGH: You might be surprised to know that I would agree with most of what Alan has said, and I did. I think that public reporting is the key. I do believe that we're going to need to have appropriate performance (indistinct) and appropriate data collection in order to make that public reporting real and trusted and valid and comparative. So there is a lot of work and a significant amount of money, and if that is applied the culture will change. I don't see any of the professions dragging their heels because there is valid information out in the public domain. We do it every day, individually, to our patients. The professions in health, having come as far as they've come in accepting the safety and quality agenda over the last six years, are not dragging their heels with this. It's interesting that public reporting does have a major effect, it did in North America when they started to report individual cardiac incidents. That data was not valid, necessarily, in terms of the complexity of what each surgeon was doing. It wasn't the individual that changed, it was the systems that changed. It was the hospitals and the hospital groups that changed their systems and support structures in response to the public reporting, rather than the individuals whose names in the performance appear. So it really does get back to an absolute systems issue.

Regulation captured by professions? Maybe. A bit less as time goes by. Public benefit we demonstrated to get authorisation from Alan's Commission, and we applied to continue to be a monopoly educator of surgeons. Yes, there were conditions that applied and, yes, Alan didn't get much support from government. He'll get more now. The college would be prepared to move further now. Every idea has its time - and Bob is shaking his head and Bob is leading the push for some of the university activities, and, yes, he's meeting some resistance. Bob, there are ways around the mountains. But, nevertheless, I think that ultimately the good of the public, the public value, is something that will be delivered. The public value that people want out of healthcare education will be delivered. There is still an enormous altruism that underpins

professional activity.

CATHIE HULL: Could I just make a comment from within the hospital system as an emergency doctor who really thinks both what Allan Fels and Bruce Barraclough said, that please don't monitor hospital deaths as an indicator of quality of care for the very reason that we have this Sir Cyril Chamber quote up on the board. We already have people who are too afraid to let people die on their shift, under their care, in their hospital. I would like to see more deaths in my hospital, not fewer.

My second comment is, I don't think anyone is afraid of the monitoring of their performance. It already happens a lot informally, and I don't think anyone is against this. But I could say that the chat in the hospital emergency departments was that the best pay for any shift was at Campbelltown Hospital, and only the financially desperate went to work there because there was no back up. So the worst doctors went to the worst circumstances at those times.

BRUCE BARRACLOUGH: I agree with you, by and large deaths are not a real measure of the performance of the system and for all the reasons that you've said. In certain exercises, maybe in cardiac surgery, you can use death as one of the indicators. We need to develop very simple, very straightforward process indicators. Everybody loves to talk about outcomes and ultimately the outcomes are the important issue, but outcomes that are dealing with process. Outcomes, by and large, are dependent on process, but also on the state of play of the patient and all the comorbidities. To actually try and stratify for all of those things, that is extraordinarily difficult. But if you measure the processes that underpin the outcomes, you'll get a very good measure of whether the right thing is happening. We ought to be reporting the adequacy of process as a very good surrogate for what's going on in any part of the health system, not just hospitals. Hospitals we talk about and we use as examples because they are functioning systems, some better functioning than others. But they're functioning systems and it's harder to see the systems' activity in the diffuse private sector. But once you stand back from it, you can see the patterns, you can see the control mechanisms, and it is a system just the same.

DANNY CASS: I'd agree with Bruce that we are very keen to know what our death and serious complication rate is in the patients we treat. However I did detect a lack of follow through. In the area of trauma we've got a very sophisticated method of measuring the severity of injury (one of the most sophisticated in the world) from the AIS scoring system. Trauma hospitals

have put these measures in place. We now know our death rates from trauma within hospitals; we have a system where we can actually calibrate that to the seriousness of the injury: a critical mortality. We collect that and can compare hospital to hospital. Within hospitals they've got facilities now that compare surgeons, from the fully trained committed trauma surgeon, versus the surgeon that is on call for trauma and comes in occasionally, as happens in a few hospitals. We can and do measure that. What we can't get from the government, and we've been to the Federal Government a few times, is funding for a National Trauma Database. So with hospital and State Government support we do all this work, we set up the processes, and we go to the Federal government and say, "Look, we need the money to make this process work at a national level," and they baulk at that point. That's happened to a lot of databases, in that we do all the work, as clinicians, to make it happen locally. We are desperate to have the information publicly known at a national level, but we trip at the last hurdle, which is money. Therefore there is a lot of talk about a transparent information system for the public, but it is expensive and there are not the funds to make it happen.

