

REALITY BITES: TRANSLATING ELECTION COMMITMENTS INTO HEALTH POLICIES AND PROGRAMS

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What I would like to do today is to set the stage for the input from our expert panel and what I hope will be an interesting question time with the audience.

In setting the stage I would like to address, at least briefly, these issues:

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- Outline of election promises
- What has happened since the election
- Timetables around various commissions, advisory groups, the new Australian Health Care Agreements, etc
- Possible approach to AHCAs and other SSPs
- Budget constraints
- Other constraints – PHI rebate, workforce, emphasis on fee-for-service
- Doing more than bandaid fixes – will promised actions get the reforms needed?
- Back to the future – reinventing the Sax Commission
- Lessons from elsewhere

In future seminars in this series we plan to look in detail at how we might move to get the specific changes in the health care system that are needed.

Changing the health care system, even in the absence of reform, is no easy task. I think the best analogy for the health care system is that it is like a naval flotilla, with the federal health system as the aircraft carrier that takes forever to change direction.

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Without belabouring the analogy too much, although it's fun to try, let me just make two points.

One: if the naval flotilla does not have a sailing plan that is agreed to by all, and a strong admiral at the helm, then there will be chaos.

And two: no matter how modern and up-to-date your ships and equipment are, you will still need life jackets that work, and real sailors to run the show.

I'll leave the rest of the analogies to you.

Let's begin with an outline of the Government's election commitments.

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My blunt assessment of Labor's election commitments in health is this:

They got off to a good start when forced by John Howard's actions over the Mersey Hospital to put forward a policy on public hospitals.

Labor's policy outlined a partnership approach under which the Commonwealth and State and Territory governments will work together to end the cost and blame shifting in health care.

The package offered a carrot (\$2 billion in additional funding) and a stick (meet these reform standards or be taken over) to help the States and Territories address the problems currently facing public hospitals.

And it offered a process for reform through the National Health and Hospitals Reform Commission.

Explicit in the National Health Reform Plan was a process for moving the funding relationship under the Australian Health Care Agreements towards a greater focus on patient outcomes by offering financial incentives to the States and Territories to implement programs to reduce avoidable hospitalisations and readmissions; reduce non-urgent emergency department presentations; tackle waiting times for elective surgery; and help get the frail elderly out of hospital into residential aged care.

And implicit was the recognition that hospitals do not deliver health care in isolation from general practitioners, dentists, community health services, and community and residential services for the aged, the disabled and the mentally ill.

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Arguably that was the policy high point. After that we got six weeks of piecemeal policies, and local funding commitments that added to the multitude of health programs and ate into the \$2 billion commitment to the National Health Reform Plan, but did nothing to build on the earlier commitment to strengthen and reform the health system.

But that doesn't mean this won't happen. Commitments to have an expert taskforce develop a National Preventative Health Strategy, to make obesity a National Health

Priority, and work with the States and Territories to ensure an integrated approach to the delivery of mental health services will make a real and positive impact – if and when they move beyond words into action.

I can say from personal insight that no new government can come into office from a decade in Opposition with a complete suite of fully-developed and fully-costed health policies. So rhetoric and obvious down-payments are important.

But there is a healthy skepticism in the electorate about what will, post election, turn out to be core and non-core promises.

What has happened since the election?

As a first observation, I note that the Prime Minister's office remains the key driver for health policy, indeed for most policy initiatives. This is both a plus and a minus.

On the plus side of the ledger: policy is happening at the highest levels, and this helps to ensure funding and coordination across portfolios. And it enhances the idea that the buck stops on the Prime Minister's desk.

On the minus side: it is too easy to sideline the expertise and knowledge that resides in the Ministers' offices and the Departments and to have announcements rushed out of the Prime Minister's office with little consultation with stakeholders.

And as a general observation, I would note that real progress is only achieved when politicians are able to steer the delicate course between endless talkfests and making decisions in isolation without due consultation.

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Arguably the most important announcements from the government since the election have been around Indigenous health

I think we are all entitled to feel as a consequence of the verbal and financial commitments to date that the Rudd Government has really accepted the challenge to reduce the health inequalities between black and white Australia.

