

**UNITED KINGDOM – AUSTRALIA SEMINAR**  
**FEDERALISM, FINANCING AND PUBLIC HEALTH**

**SEMINAR PAPERS**

**14-16 September 2003**

**Old Parliament House, Canberra, Australia**

*The views expressed in this report are those of the individual authors and not necessarily those of the Nuffield Trust, the Health Foundation or the Australian Government Department of Health and Ageing*

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## Preface

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In September 2003, the Nuffield Trust (UK), the Health Foundation (UK) and the Australian Government Department of Health and Ageing jointly co-hosted and chaired the United Kingdom-Australia Seminar on Federalism, Financing and Public Health in Canberra, Australia's capital.

The seminar brought together forty invited decision-makers and health experts from both countries to discuss the design and management of changing health economies for better health and quality health care.

Building on a successful trilateral seminar in 2001, involving the United Kingdom, Australia and New Zealand, the Seminar reiterated that there is valuable learning from a collaborative discussion of converging challenges, despite cultural, institutional and structural differences in health systems.

Both countries will experience an emerging burden of chronic disease as the population ages, rising costs driven by new medical technologies and pharmaceuticals and a need to focus more on prevention and primary health care. Against this background, current policy and political imperatives for both countries require governments to increase patient choice while maintaining equitable access, despite increasing pressure on health budgets and rising expectations.

Ensuring the sustainability of financing will be a key challenge for governments if they are to respond to current pressures and expectations and avoid unnecessarily burdening the next generation.

The United Kingdom-Australia Seminar explored these challenges focusing on:

- how health systems can be designed and managed to enable the private sector to play a greater role;
- the capacity of federated or decentralised arrangements to enable health systems to become more democratic, efficient and responsive to local communities;
- designing appropriate incentives and professional skills to support an integrated health prevention, promotion and restoration role; and
- diversification of financing arrangements to facilitate private sector involvement in the delivery and financing of services.

The Seminar provided an insider's perspective on the workings of each country's health system, together with opportunities for questioning the economic, social, cultural and political conditions influencing the directions of reform. This, combined with an atmosphere for informed and intellectual debate, is something that the Internet is not yet able to offer.

We wish to thank the speakers and participants for sharing their expertise and insights and for contributing to increased learning across and between the two countries and their health systems.

John Wyn Owen CB  
Secretary Nuffield Trust, United Kingdom

Mr Stephen Thornton  
Chief Executive  
The Health Foundation, United Kingdom

Ms Jane Halton  
Secretary  
Australian Government Department of  
Health and Ageing

# Seminar Summary

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Lynette Glendinning

*Lynette Glendinning is Director of P.A.L.M Consulting Group*

## 1. Background and Purpose

The United Kingdom - Australia Seminar on Federalism, Financing and Public Health was held at Old Parliament House, Canberra on September 14-16, 2003. Jointly supported by the Nuffield Trust (UK), The Health Foundation (UK) and the Australian Government Department of Health and Ageing, the seminar convened thirty five decision makers and health experts from both countries to discuss the design and management of changing health economies for better health and quality health care.

## 2. Policy Imperatives

The Australian Health Minister, Senator Kay Patterson, opened the Seminar by identifying a number of challenges facing health systems. These challenges include the emerging burden of chronic disease as the population ages, the rising costs of medical technologies such as prostheses and pharmaceuticals and the need to focus on prevention and primary health care. Ensuring sustainability of financing will be a key challenge for governments if communities are to avoid unnecessarily burdening the next generation.

Ms Jane Halton, Secretary of the Australian Government Department of Health and Ageing, argued that Australia must address the challenges of federalism and geographic dispersion as it undertakes system reform. This will demand more rigorous evidence to underpin decisions and improved focus on service quality through consumer and provider

involvement and a strong focus on prevention.

Mr Simon Stevens, Health Advisor to the Prime Minister of the UK, outlined the fundamental shift underway in the UK health system. The UK is increasing health spending to 9.4% of GDP by 2008, retaining the benefits of a universal tax based model, free at the point of delivery. The challenge for the UK now is to undertake major transformation of the supply side of health from a centralised to a devolved service, able to offer wider choice and greater diversity of provision but bound by common standards, tough inspection and shared values.

The policy imperatives for both countries require governments to increase patient choice while maintaining equitable access, despite increasing pressure on health budgets and rising expectations. It will be critical therefore to develop more rigorous evidence to support decisions and provide a basis for measuring the effectiveness of interventions. Equally, there must be a focus on the quality of delivery across both public and private sectors through enhanced prevention and involvement of consumers.

As Mr John Wyn Owen, Secretary of the Nuffield Trust noted, governments in a global economy will need to develop the competence to design and manage reform in health care so that it is both resilient and sustainable. This will require a capacity to address the determinants of health as well as the health system itself.

### 3. Common Themes

#### *Managing the Mixed Economy in Health Care*

Both Australia and the UK are developing health care systems in which both the private and public sectors have a role to play. These emerging systems must meet multiple objectives including maximising health gain, equitable distribution and efficient use of resources, improvements in service quality as well as acceptable levels of accountability.

Mr Philip Davies, Deputy Secretary of the Australian Government Department of Health and Ageing, reminded the Seminar that increasing diversity was a characteristic of maturing health systems and that this diversity was manifest not only in the changing balance between public and private financing but also in the changing balance between acute and chronic care, treatment and prevention, investment in capital rather than labour as well as in the increasing diversity in the health workforce. While providing choice and responsiveness, a diverse system also risks confusing consumers and providers and increasing costs.

The World Health Organization's World Health Report 2000 argues that health policy and strategies need to cover the private financing and provision of services as well as the state funding and provision. Government must assume ultimate responsibility for the overall performance of the whole system. This demands a new role for government – that of overseer and trustee rather than operational manager, what the WHO calls 'stewardship'.

Professor Ray Robinson of the London School of Economics, cited the three important 'stewardship' roles identified by WHO for government in ensuring coherence across all sectors as:

- setting direction by formulating health policy, defining vision and establishing clear performance indicators in conjunction with consumers and the wider public;
- exerting influence through regulation and advocacy, particularly as decreasing central control requires greater independence;
- collecting and using intelligence by identifying and transferring innovation and good practice across the system.

Leaders and managers will need to exercise stewardship, in health, by managing the health system; of health, by overseeing strategy; and for health, by advocacy in trade, industry and other parts of the socioeconomic system. Competent change management will be the critical capability required of leaders.

#### *Federalism and Health and Health Care*

In a joint presentation, Mr Roger Wilkins of the NSW Cabinet Office and Mr Scott Greer of the Constitution Unit of University College London, argued that decentralised or federated systems were effective because they were more likely to enhance democracy, policy effectiveness (the capacity to experiment) and efficiency or fitness for local purpose. A federated system, however, requires that local areas have real power, a formed constituency and an independence of voice through local media. In addition there must be sufficient coherence to avoid dysfunction. It was recognised that in Australia federalism was creating dysfunctionality and that it had the potential to do the same in the UK.

In moving to a more federated system with semi-autonomous regions, the UK will need to avoid the risk of constant

restructuring and recentralisation and configure in ways that enable real experimentation and the transfer of lessons learned. For Australia the challenge is to move beyond adversarial negotiations involving cost and blame-shifting, in order to generate greater coherence across the continuum of care.

The plenary discussion recognised federalism is built on trust and that this means investing in networks rather than institutions, while providing safe harbours for experimentation. To avoid dysfunctional federalism, health systems will need to more clearly align incentives and funding with objectives. This requires the development of meaningful metrics based on evidence as a basis for comparison.

### ***Public Health***

Professor Peter Donnelly, Director of Public Health in Scotland, defined public health as multi-professional, cross agency and focused on protection, promotion and restoration. Public health is most effective when these elements are integrated and this integration requires a willingness to accept that return on investment may take ten to twelve years. Increasingly, professionals will be the key deliverers of prevention and promotion and they will need to be provided with appropriate incentives and skills in order to undertake an integrated health prevention, promotion and restoration role.

Mr Robert Griew, in conjunction with Dr Tarun Weeramanthi, respectively Chief Executive and Principal Medical Advisor of the Northern Territory Department of Health and Community Services, outlined the needs of aboriginal communities in the Northern Territory whose median age of death is fifty years. The co-morbidities and co-occurrences of illness in indigenous communities demand an integrated and pragmatic approach that moves beyond a

focus on clinical efficacy to issues of human dignity and justice. In designing the health systems of the future it will be important to rebalance the 'law of inverse need', whereby the relatively advantaged consume the bulk of the health budget and to remove false dichotomies between acute care and public health. The system must be underpinned by appropriate public health law and policy as well as an evidence base and clear performance measures.

Indigenous health will test the commitment of Australians to an integrated approach to public health. The UK will need to avoid the risk of marginalising rather than integrating prevention, promotion and restoration.

### ***Financing and Delivering Services***

Mr Michael Davis, Chief Executive of Catalyst Healthcare Management in the UK, noted that the impact of diversification on health financing has seen innovative and entrepreneurial approaches emerge. The UK Private Finance Initiative is a performance based means of procuring property over an extended time scale. It replaces conventional public works contracting with contestability between the stated, desired outcomes and differing approaches to design logistics, financing and construction of appropriate facilities.

The success of this initiative will only be sustainable if the public sector can better define and plan service capability across multi sectoral systems. Sustainability also depends on the capacity of the private sector to make a dynamic contribution and to find its security in portfolio investment strategies that are larger in scale, lower in risk and higher in mutual gain.

In a presentation from Mrs Helen Owens, a Commissioner of the Australian Productivity Commission, it was noted that Australia has had a strong

involvement of the private sector in the delivery of health care and to a lesser extent in its financing. However the role of the private sector is somewhat ambiguous, given that governments at all levels in Australia have pursued diverse policies to promote the public-private sector mix. The role of the private sector is viewed variously as supplementing public services, providing alternative services or supplementing public funding eg through private health insurance. This ambiguity is exacerbated by the difficulty of providing a reliable assessment of the relative performance of the public and private health sectors.

For Australia, the challenges into the future will require dealing with the disjunction between public and private sector funding and service provision. The vulnerabilities faced by the private sector due to changes in government policy, structural changes in the health insurance market, technological advances and changing public perceptions will also need to be addressed.

The plenary discussion agreed that governments will need to provide better policy and regulatory frameworks, identify how risk will be addressed and become more sophisticated in procurement, asset and infrastructure management, while working with the private sector to develop innovative and effective ways to both finance and deliver more diverse health care.

#### **4. Strategic Direction for Future Health Systems**

The following summary statement outlines the shared strategic directions for both Australia and the UK as well as the bilateral implications arising from the Seminar.

#### ***4.1 The Vision for Future Health Systems***

The effective health care system of the future in both the UK and Australia will be more:

- focussed on healthy people and prevention;
- capable of providing patient choice;
- able to address inequity;
- resilient, adaptive and ultimately sustainable.

This health system will be characterised by:

- a mix of both private and public sector finance and delivery;
- diversity and complexity that enables local responsiveness and innovation;
- integration of the prevention promotion, and delivery of health services;
- a robust evidence base to support decisions and to transfer what works intelligently.

#### ***4.2 The Operating Environment for Health***

In planning the health system of the future, decision makers will need to take account of emerging trends impacting on the design and effectiveness of the health system. These factors represent both challenges and opportunities and include:



- increase in costs and opportunities through advances in technology;
- escalating burden of chronic disease as the population in both countries ages;
- higher levels of consumer demand and expectations;
- continuing pressure on health budgets;
- ‘globalisation’ of health requiring adaptation to global factors while also forging local responses;
- challenges to the numbers, skill and adaptive capacity of the health workforce;
- pressure to demonstrate action within electoral time frames while recognising that return on investment in public health is often about ten to twelve years.

### **4.3 Strategic Risks**

#### *Risks*

Given the challenges in the future operating environment, the major risks to achieving the desired vision for health are that:

- Australia fails to move to a more functional form of Federalism and therefore lacks a coherent system of primary care focussed on the patient.
- the U.K. fails to decentralise appropriately and does not develop a capacity for

innovative and genuine local participation.

- neither country manages the anxiety and uncertainty of consumers and providers through the transition process and governments consequently find it difficult to sustain reform.

To address the risks, it is therefore critical to the success of the desired vision that both the UK and Australia focus on the four key factors of success.

### **4.4 Key Factors of Success**

#### *Change*

Both countries must competently manage the transition from the current system to a more diverse yet integrated system. This will require a particular focus on the management of community and provider perceptions and expectations.

#### *Diversity*

The UK and Australia will both need to design and steer more diverse, complex systems by building networks of cooperation as well as developing robust evidence and measurement to underpin decisions.

#### *Integration*

Both countries face the challenge of better integrating prevention, promotion and delivery so that the patient journey is the focus of the system.

### *UK – Focus on Capacity*

In addition to the above factors of success, the UK needs to build an architecture and capacity in its health system that will facilitate constructive diversity and avoid recentralisation or constant restructuring.

### *Australia – Focus on Coherence*

Australia will need to develop a more coherent approach to federalism if it is to deal with the burden of chronic disease and ensure the sustainability of its health system.

## **4.5 Strategic Responses for Government**

In meeting these challenges, governments have an important and changing role as stewards of the whole health system that goes beyond the management of publicly funded and publicly delivered elements. The key tasks for the governments of both Australia and the UK in steering their respective health systems towards the desired future are to:

### *Provide Direction*

Both governments need to formulate policy, set strategy and then clearly articulate the vision, rationale and key indicators of effective performance that ensure that all constituencies have shared expectations. In undertaking this task they need to involve consumers, providers and citizens in order to shape the public discourse to focus on the burden of disease for future generations.

As part of their direction setting role, governments in Australia and the UK

now need to develop coherent public health strategy based on evidence and subject to rigorous analysis and accountability.

### *Exert Influence*

Having set clear direction, the governments of both Australia and the UK will need to ensure they have the capacity to influence and shape the system. This requires the development of regulatory frameworks designed to ensure appropriate independence and to deal with a mixed system. Governments will need to ensure that incentives are aligned with objectives so as to shape the behaviour of individuals and agencies towards the desired directions. They will also need to ensure that new models for identifying and sharing risk are developed and vehicles for ensuring the necessary capital and infrastructure are available.

### *Gather and Disseminate Intelligence at all levels*

To secure appropriate intelligence and disseminate it at all levels will require the engagement of consumers, the health workforce and communities to clarify what they value. It will also be necessary to build a robust evidence base and metrics for fields such as health prevention, resource management, and relative private/ public sector performance. In undertaking this task, governments will need to ensure that there are ‘safe harbours’ in which innovation can be nurtured and disseminated.

## **4.6 The Way Forward for Australia**

- Focus the health system and debate to address the burden of chronic disease:
- commission an Intergenerational Report Mark II to quantify the costs and benefits of chronic disease in economic terms and focus on investment now and for the future.
- develop pathways, protocols, incentives and support tools to address chronic disease including targeting a robust evidence base and IT/HR tools.
- set directions by ensuring the delivery of consistent shared messages to the community across jurisdictions.
- Reform primary care through a more comprehensive and coordinated approach to care
- Assess the use of private capital for infrastructure, and sustainable payment models including requisite safety nets.

#### ***4.7 The Way Forward for the United Kingdom***

- Exert influence in multiple ways, including through regulation based on intelligence. Determine what data, especially in a mixed system, is needed to underpin this intelligence and examine current regulation and other levers of influence to determine their appropriateness.
- Secure intelligence based on timely, rigorous health services research and sound data collection systems in order to finesse management processes.

- Determine the role for regions in governance and ensure that local government and other organisations are aligned with the directions for the whole system.
- Radically reconfigure public health including funding, responsibilities, roles and educational requirements.
- Undertake a detailed analysis of trends in PFI, especially the apportionment of risk to ensure their long-term place in the UK system.

#### ***4.8 The Way Forward – the Bi-Lateral Agenda***

The following issues were deemed useful by each country for future bilateral discussions and collaboration. Whatever the content of the discussion, the development of appropriate metrics to underpin such discussion is crucial.

From Australia's perspective, useful collaboration might focus on quantifying the burden of disease, models of primary care, variable financing models, workforce issues, effectiveness measures for IT and Electronic Decision Support and systems of aged care.

For the UK, consideration of public health and primary care would benefit from further bilateral discussion as would further exploration of the differential models and outcomes in a more devolved UK system.

# Policy Imperatives: United Kingdom

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Simon Stevens

*Simon Stevens is Health Policy Adviser to Prime Minister Tony Blair*

## Summary of points covered by Simon Stevens

### 1. Context

- UK health underinvestment – funding system, or funding quantum?
- 2003 tax increases; health spend from 7.5% to 9.5% GDP in 5 years
- switch of debate from financing to supply side: how to ensure output, responsiveness and quality not input price inflation (see Annex)
- the end of British exceptionalism re the NHS?
- caveat: focus discussion on England; healthcare not public health

### 2. New NHS anatomy

- capacity growth – health professionals; infrastructure incl PFI&IT
- new national architecture – NICE/Nat Service Frameworks/Commission for Healthcare Audit and Inspection/the Modernisation Agency
- new local architecture – Primary Care Trusts, foundation trusts, private providers

### 3. New NHS physiology

- the 3 dimensions of UK health reform
- capitated PCT unified budgets

- hospital payment reform
- patient choice
- labour market and pay reform – GPs, hospital specialists, nurses et al
- interface with social care

### 4. Some key debates

- funding/regulation/ownership – relative value-added of each
- pluralism v localism (and democratic accountability)
- choice v voice (and impact on equity)
- integration v contestability, ‘make’ v ‘buy’ (Kaiser v United)
- chronic disease v elective care
- how to animate PCTs – contestable networks?
- nature of regulation
- the changing division of labour
- rights and responsibilities

## Annex: The Current NHS Reform Programme

Delivery the NHS Plan Executive summary  
(full document at [www.doh.gov.uk/deliveringthenhsplan](http://www.doh.gov.uk/deliveringthenhsplan) )

“1. There are two arguments that matter on the health service. One, how is it funded? Two, how is it run?