BRUCE BARRACLOUGH: Danny is having a small serve at me because I refused his application for funding of that database. The reason that that was refused, was, first of all I had to convince 26 others on council, and then we had to convince nine health departments. There is no single government in this land that will put their hand up to fund any register or a database that's likely to need a 20-year time frame, when the political time frame is three to four years. The fight between state and Fed as to who funds the database activity is still an ongoing fight, and somewhere at the policy level, and maybe the Menzies Centre, can help me to sort that out. I thought it was going to be one of the easiest tasks of council, was to set up numerous registers and audits, and I may have, in the depths of a beer, promised Danny something like that, but it's just not possible to get State Governments and Federal Governments to agree on who funds the extraordinary amount of money that would be needed for national databases across a range of health priorities.

STEVE CORBETT: I'm Steve Corbett from the Sydney Western Area Health Service. In other health domains, such as public health or occupational health and safety, food safety, the precise definition of the regulatory architecture is in an appropriate Act, a legal instrument which gives force to a regulation, including metaregulation. Is there a need to do that in Australia across the board?

ALLAN FELS: You probably know more than me, Bruce, but we, of course, came across this in looking at the surgeons, and indeed the reason that we were able to poke our nose into this area was that the system was not established by statute. If it had been, then there would have been automatic protection of it from the Trade Practices Act. Now, we tried to document to some extent, and we got plenty of cooperation, actually, on how the system works, although I still think it was a fairly incomplete report. So my impression is that the overwhelming answer to your question is, yes, there is a vast area in medicine where the system of regulation and governance is not fully stated and it's not helped by the great complexity of the system.

BRUCE BARRACLOUGH: It is the complexity of the organisation of the system, not the complexity of what we do that is the problem.

Yes, you're right, it would be great if we had a food authority that had the statutory and regulatory power to do this, but it took years to get that agreement by the states, and any change in that takes years to actually sort out. So to get the statutory and regulatory authority for some body like CASA for the airlines, for healthcare is really a pipe dream, I think. Every one of us that works in healthcare has probably got two or 300 different items of regulation that we need that applies to our activity every day. We've got nine sovereign governments rapidly increasing the amount of regulatory activity that's going on, and numerous other regulatory players in that extraordinary pyramid that John Braithwaite has developed applying to us as well. I think we must accept that this is never going to be simple. I think that given that we've accepted this is not simple, let's actually look for the way through so that we can get this to work properly. The metaregulatory exercise is probably a significant way through, based on continued professional self regulation, in much the same way as happens in the finance world. If you change the currency from money to safety, it's easy.

ALLAN FELS: Yes, I just also was going to say that this is an area par excellence where this issue of optimising the mix of self regulation and external regulation is really challenging. If it's all done just by self regulation, then you'll get a mixture of results. Sometimes it works very well, other times very, very poorly. On the other hand, if you just try to do it all by external regulation, it's impossible, there is so much of it. Also it kills off the efforts made on a voluntary basis by many committed people to make the system work well, and so you have quite a complex set of trade offs in this area. The financial system has had the same thing, it's a bit simpler there, but it has this mix that some self regulation is good, others it is just pretentious and to ward off external intervention, and then the external intervention has had

mixed effects and, in some cases, has stultified good work that would otherwise have occurred.

JIM GILLESPIE: I'm afraid that this will have to be the last question or comment because we're running a bit out of time. But there will be further time after that.

VIOLA KORCZAK: Viola Korczak from the Australian Consumers Association. This question is directed more at Bruce: I agree with the need for a change in culture, especially in more consumer involvement, for example, reporting adverse events. I just wanted to ask you to comment on the decision to cut the funding to the Adverse Events Line, given that there are similar mechanisms in the US and UK and other countries, and what is the rationale for it?

BRUCE BARRACLOUGH: What's being referred to is something that council funded, both some research to show that it was appropriate, and then some activity to allow consumers to report adverse medication events directly to people who were managing (indistinct) Queensland. It was separate from people asking for advice about medications, but in fact it was in the same room, fortunately, and so the same people were performing much the same function. But it was a magical experiment. It worked, it showed that consumers could effectively report adverse events in their own medications and they were almost as accurate as doctors in doing that in terms of the number of activities that needed to be reported from other authorities (indistinct). So it was a very successful exercise.