The Prime Minister and all his Cabinet, together with outside experts, now must begin the long-term task of addressing social justice and economic independence, the medium-term task of building sustainable services and infrastructure, and the short-term task of delivering needed public health measures and primary care. And they must do all of these things simultaneously.

This must be a genuine whole-of-government effort, and the seemingly small issues such as treatment for ear infections, dental caries, eradication of trachoma and anti-smoking

programs cannot wait for new housing and better water supplies but must be delivered now, even as the push is on to build capacity and sustainability, especially in isolated communities.

My biggest concern is that the focus is always to the north. Almost twice as many Aboriginal and Torres Strait Islanders live in NSW as in the Northern Territory, and 40,000 of these people live in Sydney. The targets that the Rudd Government has bravely set will not be met by efforts concentrated in the Northern Territory. Yet I hear little about how to address urban needs and issues.

Juggling prevention and treatment

For Indigenous health as for health reforms in general, the real issues lie around bringing together the programs and policies that address health and wellbeing with those that treat and manage people who are sick.

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This was acknowledged in the Fresh Ideas, Future Economy paper on prevention issued during the election campaign. *“Keeping people well, in addition to treating and managing those who are ill, must become an express, dual purpose of Australia’s health system. This objective needs to underpin both the Australian Health Care Agreements and Medicare.”*

Timeframes

As the Government moves to tackle these issues and election commitments on hospitals, prevention and primary care, they are immediately confronted with a set of problems around timeframes and information flow and required funding agreements.

The Rudd Government has made it clear that the next AHCA will extend well beyond mere financial agreements through which the Commonwealth hands over money to the states for the operation of public hospitals.

There have of course been dark mutterings from previous mandarins at both levels of government about whether this is possible. The reality of the proposed partnerships is easier said than done (they are about money after all). But no-one wants a repeat of the 2003 debacle over the AHCA, and the public just wants things to work. It is certainly only possible if there is agreement about the policies that the AHCA are to implement and the performance indicators that will measure the success of these policies.

And there is a big deadline looming with the current set of Australian Health Care Agreements (AHCA) due to expire on June 30.

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The timetable as we know it looks like this:

COAG met today. The newspapers had all the news ahead of the communique, although behind closed doors there was certainly some less collegial discussions around money and indexation, who needs more and who is unfairly getting more, how those who perform should be rewarded, and what punishment will befall those who do not meet the performance criteria.

We should not forget that COAG has set up a workgroup in health, chaired jointly by the federal Minister for Health and NSW, whose work is expected to feed into that of the National Health and Hospitals Reform Commission.

There are ongoing meetings of both the Australian Health Ministers' Conference and the Australian Health Ministers' Advisors Conference. The most recent of these was held at the end of February, when AHMC set up a series of 'areas of focus'. We know that these meetings have had what has been described as 'robust discussion' around performance indicators and reporting requirements.

The 2020 summit will meet on April 19 -20. The hope is for new ideas and a vision for the future. Whether or not these result, and whether or not these are then subsumed into the government's future plans is a big unknown.

We would assume / hope that the findings of the 2020 summit's 100 health gurus will be fed into the work of the National Health and Hospitals Reform Commission.

The NHHRC has been asked to provide some advice on performance measures for the AHCAs by April, and the Australian Institute of Health and Welfare has been commissioned to do some of this work. The timelines are very tight for issues that are both important and controversial. The NHHRC has been told to focus on elective surgery, aged and transition care, and quality.

The NHHRC is required to provide an interim report by the end of 2008 and a final report on long-term reforms by June 2009.

But where is the agenda on prevention and primary care in all this?

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Prevention and primary care

The Government has committed to a raft of initiatives in prevention and primary care, including a National Preventative Healthcare Strategy, a new Preventative Health Care

Partnership with the States and Territories, a National Primary Health Care Strategy, the reinvigoration of the role of the primary care system, and treating preventive health as a first order economic issue is clear. This commitment encompasses all aspects of prevention, from primary to tertiary prevention.

And since the election Minister Roxon has stated her determination to shift prevention from the margins to the centre of health care.

However I would argue that the benefits of the proposed prevention agenda will only be realised if there is greater clarity as to what constitutes preventive health activities, who is responsible for carrying out the preventive agenda, and how it is integrated within the health care system.