2. On the first question, more investment has to be paid for. Either through taxation, social insurance, or private insurance or individual charges. **No system is free.** Many systems are not only more expensive than taxation but leave millions uninsured, without any cover at all. We believe that the benefit of a universal tax based model is that it is an insurance policy with no “ifs” or “buts”: whatever your illness, however long it lasts, you get cover as long as you need it. We made our choice in the Budget stating plainly that for the NHS to improve faster and tackle years of underfunding, more money is needed. The Budget now demonstrates how, within our tough public finance rules, **we will through general taxation be able to fund a ‘catch-up’ period to get us to health spending of 9.4% of GDP by 2008 – easily on a par with European levels of health spending.**

3. On the second question, we believe that any system for delivering health care must uphold the founding principle of the NHS – that it is free at the point of use based on need, not ability to pay. But Chapter 1 describes how **the 1948 model is simply inadequate for today’s needs.** We are on a journey – begun with the NHS Plan – which represents nothing less than the replacement of an outdated system. We believe it is time to move beyond the 1940s monolithic topdown centralised NHS towards a devolved health service, offering wider choice and greater diversity bound together by common standards, tough inspection and NHS values. This

will be underpinned by support for staff – with more staff, greater flexibility, increased freedom to do their job even better. The aim: shorter waits, better cancer and heart treatment, modern but compassionate care.

4. So we believe in the traditional method of funding, but a completely new way of running the service. It is this **reform of the supply side** system design which this document focuses on.

5. Chapter 2 outlines some of the key benefits that this extra health spending will bring. **Waiting times for operations will fall from a maximum of 15 months now to 6 months by 2005, and 3 months by 2008.** Waits in A&Es and primary care will fall too. And extra investment in major conditions will cut cancer and cardiac death rates, and improve services such as mental health and for older people.

6. Chapter 3 summarises some of the key building blocks to growing capacity. Compared with latest available headcount figures, there are by 2008 likely to be net increases of at least **15,000 more GPs and consultants, 30,000 more therapists and scientists, and 35,000 more nurses, midwives and health visitors.** Primary care services will be expanded. More elective surgery will take place in new freestanding surgical units or ‘diagnostic and treatment centres’. Hospital capacity is likely to grow by at least 10,000 more general and acute beds.

7. To help ensure that the large extra investment the NHS is now getting translates into capacity growth not inflation, **a greater share of the new funding will be used on training new health professionals for the future, and on capital infrastructure and modernised information technology rather than current spending.**

**8.** Chapter 4 explains that we are confident that the new national architecture we put in place in our first term is right. There is now broad support for a national body like NICE to ensure growing NHS spending is targeted on the most cost-effective treatments. There is wide support for National Service Frameworks covering cardiac, cancer, mental health services and other major conditions. There is consensus on the need for an external independent inspectorate to assure the quality of hospitals and primary care on behalf of patients. On the need to spread best practice through the NHS Modernisation Agency. And whereas the 1990s were spent debating internal NHS structures, there is now almost complete agreement that Primary Care Trusts are the right approach. So **in just five years, this new architecture has radically changed the way the NHS operates.**

**9.** But having got the structures right, Chapter 4 goes on to argue that we now need to introduce stronger **incentives** to ensure the extra cash produces improved performance. Primary Care Trusts will be free to purchase care from the most appropriate provider – be they public, private or voluntary. The hospital payment system will switch to **payment by results** using a regional tariff system of the sort used in many other countries. To incentivise expansion of elective surgery so that waiting times fall, hospitals or DTC/surgical units that do more will gain more cash; those that do not, will not.

**10.** Chapter 5 underpins the new incentives with the introduction of **explicit patient choice**. Over the next four years, starting this year, the Scandinavian system will be progressively introduced across the NHS in which patients are given information on alternative providers, and are able to switch to hospitals that have shorter waits. By 2005 all patients and their GPs will be able to book appointments at both a time and a place that is convenient to the

patient. This might include NHS hospitals locally or elsewhere, diagnostic and treatment centres, private hospitals or hospitals overseas.

**11.** Chapter 6 explains that as NHS capacity grows organically, we will continue to use private providers where they can genuinely supplement the capacity of the NHS – and provide value for money. This will also expand choice and **promote diversity in supply**, particularly for elective surgery. New PFI mechanisms, joint venture companies, and international providers will all be developed.

**12. Devolution** to the frontline will be stepped up, as Chapter 7 describes. The Department of Health will be slimmed down as, for example, in future negotiations over national employment contracts will be undertaken by NHS employers collectively rather than by the Department of Health. Instead of all public capital being allocated by the Department of Health from Whitehall, we will consider establishing an **arms-length Bank, controlled by the NHS itself**, which would invest capital from the Budget settlement for long term and innovative capacity growth and redesign. It will particularly focus on strategic shifts in configuration to more community and primary care based services. As regards revenue funding, locally run **Primary Care Trusts will hold over 75% of the growing NHS budget.**

**13.** The first NHS **foundation hospitals** will be identified later this year, with freedom and flexibility within the new NHS pay systems to reward staff appropriately, and with full control over all assets and retention of land sales. We will explore options to increase freedoms to access finance for capital investment under a prudential borrowing regime modelled on similar principles to those being developed for local government.

**14.** Chapter 8 makes the case for a **radically different relationship between health and social services**, particularly to improve care for older people. As the Wanless Report suggests, we will legislate to make local authorities responsible for the costs of hospital bed blocking. Rather than imposing structural reorganisation or nationally ringfenced budgets, this scheme means that social services departments will be incentivised to use some of their large 6% real annual increases to stabilise the care home market and fund home care services for older people. There will be matching incentive changes on NHS hospitals to make them responsible for the costs of emergency readmissions, so as to ensure patients are not discharged prematurely.

**15.** As well as growing the numbers of health professionals, there need to be **fundamental changes in job design and work organisation**. Chapter 9 sets out how this requires new contracts for GPs, consultants, nurses and other staff. The new NHS pay system will allow greater allowance for regional cost of living differences, and free local employers to design new jobs breaking down traditional occupational demarcations. In seeking to expand the size of the healthcare workforce, a careful balance will be struck between the need to pay staff competitive rates in tight labour markets, and the need to ensure productivity gains on a par with the wider economy. Staff will be supported to continue life long learning.

**16** Given UK health capacity constraints, there are difficult judgements on the speed of funding increases. Too slow, and we miss the opportunity to improve the nation's healthcare, with the risk that people simply give up on the NHS. Too fast, and investment might produce input price inflation, rather than improved output and responsiveness. On best advice the Government has decided that 7.5% is the optimal level of real NHS growth in

England over the next five years. Higher than that would be unlikely to expand healthcare capacity any faster. Lower than that would mean an excessive and growing gap between supply and demand. But the **Government is determined to ensure that additional funding is backed by independent oversight of how the resources are being used**, to ensure they deliver the intended results.

**17.** Chapter 10 therefore describes how at a local level, **PCTs will be required to publish prospectuses**, accounting to their local residents for their spending decisions, the range and quality of services, and explaining the increasing choices that patients will have.

**18.** At a national level, legislation will be introduced to establish a **new tough independent healthcare regulator/inspectorate** covering both the NHS and the private sector, with a new Chief Inspector of Healthcare – not appointed by Ministers and reporting annually to Parliament. An equivalent body will be created for social services.

**19.** In summary the NHS is now on a stable financial footing and can face the future with confidence: with the NHS Plan in place; investment and reforms beginning to show results; power shifting to the NHS frontline. The changes will take time. But with investment to reform, the best days of the NHS are ahead of us, not behind.”

## The New NHS

### 1948 NHS model

### New model NHS

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**Values:** free at point of need

**Values:** free at point of need

**Spending:** annual lottery

**Spending:** planned for 5 years

**National standards:** none

**National Standards:** NICE, National Service Frameworks and single independent healthcare inspectorate/regulator

**Providers:** Monopoly

**Providers:** Plurality – state/private/voluntary

**Staff:** rigid professional demarcations

**Staff:** modernised flexible professions benefiting patients

**Patients:** handed down treatment

**Patients:** choice of where and when get treatment

**System:** top down

**System:** led by frontline – devolved to primary care

**Appointments:** long waits

**Appointments:** short waits, booked appointments



# Policy Imperatives: Australia

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Jane Halton

*Jane Halton is Secretary of the Australian Government Department of Health and Ageing*

## Introduction

- The Australian health system has enjoyed a long period of stability for the last twenty years. Reforms have been incremental, designed to “fine tune” pressing issues.
- The Australian community values Medicare very highly, and the government is committed to ensuring its strength and sustainability over the longer term. Sustainability of the health system appears, however, to be coming under challenge. This has become a major concern for both the government and the community.
- A sustainable health system is one that will continue to operate in a viable and affordable fashion for the foreseeable future and beyond.
- In the UK it has been recognised that a low level of investment in the health system could cause it to falter, so more has been spent and widespread reforms have been introduced. In Australia, the challenge is different. Expenditure growth has been accelerating.
- Australia now spends 9% of GDP on health. This is still in the mid-range of OECD countries, a positive situation given our very high healthy life expectancy. Given our expectations of an ageing population, contracting workforce and rapid technological developments, there is now concern that the expenditure growth will create major fiscal pressures.
- As part of the 2002-2003 Budget, the Australian Government released an Intergenerational Report that assessed the long term fiscal impact of current policies over the next forty years. The Report identified an emerging gap between government revenue and expenditure, with increased health and aged care expenditure accounting for a large part of the projected gap.
- Projections indicated, for example, that Federal Government expenditure on health as a proportion of GDP could double by 2041-42.
- The rapid escalation of health and aged care costs was attributed to two main factors:
  - a doubling of people aged over 65 years during the next four decades; and
  - rapid technological advancements, combined with community expectations of access to the latest health treatments.
- The Intergenerational Report created a context of concern and scrutiny, focusing the attention of policy-makers and the community on the long-term costs of our health and aged care system. It brought to our attention the importance of ensuring that our system meets the changing needs of the Australian population without prohibitive cost.

- This brought into focus two key questions – how do we decide what government should pay for, and how do we contain burgeoning demand?
- These questions sometimes occupy the public agenda more than other important issues, such as how we effectively manage the system, and more importantly, what outcomes can we achieve?
- But “behind the scenes”, policy-makers know that all these questions are linked, and that they would all benefit from structured solutions to these issues.
- Responses to the sustainability challenge in Australia include:
  - more evidence-based decision making;
  - better quality in health care delivery; and
  - a well-balanced public/private mix.

### **More evidence-based decision making**

- Public expectations of access to new technologies is a huge component of health expenditure growth. This applies across pharmaceuticals, diagnostic services and medical procedures.
- For example, expenditure on the Pharmaceutical Benefits Scheme has grown by 60% in the last four years and is projected to be more than federal expenditure on public hospitals in 40 years.
- Clearly we can't “have everything”. We will soon face difficult decisions about where our resources should be allocated. To make those decisions soundly, we need to emphasise the use of rigorous evidence about health outcomes and relative costs.

### ***PBAC and MSAC***

- Australia's Pharmaceutical Benefits Advisory Committee (PBAC) has been a leading international example of evidence-based processes for making decisions about public funding. Our Medical Services Advisory Committee (MSAC) has been introduced more recently to undertake a similar function for medical services.
- Now we are moving to apply these methods more widely, not just to pharmaceuticals and medical services but to prostheses funded by private insurance and to preventive health measures.

### ***Evidence requirements for prevention***

- Australia is committed to establishing a strong evidence base for our decisions about preventive health measures.
- We must ensure that decisions to put resources into more prevention are based on solid epidemiological and cost effectiveness evidence. This applies at both the whole-of-system level, where emphasis is shifting from curative to preventive measures, and at the level of funding for specific individual interventions.
- In November 2001, we published a report titled '*Returns on Investment in Public Health: an Epidemiological and Economic Analysis.*' The report quantified the benefits of previous public health measures, demonstrating excellent results.
- In addition to the immunisation success story (eg measles programs saved an estimated \$155 for every \$1 expenditure from 1970-2000), the report found that:

- Programs to reduce smoking have saved the Australian Government \$344 million, or \$2 for every \$1 spent on anti smoking programs over the last three decades.
- Australia’s HIV/AIDS transmission rate would have been 25 per cent higher if we had not invested so heavily in education and prevention programs.
- Through the OECD health project we are supporting international research into the impact on health systems of new technologies, particularly medical technologies and bio-pharmaceuticals.
  - A number of OECD countries are concerned about the impact of new technologies on long term health outcomes and health expenditures and are looking for more equitable ways to manage their adoption and diffusion into the future.
  - There has been considerable interest in Australia’s technology assessment mechanisms with a number of countries wanting to learn more about our achievements. While already at the forefront of work in this area Australia is looking to further refine our assessment mechanisms, particularly by developing more sophisticated economic modelling techniques.
- In re-negotiating the Australian Health Care Agreements, we have required that the States and Territories publicly commit to a specified level of funding for the upcoming five-year Agreement period. They will need to report on progress against that funding commitment each year. They will also be required to commit to a new performance reporting framework.
- These requirements will help improve federal decision-making and national policy outcomes. They are also intended to reverse the trend of State funding for health decreasing when Commonwealth funding increases.

### **Balancing the public/private mix**

- Our focus has been to provide a broad-based investment platform for the health sector, including both public and private sector financing. Ensuring a balance of public and private financing helps secure the long-term sustainability of our system, by sharing the costs between individuals and governments.
- Australia maintains a strong equity focus through our universal public system, while ensuring choice through voluntary private insurance. There has also been a strong commitment to equity in the private system through the maintenance of community rating so that the elderly or sick do not attract higher fees.

### ***Accountability***

- At a system-wide level, information is also important for sound decision-making. Australia’s federal structure makes it particularly important to have adequate and consistent information about the expenditure of federal funds by the States.
- In order to achieve increased private investment and maintain the fairness of community rating in the private system our approach was to offer a mix of both financial incentives for all and benefits for taking out private health insurance early in life. This mix of incentives has been very successful in encouraging younger people back into voluntary private health insurance.

- The whole health sector benefits from a strong private system. It takes pressure off the public hospital system, provides choice for consumers and importantly provides increased investment in health care without increasing taxes.
- Australia's particular system of parallel public and private insurance has drawn attention internationally, and is the subject of an OECD Health Project case study. The case study focuses on the interdependence of the public and private schemes and will form part of a wider study on the private health industry in OECD countries.
- In the context of re-negotiating the Australian Health Care Agreements, a Reform Agenda was developed by the Australian Government and the States and Territories that addresses many of these difficult interface areas. For example:
  - The Pathways Home initiative will help people leaving hospital, particularly the elderly, to make a smooth and easy transition home using step-down and rehabilitation services.
  - A Draft Framework for the Care of Older Australians has been developed by representatives of the State and federal governments to guide improvements at the interface of aged care, hospital and community services.

### **Better quality**

- Another important way to improve sustainability is to increase the quality of health services – to secure better value for our expenditure.
- There are opportunities to improve safety and quality at all levels of the health system. The Australian Government has responded with a number of initiatives to provide direction at a national level.
- The split funding responsibility between federal and state governments does place a constraint on reform in the Australian system, making consistent reform at a national level very challenging.
- For example, we have an initiative to supply pharmaceuticals to patients being discharged from hospital through the federally funded Pharmaceutical Benefits Scheme. The arrangement avoids patients being discharged with limited supplies of medication and having to attend a GP then a pharmacist to receive follow-up prescriptions shortly after leaving hospital.

### ***In partnership with States and Territories***

- The interface between Australian Government and State or Territory services can be an area of difficulty within our federal structure. For example, general practice and aged care are funded by the federal government but public hospitals are funded and managed by State governments. This can create frustrations for service providers and consumers when a person needs to move between systems and it is not as seamless as we would like.
- Several years after the reform was introduced, only three of the eight State/Territory jurisdictions have signed up. This contrasts somewhat with the system of Chief Executive Circulars in the UK.

- Nevertheless, the jurisdictional split can create a “dynamic tension” that requires more patience, encourages stability and makes top-down policy less tenable. It encourages innovation and diversity at a local level and ensures that different States can provide services to meet local needs.

### ***In General Practice***

- Primary care is a different situation, where the Australian government is the only public funder. Even so, reform can be just as challenging because services are delivered by private practitioners, leaving the government with limited policy levers and no direct control.
- The fee for service system also acts as a constraint to quality-based policy initiatives.
- In response we have encouraged the development of a more mixed remuneration system, using Enhanced Primary Care (EPC) MBS items and Practice Incentive Payments. These measures are designed to increase the focus on service quality not volume. The shift has created some tensions with parts of the profession, but they are being managed constructively.