Council was coming up to its finish. The evaluation was largely not completed at that time and I haven't even seen the results of that evaluation. But my understanding of some preliminary information that I had was that part of a recommendation was that the event line was used for people to seek advice when problems were happening, whether they were toxic or not, and there was a more efficient way of providing the same service. I guess that something like Council isn't a long-term funder of implementation of initiatives that it might put on the table. Even the new Commission is unlikely to fund that. They would see that as an implementation task for one or other of the (indistinct) governments. The catalytic groups, like Council, has limited funds and can't fund every really good and effective idea that's out there. There are millions of them. There are so many good people with good ideas that work, you would have to make a selection. Then it's up to government, following the will of the people, one assumes, that fund the long-term activity. I think the consumer movement will need to keep pushing government, rather than the catalytic bodies, to get that funding.

JIM GILLESPIE: Right. I think we'll have to end the session at this point, so I'll thank both of the speakers for a very illuminating session. We'll now ask Dan, who now has got the very pivotal job of to sum up or give thoughts on what's happened in the last day or so.

DAN FOX: Thank you. It is I, Dan Fox, who stands between you and lunch.

But I want to thank everyone for contributing to my education.

I will not summarise because you're all smart people and heard everything and took it all on board. I want to make a few comments, as I did yesterday during the discussion period, tell a few war stories, and then come back and in one sentence and only one sentence, say, "See, I was right in what I told you yesterday," but you could expect no less from a keynote speaker.

The first point from this morning's discussion led me to observe that for all the problems in public and private insurance in Australia that Mary Anne and Andrew talked about, two financing mechanisms that I wish on nobody are experience rating and medical underwriting Listening to your thoughts on how to make a very good Australian system a better system, reminded me of one of a generalisation that I didn't make as clearly yesterday as I wish I had, so I'll take advantage of a second shot: every country's health policy is unique, but in a global context. Both parts of that sentence, I think, are equally important.

The chronic disease discussion reminded me of a humiliating moment in my professional life. In 1985, I had just finished reading page proofs of the book in which I summarized my research and thinking about the first global health policy, hierarchical regionalism. I was feeling good because most of the health policy literature emphasized vested interests. Some of it also addressed the behaviour of institutions. I had added a third category--ideas: and in particular governing ideas that become beliefs and that inspire people to act. Such ideas make particular policies seem to be the right thing to do. They also make particular clinical intervention seem like the right thing to do.

Feeling good, I was unprepared for the next thought to hit me: I had left out illness, like everybody else did. I assumed that there was a burden of disease and that ideas, interests and institutions respond to the burden of illness. As you can imagine, having spent the better part of five years on this project, I was not going to throw away the proofs, tell my publisher, "Wait another year and I'm going to think through the problem of illness as a fourth driver of health

policy." I persevered in my research, informed by political practice, and later concluded that a good part of health policy globally, over many years, had been devoted to the denial of the complexity of the chronic disease and the complex responses required to address its human manifestations, as Steve so elegantly put it this morning.

I'm will tell you another story about how I belatedly realised the importance of chronic disease. It's a little bit like when Christopher Columbus and his three little boats were approaching the shore of the West Indian Island that they mistook for a place where they were more likely to get rich than dead. One of the people who would later be caller Amerindians watching these guys row toward the beach, said to his buddy, "What is this stuff about Columbus discovering America? I thought we were already here." Chronic disease was there. But we make pictures in our head. We think about disease in metaphors, and I learned this the hard way. I was helping to make AIDS HIV policy for New York State, just as I, sort of, ruefully returned my page proofs to Princeton, New Jersey without making changing them to say, "Whoops, I forgot disease." I was helping to make AIDS HIV policy for New York State, the jurisdiction that then had the largest number of Americans who were infected with the disease. I did two things: Part of it got me into trouble, I'll tell you about that first, and then I'll tell you the part that got me more deeply into chronic disease.

The part that got me into trouble was that San Francisco had a coordinated care system for persons with AIDS. This system was integrated, from volunteer care givers in neighbourhoods up through the hierarchy to the AIDS wards, of San Francisco General Hospital, which was a University of California teaching hospital. My masters and I decided to come as close as we could in N to replicating what had happened in San Francisco because of a very together gay population and a strong Health Commission of the City and County of California chaired by Phil Lee, who, under both Lyndon Johnson and Bill Clinton, was the nation's senior health policy official. I called Phil, a friend and mentor, and said, "If I can persuade New York State to send every senior official involved in making AIDS policy to San Francisco for a weekend can you lay on everybody, from the people who organise the volunteer care givers, on up through all of your colleagues at the University of California, San Francisco? He said, "That sounds really great, and there are lots of good gay bars to go to in the evenings to talk to bartenders about the uptake of condoms in the bowl on the bars."