I make this statement because there really does seem to be some confusion about what the Health Minister means by what she insists on calling her 'preventative health agenda'.

Several of us have been engaged in quite an animated discussion over the need to foster a common understanding of prevention terminology across the continuum of prevention and care and to address the confusion that arises when other terms such as preventive health, population health, public health, primary health care, primary care, early intervention, and chronic disease management are also used.

Is the preventive care that will be delivered by GP Super Clinics about keeping patients fit and healthy through fluoride in the water, better nutrition, anti-smoking programs, tackling binge drinking, and ensuring everyone gets their vaccinations and mammograms (primary and secondary prevention activities) or is it about reducing the negative impact of established disease by restoring function and reducing complications, thus preventing unnecessary hospital admissions (tertiary prevention)?

It's not clear.

Which part of the workforce is best responsible for these different activities, and what are the consequences if we think that it can all be done by GPs and practice nurses?

And where does the funding come from for each of these activities? Will it come from Special Purpose Payments (SPPs) such as the Public Health Outcomes Funding Agreements (PHOFAs), from Medicare, or from some other route?

These are very timely questions, given the drive by Treasury to have the PHOFAs and other health-related SPPS rolled into the AHCA's.

This proposal makes some people very nervous as it could mean even less money for public health. But on the other hand, it also offers the prospect of finally having incentives to measure the value of an investment such as flu vaccinations for the elderly and its impact on attendances at Emergency Departments and hospital admissions each winter.

And so we are back to the issue of performance indicators for the AHCAs. It seems that these will need to also encompass prevention activities. In fact I think that there are some who would say that unless a strong set of performance indicators for public health programs is part of the new AHCAs, any attempt to role the PHOFAs and other SSPs into the AHCAs will simply see prevention money spent on clinical priorities.

Mental health commitments

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The Health Minister has committed to: putting mental health on the COAG agenda, an integrated approach to service delivery with the States and Territories, the establishment of a National Council on Mental Health, a focus on prevention and early intervention, and an evaluation of existing mental health services.

Will these commitments on mental health be delivered in isolation from the rest of the health care reform agenda?

Before I get to what I think the most likely resolution of these issues is, I would like to talk just a little about budget constraints.

Budget constraints

This government has a mantra around economic responsibility, and we have been warned that the May Budget will be tough. It's also not clear what impact the looming US recession will have on Australia's economic situation this year and into the future.

There is no doubt that election promises will be delivered. But everything else will have to be paid for by budget cuts or reworking current programs.

With respect to the AHCAs, it should be noted that funding for these would have been included in the forward estimates developed under the Howard Government, presumably with the current indexation levels, so I don't see much possibility for any new financial largesse there.

What will happen with the Australian Health Care Agreements?¹

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¹ Note that this seminar was presented before the communiqué from the March 26 COAG meeting was released. The predictions made do not exactly match the COAG commitments in health.

Here's my prediction.

- The Government will put a new set of agreements on the table by June. It's my understanding that any new agreements will require legislation.
- These will include a set of performance indicators for addressing elective surgery, accompanied by the increased funding (\$150 million) already announced for this work.
- There will also be \$200 million for systematic approvals such as construction of day surgery units, as promised during the election.
- It will also include federal funding for the 2000 transition care beds promised during the election, and the states and territories will be allowed to keep the savings that will result (estimated at \$937 million a year) provided that these are reinvested in health.
- There will be \$25 million for follow-up colonoscopies for bowel cancer screening, as promised during the election.
- The prevention agenda will be addressed by rolling the PHOFAs and other SPPs up into the AHCAs (which will also help give the impression that funding has increased). States will be told that this will help them achieve efficiency dividends which they can claim as increased funding.
- There will be a new set of performance indicators around elective surgery, transition beds, quality and safety, possibly e-health and the promise of \$300 million in dividend payments to States and Territories that meet reduction targets.

Other than that, there will be no increased funding or changes in indexation.

We now know that the AHCAs will be rolling agreements with periodic reviews of performance. The States and Territories will push for as much financial certainty as possible, and limited reporting against performance indicators. It is not at all clear to me how you put teeth in these agreements.

The proposed structure of the new, enlarged AHCAs will make it easier for the Government to slot in policy changes and reforms without having to wait for five years.