### ***With Consumers***

- Consumers can also be encouraged to take more responsibility for safety and quality issues.
- For example, we recently released a 10-point guide for consumers on what to look for and ask about, in order to improve the quality and safety of health services they receive.
- We have also launched a campaign to educate members of the community about the Pharmaceutical Benefits

Scheme, and how to use it responsibly to ensure its long term viability. The campaign includes a national advertising program and information tools including a campaign booklet, free telephone information service, website and community information booths.

- This is an important example of managing consumer expectations by drawing to their attention the ramifications of irresponsible uninformed access, including over use.
- In other cases, information overload can be almost as much of a problem. Increasingly patients are coming to doctors’ surgeries armed with bundles of information from the internet – some of it accurate and helpful, some of it misleading or alarmist.
- This creates new expectations of our workforce: that they will also be familiar with the new information in order to help patients discern the quality from the dross; that they will provide access to every new cure; and that they will communicate with patients on a basis of shared information and decision-making, not traditionally a feature of the doctor-patient relationship.

### ***Quality health outcomes through prevention***

- Prevention is taking an increasingly higher profile position in our health policy debates.
- The Minister has identified that focusing more on prevention is important for improving health outcomes and enhancing sustainability, and she is committed to achieving that result.

- Increasing the role of prevention in the mainstream health system will help sustainability by reducing the unnecessary financial burden of avoidable illness and by increasing the productivity of our workforce.
- This will be particularly important as the proportion of our workforce in the “mature” age categories increases. Older workers have tended to be more susceptible to leaving the workforce due to health problems.
- The real challenge is turning knowledge about the potential benefits of prevention into real life improvements. This requires both sound policy solutions, and the more difficult challenge of persuading and motivating individuals to change their own behaviour.
- In its most recent Budget the Government announced a ‘Focus on Prevention’ package of several measures to improve the health and productivity of our ageing workforce and ease cost pressures on the health system. One of the initiatives receiving funding will encourage the use of “lifestyle prescriptions” in an effort to increase behaviour modification before turning to medication.
- A significant recent achievement has been the establishment of a National Obesity Taskforce. The Taskforce was established in November 2002 under the auspices of the Australian Health Ministers’ Advisory Council. The work of the Taskforce has highlighted the need for consistent, action-oriented information to be delivered to the community on the importance of increasing levels of physical activity and encouraging healthy eating patterns in children and families.
- The Australian Government Department of Health and Ageing has a reputation for leading the way on healthy lifestyle change in Australia. This was demonstrated by the Department’s pioneering ban on smoking in the workplace.
- In that tradition, we are now leading the way on physical activity, with the introduction of a “10k a day” program to encourage healthy levels of physical activity (10,000 steps each day) among department employees. This is the sort of direct way in which policy makers can provide leadership to the community.

### **Conclusion**

- From this quick run down of Australian policy imperatives we can see that the Australian health policy context is very different to the UK’s, but that there are many common issues.
- Both countries for example, are likely to face confronting decisions in the near future about how to maintain equitable access to high quality care in the face of rising costs, fiscal pressures and apparently limitless technological advances.
- Demographic shifts will further increase the demands on both our systems – challenging their financing mechanisms and demanding new service delivery arrangements.

It is interesting to note that in many ways – such as emphasising evidence and quality outcomes, and seeking a balance between public and private – we are moving in similar directions to solve related problems, despite our very different starting points.

# Managing the Mixed Economy in Health Care: A New Role for Government?

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## Preamble

*This paper has been prepared as a background document for the second plenary session ‘Changing health economies – design and management’. It focuses on two trends noticeable in the UK, Australia and many other health economies; namely, (i) the changing public-private mix and (ii) decentralisation of decision making involving both the public and private sectors. The paper considers the role of government in the light of these trends. It does not seek to present a comprehensive or definitive account of the subject. Rather it sets out to provide an overview and to raise a number of issues for discussion at the conference.*

## 1. Background.

In both Australia and the United Kingdom the roles of the public and private sectors in health care are changing. In Australia, there has been a dramatic increase in private health insurance, increasing use of private finance initiatives in funding capital projects, greater pluralism in the supply of services through co-location and similar initiatives, and a variety of schemes involving the private management of public hospitals. In the UK, private health insurance remains fairly static with around 12% of the population with private cover. But on the supply side, greater involvement of the private sector is taking place on a number of fronts. The private finance initiative

currently accounts for over 80% of funding in the case of major NHS capital projects and its role is set to grow even more in the future, including expansion into the primary care sector. Since 2000 – when the Secretary of State signed an historic concordat with the Independent Healthcare Association - government policy has sought to encourage public-private partnerships in provision through NHS funding of privately provided services in a variety of areas. The provision of private intermediate care beds and private sector involvement with new forms of diagnostic and treatment centre are just two examples of this trend. The possible franchising of the management of failing NHS hospitals to the private sector has also been discussed by ministers.

Clearly both Australia and the UK are developing health care systems in which the private sector is expected to play a far larger role. A number of factors can be identified as contributing towards this trend.

At the macro-economic level there has been a growing acceptance of the limits to growth in public expenditure. This is often expressed in terms of the adverse consequences of public spending on overall economic growth (ie. crowding out) and taxpayers’ unwillingness to pay additional taxes to fund higher levels of public expenditure. In the light of these constraints, and because health care is overwhelmingly publicly financed in most advanced economies, attention has turned

to ways in which private finance can be used to supplement public finance. At the political level, this movement has been reinforced by the (originally) new-Right emphasis on individual responsibility and a preference for private sector solutions.

At the micro-economic level, the case for a larger role for the private sector has been based on alleged public sector failings. Public sector bureaucracies have been criticised as being inherently inefficient and unresponsiveness to user needs. This was a constant theme of UK government policy from the 1980s onwards. It gave rise to a succession of privatisation schemes and, eventually, the 1991 NHS internal market reforms. The private sector is currently seen as a source of management expertise, entrepreneurial skill and additional capacity that can all be used to improve health care services.

A closely related development has been the growth of private sector-style management methods *within* the public sector. This has been dubbed the 'new public sector management' with its emphasis on financial devolution, explicit standards of measuring performance, clear identification of the relationship between inputs and outputs, increased accountability, belief in the superior efficiency of private sector management methods and the use of contracting-out and competition in the production process (Jackson and Price, 1994).

Both the macro and micro-economic cases for greater private sector involvement have been hotly debated. The UK experience with the private finance initiative provides a good example of this type of debate (Sussex, 2001). But it is not the aim of this paper to rehearse these arguments. Rather it starts from the position that changes are underway, and discusses the role of government in relation to these changes. Most of the discussion centres on the micro-economic question; namely, what is

the new role of government if greater devolution of decision making and pluralism in the supply of publicly funded services takes place?

## **2. A new role for government.**

In its *World Health Report 2000*, WHO argues that health policy and strategies need to cover the private provision of services and private financing as well as state funding and state provision. Only in this way, it maintains, can health systems *as a whole* (italics added) be orientated towards achieving goals that are in the public interest. If this approach is adopted, WHO argues that government has a crucial role of *stewardship*.

As a steward of the health care system, government must assume ultimate responsibility for the overall performance of the system. It will need to ensure coherence and consistency across departments and sectors. But in doing so, its role is one of oversight and trusteeship. Put another way: it needs to row less and steer more.

In its report, WHO identifies three key tasks of stewardship: namely,

- formulating health policy – defining the vision and direction,
- exerting influence – through regulation and advocacy,
- collecting and using intelligence.

Given the space constraints of this paper, most of the remaining discussion focuses on the regulatory role of government, although some brief consideration is given to the other two tasks.

### ***Formulating health policy***

As governments relinquish hierarchical, command and control approaches, and



devolve increasing responsibility for the provision of services to local providers (both public and private), so the need for a national health policy framework becomes even stronger. This framework will need to set out the general values that the health care system is expected to embody and to specify national objectives. The *NHS Plan* and the subsequent paper *Delivering the NHS Plan* are examples of documents that seek to fulfil these functions in the case of the UK. In the context of our discussion, it is relevant to note that the NHS Plan expresses a commitment to pluralism in the supply of services and also devotes considerable attention to the desired balance between local autonomy and national standards. With greater emphasis on devolution of decision-making, the national level is also the place where important population based objectives - such as reducing inequalities in health and pursuing public health programmes - need to be specified (Robinson and Dixon, 2002).

Of course, the history of health policy is littered with national planning documents that have failed to bring about intended changes, most notably because of failures of local implementation. This poses a dilemma for governments in their quest to row less and steer more, especially when the ultimate responsibility for performance of the system is centralised. The dilemma was summarised by Clive Smee, when Chief Economic Adviser at the English Department of Health, in the following terms:

*'ministers and the centre are finding it difficult to reconcile devolved accountability with the demand for detailed monitoring created by parliamentary interest in operational issues. In consequence, the centre is drawn into a whole range of issues, from hospital catering standards to freedom of speech of hospital staff,*

*that it once expected to leave to the discretion of local management. The dilemma is that without substantial operating freedom, trust management cannot be expected to produce better performance...but that with such freedom there is bound to be diversity of behaviours and performance. The existence of outliers is then seen - by press, auditors and politicians - as a cause for central regulation'.* (Smee, 1995, p.190).

The dilemma surrounding political imperatives is likely to intensify as public finance is increasingly used to fund privately provided services.

#### *Exerting influence – regulation.*

It is generally accepted that market failures within private health care markets will prevent them from achieving an efficient allocation of resources. Asymmetry of information between patients and providers (leading to supplier-induced demand) and the existence of spatial monopoly in hospital provision are two widely cited market failures. In addition, a private market system is unlikely to achieve the equity objectives (eg. in terms of access to health care) that most governments accept as desirable. Thus for reasons of both efficiency and equity, governments around the world have subjected the health care system to tight regulation. Indeed, in many countries, government intervention has gone even further and replaced both private finance and provision with state finance and provision.

However, as was pointed out earlier, increased emphasis on *government failures*, particularly on the supply-side, has given rise to waves of privatisation, the introduction of greater contestability or competition through sub-contracting to the

private sector and decentralisation of decision-making through the creation of quasi-markets within the public sector. What implications do these trends have for health sector regulatory activities in the three main areas in which they take place: namely, the regulation of *capacity*, *price* and *quality*?

Regulation of capacity is traditionally seen as necessary to avoid supplier-induced over-supply. Countries such as the United States (with for-profit private providers) and the Netherlands (with not-for-profit private providers) both have extensive experience of legislation designed to restrict private sector expansion in cases where it is dependent on public funding. For the most part, however, such regulation has been rather ineffective.

Avoidance of controls seems to have been widespread. In the light of this experience, it would seem unwise to rely on this mechanism to control the growth of capacity within a more mixed economy.

There is, however, one area in which this form of regulation is currently important. This concerns health technology assessment agencies (as found in, for example, France, Sweden, the Netherlands and the UK) and the ways in which they seek to influence the take-up of health care technologies among providers. Given the rate of technological advance in health care, and its cost implications, this would seem to be an area where continued efforts will be made to regulate supplier-induced expansion. In this connection, the Australian experience with the 'fourth-hurdle' for public reimbursement of pharmaceutical expenditures is being watched with interest in many other countries.

On the question of price regulation, both Australia and the UK have recently introduced, or are moving towards, a form of yardstick price competition. This

involves the adoption of centrally determined prices based upon diagnostic related groups (DRGs). This system was first introduced in the United States during the 1980s as part of a Medicare prospective payment system designed to control costs. Since then a number of countries have adopted this general approach, with the Australian system about to be adopted in Germany. In the UK the move to nationally specified prices based on health related groups (ie. a variant of DRGs) is meant to avoid the protracted negotiations over prices (costs) which characterised the internal market of the 1990s and to focus competition among providers on quality.

The adoption of centrally specified, DRG-based prices means that all providers face uniform prices. The theory is that this provides them with incentives to reduce costs as any excess of price over cost accrues to the provider as a surplus. Ultimately, as in a market system, those providers that are able to meet the yardstick price will flourish whereas less efficient ones will be under the threat of bankruptcy. In those systems where there is substantial unit cost variation prior to the introduction of yardstick competition – as in the UK – the ordered transition to the new system will obviously take time, if politically unacceptable hospital closures are to be avoided. In short there needs to be a balance between the competitive spur for greater efficiency and the maintenance of a socially and politically acceptable configuration of hospital facilities. The Australian experience with this trade-off should be of great interest to a UK audience.

In the United States, the DRG-based payment system has been applied to private hospitals as part of the prospective payment system and also as part of the move towards managed care. Whether these hospitals can be incorporated within the same system as public hospitals in

those health care systems where public hospitals dominate is unclear. On the one hand, the case for a level playing field between the public and private sectors is clear. On the other hand, different case mixes and cost structures between the two sectors could pose problems.

The regulation of quality probably poses the most important and, at the same time, the most difficult regulatory challenge. Quality has a number of dimensions relating to structure, process and outcomes. In the UK, the newly formed Commission for Health Care Audit and Inspection (CHAI) will play a central role in the drive to monitor and improve quality standards at hospital and primary care trusts. However, current measures of performance are overwhelmingly focused upon structure and process rather than the ultimately more important measure of outcome. A key challenge facing policy-makers in this area will be to bring together the work of the more micro, research-based health outcomes movement with the institutional structures (such as CHAI) being developed to improve quality in every day service provision.

On a more operational level, agencies such as CHAI need to reconcile their monitoring and audit function with the need to motivate and actually improve performance. This raises the thorny issue of whether regulators can both police provider organisations and discharge a developmental role. The question also encompasses the major challenge of improving the quality of clinical practice through clinical governance. As we move from a world in which professional self-regulation played a major role into one in which clinical professionals are expected to be more accountable to external bodies for their actions, a host of issues surrounding professional acceptance, morale and, crucially, implementation in practice, arise.

How will these tasks be carried out in a more pluralist system? Can common systems of monitoring and audit apply across sectors? How will clinical governance develop in the private sector?

### *Collecting and using intelligence*

Markets generate information. It is no coincidence that the US health care system has more advanced information systems than any other health care system in the world. On these grounds, there is no reason to fear the growth of pluralism. On the contrary, it can be expected to enhance the information that patients, in particular, have at their disposal.

But there are some aspects of information and intelligence that have a more 'public good' quality and which therefore individual provider organisations cannot be expected to generate and disseminate. Government, in its stewardship role, will need to take responsibility for collecting and using this information and intelligence. Within this category, WHO includes information on priority setting, patients' rights and broad population-based measures of health system variations.

### **3. Concluding comment.**

It is well known that health systems need to meet multiple objectives. The underlying objective for most systems is usually taken to be the maximisation of health gain. But others include: efficiency in the use of resources; equity in the utilisation and finance of health care; maintenance and improvement of service quality; responsiveness to user needs; and acceptable systems of accountability. Meeting these objectives is a complex task. There are often trade-offs between them which mean that questions of balance need to be addressed. There is no reason in theory or practice to suppose that individual actors or organisations (public

or private) will reach an acceptable balance if they act completely autonomously. A *laissez faire* system will not deliver. Recognition of this fact has established the long standing case for government regulation of the health sector. With the growth of more pluralist systems, this case remains valid, but the ways in which regulation is carried out need to be reappraised.

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# Management of Diverse Health Economies

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This year's Australia/UK Bilateral Meeting focuses on the design and management of changing health economies. A key consequence of change in the two countries' health economies is greater diversity, both within each country's system and between the two systems.

This introductory paper seeks first to explore some of the reasons for, and manifestations of, diversity in modern health economies. It then explores some of the challenges that diversity presents for those who use, deliver and manage health services.

## **The emergence of health systems**

Organised health systems, as we would recognise them today, are a relatively recent phenomenon. Mankind has sought to alleviate the pain and suffering associated with ill-health, and indeed to prolong life itself, since time immemorial; and a vast array of treatment and preventive approaches have emerged with that aim in mind. However, it is only within past 100 years or so that the many different components that contribute to protecting and improving health have been brought together into organised systems. The organisations, regulations, and established ways of working (collectively, the institutions) that we now regard as making up our health systems are thus quite young.

The emergence of formal health systems during the 20<sup>th</sup> century parallels two

significant developments in the health care arena: the growing technological sophistication of service delivery; and the formal collectivisation of health financing.

The first of these, growing technological sophistication, meant that many aspects of health care could no longer be essentially a 'one-to-one' activity. The equipment that was necessary to deliver modern diagnostic and treatment services was costly and thus access to it had to be shared among communities. Furthermore, the emergence of those new technologies led to increasing specialisation of knowledge and hence of labour. It was no longer possible for a single practitioner to gain mastery of all available techniques and as a result individuals needed to access multiple service providers during an episode of care. New technologies also created new risks, and so the need for formal regulation of health services and those who delivered them also increased.

As health care grew in technological sophistication it also became more expensive and individuals and families were exposed to greater levels of financial risk. As a result, new approaches evolved to enable those risks to be spread among larger population groups. The result was the now commonplace pattern of insurance arrangements based on taxation, social insurance and private insurance which are present, to some degree, in all industrialised countries' health systems<sup>1</sup>.