My colleagues in state government, were terrified that they would read on page 1 of the New York Times: "12 senior officials have a long weekend in San Francisco at the expense of the

taxpayer."

The second thing I did, was help to make AIDS a chronic disease story: One of the other things I did as part of my job was to ask , "What's is it really costing us to treat AIDS?" We were getting wild cost estimates that were feeding bigotry about a gay plague . I organised a health services research project to count what was spent on AIDS patients in four very different hospitals in southern New York . The institutions were not very happy about this, but the study was paid for by the major private sector payer in the state and the major public payer.

At that time the average length of life for persons with AIDS from diagnosis to death was 18 months. As I looked at the data from the cost study it became clear that I was looking at data about chronic disease. I was not looking at a plague. I was looking at a disease that, in only 18 months, afflicted patients with the terrible experience of progressive intermittent frailty; of being in and out of institutions of various kinds and of often being in the wrong place-- an acute hospital when they could have been in a nursing home, or at home receiving healthcare of various levels of technological complexity.

You can read about this in a book that I co-edited, called AIDS, The Making of a Chronic Disease. I tell the story of how I started taking my slides to oak-panelled rooms all over the United States and telling America's health policy establishment and research policy establishment, "Hey, look, we got a chronic disease here, we don't have a plague. Change the model in your head because as we learn more about how to control this disease, as the science gets better, patients will live longer. AIDS will be a chronic infectious disease like tuberculosis." As Bruce absolutely correctly picked out in his talk the progress of science is important to making our regional health hierarchies more effective. So it was in 1986 and 1987 that the scientists supported me about AIDS as a chronic disease, in particular Bill Haseltine a distinguished researcher at the Harvard Medical School who had been thinking about analogies between diabetes and AIDS.

What I'm emphasizing is the importance of perceiving chronic disease as an experience that people have from onset through a lot of adventures, some of which are not entirely unpleasant. I think that's the moral of what Steve said so well today.

I had another lesson about making policy for chronic disease in 1990 and 1991/ Soon after I became president of an endowed foundation, the Chairman of the Republican Party National

Finance Committee told me, "Sometime in the warm weather of this year, the US Congress and the President is going to sign the Americans with Disabilities Act. What can the foundation do to help implement the Act?" The Disabilities Act had overwhelming support across the political spectrum, led by Senators Bob Dole and Tom Harkin, members of opposing parties who had a common experience: Dole was , a severely wounded veteran of World War II; Harkin had a brother who had severe hearing loss. They just made the new law and my organization helped to mobilize public and private sector groups during its implementation. The disability and chronic disease causes had merged.

As a result of a very successful implementation effort, Steve's patient would have had no trouble getting the grab bars in the bathroom because they are required by local housing codes as a result of the Disabilities Act. If the house was built after 1990, the builder would have had to install them. Whoever the patient rented from, if he rents, and the house was built before 1990, if the patient said, "Put them in," they were installed. We discovered the importance of universalising responses to the disabilities that people are going to live with as a result of chronic disabling conditions, however they acquire them; at birth, before birth, or as a result of their behaviour .Everybody in America now appreciates kerb cuts. Wide stalls in public restrooms are great places to change clothes.

I am not starry eyed about this. On the down side, I organized a project with a several huge American corporations to see if we could document a business case for chronic disease prevention, early detection, care giver support, and care coordination; a case, that is, that we could measure in dollars. The current jargon is to increase "presentism" as opposed to absenteeism in the workplace. We published evidence from companies that had done this successfully. We tried to make our article o convincing that chief financial officers of other multinational corporations would be persuaded to pay for population health improvement among their workforce. But it is still anathema within the business culture of the United States.

Somebody raised the question earlier today about models of care around the world. In general, the organization of care is driven by funding and regulatory policy. For example we had proliferation of nursing homes in the United States as a result of a Federal financing policy that forced just about everybody with a serious chronic disease to have longer stays in nursing homes than they needed because there was no pay for care outside facilities.. But models evolve. I told a story, yesterday, about Dave Lawrence, after he became CEO of Kaiser Permanente, saying he could address variation in clinical behaviour because he had command

of his organizational culture, the medical side and the hospital and business sides.

Someone also mentioned Ed Wagner visiting Australia and being impressed by the management of chronic disease. Just after David Lawrence became CEO of Kaiser, he and I went to Ed, who is based at an integrated delivery system called the Group Health Cooperative of Puget Sound. We asked Ed to "write down what you know about models of addressing chronic disease;" that was the first publication of Ed's chronic disease model. What I've watched over the last 10 years is the process by which the model improves when Ed comes back from Canada or Australia, or Germany and says, " I learned something that I can incorporate into my thinking about the model." That is a living example of cross-national pollination.