It also means that the long-term reform agenda will be a set of promises based on "we will assess the advice that is provided to us in the future" (ie June 2009). Look to the government's behaviour around the Garnaut report as an example.

Perhaps we should hope that the people on the NHHRC are able to sell the findings of their report as effectively and persuasively as the people on the Lockhart stem cell review did.

Other constraints and issues

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There are a raft of other issues and constraints that the Government will face.

Key amongst them are:

1. The growing cost of the private health insurance (PHI) rebate.

At a cost of \$4 billion a year, this is a budget item that can hardly be excluded from the debate on health reforms.

It is possible that if the Rudd Government really can improve the performance of public hospitals in demonstrable ways, then working families, with budgets already under pressure, will respond by dropping their private cover. That will bring a different set of problems for the government to confront.

However with election commitments made to keep both the PHI rebate and the Medicare safety net, don't expect the government to voluntarily bring forward either of these issues. We will have to rely on the 2020 summit and the NHHRC to put these issues on the table and to bring pressure to bear for them to be addressed.

2. The consequences, especially for prevention and management of chronic illness, of the current emphasis on fee-for-service.

Linked to this is the commitment made by the Health Minister to review the number of items currently on the Medicare Benefits Schedule (MBS) and to look at how these are reimbursed. I understand that this work is currently being undertaken in-house by the Department of Health and Ageing.

My expectation is that any proposed changes would only go forward if this could be done in a cost neutral way, where there would inevitably be winners and losers to fight over the consequences.

However it might be possible to do this in such a way that increased MBS fees meant diminished out-of-pocket costs for patients, and thus were offset against savings to the Medicare safety net. Achieving this outcome would be much more difficult.

3. We should note that no-one is currently talking about the Pharmaceutical Benefits Scheme (PBS). So in this environment discussion of PBS reforms must wait for another day.

Will promised actions get the reforms that are needed, or will we end up with more bandaid fixes?

This really is the key question. At the moment I think we have to say that there is an exciting possibility for some real reforms and needed shifts in focus and funding in health.

Clearly there will be changes and new policies. We need to push this Government to do a much better job than the previous one in terms of assessing the impact of these changes and policies.

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That is why my colleagues and I have made in the case, in an article published last December in the Medical Journal of Australia, for an Office of Accountability for Health, modeled on the US Government Accountability Office. The GAO's work includes oversight of federal programs, insight into ways to make government more efficient, effective, ethical and equitable, and foresight of long-term trends and challenges.

That is why it is important that longitudinal studies such as Bettering the Evaluation and Care of Health (BEACH); the Australian Longitudinal Study on Women's Health; the 45 and Up Study; and the National Nutritional Survey are funded so they can continue into the future.

That is why it is important that the NHMRC funds more health services and health policy research.

And that is why it is important that the public health research and the program evaluations done by health departments are not kept hidden, even from Freedom of Information requests, but are available for public scrutiny and learning.

A proposal about what should happen.

Back to the future – reinventing the Sax Commission

One of the approaches taken at the very beginning of the Medibank / Medicare system provides some instructive insights into how an independent and expert advisory committee can work long-term within the current political and federal system.

To the extent that the National Health and Hospitals Reform Commission has borrowed the name of this earlier committee, it may also pay to look at what else can be borrowed and utilized.

The Hospitals and Health Services Commission (often known as the Sax Committee after its Chairman, Sydney Sax) was established by legislation and had three full-time and six part-time commissioners.

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Its work was described as “a judicious blend of study and action”. The Act under which it was established gave the Commission wide ranging powers relating to health planning, the provision of advice, and the making of grants.

It was a remarkably successful organization. It demonstrated the value of a federal level entity capable of analyzing data, developing appropriate policy proposals, translating them into program and implementing rigorous evaluation mechanisms in close coordination with numerous public and private organisations.

It established working parties, of commission members only, chaired by a full-time commissioner, standing committees, chaired by a full-time Commissioner, and advisory committees.

In 1974-75 the Commission distributed funds of \$140 million, about 9% of the total federal spend on health in that financial year.

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Here is how former Commissioner Richard Southby outlined the pros and cons:

Positives:

- A comprehensive approach to national health policy development, based on analysis of data and widespread consultation
- Emphasis on planning and evaluation of health services
- Considerable cooperation between commonwealth and state levels of government.