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<sup>1</sup> In 2000 the share of health funding that was collectively controlled (by government or insurers) ranged from less than 20% in Georgia, Myanmar

Instead of being based solely on transactions between individual consumers and individual service providers, a great deal of health care now involves third party funders in some guise.

The emergence of systems to organise funding and delivery of services can thus be viewed as a natural consequence of these and other, broader, social changes.

### **Growing diversity**

In countries that adopted ‘Beveridge’ style health systems, with taxation meeting the majority of health costs, governments played a dominant role in funding, regulating and delivering services. Independent insurers and service providers retained, at most, a limited role.

In former British colonies, for example, a central health department typically stood atop a sizeable hierarchy of directly-employed staff who worked in state-owned facilities to deliver wholly publicly-funded services. Individual hospitals and clinics might have had their own identity, but reporting lines were often to heads of professional services at regional or national level with limited scope for direct local-level control of resources.

While such models remain in some less-developed countries they are now increasingly rare. Recent years have seen a growing recognition of the importance of local autonomy within the context of more sophisticated national or regional accountability frameworks. The founding of the British NHS in 1948 was, arguably, among the earliest examples of such a ‘loosely coupled’ health system. More recently, countries such as New Zealand

(with the establishment of Area Health Boards in the late 1980’s), Hong Kong (which set up a separate Hospital Authority in 1992) and the Australian States and Territories (through the development of models such as New South Wales’s Area Health Services) have sought to distinguish the policymaking and regulatory roles of government from its role in delivering health services.

Alongside such developments, most health systems have also retained a degree of diversity in service delivery roles. For example:-

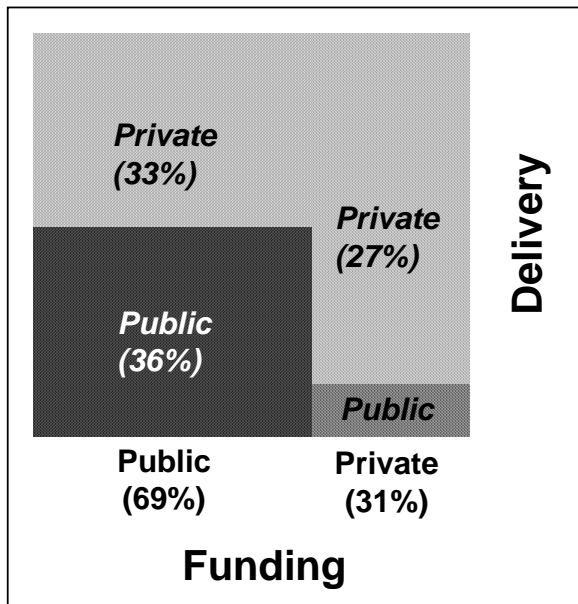
- GPs have retained their private, self-employed status in both the UK and Australia;
- charitable and religious bodies have traditionally played a significant role in delivering services for elderly people and people with disabilities; and
- private (for-profit or not-for-profit) health insurance has continued to co-exist alongside publicly funded cover in most countries.

During the past 20 – 25 years, however, health systems in many Western democracies have undergone a further evolutionary step with non-governmental and private sector service providers emerging to play a greater role in both the funding and delivery of services. Figure 1 illustrates, in the case of Australia, how the ‘source and application of funds’ in health was shared between the public and private sectors in 2000.

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and India to almost 99% in the small Pacific nations of Kiribati and Nauru. The proportions of collectively controlled health funding in Australia and the UK were 83% and 89% respectively. (Source: World Health Organisation. *World Health Report 2002*. WHO, Geneva)

**Figure 1: Funding and delivery of health – Australia,**



There are many reasons for such developments. They include a desire on the part of governments to refocus resources away from direct delivery of services and onto core strategic and direction-setting roles (“steering instead of rowing”); and a commonly-held (but frequently disputed) view that there are many aspects of health service delivery where governments hold no natural advantages over other providers.

The changing balance between public and private sector involvement is just one example of increasing diversity within health systems. Others include:-

- a movement from acute to chronic disease – systems can now no longer concentrate just on addressing ‘one-off’ health problems and need also to be able to assist patients who may live with a chronic condition for many years<sup>2</sup>;

<sup>2</sup> It has been estimated that 80% of the burden of disease in Australia is now attributable to chronic conditions.

- a changing mix between treatment and prevention – due in part to the need to reduce chronic disease, but also in an effort to contain future health care costs, systems now complement traditional curative services with efforts to prevent ill-health and/or to intervene early to minimise the severity of disease;
- a new balance between institutional and ambulatory services – as new treatment and diagnostic technologies (including new pharmaceuticals) mean that more conditions can be treated in primary care settings;
- a continuing readjustment between capital and labour – with sophisticated analytical equipment, computerised record keeping and, in the near future, robotics and nanotechnology, changing the demand for specialist skills in health; and
- shifting professional boundaries – which reflect factors such as increasing clinical sub-specialisation, technologically driven de-skilling of some professional activities and higher levels of training for nurses and other allied health professionals.

Figure 2 summarises how such changes are leading to more diverse health systems.

**Figure 2: Diversification in health**

System characteristic	'Traditional' orientation	➔	Emerging diversity
Financing	Public financing of services and capital		Mixed public/private financing
Consumers' needs	Acute care dominates		Balance between acute and chronic care
Service orientation	Treatment focused		Treatment and prevention
Service settings	Hospitals and long-stay institutions		Hospitals and ambulatory settings
Service inputs	Weighted towards labour		Labour and capital
Workforce	Rigid and static demarcation of professional boundaries		Multi-skilled and versatile

Furthermore such changes can in some cases have a synergistic impact. For example, in Australia, technologically-driven growth in (privately-provided) out-of-hospital services over the past 20 years has led to an increase in patient charges and, as a result, a change in the balance between public and private funding of health.

Taken together, changes such as these are adding to the complexity of modern health systems. Indeed, at the risk of semantic over-interpretation, the use of the term "health economies" in preference to the more familiar "health systems" in the title of the Australia/UK Bilateral Meeting could be seen to suggest that the level of complexity in health has now reached a point where at least some of the characteristics of an organised system are absent.

What challenges does this growing diversity present for those who use, deliver and manage our health services?

**Users**

Diversity in health systems can have both favourable and less favourable implications for service users.

Positive impacts might include:-

- access to a wider range of services and service providers – through the involvement of more and varied players in the sector;
- better health outcomes – as systems develop new capabilities and new services to respond more effectively to actual and potential health problems;
- increased responsiveness – with new providers, new forms of professional practice and new service delivery modalities underpinning innovation;
- greater choice – by using private funds to purchase more timely and higher (perceived) quality services.

On the negative side, possible adverse effects of increasing diversity could be:-

- disorientation and uncertainty – as familiar institutions and patterns of service delivery change;
- a lack of coordination and increased fragmentation (the flipside to access to an increased range of services and providers)



- quality failures – as a result of inadequate communications, lack of standardisation, poorly managed interfaces and potential conflicts between different providers; and
- increased costs – as a consequence of new providers and new forms of service falling outside the scope of established funding arrangements.

A key responsibility of governments is to help the population to understand the impacts of increased diversity, to manage effectively the changes it brings, and to pursue actively strategies to overcome any adverse consequences.

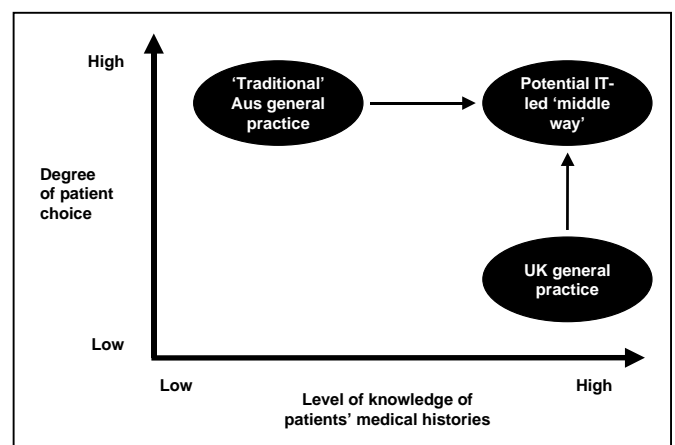
A current case in point from Australia stems from the movement of high-tech diagnostic and treatment services from the public (hospital) sector to (private) ambulatory settings over the past 20 years. While that change has clearly benefited patients in many ways it has also exposed some of them to significant financial risk. For example, total patient payments for CT services have grown by 250% in real terms over that period, with equivalent increases of more than 300% in both radiotherapy and ultrasound costs. As a result of such spending, in 2002 more than 30,000 families faced out-of-pocket costs in excess of A\$1,000 in respect of charges levied above the Medicare subsidy level for GP, specialist, imaging and/or pathology services.

As part of its proposed Fairer Medicare package, the Australian Government is seeking to introduce new safety nets to protect people against such excessive out-of-pocket costs.

In other areas, it may well be that the same technological innovations that are driving diversity in so many aspects of today's health systems can also be used to moderate its adverse effects in other areas.

General practice is a case in point. Diversity in general practice might include allowing patients the freedom to consult different GPs at will. That is currently a characteristic of general practice in Australia and, with the advent of walk-in clinics, is also increasingly the case in the UK. Such diversity no doubt supports the goals of choice and responsiveness. It could, however, also be considered to be detrimental to prevention, early intervention and management of chronic diseases since different GPs might have inadequate knowledge of and access to patients' medical histories (an example of poorly managed interfaces - as detailed above). In fact, the development of electronic patient records offers the prospect of reconciling choice and diversity, on the one hand, with assured access to patients' histories on the other. Figure 3 illustrates this possible IT-led 'middle way'.

**Figure 3: IT helping to manage the risks and realise the benefits of diversity**



The above examples suggest that, if changes are well managed, and there is good communication and consultation, it should be possible to minimise the negative impacts of increased diversity on service users.

## Service providers

To the extent that diversity in its numerous guises leads to choice, competition and, ultimately, to changes in patterns of service it is likely to create both ‘winners’ and ‘losers’ among health care provider organisations and within the health workforce.

Most people find the prospect of change uncomfortable, and health professionals are no exception. Increasing diversity is thus likely to create the same risks of disorientation and uncertainty among the service provider community as among service users. There are plentiful examples of individual providers and/or lobby groups organising to oppose changes in the funding, organisation or focus of health systems when such changes are perceived to be prejudicial to their particular interests.

Furthermore, diversity by its very nature challenges monopolies. Thus, in cases where service providers have historically exploited monopoly positions to extract economic rents increasing diversity may lead to significant income reductions. Again, the end result might be significant disquiet among those affected.

As health systems become more diverse they can also create opportunities, both for new service providers to emerge and for existing service providers to adopt new roles, or to extend their existing roles.

A notable example arose as a result of far-reaching changes to health funding arrangements made in New Zealand in the early 1990s. Those changes meant that government subsidies, which had previously been ‘tied’ either to specific publicly owned providers or to specific professional groups (such as GPs), were replaced by contract-based payments. Such payments could be made to any appropriate service provider. As a result,

large numbers of new providers emerged including many that set out specifically to offer services tailored to meet the needs of that country’s indigenous Māori population. Figures suggesting a more than ten-fold increase in the numbers of such providers are often quoted. Those new providers were able to extend the range of services delivered by the publicly-funded health system, as well as offering new employment opportunities to health professionals and others, at least some of whom may previously have had little or no scope to practice in their specific areas of specialism.

So, from the service providers’ perspective, diverse health systems can be both threatening and liberating.

In contrasting the UK and Australian health systems it is also interesting to question whether the greater diversity found in the latter (specifically in terms of organisational arrangements) can be linked to differences in attitudes within the health workforce.

It is clear, to an outside observer, that the British NHS is a very strong and visible ‘brand’ from an employment perspective. Historically, it also provided a framework for standard national terms of employment and for industrial relations, as well as facilitating staff movement and redeployment. Even among those such as GPs who are not directly employed by the NHS (but rather are contractors to it) the sense of ‘belonging’ to an organisation of such size and iconic status is no doubt often a source, if not of pride, then at least of feelings of community.

In Australia and other countries with similar but more diverse systems, there is no single national health ‘service’ that is akin to the NHS. The country’s federal structure, which assigns responsibility for managing public hospitals to States and Territories while requiring the

Commonwealth to pay subsidies for privately provided primary care, means that NHS-like solidarity could never exist. Even within a single State or Territory hospital doctors and GPs look to different governments in many aspects of their professional life; and the fact that many aspects of professional regulation (eg medical and nursing registration, regulation of pharmacy practice) are primarily State and Territory responsibilities gives still more opportunities for diversity in professionals' attitudes and practices.

While it is difficult to provide evidence of how such diversity plays out in practice it is likely that the multiplicity of employment arrangements in Australia means that there is no (near-) monopsonist purchaser of labour as might be encountered in other systems. It is certainly the case that employment conditions for health professionals employed by one jurisdiction are cited in negotiations with others.

It is also interesting to speculate whether greater diversity in employment relations might also give rise to subtle differences in the balance between the 'professional' and 'organisational' loyalties of staff. Does the absence of a strong, national health 'service' (akin to the NHS) in countries such as Australia leave an 'allegiance gap' which is filled by professional bodies and trade unions becoming more prominent?

## Leaders

The keys to success as a leader (politician, bureaucrat or manager) in today's more diverse health systems are doubtless different from those that existed under previous models.

Today's health systems have little in common with the former 'command and control' systems, which were typically characterised by rigid hierarchies and rule-based approaches to management. Greater

diversity means that leaders need to work more through informal and often loosely structured processes of networking, negotiation and influencing rather than being able to rely on the ability to issue instructions and have them obeyed. That, in turn means that today's health leaders need new skills and competencies.

WHO coined the term 'stewardship' to describe the expanded role of today's health leaders. Although it is a term that has gained currency in the health policy vocabulary, it is not one which is yet well, or even uniformly, defined.

The World Health Report 2000, where the concept first gained prominence, states that stewardship encompasses:-

- formulating health policy which defines the vision and direction for health;
- exerting influence through regulation and other means; and
- collecting and using intelligence

Another definition<sup>1</sup> suggests that stewardship comprises the following activities:-

- overall system design;
- performance assessment;
- priority setting;
- intersectoral advocacy;
- regulation; and
- consumer protection.

An even broader characterisation is provided by the report of a WHO consultative meeting held in 2001<sup>2</sup> which

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<sup>1</sup> Murray CJL, Frenk J. *A framework for assessing the performance of health systems*. Bulletin of the World Health Organization, 2000, 78 (6): 717 - 731

<sup>2</sup> WHO Global consultation on stewardship, Geneva, 10/11 September 2001

identified a total of 19 stewardship activities as detailed in Figure 4.

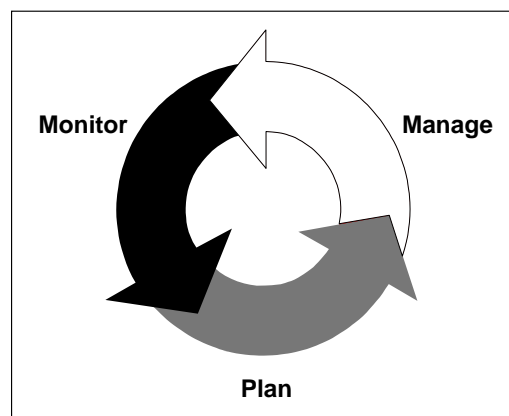
**Figure 4: Stewardship activities**

<ul style="list-style-type: none"> <li>Establishing and institutionalising transparency in management</li> </ul>	<ul style="list-style-type: none"> <li>Monitoring and evaluation of public health</li> </ul>
<ul style="list-style-type: none"> <li>Policy analysis</li> </ul>	<ul style="list-style-type: none"> <li>Policy formulation</li> </ul>
<ul style="list-style-type: none"> <li>Development and promulgation of an over-arching national health plan</li> </ul>	<ul style="list-style-type: none"> <li>Defining and promoting a vision for health</li> </ul>
<ul style="list-style-type: none"> <li>High-level investment and resource allocation decisions</li> </ul>	<ul style="list-style-type: none"> <li>Advocating for healthy public policies in other sectors</li> </ul>
<ul style="list-style-type: none"> <li>Consensus building inside and outside the health sector</li> </ul>	<ul style="list-style-type: none"> <li>Encouraging dialogue between communities and the health system</li> </ul>
<ul style="list-style-type: none"> <li>Strategic institution building</li> </ul>	<ul style="list-style-type: none"> <li>Regulation and enforcement</li> </ul>
<ul style="list-style-type: none"> <li>Creating incentives</li> </ul>	<ul style="list-style-type: none"> <li>Synchronisation of health players</li> </ul>
<ul style="list-style-type: none"> <li>Communication</li> </ul>	<ul style="list-style-type: none"> <li>Consumer education</li> </ul>
<ul style="list-style-type: none"> <li>Intelligence gathering</li> </ul>	<ul style="list-style-type: none"> <li>Establishing, promoting and strengthening shared values and the ethical base for health action</li> </ul>
<ul style="list-style-type: none"> <li>Policy evaluation and correction</li> </ul>	

What seems to be clear from the foregoing is that stewardship involves taking a much broader view of health than is perhaps implicit in more traditional approaches to health system leadership. That breadth can be discerned in much current thinking on the roles, competencies and critical success factors for health sector leaders.