Bruce and I met at the convening meeting for the WHO global effort to improve patient safety. It was an interesting meeting because people from every country said the same or similar things; clearly there was an international movement . Each country was doing its variation on an international theme: promoting changes in the culture of healthcare organizations. But you do have some authority; culture change is not entirely, perhaps not even primarily, a result of voluntary action. The leaders of the quality movement have the authority of being created or endorsed by the demand side of the health sector and the authority of solid knowledge. What is being created, and what Bruce talked about so brilliantly, is a system of collaborative regulation, which is demonstrably more effective than a system of identifying harms and punishing people who perpetrate them.

In the first week of August of 2000 I had an urgent call from the Under Secretary of the US Department of Agriculture. She said, "I didn't know anything about you until yesterday, but a lot of people in this town tell me that nobody should get involved in what I'm about to tell you." This is a regulatory story and it's a story about culture change and it's a story about safety. In 1993 there were deaths in the states of the Pacific North West as a result of e-coli poisoning acquired from hamburgers sold by a fast-food chain. The Under Secretary was a food scientist. As a scientist, she was distressed that since 1906 US regulatory policy had assumed that any pathogen that could harm a human being or reasons to suspect the presence of such a pathogen would be visible to the naked eyes the probing touch of federal inspectors, whom the law required to be on the production line at every plant that packs meat, poultry and eggs, from the time it opened to the time it closed. The Under Secretary and her colleagues, borrowing from the food and the airline industries, introduced a form of root cause analysis and

made that the basis of a new regulatory system.

That new system was about chickens, cattle and pigs but it is relevant to health care. The feds rolled it our, first, to big packing houses where senior executive had MBA degrees and thought this was terrific to do science-based collaborative regulation. They wanted to show the federal inspects the cultures they had made to detect bacteria and they wanted show them electronic records; just as you would do in a hospital that prioritized safety and quality.

Then the feds rolled out the new regulations to the next tier. By now we were at about 1997. The next year there was a little resistance. Finally, in 1999, the Department of Agriculture took a deep breath and applied the regulations to the mom and pop meat packing houses. When she called me in August 2000, the Under Secretary said, "We had 58 incidents of violence against FSIS(Food Safety Inspection Service) staff over the last year. They culminated, yesterday, in Mendiceno, California, where an irate sausage maker shot and killed three inspectors." You think it's tough in the health sectors All the Under Secretary wanted us to do was to find a way to reduce the incidence of violence secondary to the implementation of regulatory system based on the scientific methods of root cause analysis. I used one of the oldest tricks in the political playbook, I said, "Let's find the 20 to 30 people in the country--union leaders, management, consumer advocates-who can make this happen. Let's lock them in a room and say, 'We're not going to let you out of the room until you agree on a process to address the causes of the violence,' and then we'll come back in two weeks and we'll talk about how we're going to implement the process and then we will implement it. ." I'm happy to say that the new Secretary of Agriculture in the Bush Administration told a committee of the US Senate eight months later that there had been no violence since the murders . But improving safety and quality is hard. A federal Court judge appointed by the George Bush threw out the regulatory system because people should be responsible for their own behaviour and cook meat to temperatures that kill pathogens.

In sum, I heard a great deal today that confirms my hypothesis that if the demand side of the health sector requires greater accountability for quality on behalf of the public, the supply side will, with effort and difficulty and grace and diplomacy and sometimes a little snarling, come along. Thank you very much.

STEVE LEEDER: Thank you very much, Dan, for those war stories and for the wisdom that they impart, and thank you, indeed, for a wonderful visit. We're deeply appreciative of you spending the time with us.

As Dan said, the only thing that stood between him and us and lunch was him, so just to conclude I would like, on your behalf, to thank Diana, who has been the chief organiser of all of the technical background to this wonderful seminar, and to say to you that I don't think alcohol is going to be served with lunch, is it, Diana? But if you're very nice to her, you might be able to get a glass of this from her (presents her with a bottle of wine).

Jim Gillespie has played a major role in conceptualising and putting the seminar together. Jim, we're very grateful to you for that, and, Bob, for your support, and of course to John Coghlan and Sandra McKenzie from the Menzies Foundation. So to all of you, to all who have participated as formal speakers or informal contributors, my thanks and I wish you journey in safety. Thank you very much.

oo00oo