Negatives:

- Ability to bring about change slowed by the federal system, especially in relation to financial arrangements.
- Dismissal of Whitlam lead to its eventual disbandment.

I would argue that the Government should consider morphing the NHHRC into something like the Sax Commission, with appropriate standing committees to address Indigenous health, mental health, prevention, primary care and workforce planning. They could also take on the sort of work that we proposed for the Office of Accountability for Health.

Lessons from elsewhere

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While Australia's health care system is not much like the National Health Service, there are many analogies between what Australian Labor has promised to deliver and what British New Labour has been working towards for most of this decade.

The health system that the Blair Government inherited in 1997 after 20 years of Conservative rule was coming apart at the seams. There were long waiting lists, dilapidated facilities stretched to capacity, outdated equipment, underpaid staff, inefficiencies and inequalities. The initial priority was addressing hospital problems, including fall-out from the scandalous cover-up of mismanagement of children's cardiac services at the Bristol Royal Infirmary.

Is this starting to sound familiar?

It should give pause to politicians and policy advisors that concerted reforms in the UK, backed up with substantial funding increases, have been slow to have a real impact and that many positive changes have been accompanied by a raft of new problems and cost over-runs.

Since 2002 the UK government has increased investment in the NHS by nearly 50 percent (more than £43 billion. New pay deals for the health workforce and price inflation account for 43 percent of this extra investment. The achievements are impressive. Commitments to increase the health workforce have been met with 9,500 more doctors, 20,000 more nurses and 6,500 more allied health professionals. Three quarters of MRI and CT scanners are new and 100 new hospitals and 3,000 more GP premises have been built. As a result of increased resources, the health of the population has improved, targets for increased numbers of procedures have been exceeded, and elective admissions and outpatient attendances have increased, and waiting times for inpatient and outpatient treatment have improved considerably.

However the expected productivity gains have been elusive and decreased costs for hospital services have not been realized. Savings have not been made because the proposed e-health program, recognised as key to productivity improvements and health gains, is well behind schedule and because the recommended framework of public health objectives for tackling the prevalence of important determinants of health status – things like smoking, obesity, physical activity and diet – was not taken forward. The overall assessment, made last September by Derek Wanless, is that if health policy remains focused on what he sees as short-term imperatives, health care costs will continue to rise.

The ongoing NHS reform saga of the past decade holds many lessons for health reform in Australia that should not be ignored.

Administrative reform of the public health functions of government

A number of countries have recently taken a bold approach to ensuring that preventive health gets the impact it needs by separating out the public health function from the administration of the rest of the health system.

Sweden has a Ministry for Public Health and an independent Institute of Public Health. This is backed by a National Public Health Policy and a legislative requirement that the public health impacts of all political decisions are considered.

Canada has a Minister for Public Health and a Public Health Agency within the Health Ministry. The Agency was created in 2004, following a report on the SARS outbreak (ref) and it represents a new approach to federal leadership and collaboration with the provinces on health issues.

In 2004 the UK Government produced the public health white paper, *Choosing health* which sets out a commitment to reduce health inequalities and better tailor health and care services to meet individual needs, together with the actions that individuals and organisations could take to make this a reality.

The Blair Government took three important steps to ensure this happened.

To ensure what it calls ‘joined up action’ across Government bureaucracies, the Secretary of State for Health coordinates action through the Cabinet Sub-Committee set up to oversee the development and implementation of the Government’s policies to improve public health and reduce health inequalities.

To avoid the risk that in some cases, interventions may contribute to widening health inequalities, government departments, and particularly the Office of the Deputy Prime Minister and Department of Health, must ensure that initiatives and programs are health inequality ‘proofed’ so that any negative effects on health inequalities are recognised and addressed.

In addition, health is included as a component in regulatory impact assessments.

The British approach to ensuring that health is included in the regulatory impact assessments is a crucial one given that non-health factors related to the social and physical environments in which people live and work are key determinants of health but these environments are shaped by policies which are often developed and implemented without regard to their health implications

Conclusion

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Australia is posed at the beginning of a major voyage into health reform that has the potential to deliver very real benefits in terms of health outcomes and quality of life.