In light of the above, we can consider the nature of the leader's role in a diverse health system in relation to each of the three key areas of planning, managing and monitoring (Figure 5).

**Figure 5: Leadership roles**



### *Planning*

Individual service providers must, and do, continue to prepare detailed operational plans for their specific areas of activity. At the national level, however, planning in contemporary health systems is more about setting out strategic directions and defining the ‘rules of the game’ than it is about developing detailed specifications for future patterns of service delivery. The focus is more about establishing an environment in which the right things will happen rather than attempting to determine how, when, where and by whom those things will be done.

Increasing complexity, in health and in broader society, is also changing the nature of the planning task from charting a path for a health system to building robustness and resilience into that system.

The medical workforce, for example, is an area where traditional planning approaches have clearly been found lacking. Despite many years of workforce planning effort and the development of increasingly sophisticated analytical approaches for forecasting supply and demand, most western countries now find themselves confronted with serious, if not critical, shortages of appropriately skilled medical staff. But perhaps such an outcome is inevitable given the disparity between the time it takes to produce a qualified doctor and the pace of change both in treatment technologies and in social attitudes. Can a ‘long-cycle’ process such as conventional medical training ever be expected accurately to track the impacts of the increasingly ‘short-cycle’ processes that underpin not only the ways in which we seek and receive health care but also our

attitudes to work, to family and to how we live as a society?

Perhaps the answer, in terms of how we plan our medical workforce, lies less in developing more and better planning models and more in ensuring that the health workforce of the future is better able (and better supported) to adapt to change whenever and however it eventuates.

Likewise for other key aspects of our health systems; the leader’s role now is less one of drawing and following a map and more one of defining the destination and ensuring that the travellers have all they need to find their way towards it.

### *Managing*

Managing a diverse health system also requires new skills. Service providers who are not directly controlled are less likely to respond to direct commands. Rather, their actions will be shaped by a more complex array of incentives, regulations and (professional and other) obligations. Accordingly, the contemporary leader’s management role is increasingly one of shaping incentives, defining regulations and enforcing obligations rather than issuing instructions. A particular skill that is now required of many health care leaders is that of specifying, in contractual or quasi-contractual (‘service agreement’) terms, what it is that they require a particular provider to deliver.

It is, however, possible to overstate the ‘arms length’ nature of management in a modern, diverse health system. Regardless of the extent to which decision-making (and responsibility for its outcomes) is delegated the public will typically continue to hold their government responsible for the performance both of the system as a whole and of individual components within it.

This point is again exemplified by experience in New Zealand, which has so often been the laboratory for health system experimentation in recent years. There, moves were made to distance government from decisions both on what services should be provided (by establishing separate ‘purchasers’ at arm’s length from government) and on what part the public sector should play in delivering them (by setting up public hospitals as stand-alone state-owned companies). It was assumed that the role of government would reduce to one of broad goal definition, performance monitoring and regulation; and consequently its engagement with the public would primarily focus on such broad, strategic issues. In the event, however, the public obstinately (but understandably) insisted on continuing to hold the government to account for all aspects of the system’s performance, both micro- and macro-.

While it may be appealing to subscribe to the view that governments’ role in health system management is now one of steering rather than rowing it seems clear that, in the minds of the public at least, government should continue to have at least a light touch on the oars.

### *Monitoring*

Monitoring health system performance can be seen as completing the feedback cycle of management (with the results of monitoring being used to shape plans for the future).

The task of monitoring in diverse health systems presents particular challenges. Typically, there are more players and a broader range of services to be monitored; and there are higher expectations of openness and accountability. The emergence of initiatives such as the performance assessments carried out by the Dr Foster organisation in the UK are

symptomatic of the hunger for comparative performance information.

Increasing diversity has had an impact both on the ‘how’ and the ‘what’ of performance monitoring in health. What was once often a straightforward (if somewhat cumbersome) process of hierarchical reporting in most health systems has now become one of agreeing appropriate performance expectations for different aspects of the system and then developing information systems that can provide accurate and timely data on achievements against those expectations. Once again, new skills are needed to specify, collect and interpret performance data.

Likewise, in terms of the data themselves, changes in approaches to service delivery are forcing health leaders to rethink how they measure achievement and success. To cite just one simple example, perennial measures of resourcing such as hospital beds per capita and doctor/population ratios are becoming increasingly irrelevant as, respectively, more services are delivered on an ambulatory basis and, in some systems at least, tasks that once required the involvement of a doctor are now safely and effectively assigned to nurses or paramedical staff.

Greater diversity has undoubtedly brought with it greater sophistication in approaches to monitoring the performance of health systems and their component parts. That is due, in part at least, to the fact that the decoupling that now exists between players within health systems means that information requirements and reporting arrangements have to be specified in greater detail. Health leaders are no longer masters of all they survey, with access to any and all information produced with the systems they oversee. Rather they are obliged to specify what they will monitor and how they will do so.

Modern, diverse and decentralised health systems are often contrasted with the original and highly centralised design of the NHS in which, according to Aneurin Bevan, the sound of a dropped bedpan in Tredegar Hospital would reverberate around the Palace of Westminster. But diversity does not equate to disinterest and, in reality, contemporary monitoring arrangements would probably ensure that data on dropped bedpans were routinely collected, stored in a powerful management information system and, if not routinely reported to Westminster, could at least be accessed if and when the need arose.

Of course, monitoring does not just involve looking at what is achieved within a health system, but it can also extend to encompass comparisons of what is achieved among different health systems. Increasing diversity means that the countries of the world now provide us with numerous models of how health systems can be designed and operated. Indeed, the past 25 years of health reform can be viewed as a large-scale natural experiment in which various approaches have been tested. The fact that there is still no clear consensus on what works best is undoubtedly testimony both to the underlying complexity of health policy and to the relative lack of sophistication in evaluation methods.

Traditionally, comparisons of health systems have focussed on a few key measures of resource inputs and service outputs. In the case of the OECD countries, for example, such data have been systematically collected and disseminated on an annual basis for many years. In light of the observations above, however, it is questionable whether such comparisons are still of value. Should we congratulate a country that has a lower than average ratio of hospital beds to head of population for moving away from costly institutional services? Or should we

commiserate with such a country on the grounds that its health system is starved of a vital resource?

Indeed, it is issues such as the above that underlay the moves by WHO to develop the approach to health system performance assessment outlined in the World Health Report 2000. By focusing on five 'universal' goals, it was claimed, the WHO approach offered a more sound basis for inter-country comparisons. At the same time, however, it generated considerable controversy because it meant that WHO was taking a position on what health systems should be trying to achieve; a normative role that is rarely adopted by UN agencies. The WHO approach was notable also for its use of an analytical technique known as frontier analysis to ensure that health systems were compared on a like-with-like basis, making allowance for differences in countries' GDP and level of development.

Ultimately, WHO's work on health system performance assessment aimed to establish an evidence base on what works best in health system design and operation. In essence it sought to formalise the natural experiment of health reform by using the diversity of health systems to develop and test hypotheses on the relationship between how the key functions of a health system are undertaken and how well that system performs. Whether such a goal could ever be achieved, given the vast array of ways in which health systems can and do differ, is questionable.

## **Conclusion**

Organised health systems are a relatively recent phenomenon and, during their existence, they have become steadily more diverse. Today, most health systems encompass a broader range of providers, delivering a greater mix of services and drawing on a wider variety of funding sources than ever before.

Diversity adds complexity, which in turn may present challenges to those who use, deliver and manage our health systems. At the same time, however, diversity can enhance choice, offer opportunities for innovation and provide a fertile test bed for developing and comparing new ways to organise and deliver health care.

Perhaps the greatest risk of growing diversity is its potential to create disorientation and uncertainty among those who use and deliver health services. Accordingly, one of the main challenges for those who set health policy and are responsible for its successful implementation, is to act as effective change managers: to explain the rationale for new ways of organising and delivering health care; to demonstrate their benefits; and to address any fears that they might generate.



# Decentralisation: Promise and Problems

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Roger Wilkins and Scott Greer

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## I.Promise

Why is decentralisation a good thing in politics and policy? It certainly seems to be such; a majority of countries around the world from Britain to Peru are creating or strengthening regional levels of government while across broad swathes of public policy in many countries the centre is promising to devolve power and take a step back to let the local level work with less constraint. There are three tested arguments suggesting that this regionalising trend is happening for good reasons and that it can produce desirable effects.

The first argument is from *democracy*. The argument is simply that some jurisdictions have different preferences. Scotland and Wales would never have elected Margaret Thatcher, and her policies had less resonance and less popularity there than they had in England. The experience of having their preferences routinely overruled by London, by a government seen as English, convinced the political classes of Scotland and Wales that they would like autonomy. It is not hard to argue that communities such as the Scots have different preferences and good political institutions allow them to express them.

The second argument is from *policy*. This argument makes states and other decentralised governments what the American justice Louis Brandeis called the “laboratories of democracy.” More jurisdictions means more experiments can

run concurrently. More jurisdictions also means that it is more likely somebody somewhere is experimenting. Finally, it can be hazardous to experiment with policies across the whole country, runs the argument; instead, ideas can be tested in particular jurisdictions and adopted if they prove good.

The third argument is from *efficiency*. The logic of economists also suggests that decentralised provision of public services can be good: they argue that providing the same service everywhere, according to the same rules, is likely to underprovide in some areas, overprovide in others, and sometimes miss the point. The UK’s major hospital building programme of the 1960s, for example, was designed to provide the same health services across the whole country (so that, for example, local areas would all have the same ratio of hospital beds to population). It found that areas with poor health were underprovided and some areas almost overprovided—equal provision did not mean equity. Had hospital resources been allocated locally they would have better suited the needs of the population.

## II.Problems

Nevertheless, decentralisation can go wrong and there are specific mechanisms that lead to recentralisation. What can go wrong when we try to gain the advantages of decentralisation? What kinds of institutional and political problems can emerge?

The United Kingdom has a short history of constitutional devolution and a poor history of devolution to local government. Northern Ireland, Scotland, and Wales have only had their governments for five years (and Northern Ireland's self-government has been intermittent and overshadowed by the peace process). The history of local government and local self-government within the health services has largely been a story of increasing centralisation. Governments arrive in power intending to devolve health services to the local level and leave the health system more centralised than before. The concentration of power and accountability in the government explains this pattern—the Prime Minister is routinely blamed for bad cancer treatment in Birmingham or an unethical doctor in Liverpool, and the centre correspondingly tends to intervene at the local level. Neither the public nor the political class focuses on the local or regional boards and managers, and the managers lack the democratic or professional legitimacy to stand up against centralisation. *Therefore, the problem for the UK is creeping recentralisation.* It is an open question whether the new devolved governments of Northern Ireland, Scotland, and Wales are capable of resisting the temptation of voters and politicians alike to concentrate on the executive in London. It is an even more open question whether local government or new local units of the health service can ever be more than rubber-stamps for Whitehall—no matter how convinced Whitehall might be that they should be otherwise.

In Australia there has also been a process of centralisation of power since federation in 1901. But the central issue confronting Australia now is how to share responsibility in key areas of policy and service delivery, not whether to share power. How do you configure roles and responsibilities for health, education, security, the environment, etc, to provide

the best outcome for citizens, including the advantages of federalism we have referred to?

#### **a. Australia**

A key issue in Australian federalism as it relates to health policy is not only the degree of dominance of the Commonwealth, or the level of autonomy of the States, it is also the *dysfunctional split* in responsibility for health between the Commonwealth and the States.

The Commonwealth has broad responsibilities for medical benefits, pharmaceutical benefits (except in public hospitals), general practitioners, university education of health professionals and aged care funding. The States have broad responsibilities for public hospitals, accreditation of private hospitals and aged care facilities, and health professional registration. This split of responsibilities leaves the Commonwealth and the States open to 'cost-shifting' from one jurisdiction to the other. Given the size of health budgets, cost-shifting, and its prevention, dominates health policy interaction between the Commonwealth and the States.

The following is a list of instructive examples of how this problem manifests:

- 'First point of contact' services provided by emergency departments and by general practitioners are the responsibility of State governments and the Commonwealth government respectively. State governments argue that Commonwealth government cost-containment policies which affect the number and availability of general practitioners have an effect on demand for emergency department services with many patients presenting at emergency departments with ailments better dealt with by general practitioners. This shifts the costs of

primary care onto State government as well as shifting political pressure onto the States.

- States also argue that the Commonwealth is not providing sufficient primary health care funding (for general practitioners and community health care) to adequately meet the needs of patients with chronic conditions like cancer and mental health conditions. This increases demand for hospital services and shifts costs and political pressures onto the States.
- The transition between acute care and aged care is also problematic. States argue that there are a large number of aged people in acute (hospital) care when they should more appropriately be in aged care facilities. This means that the costs of the care of these aged people have been shifted onto the States with the additional problem of the people tying up resources and artificially inflating demand for hospital services.
- Access to elective surgery in public hospitals is another area of dispute. The Commonwealth is responsible for paying medical benefits to cover part of the costs of surgery in private hospitals and day care facilities (with the remainder borne by the patient). The Commonwealth argues that long waiting times for elective surgery in public hospitals drive up demand for private surgery of this type, consequently driving up the Commonwealth's costs for medical benefits.
- Funding for pharmaceuticals is also dysfunctionally split as the States fund pharmaceuticals in public hospitals with the Commonwealth funding the remainder of pharmaceuticals. Pharmaceuticals are provided for free

as part of a patient's public hospital treatment but under the Commonwealth Pharmaceutical Benefits Scheme patients are required to make a co-contribution. Cost-shifting occurs at the transition points as patients with ongoing pharmaceutical needs move in and out of public hospitals.

- Workforce issues lie across the dysfunctional split of responsibility also with the Commonwealth funding education of health professionals through the university system and the States being responsible for professional registration and generally being the larger employer of health professionals. In effect, the Commonwealth controls the number of nurses, doctors and other professionals available to the system and thus the capacity of the system. However, the political pressure resulting from workforce shortages falls disproportionately on the States.

The Commonwealth is responsible for regulating private health care and private health insurance. The States argue that Commonwealth policies in this area undermine health system cost-containment strategies by increasing resources available to the private health system. This increases wage demands from health professionals in the public hospital system, a cost borne by the States.

## **b. UK**

The problem of decentralisation in the UK is simple: the key political institutions exert a powerful centripetal force. The executive dominates Parliament and both dominate press coverage; the result is tough party discipline and a powerful political focus on the activities of those few who inhabit the "Westminster village." Meanwhile, the doctrine of parliamentary sovereignty has teeth: local

government is financially dependent on Westminster and can be reorganised by legislation, while the English NHS is largely composed of organisations that can be merged, abolished, reformed or otherwise altered at low political cost and that are on a daily basis subject to central intervention.

What explains this inability to sustain a vital local or regional level of politics and policy? The problem is twofold. First, there are problems of resources. Neither local units of the health service nor local government have the resources to vary significantly; their responsibilities as defined by the centre and their obligations to fund existing programmes mean that they have very little autonomy. Second, there is the problem of local democratic legitimacy. Governments have always had problems endowing the health services' local organisations with democratic legitimacy, and the commitment of UK governments to local democracy in the NHS has usually been half-hearted at best. Local autonomy threatens national standards and bad headlines that will attach themselves not to a largely unknown regional health board or district health authority but to the government. As a result, the tendency has been to replace local, geographic units with various agencies that take over local government functions and to deprive the local units of the health service of all but the most minimal autonomy to tailor services to local needs. Put simply, the government writes the rules, holds the purse strings—and is under constant political pressure to use its power to standardise the local level rather than let it experiment.

What, then, of “formal devolution,” ie. the creation of strong legislative or quasi-legislative governments for Scotland, Wales, and Northern Ireland? These governments are in essence very autonomous. The UK has adopted a very unusual form of devolved government that

gives great autonomy to three of its subunits (especially Scotland) and none at all to England, which has 85% of the population. Scotland, for example, has powers over almost every aspect of health policy; there is effectively no regulatory framework constraining it. Furthermore, the three devolved countries are all funded by an overall block grant set by a population-based formula. So long as the UK Treasury is bounded by this formula there is little discretion for central government intervention in devolved affairs by means of finance. Scotland, and to a lesser extent Northern Ireland and Wales, are sealed off from formal influence, and all three have already made decisions known to be unpopular with the central government. They have also, however, also centralised their health systems yet more.

This suggests that the UK has found a model that is capable of resisting centripetal tendencies in its politics (it does not follow that the Scottish or Welsh policies are necessarily better). That model is of a large, ideally national government with an identifiable political arena of press and politicians and a range of policies so that it can attract talent and attention and develop priorities out of its various competencies. The extent to which such a model could be replicated within England can be questioned, since England is economically and socially centralised in London, and the extent to which the extreme autonomy of Scotland could be a model for a thoroughgoing decentralisation of the UK state is also questionable.

