

# Translating Election Commitments into Health Policy and Programs

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*As the Government moves to tackle its election commitments in health, it must juggle the information flow from a raft of new working groups, advisory committees and commissions, assess and develop policies, and then implement agreed policies and performance indicators into funding agreements. This paper examines the issues that are likely to arise in this process.*

## Introduction

Labor's election policy on health reform was driven by the problems currently facing public hospitals. It 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 (AHCAs) 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 to help get the frail elderly out of hospital and 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.

To that end Labor also committed to an expert taskforce to develop a National Preventative Health Strategy, making obesity a National Health Priority, a National Primary Health Care Strategy, and working with the States and Territories to ensure an integrated approach to the delivery of mental health services. All of these proposals will make a real and positive impact – if and when they move beyond words into action.



## Developments since the election

**Arguably the most important announcements from the Rudd Government since the election have been around Indigenous health.**

The Government has really accepted the challenge to reduce the health inequalities between black and white Australia, and has committed to closing the gap in Indigenous life expectancy within a generation (by 2030), halving the rate of infant mortality by 2018, and ensuring that Indigenous people have the same access to health services as the rest of the population by 2018.

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 decay, 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.

It is also imperative that the focus is not just on the issues in the Northern Territory. 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 ambitious targets that the Rudd Government has set will not be met by efforts concentrated in the Northern Territory. Yet to date little has been said about how to address urban needs and issues.

## Timeframes

As the Government moves to tackle these issues and election commitments they are immediately confronted with a set of problems around timeframes and information flows and required funding agreements.



There are now a raft of new working groups, advisory committees and commissions looking at health reform issues.

The Council of Australian Governments (COAG) has set up a working group 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 (NHHRC).

There are ongoing meetings of both the Australian Health Ministers' Conference (AHMC) and the Australian Health Ministers' Advisors Conference (AHMAC). The most recent of these was held at the end of February, when AHMC set up a series of 'areas of focus'. These meetings have had what has been described as 'robust discussions' concerning the adoption of performance indicators and improved reporting requirements.

The *2020 Summit* will meet on April 19 -20. The hope is for new ideas and a vision for the future. It is assumed that the findings of the *2020 Summit's* 100 health gurus will be fed into the work of the NHHRC.

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 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.

The announcement from COAG that the new agreements will be rolling agreements, with periodic reviews, does make it easier to incorporate health reforms into the AHCAs as they are developed.

The Government has made it clear that the next AHCAs will extend well beyond mere financial agreements through which the Commonwealth hands over money to the States and Territories for the operation of public hospitals. However in an early concession next year's set of agreements will not include any performance indicators.

The Prime Minister has also promised the States and Territories additional funding of \$1 billion for 2008-09. However, it is not clear how much of this is new money additional to



election commitments which include \$150 million for elective surgery backlogs, \$200 million for systematic approvals such as building day surgery units, \$25 million for follow-up colonoscopies for bowel cancer screening, and funding for 2000 transition care beds. Presumably the States and Territories will be allowed to keep the savings, estimated at \$937million a year, resulting from the provision of these transition beds.

## Prevention and primary care

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.

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.”*

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. 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 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. For example: 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 preventive care about reducing the negative impact of established disease by restoring function and reducing complications, thus preventing unnecessary hospital admissions (tertiary prevention)?



Which part of the health 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 source? These are very timely questions, given the drive by Treasury to have the PHOFAs and other health-related SPPS rolled into the AHCAs. 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.

Unless a strong set of performance indicators for public health programs is part of the new AHCAs, any attempt to roll the PHOFAs and other SPPs into the AHCAs will simply see prevention money spent on clinical priorities.

## Constraints and issues on health care reform

The Government's commitment to fiscal responsibility will constrain new spending in health, and there is a raft of other issues and constraints to be worked through.

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, despite the election commitment to keep the PHI rebate.

It is possible that if the 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.

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. This work is currently being undertaken in-house by the Department of Health and Ageing.



The 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 make changes 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 difficult.

3. The **Pharmaceutical Benefits Scheme (PBS)**. There are rumours about the Government looking for savings from the PBS and possible PBS reforms. The increases in the PBS co-payments and safety net thresholds put in place in 2005 saw a substantial decline in the number of prescriptions filled, and we do not yet know the impact of this on health outcomes.

## The likely effectiveness of reforms

At the moment there is an exciting possibility for some real reforms and much-needed shifts in policy focus and funding in health. Clearly this Government will need to do a much better job than the previous one in terms of assessing the impact of these changes and policies.

- That is why my colleagues and I have made a case, in an article published last December in the Medical Journal of Australia, for an Office of Accountability for Health, modelled on the US Government Accountability Office<sup>1</sup>. 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.

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<sup>1</sup> Russell L, Leeder SR, Armstrong BK, et al. *The first 100 days: An open letter to the new Minister for Health*. Med J Aust. 2007; 187 (11/12): 608-609.



- 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.

## Back to the future – reinventing the Sax Commission

One of the approaches taken at the very beginning of the Medibank / Medicare system provides some insight 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 utilised.

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. 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 analysing data, developing appropriate policy proposals, translating them into programs 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 Commonwealth spend on health in that financial year.

As it currently stands, the NHHRC is due to disappear after it delivers its final report in June 2009. 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 proposed for the Office of Accountability for Health.



## Lessons from elsewhere

While Australia's health care system is not much like the National Health Service (NHS), 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.

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 Sir Derek Wanless in a report for the King's Fund, is



that if health policy remains focused on what he sees as short-term imperatives, health care costs will continue to rise.

## Conclusion

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. However translating promises into action will require a concerted consultative process on planning and reform, development and agreement on performance indicators, and the ability to move simultaneously on a number of fronts while confronting vested interests opposed to change. The ongoing NHS reform saga of the past decade holds many lessons for health reform in Australia that should not be ignored.

*This paper is an adaptation of a seminar given at the University of Sydney on March 26, 2008.*