### **III. Conclusions and questions**

There are two challenges to any effort to gain the benefits of decentralisation in public policy. The first is recentralisation—that the central government, blessed with greater funds and autonomy, and sometimes legal

superiority, can effectively void the power and autonomy of the local levels. The second is cost- and blame-shifting behaviour when there are multiple players in health services. This means that if we are to reap the benefits of decentralisation while also providing quality services and sustaining citizenship rights, we must develop answers to some key questions:

- What forms of intergovernmental relations and finance mitigate problems of cost-shifting and blame avoidance?
- What degree of divergence in policy and performance will the public tolerate? To what extent should the central government police this?
- Does the very high degree of autonomy given to Scotland represent a generalisable model, or should the UK look to the more multilateral and negotiated order seen in Australia and other Commonwealth federations?
- Do the experiences of devolution to Scotland and Wales and Australian federalism suggest that England's health service would work better if it were regionalised and run by democratically elected assemblies or boards?

# Investment in Prevention and the Contribution of Population Health Policy to Improving Health Outcomes

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Peter D Donnelly

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## Introduction

Public Health can be defined in the following way:

*‘Public Health is one of the efforts organised by society to protect, promote and restore the people’s health. It is a combination of sciences, skills and beliefs that is directed to the maintenance and improvement of the health of all the people through collective or social actions. The programmes, services, and institutions involved emphasise the prevention of disease and the health needs of the population as a whole. Public Health activities change with changing technology and social values, but the goals remain the same: to reduce the amount of disease, premature death, and disease produced discomfort and disability in the population. Public Health is thus a social institution, a discipline and a practice’*

A Dictionary of Epidemiology edited by John M Last, published by The International Epidemiological Association, 1988

Public Health is thus by definition multi-professional, cross-agency and equally concerned with the three domains of health protection, health promotion and health restoration (or health service provision, if you prefer). My first message and perhaps

the single most important thing that I am going to convey to the session is that Public Health is at its most effective and influential when these three domains of health protection, health promotion and health restoration are integrated. In an attempt to illustrate and hopefully support this argument I wish to deal sequentially with the following issues:

- Investing in prevention
- The Public Health role of healthcare professionals
- The thoughtful design, regulation and commissioning of health systems to promote health
- Public Health Law

The first of these issues involves us in directly addressing the question of why we should consider investing hard pressed healthcare resources in prevention. I would argue that it is no longer good enough simply to rely upon trite statements such as “prevention is better than cure” or to make unsubstantiated assertions around the long-term benefits of primary prevention in the absence of supporting evidence. Rather we have to bring increasingly to the field of prevention the disciplines of evidence based practice and health economic analysis that have come to bear recently upon the introduction of new pharmaceutical and technological agents into healthcare practice. Nor is it good

enough simply to argue that investment in prevention must be made as a statement of faith or to rely on rather woolly evidence of capacity building and raised awareness as proof of likely future beneficial impact. To be blunt about it, we need to bring to bear the same rigour that governs the use of new entry pharmaceuticals and technology and the same robustness that would apply to the way that we manage down an unacceptably long waiting list for elective surgical procedures.

We also must escape the idea that prevention is somehow different, distinct and divorced from that which occurs in the provision of healthcare services. In fact much of that which clinicians perform as part of their day-to-day jobs is best described as secondary and tertiary prevention. So the clinician who picks up a middle age women's osteoporosis as a result of dealing with her fractured wrist and as a result ensures that future fractures are prevented or at least delayed is as involved in prevention as the community based worker encouraging elderly groups to maintain their calcium and vitamin D intake and to undertake weight bearing exercise as a way of reducing the risk of fractures. I shall return to this theme when I address the public health role of healthcare professionals but perhaps suffice here to argue that prevention and care are part of a spectrum of community and clinical activity rather than separate endeavours.

### **The Investment – Prevention Time Lag**

It is important now to address specifically the single most obvious barrier to investing in prevention in a mixed economy system working within the liberal democratic tradition. I refer to the long lead-time that exists between investment and return. If we start with one of the better known and quantified examples it takes somewhere between 12 and 15 years before any decrease in

cigarette smoking will be reflected in a decrease in the incidents of lung cancer. Indeed some have argued that wholesale reduction in smoking prevalence may (at least in theory) lead to an initial increase in lung cancer as those who would have succumbed in the interim to myocardial infarction live long enough to contract and die from lung cancer. I hesitate even to note this, as I have no desire to be misreported as the first Director of Public Health to suggest that giving up cigarette smoking increases your risk of lung cancer and that of course is not, I repeat not, the case but the example is salutary in terms of the complexity that one can get into in articulating the case for prevention.

One of the American president's, I think Eisenhower, is reported to have said that politicians focus on the next election whereas statesmen focus upon the next generation. When I perhaps unwisely put this to the Scottish Deputy Health Minister he quite fairly made the point that unless he focussed on the next election and got himself re-elected there was not much prospect of him ever becoming a statesman! Interestingly his political boss the health minister later went on to use the same original quote when launching a government white paper on the challenge of improving Scotland's Health and tackling our marked health inequalities (Scottish Executive 2003). But the serious point remains and the challenge to us involved in Public Health is how we help our politicians become statesman and to focus beyond the next election and rather on the next generation and therefore be understanding and supporting of the need for a balanced programme which invests in prevention as well as cure.

The argument for prevention can be further complicated by the cross-agency and multi-sector nature of the investment that is required. Yet there is creditable evidence that investment in anti-natal care, early nutrition, parenting and early years

nutrition all have an important role to play in the establishment of health promoting lifestyles in middle and later years (Scottish Executive 2003).

In this regard traditional political and civil service systems as arranged in ministerial silos can be unhelpful. What are required are the sort of crosscutting initiatives that explicitly acknowledge how decent housing and environment, educational attainment and employment opportunities have profound and fundamental effects upon the attainment of good health. If you wish corroboration of this I would point you towards the health inequalities that continue to persist in our most affluent democratic countries and which almost invariably mirror inequalities in terms of income, housing quality, education attainment and employment status (Leon et al 2003).

### **Devolution and Federalism**

In terms of the theme of this conference it would be interesting to explore whether federalism in the case of Australia or devolution in the case of the United Kingdom helps or hinders the process of encouraging such cross-cutting public health promoting initiatives. My impression from working in Wales and Scotland, either side of devolution, suggests that devolution has helped in this regard. I am less clear whether this is a result of; the more local nature of democracy, the greater participation in democracy that flows from a large number of elected Assembly members in Wales or members of the Scottish Parliament north of the border, or perhaps most likely from the more consensual politics that has flowed in both counties because of the differing electoral systems from Westminster. In the case of Wales and Scotland, the assembly and parliament respectively are at least to some extent proportionate with top up members in both cases allowing a representation more reflective of the popular vote and

permitting entry into parliament of parties who would not otherwise be represented in a purely first past the post system.

Undoubtedly the committee system that operates in Wales and Scotland also appears to give rise to thoughtful and considered debate and my experiences in giving evidence to committees of elected representatives in England, Scotland and Wales is that the devolved bodies certainly appear to operate in a less overtly party partisan way at least in terms of evidence gathering. I appreciate these observations are hardly scientific but the difference in the quality of experience was so marked that I think it worth mentioning.

### **The Public Health Role of Health Care Professionals**

I now should move on to my second topic, which is the Public Health role of Healthcare Professionals. I wish to strongly argue that healthcare professionals are in a unique and privileged position in terms of their public health capacity. The tragedy is they probably do not in a large part realise this. Let me give you two examples one from Australia and then one from the United Kingdom. If I can start with the Australian example many of you will be aware of the legislation that now requires back yard swimming pools to be fenced in. This legislation really arose in part because of the campaign led by Australian paramedics who were becoming increasingly distressed at being called to attempt to resuscitate drowned toddlers. I am in no doubt that the fact that the advocacy came from these respected front line health care professionals made their representations that much more effective. The results of their legislation fully justify their actions. (Thomson & Rivera 2003).

My UK example is drawn from the field of oral maxillo facial surgery, a highly specialised hybrid discipline encompassing qualification in medicine and dentistry and



higher specialist training in the field of surgery to the face, mouth, jaws etc. A large part of the emergency work in this specialty is as a result of trauma some of it related to road traffic accidents but much of it related to violence. A UK colleague from Cardiff became increasingly aware that much of that violence was alcohol related and indeed occurred on Friday and Saturday night. Young people, largely young men, drinking too much alcohol with often the assailant and the victim being equally inebriated. He also was astute enough to observe that the individuals returned to accident and emergency or out-patients OMFS clinic for follow-up or to have stitches removed. During this procedure there was what he has come to term a “teachable moment,” when the now sober and reflective individual may be receptive to a skilfully given preventative measure aimed at avoiding repetition. However the really credit worthy aspect of this tale, is that he then went on to demonstrate in a properly designed study that one could bring about a reduction in these individuals in problem drinking through such an appropriately timed carefully delivered intervention (Smith et al 2003). I think I as a Director of Public Health could have spent many fruitless years and unproductive hundreds of thousands of pounds or dollars of tax payers money in less focused, less timely interventions to reduce problem drinking with much less benefit.

Finally in this section if I could return briefly to cigarette smoking. I do think it is noteworthy that following the ground breaking work of Doll and Hill (1951) in this area the medical profession did reduce greatly their own smoking prevalence. This provision of example undoubtedly catalysed change in the general population. I am less clear that the same has happened with alcohol and the light-hearted remark that the definition of an alcoholic is someone who drinks more than his doctor has unfortunately some foundation in truth

with alcohol abuse rates, drug misuse and suicide rates amongst the medical profession being rivalled only by publicans and journalists. Unfortunately such abuse appears prevalent amongst even recently qualified doctors (Birch et al 1998) Never the less my general point I think is sustainable namely that healthcare professionals are in a unique and privileged position to provide timely and focussed health promoting messages. They generally are regarded as a respected source of information. They have the capacity to lead by example and here lies a further reason for not separating health promotion from healthcare provision.

### **The Design, Regulation and Commissioning of Health Systems**

Turning now to the third of my four subject areas, which is the need to thoughtfully design, regulate and commission health systems in such way as to promote health. The first rule that medical students and junior doctors are encouraged to learn is first do no harm. We need to, I believe, apply that as rigorously to the work of those of us who design, regulate, commission and manage healthcare systems as we do to the work of individual clinicians.

Let me explain; health inequalities and the disparity between health outcomes for rich and poor in society may have their origins in unequal socio-economic and educational opportunity but they undoubtedly can be sustained and made worse by the thoughtless design, regulation and commissioning of health systems.

We know for example that there is almost always a “halo effect” around facilities of highly specialised technical expertise which through so called provider drive means that access to healthcare can depend as much on geography as on need (Hull et al 1997). Now of course geography is

relative and I still smile when I recall a discussion with an intensive care colleague at the Sick Children's Hospital in Perth, Australia. I had just recounted the difficulties I was having in getting some individuals in Swansea to accept that some of the highly specialist healthcare provision they needed may have to come from Cardiff 30 miles distant. He then proceeded to draw the catchment area for his intensive care unit onto a map on his wall and I recall the boundaries extending as far north of Papua New Guinea and in all covering an area that must have approximated the size of Western Europe. I returned to South Wales – Old South Wales that is – and used the comparison shamelessly!

However the point that access can be based on geography rather than need I think has been demonstrated repeatedly. Interestingly the more you move away from emergency and acute services through elective services to preventative services then the more striking this inverse care law becomes. The inverse care law you will recall was coined by a Welsh GP named Julian Tudor-Hart (1971) who observed that access to healthcare services appeared to be inversely related to need. That was not largely a product of differential provision between rich and poor areas but rather the relative inability of less socially adept individuals to articulate their way successfully through the healthcare system. Examples of this abound. The people who turn up for screening are often those least at risk of the disease. This certainly applies in terms of cervical cytology, health promoting activities such as exercise, dieting regimes and smoking cessation initiatives (Goddard & Smith 2001).

Interestingly the one contrary example involves breast cancer where the epidemiology dictates that those most at risk of getting the disease ie. social classes 1 and 2 are in fact those most likely to turn

up for the screening (Hurley et al 1994). This well known exception is a product of the presumed causality of the disease and the effect of for example delayed child bearing on hormonal mediators (Chie et al 2000).

Nevertheless as a general rule elective and preventative programmes are much more likely to miss the mark in terms of addressing need than programmes based on an emergency response. If you don't believe me I suggest you seek to spend time in a casualty department in a large urban area and then you will see all of life! Regardless of the specific presenting problem, those who attend include in disproportionate numbers the most needy in our society, those with socio-economic and employment problems as well as health problems, those most likely to be dependant on drugs and alcohol and those who otherwise find access to healthcare difficult.

Yet lest I be misunderstood this is not an argument to move wholesale over towards a reactive healthcare service although undoubtedly the reactive capacity of the healthcare service can contribute to the previously mentioned opportunistic health promotion interventions.

Rather it is an argument to think very carefully how we focus all our improvements in healthcare. What I think we should do is apply what I would term a health inequality sieve to every substantial change in healthcare service provision.

Now this falls short of requiring a formal health impact analysis every time we want to open a few more dialysis beds or argue for some minor re-provision of elective surgical services. However if we were to have the self discipline to consider what the possible effects in terms of health inequalities might be every time such a change was proposed much in the same way as some local government authorities

have for many years done this in terms of consequences, for racial and sexual equality then I think we would at least avoid making the most obvious mistakes.

### **Public Health Law**

That brings me to my final topic of the four Public Health Law. I am not a lawyer and profess no great expertise in this area but I have given some thought not simply to what could be termed specifically Public Health Law but also to the legal framework within which much of public health is practiced. Of course Public Health has a long-standing association with legal sanction. Historically often of a rather punitive and authoritarian nature. I am thinking for example of laws and regulations around quarantine and restriction of liberties (WHO 2002). Vaccination or certification proving that you have had the vaccination may in some parts of the world prohibit you from attending school or even entering the country. In some parts of the world carriage of a particular disease may debar your entry and often such legislative restrictions owe more to ill informed fear and prejudice than they do to any objective defensible appraisal of true levels of risk (Flahault & Valleron 1990). In many countries these laws need rewriting and some important work in this regard has recently been completed (Monaghan et al 2003).

However it is not that particular aspect of Public Health legislation that concerns me but arguably perhaps the opposite end of the legal spectrum namely the growing concern with human rights legislation. The Scottish Parliament as many of you will know is a primary legislative body like Westminster rather than a body concerned with secondary legislation and regulation like the Welsh Assembly. It is interesting to note that the Scottish Parliament enshrined within Scottish Law the European Convention of Human

Rights in advance of its consideration by Westminster. In addition, some years ago I attended an excellent conference in Melbourne organised by the Australian Public Health Association which specifically focussed upon Public Health and Human Rights. Until that time it had not been something that I had particularly considered and I was grateful to the Australian Public Health Association for making me reflect on this matter.

I think there are two effects that I would like to try and tease out. The first is the direct rights based effect of such legislative provision which for example will increasingly mean that the resource allocation decisions of authorities commissioning health services will be held up to scrutiny and challenged if they are found to be discriminatory in any way. I think the inevitability of this is increasingly understood and accepted and is becoming seen as legitimate and positive.

However I think there is a less well understood but perhaps in the longer term more profound effect of a progressive move towards a rights based culture as a framework for Public Health practice. To demonstrate this I would like to discuss briefly the example of immunisation.

In particular the difficulties we have been having in the United Kingdom around measles mumps and rubella (MMR) vaccination. Over the last five years or so there has been a well articulated but I believe scientifically unfounded concern that childhood immunisation with MMR maybe be linked to a number of diseases including autism (Wakefield et al 1998; Taylor et al 2002; Black et al 2002). As a result MMR vaccination has fallen off and for the first time in many years we are beginning to see sporadic cases of measles (McBrien et al 2003). There is now a genuine fear that a full-blown outbreak of measles could occur if immunisation rates

continue to fall. The response of the UK Department of Health has been to repeatedly assert that the scientific evidence does not support any cause or link between MMR and any disease of childhood and whilst they have not banned the import of single dosed vaccines of measles, mumps and rubella they certainly have not facilitated any increased provision of these agents in the way that proponents of split, rather than combined, vaccinations would request.

There are interesting arguments on both sides. One depending upon the rights of parents to choose to immunise their children with single vaccines if they wish and one on the government's side around the worry that this would provide a period of greater exposure to measles whilst vaccination was incomplete (Ramsay et al 2002). My purpose is not to rehearse these arguments which could justify a session, in and of, themselves. Rather it is to suggest that this whole debate is not unrelated to the growing rights based culture within which Public Health professionals have to act. To understand this I think we have to consider why it is that people are prepared to accept considerable risk when they feel it is entered into voluntarily and if they feel they have some degree of control whereas they are absolutely not prepared to accept any significant risk if they feel it is imposed. As an example, cigarette smoking over the course of a lifetime kills every second person who does it. An average member of the public might not understand the statistics to be as stark as that but they certainly know that it is a highly risky thing to do and yet they continue to it. Thus, whilst we must not underestimate the powerful confounding effect of nicotine addiction, many smokers would seem to regard smoking as something over which they exercise discretion, control and choice. Yet that very same member of the public may be utterly unwilling to accept a very low risk consequent to for example an environment

exposure to a small amount of industrial pollutant or naturally occurring carcinogen such as radon gas.

The difference I think comes down to the unacceptability of imposed risk. Even if you were to accept the assertions made by the opponents of MMR that there is a causal link between MMR and autism, (an assertion which I incidentally don't accept,) then the absolute risk of developing autism as a result of MMR immunisation would be extremely small.

I therefore think it is likely that part of the objection that many people have to combined MMR immunisation is because they place it in the mental box that is labelled 'imposed risk' and not in that which is labelled 'voluntary risk'. Also in part they are less prepared to accept risks on behalf of their children than they would when deciding for themselves.

Where does this lead us in a policy sense? What I think it means is that we have to give renewed consideration to how we communicate risk and how we take and implement policy decisions. People need to come to see immunisation as something that they enter into voluntarily on an informed basis as our partners rather than our subjects. This is much harder of course than just telling people to trust us. But I think in a rights based culture where increasingly people have access to at least as good information as those who are making decisions on their behalf then we have to seek to genuinely involve the public as co-deciders and if you like co-investors in their own health.

Now this does not of course mean that there is no legislative component to Public Health. On the contrary there are many good examples of legislation enabling or at least reinforcing important Public Health initiatives. I mentioned earlier on in my talk the fencing in of back yard pools. I could have equally mentioned seatbelt

legislation or motor cycle helmet legislation. In some cases the legislation is absolutely required to drive changes in population behaviour. In others it is largely a reinforcing measure which comes along after a population has started to comply and of course there is a whole political art of determining at what point legislation which is restrictive of individual freedoms is publicly acceptable and therefore politically viable. The current debate in the UK includes that of a possible ban of smoking in public places. The fact that the Chief Medical Officer called for such a ban whilst launching his 2003 report (Department of Health 2003) is itself suggestive of a changing climate of opinion.

However, there is a much wider field of legislative and political action, which we need to consider in the context of public health. If we return to my example of Friday and Saturday night alcohol related pub and night club injuries then undoubtedly legislation around licensing, opening hours, and availability of alcohol all contribute. As could specific legislation around the type of glass used in beer glasses and similar potential weapons. The fluoridation of public water supply is another effective and safe although admittedly controversial measure, which could be adopted. Many would accept the argument for the supplementation of bread with folic acid and of salt with potassium chloride.

More interestingly I think we need to begin to tackle issues of public policy which fall short of statutory legislation but which could never the less have a major impact.

So for example a colleague of mine, Phil Hanlon, has pointed out that we don't expect primary school aged children to be competent to make major decisions around their safety in terms of crossing busy roads yet we are content that they take decisions

about what they eat and drink. We see sugary carbonated drinks and fatty snacks as a matter of choice rather than a matter of ill informed unintentional self harm. I think the Public Health community can and should be more demanding of local authority school boards or health authorities in the role they can play to take seriously their responsibilities in this regard. Similarly I think we need to look at planning legislation carefully. Another colleague recently remarked on how sad it was that the last fresh fruit and vegetables shop in one of Scotland's major cities, Dundee, was about to be turned into another amusement arcade.

He was trying to think of loopholes in the planning legislation that might allow him to stop it. My question is simply why should he have to look for loopholes? Surely there should be a presumption in planning legislation in favour of the public good in public health terms. Hopefully a new power of community wellbeing may facilitate this.

Finally perhaps I can share with you one amusing anecdote that a council colleague of mine told me about one of the poorer areas where we both work. We have been running a joint initiative around improving children's diets specifically the provision of fresh fruit on a daily basis to local schools. He declared at a recent meeting that we were definitely making progress because the children in his area have stopped breaking into the local shops to buy sweets and were now breaking into the local shop to steal apples and bananas.

## **Summary**

I have covered the arguments for, and difficulties in, investing in prevention. I have stressed the crucial opportunistic public health role of healthcare professionals. I have discussed the need for thoughtful design, regulation and commissioning of health systems so that at

the very least we don't inadvertently increase pre-existing inequalities in health and finally I have briefly discussed not just the role of the specific public health law but also the wider contribution that legal and public policy initiatives can have in improving health.

Throughout I have tried to reinforce the message that separating out health protection, health promotion and healthcare provision is unhelpful. Public Health is indeed at its most effective when it operates simultaneously in these three domains, when it is less precious about its function and is more focussed on outcomes and when it is prepared to cede to others the credit when things go well and accept responsibility when more needs to be done. Such an approach is I think essential if we are to turn our healthcare professionals into health promoters, our sweet thieves into apple thieves and our politicians into statesman.

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# Investing in Prevention and Public Health in Northern Australia

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We start agreeing strongly with Professor Donnelly that we need to move away from platitudes. In this talk we will provide examples of where prevention is clearly not better than cure. Then to argue instead that preventive and curative options must be seen as part of a continuum, and subject to the same evaluative calculus that asks, 'What kind of intervention is proposed, targeted at whom, in what fashion, for what benefit and at what cost?' We will go on to present a number of other false dichotomies where preconceived notions can interfere with clear thinking— namely whole population versus high risk strategies for prevention, lifestyle versus drug strategies, and social versus medical determinants. We will also consider how a range of such interventions can be combined in the environment of northern Australia where we work, and then explore the politics of such an investment within Australia's federal system.

## ***Number needed to treat – the link across the care continuum***

Muir Gray in his textbook on Evidence-based Healthcare posits clinical care and public health as two ends of a spectrum, joined by the epidemiological concept of number needed to treat or NNT.<sup>1</sup> Clinical care is for individuals who generally feel ill, and the treatments offered are relatively high cost but with a low number needed to treat. One would hope that for pneumonia, for example, you would only have to treat

a small number of people with antibiotics to see definite benefits.

However, public health is directed at the health of often asymptomatic populations, and the NNT is high though the cost of treating each individual is low.

Immunisation is the archetypal low cost public health intervention though many hundreds have to be treated to prevent one adverse event. Muir Gray points out that forms of managed care represent a potential mid-point on the spectrum.

## ***Whole population or high risk strategy?***

So, then, if we accept the continuum concept - how do we allocate resources across it? No one knows the precise answer, but the decision must be informed by good data where possible, rather than made on purely historic grounds or on wishful assumptions. To give one example: the 1999 National Health Priority Areas Report on Cardiovascular Disease estimated the percentage of coronary deaths that could be avoided in the Australian population aged 35-79 years by either the improved management of heart attacks or by interventions targeted at three population groups – those with no history of hypertension, hypercholesterolemia or heart disease (Group 1 constituting 72% of population), those with a history of hypertension or hypercholesterolemia but no history of heart disease (Group 2 or 23% of population), or those with a history



of heart disease (Group 3 or 5% of population).<sup>2</sup>

Most public health practitioners would be aware of Geoffrey Rose's prevention theorems, one of which says that 'a large number of people at a small risk may give rise to more cases of disease than the small number who are at high risk'.<sup>3</sup> They would then assume that since group 1 is the largest group (72% of the population), even though the absolute risk is low, a small decrease in risk would make the most difference to the whole population. However Rose's theorems were formulated when we knew less about the co-occurrence and clustering of risk factors, and they need to be subjected to empirical testing.

The authors of the NHPA report have modelled, using data available to them, what could plausibly be achieved with risk factor modification in all the groups, and through evidence based care in Group 3 with known heart disease, over and above what is being currently achieved. It turns out that the greatest gains are achievable in Group 3, with a potential reduction of 17% of all coronary deaths. Another 13% could be prevented by focusing on Group 2, and only 7% by focusing on Group 1. So, the data here supports a high risk strategy rather than a whole population strategy. Interestingly, only 4% of all coronary deaths can be prevented by improving the acute treatment of heart attacks. 59% of coronary deaths were not considered to be preventable. One could argue with the assumptions and the methods, but the point we are making is that, where possible, it is good to have some data as a starting point for decisions. In the Aboriginal context, our chronic disease data suggests that the majority of the population are at moderate to high risk, so that the very boundaries between high risk and whole population strategies become blurred.

### *Lifestyle or drugs?*

If we now turn to the US Diabetes Prevention Program data from last year to illustrate the care with which we need to contextualise and interpret data. Over 3000 patients with impaired glucose tolerance were randomised into three groups: standard lifestyle advice (the control group), intensive lifestyle program or the drug metformin.<sup>4</sup> The intensive lifestyle program aimed to reduce each patient's weight by 7% and to have them engage in 150 minutes of moderate physical activity per week. The trial was stopped after 3 years follow up. The incidence of diabetes was 11, 8 and 5 cases per 100 person years in the three groups. The lifestyle program reduced the incidence of diabetes by 60% and the metformin group reduced it by 30%, compared to the control group. These are dramatic reductions and show the potential for disease prevention, and the relative effectiveness of lifestyle change. However, when one looks at the intensity of the lifestyle program which was taught in 16 one-to-one lessons followed by individual and group sessions, one wonders whether most people would prefer to take the drug and avoid the education? The point here is that patient preferences and their assessment of acceptability need to be factored in to policy decisions, and one cannot assume that the whole population is as enthusiastic about lifestyle change, and as antagonistic to medications, as trained public health practitioners!

### *Underlying or proximal (social or biomedical) determinants?*

We are used to seeing complex representations of the causal webs leading to ill-health, especially in the Indigenous health and social determinants literature. And we do need to better understand the determinants and mechanisms of disease. But Leon Robertson, writing in Social

Science and Medicine some years ago, reminded us of the importance of employing preventive brooms of known effectiveness that can be deployed against often proximal determinants.<sup>5</sup> Putting child resistant caps on medicine bottles does not alter underlying child behaviour one bit, but saves lives. In fact the injury prevention literature is replete with such examples (seatbelts, bicycle helmets etc). This is likely due to the influence of William Haddon, the founding father of injury epidemiology, who stressed that though injury prevention seeks to identify a sequence of events (or causal chain) leading up to an injury, it is '*ideologically blind*' as to whether an intervention should be targeted at proximal, intermediary or underlying factors. It assesses *all* interventions on their effectiveness, acceptability and population benefit.<sup>6</sup> In Aboriginal health, instead of using the terms underlying and proximal, more often we use such terms as social and biomedical, and much has been made in the past of the inherent superiority of one or other approach, usually argued on ideological lines. Perhaps we in the Aboriginal health field have something to learn from the ideologically neutral injury prevention field.

### ***The challenge of prevention in Aboriginal and Northern Australia***

Let me turn now to the area where we work. The Northern Territory is the most sparsely populated region in Australia, one sixth of the Australian continent, 1.3 million square kilometres and 200,000 people, 28% of whom are Aboriginal (with 40% of Aboriginal people being under 15 years of age). Across Australia as a whole, the Aboriginal population comprise only just over 2% of the total population. So Aboriginal health is a mainstream issue, daily discussed in the NT, rather than a minority and sometimes peripheral issue as it can be elsewhere. Particularly so since health outcomes are so poor for Aboriginal

people. Standardised mortality rates are about four times the national average, but the median age of death of around 50 years is the more salient figure that captures the human tragedy of premature death in the young and middle-aged.

So what are the goals of health services in such a region? If we consider the cumulative impact of the size of the Aboriginal population in the NT, the incidence and prevalence of disease and the diseconomies of scale faced by our health system, we do not have any room for waste. Let me assure you – having worked in a number of jurisdictions – if one considers the humanity and ill-health of the Indigenous 28% of the NT population seriously, the NT health system is in a completely different boat to the rest.

There are two propositions that anchor our response. First, we cannot afford the false dichotomies referred to previously. Our clinical responses must have an eye to population efficacy because of the very concrete realities of the disease burden we face, and equally our population interventions have to deal with the numbers of currently sick people in the wider population.

Second, to borrow from Nobel Prize winning economist, Amartya Sen, we have to attend not only to efficacy in clinical and population health terms, but to issues of human dignity and freedom. Sen has argued that basic freedoms are interlinked and reinforce each other – access to health and education services can be seen as a type of freedom and linked to political freedoms and economic and social opportunities.<sup>7</sup> This set of freedoms is not just the goal of development, but also are instrumental as a means of development. The same point has been made in many different ways by Aboriginal people in Australia, usually reflecting negatively on their historic loss of dignity when confronted by health screening without

follow up, or a model of care that was intrinsically paternalistic.

Let me give a local example – Menzies School of Health Research in Darwin, in conjunction with our department, is currently carrying out a large scale diabetes screening study for the Aboriginal people of Greater Darwin area.

Remarkably this will be the first accurate estimate of diabetes prevalence in any urban Aboriginal population. But it is much more than that. The project is controlled by an Aboriginal Steering Committee, there are large numbers of Aboriginal people employed and the screening is linked to improved clinical follow up. Recruitment will take place primarily by word of mouth through local family groups and be open to all 5000 or so Aboriginal adults in the area.

Interestingly it is also seen by local urban living Aboriginal people as a *chance to be visible*. One of the problems of the Territory is that it is too remote, too frontier, and Aboriginal people are mythologised as exotic and ‘other’, living (as 2/3 of NT Aboriginal people do) in small discrete communities outside the major towns. But this same factor prevents recognition that the largest Aboriginal community is within the sprawling urban setting of Darwin, where they have remained up until now largely invisible, especially to researchers and public health professionals.

Thus an example of research that simultaneously promotes visibility and dignity. Research is indeed a bit of a hot topic in Aboriginal health, here as in the other settler colonial nations of the West. It is arguable that a lack of health research is not the primary threat facing Aboriginal health – in fact that is undeniable. However, the story is more complex. Many, especially urban Aboriginal communities feel their invisibility and actively seek involvement, contrary to the

myth of research exhaustion. And, more seriously still, there is a tendency to a research timidity that can actually produce fairly large amounts of research that is not of high quality and does not generate the environment of rigour and intellectual challenge that the worst health problems in the country deserve.

Peter Morris, again from the Menzies School of Health Research, published a paper in 1999 highlighting the remarkably low number of randomised controlled trials conducted in Aboriginal Australia.<sup>8</sup> He identified only 9 randomised controlled trials, and 4 other non-randomised but controlled trials. Only one trial had been conducted in adults, all the rest were in children. I am told there are about 5 more recent trials started since the paper was written, but that does not change the overall conclusion. Morris writes, and we agree with him, that Aboriginal people are being doubly disadvantaged, first by poverty, and then by poorly evidenced health care. It is an example of the inverse care law referred to by Professor Donnelly. A similar argument could be made that the quality of social scholarship in Aboriginal health does not often enough get beyond ideologically constrained or constructed statements of orthodoxy. As health research funders make more funds available quality becomes more of a challenge.

### ***Balancing investment in Aboriginal health***

There is other strong evidence for the inverse care law in Australia. We are systematically underinvesting in Aboriginal health, and within Indigenous health we are failing to balance our investment across the continuum from prevention to cure. John Deeble and others have analysed health expenditures for Indigenous people across all jurisdictions, State, Territory and Commonwealth.<sup>9</sup> Per capital total spending was only 8% higher

than for other Australians despite the almost four fold higher mortality rate. But most of this expenditure (55%) was through mainstream hospital services, with under 25% invested in community health care. With respect to the two largest Commonwealth programs, Medicare benefits to Indigenous people per capita averaged only 27% of the payment for non-Indigenous people and Pharmaceutical Benefits Scheme payments averaged only 22%. This and other data have helped drive some systems changes since to lesson this inequity, and increase Aboriginal access to mainstream programs. It has also strengthened the case for maintaining the 30 year history of direct Commonwealth funding of Aboriginal primary care services, as a top up for the poor performance of mainstream primary care funding systems, although our federal system raises some issues here to which we will return.

### ***Flexibility in roles across the continuum of care***

The implications of our analysis for prevention in northern and Aboriginal health go to the importance of a critical disposition in policy, in service design and in evaluation. We have opted for an integrated approach to service design, with clear evidence based guidelines and strategies supporting streams of care, in which primary care and specialist staff work alongside each other and unite the structures of community health with the leadership potential of the tertiary structure.

In 1999, the NT launched its Preventable Chronic Diseases Strategy, that targeted the key diseases of diabetes, heart disease, hypertension, chronic renal failure, and chronic airways disease in an integrated fashion.<sup>10</sup> It was underpinned by an evidence base that defined key result areas and best buys across the continuum of care, and has helped us focus our priorities

and investment since. Although we are still in the process of implementation, the thinking in the strategy is one of the strong points in the story to date and exemplifies the important role of specialist leadership working with primary care providers.

Many of the specialists in the NT practise in northern Australia because of their commitment to improving access to services, and a high proportion take on outreach roles direct to remote communities, many hundreds of kilometres away from their hospital bases in Darwin and Alice Springs. This has given them a deep respect for, and good understanding of, the workings of primary care clinics, most of ours staffed by nurses and Aboriginal health workers, working in very modest circumstances, and supported by visiting departmental medical officers.

The personnel involved include a significant number of physicians, as one might expect, and surgeons prepared to undertake visiting lists not only in rural hospitals but in more remote sites as well. Even more interestingly is a move that has been evolving and on which we will build to establish clinical streams to refashion the role of these specialists in health strategy. Even the surgeons (in fact led by some of the surgeons) are advocating a new paradigm of specialist care, where specialists move beyond one to one care and take responsibility for training and skilling up these primary care workers to improve the overall standards in their specialty across the NT. Instead of only seeing patients, they have been quarantining time for activities like case conferencing and care planning with local providers, as well as education and developing protocols for management of common cases. Indeed, our specialists have provided enormous input into our standard primary care clinical guidelines that are used across the NT.

One of us has written elsewhere of the key unifying concepts in the Aboriginal health coalition – a political sub-system of interests that, while they fight with each other, are highly invested in maintaining Aboriginal health discourse within certain known parameters. Key concepts in this sub-system rhetoric include Aboriginal community control and primary health care. Both in fact are important policy precepts and both are supported by a wealth of World Health Organisation literature, from Alma Ata on. So let us be clear we are not arguing against them. However, neither any longer have a sense of self evident meaning. People argue about community control of Aboriginal primary health care without acknowledging that several participants in the conversation can simultaneously hold different concepts in mind, while ostensibly agreeing. No one argues any more that primary health care is the key domain for action to improve Aboriginal health but the weight of Commonwealth activity is in fact in primary medical care, not primary health care, albeit there are now some encouraging signs of evolution. And in the State/Territory and community sectors there is an equally important lack of clarity about the role of vertical programs within primary health care provision.<sup>11</sup>

In the Northern Territory we are now trying to take on these unresolved issues. We seek community ownership of programs and a sense of power for our communities of engagement, because that works. The commitment to community empowerment is profound across our staff, in fact to a degree I found surprising as a new arrival in the public sector in the Territory public system. And they are clear that they mean primary health care when they say it, not just some slightly reformed notion of general practise. We seek evidence and argument about strategy because that works as well. We also seek integration of sectors around core

strategies and hope we are now on the cusp of moving beyond a privileging of primary health care to the exclusion of attention to the role of the secondary and tertiary sectors. We are reforming our acute services, among other things, to make them a source of leadership across clinical streams that include primary, secondary and tertiary prevention in their ambit.

All of which brings us straight into the issue of federalism and our fractured health system. And the question, ‘Where does prevention sit in our federated health system?’

### *Federalism*

Public health is theoretically a State and Territory responsibility, along with hospitals. The Commonwealth funds primary care – at least in theory – but has also had a historic leadership role in public health. In fact the Commonwealth government became involved in health through the public health imperatives of the global flu pandemic, and workers’ health issues, in the first decades of the last century. The Commonwealth has stayed involved even as its mandate expanded to health financing and direct funding of primary care. In the latter decades of the last century the need for national leadership in public health was driven by State political conservatism in the face of communicable disease threats and the need for specific vertical funding programs, as hospital funding pressures impacted on State and Territory public health capacity.

The 1990s has seen a couple of important trends. The Commonwealth has tried to reform general practice to play a more effective role in improving population health outcomes, through setting up Divisional structures that link general practices across a region, and through funding incentives that reward specific fee for service items that link, for example, to

best practice cervical screening or diabetes care.

The Commonwealth had also, as we just noted, built up a series of national vertical public health programs, including for example HIV, women's health and immunisation, that had provided funds to the States tied to specific outcomes in specific areas. In the second half of the 1990s, however, the new conservative government in Canberra went through a (short lived) enthusiasm for a new federalism and untied much of its vertical program funding. Instead it worked effectively with the States and Territories to set up the National Public Health Partnership. The Partnership included representatives from both levels of government, and aimed to develop a national framework for public health action and clarify roles and responsibilities in public health. This is, in fact, one of the unheralded reforms of the early Howard years. Seven years on, it is inconceivable to think of operating without such a structure. It has successfully required the jurisdictions to talk together and coordinate myriad national public health strategies, and it has tackled some important public health infrastructure issues like the need to update public health legislation and address information and workforce needs.

It has also identified an imbalance in overall public health spending as a proportion of total recurrent health expenditure.<sup>12</sup> Total expenditure by all jurisdictions on core public health activities during 1999-2000 was estimated at \$931 million. This represented just 1.8% of total health expenditure. The three core public health activities attracting the highest levels of expenditure were health promotion (\$166 million), communicable disease control (\$154 million) and immunisation (\$153 million). Given the risks to people, industry and the overall economy posed simply by communicable

diseases in the last few years (SARS and the anthrax scare are only the latest examples), one can only consider this a risky underinvestment. Nonetheless an underinvestment identified through the coordinated work of the new Partnership.

But how well placed is the NPHP now to enter and influence the debate about health resourcing across the continuum of care, and influence mainstream financing? We would suggest that it is close to the limits of its effectiveness if it remains positioned as it is, and stamped if you like with the 'public health' logo. Our analysis has stressed the need to move beyond outmoded and ultimately fatuous distinctions between preventive and clinical interventions, especially for the most marginalised populations we in the health system serve. The problem is that these services – the full spectrum of the continuum of care – are themselves fractured between Commonwealth funding sources and State and Territory ones. And the NPHP, though important, is stuck in the domain of public health. None of this is helped by the swing away from a cooperative approach to Federalism, to a combative and arguably heavy-handed one in the latter years of the current Federal Government.

The challenge is not just to get clear who does what, nor to hold each other to account. Rather we should ask, how we can support the refashioning of the continuum of care in the north while public health remains still isolated from clinical service provision and while the health system as a fractured whole is both internally and between its funding sources?

### *Final comments*

Before concluding, I think it is worth making a distinction between, on the one hand, the argument for rigour and use of science and evidence, and, on the other

hand, a kind of conservative rejection of social scholarship, qualitative research, indeed anything non biomedical. We do not want to associate our argument with a call for a return to old verities whether that be the 'old' public health, or a tradition of medical professional dominance.

On the contrary, much that has been rigorous and powerful in Australia's recent public health experience has been based on a combination of social scholarship, biomedical expertise and community based participation and social action. For example, the effectiveness of Australia's initial response to HIV was based on an effective partnership between gay men and the community organisations they established, and scholars and service providers across medicine, public health and community services. Though uncomfortable for all parties at times, this partnership was the key to effective political and social action, and good health outcomes, credit for which is now claimed with a disingenuous ease by all Australian governments.

Challenging assumptions and being open to changing roles will be threatening to some. Some health promotion practitioners, for example, have raised concerns about WHO's move to form a new Department of Health Promotion, Non-Communicable Disease Prevention and Surveillance, seeing it as potentially narrowing the scope of health promotion. But Colin Sindall, writing in *Health Promotion International* in 2001, invites a different response – seeing it as a chance to bring health promotion in from the margins, build new alliances and mobilise the mainstream resources invested in health care.<sup>13</sup> He poses the question 'What would a health promoting health system look like, and how could such a system be achieved?' That is the question with which we would want to associate ourselves.

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# Evolution of the Private Finance Initiative: Squaring the Tax, Spending and Pensions Circle?

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## Introduction

This paper looks at the (uneven) trajectory of development of UK Health PFI in a sea of wider change; considers issues posed by increasing emphasis on devolution of decision making, informed patient choice, implications of new (whole systems) models of integrated care and matching all this against the lifecycle needs of people. It makes the link between ‘public’ borrowing and private pensions and savings - as a means of accelerating the rate of public service investment and stimulating an increase in market capacity and public involvement. Finally it is set in the context of “*PFI: meeting the investment challenge*” *HM Treasury July 2003*, which is explained in attachment ‘A’.

Throughout the nineties western governments increasingly adopted entrepreneurial strategies to stimulate improvement in public services. The aim – achieving better public value through encouraging contestability and innovation - characterised by choice, improved quality and greater efficiency. Put simply, strategies based on the proposition that vehicles for public service delivery do not need to be owned and managed by Government.

Policies are by now varied and widespread eg. in the Netherlands over 90% of hospitals are owned by not-for-profit organisations, Germany has introduced

individual choice amongst sickness funds, and in Spain ‘public’ companies have been created to provide public hospital services.

The UK and Australia have made similar shifts - the retention of policy determination by government but diversity in implementation - incorporating forms of purchaser provider separation and a mixed economy of providers. One of the important outcomes of this policy in the UK has been the Private Finance Initiative (PFI) as a means of stimulating capital stock replacement, paralleled in some respects by the Build Own Operate (and Transfer) hospital projects in Australia, the so called BOOT programme. More recently, the UK Government has gone a step further and stated that who provides clinical services for NHS patients does not matter as long as treatment is free at the point of need, opening the way for low-cost/high value private providers to become a potentially large element of the diversity in NHS provision.

## 1. PFI Principles

The principles of PFI are simple, a fact often missed in the heat of the debate that has been generated by a complex implementation process. It is a performance-based means of procuring property over an extended time scale. In place of conventional ‘public works’ contracting, PFI introduces contestability between the stated set of desired outcomes and different approaches to achieving

these. The client (invariably the NHS Trust as the agent of Government) describes the outputs required of the facilities and the contractor (the different PFI consortia) in a competitive environment exploits the freedoms to innovate in determining design, logistics, financing and construction of the facility. Further distinctive characteristics are:

- acceptance by the public sector that it does not need to own the facility to deliver a public service
- the PFI consortium as landlord and the Trust as beneficial occupier for the duration of the contract, usually 30 years - in return for a rental fee (unitary charge)
- lifetime (duration of contract) maintenance of the building
- rental payments start when the hospital is made available, and only continue so long as it remains functionally available and meets standards of environmental safety and quality – finally removing the harmful legacy of Crown Immunity and back-log maintenance
- shared allocation of risk determined by the principle of who can manage it most effectively
- optional provision of non-clinical services – that introduces the principle of the fully serviced building
- reversion of ownership of the asset in good condition to the Government (Trust) at the end of the contract
- low cost project finance through highly geared, off-balance sheet Special Purpose Companies (SPCs)

### *PFI and PPP – is there a difference?*

The terms PFI and PPP are often confused; both are used as means to help reshape health care delivery. However they vary markedly in their approach and structure.

#### *Private Finance Initiative*

The Private Finance Initiative is principally concerned with the procurement of facilities. It has two aims: to improve the efficiency and cost effectiveness of delivering and maintaining new buildings; and stimulating new thinking about how principles of design can be used to contribute to service change and better care.

Under the PFI regime the onus is on the Trust to be clear about what it can afford and what it wants (rarely aligned) and express this in terms of outputs required. In doing so the Trust is obliged to set parameters within which the PFI consortium has freedom to innovate in its design and delivery. These characteristics mean that PFI mandates are won with good designs that are affordable at the time of signing.

The Trust remains accountable for providing the clinical service and carries the risk of downstream changes in demand or tariffs. This places a premium on the ability of the PFI contract and the Trust to exploit the capability of the PFI consortium in anticipating and delivering future change as cost effectively as possible. Conventional measures of “Year 1 affordability” fail to put a price on this premium. Establishing incentives and maintaining good long-term relationships with the consortium is however an important consideration when the PFI brief is set and in evaluation, choosing and managing relationships with the PFI partner.

There is much talk about partnership, but in the current PFI model the bottom line is that the relationship is conducted through an inert SPC, governed by a tough contract and lenders' controls shaped by a pre-determined, inflexible risk model and an adversarial, penalty based payment system.

### *Public Private Partnerships*

Public Private Partnerships are more directly aimed at reshaping the way in which services are delivered and they tend to take one of two forms:

- integrated facility and clinical service provision – this model underpins the purchase by the NHS of additional clinical capacity by contracting (for maybe five years) with operators of chains of Diagnostic and Treatment Centres (DTCs); and in Australia the BOO(T) projects;
- shared public/private equity risk ownership models - this model is represented by the NHS LIFT programme for the renewal of the primary care estate through Partnerships for Health.

Australia also has other variants (half-way houses) that include franchise management of hospitals, eg. Modbury Hospital, SA and some forms of co-locations

In broad terms:

- PFI has most effectively been used to facilitate big-bang accelerated delivery of health facilities (mainly the larger, acute hospitals) through removing the burden of a complex master planning, property procurement, financing and management, allowing the NHS Trust to concentrate on clinical and workforce change. The PFI

consortium is the generator of property solutions to meet service need

- PPP may be viewed as a (temporary?) capacity increasing partnership aimed at driving change through extending patient choice, at least with elective surgery and DTCs

## **2. PFI Evolution and Systems Planning Optimism**

As the PFI programme gathered speed in the NHS in 1995/6, there was a market philosophy of “let a thousand flowers bloom, but the private lenders will decide which”.

It exposed many implementation problems: cultural differences between the public and private sector, weaknesses in service planning assumptions and lack of public engagement (for which the voters in Kidderminster punished the Government) and weak public sector procurement skills. The structural rigour and robustness of PFI exposed the need for rapid transition from the former input planning system to an output ethos orientated towards generating better value for money.

### ***Centralised Planning vs. Local Implementation***

The central ‘work-up’ processes for early PFIs tended towards establishing ‘planning norms’ as a condition of Trust business case approval, these involved:

- self financing principles – containment of PFI costs (meeting the unitary charge) within pre-existing cost profiles
- benchmarking PFI solutions for value for money against a risk-free Public Sector Comparator – a

theoretical assessment of project costs for a publicly funded solution

### ***Self Financing***

Business cases for PFI projects often projected:

- the stimulus and opportunity for transferring some elements of the hospital service to the ‘community’
- new facilities could be designed to be “sweated” (90% average occupancy, 365 days a year)
- substantial staff efficiencies resulting from more effective clinical models and corresponding designs

It was assumed that these efficiency gains would more than offset increased procurement costs, the outcome justifying bed reductions. But these formulae based targets proved too ambitious. Firstly, the level of integration and systems coherence between the primary and secondary sectors proved weak and ineffectual, the community facilities required were simply not in place when needed. Secondly, functional design efficiency contributed to but could not wholly support the notion of increased occupational utilisation. Equally important in practice, in the rapid transition to a new hospital, staff did not always change their working practice and adopt the new nursing and operational policies that had shaped ward and departmental functional design three years before.

### ***The Public Sector Comparator and Value for Money***

The benchmarking principle is sound, but practice has been problematic. The strength of the PFI lies in using commercial expertise to interpret and meet output needs in new and imaginative ways.

In the early stages of PFI the ‘comparator’ was constructed in a conventional manner. In a climate where PFI was ‘the only game in town’, beating the comparator was the principle criteria for success in unlocking capital investment and meant that PFI’s tended to retain input rather than output focus. This engendered a lowest common denominator attitude to cost and inhibited private sector potential. Unrealistic initial ‘optimism bias’ meant that most projects were eventually signed off at higher figures than the PSC. It is reassuring to note the new sense of realism injected by the recent Treasury report.

### ***Driving the programme Forward***

Centrally, the role of the NHS Private Finance Unit (PFU) has been a critical success factor in managing the market and developing acceptable processes and contracting frameworks. However, implementation and on-going relationship development at Trust level has not been helped by management and organisational churn, with consequent loss of corporate memory and controls over the costs and operational policies underpinning the deal that had been done. (Catalyst’s first two PFIs have seen eight Trust Chief Executives between them since 1995).

These overall difficulties gave rise to critical assessment of PFI by many prominent commentators as an issue simply of economic rationalism, ignoring the reality that it was an internalised systems and implementation problem and not a structural failure of PFI. It also imprinted in the mind of the public that PFI was the culprit and the private sector the agents of profiteering out of health investment. These deeply embedded misconceptions are proving hard to correct.

### 3. Pendulum Effect of Corrective Action

Corrective action to overcome early problems followed the twin tracks of restoring capacity with assumptions dominated by providing more beds, sometimes after signing the PFI contract, and streamlining and standardising PFI processes. It is arguable that the pendulum has now swung too far.

#### *Beds as a factor of patient care*

There is no doubt that the bed reductions assumed in early projects were unsustainable and thereby provoked the National Beds Inquiry that recommended increasing provision. In hindsight insufficient weighting was given to improving and implementing systems efficiency by promoting primary and community care as an alternative and often more effective means of alleviating demands on acute hospitals.

The change in direction prompted by the Inquiry may have the result that from a position of providing too few beds new hospitals being procured now may have too many beds within a few years of being commissioned. Well documented studies suggest that:

- many patients, particularly the elderly and chronic sick, are inappropriately occupying acute hospital beds
- the rapid advance of new technologies (including pharmaceutical and communication) will have a significant impact in determining where care will be delivered in future
- increasing ‘industrialisation’ of many interventional procedures

will improve efficiency and change demand patterns

- there may be future difficulties in staffing all the beds – getting the right workforce mix may not be easy in a volatile and competitive labour market

New thinking about whole systems service design is bound to acknowledge these issues and will inevitably promote more locality based care. In Australia for example the Hospital Admission Risk Programme (HARP) introduced in Victoria has achieved a marked reduction in the pressure on acute beds (with commensurate reductions in waiting times) by looking at alternative means of meeting demand and without reliance on increasing acute bed provision.

These types of initiatives coupled with the DTCs and new high quality hospitals coming on stream in 2006 – 2010 will provide substantial extra capacity. However the degree to which this may result in oversupply when set against meeting waiting time needs and guaranteeing choice is difficult to assess. What is clear is that these factors combined with national tariffs and consumer choice being extended to chronic diseases will have a profound effect on unattractive, old, high cost-base hospital producers.

#### *Complexity and Standardisation of PFI Process*

The implementation of PFI in the health sector was an order of scale more complex than the tried and tested projects (roads and bridges etc) that prompted its wider use across the public sector. The main points at issue were:

- the public sector - the NHS Trusts - had been subject to management cost targets, which stripped out capital and

service planning skills thus exposing them to reliance on expensive third party support to meet PFI planning, processing and risk assessment needs. This often provoked the debilitating problem of workforce disclaimer of change; a ‘them’ versus ‘us’ attitude

- the private sector were (and still are) faced with exceptionally high entry costs; Catalyst estimates an expenditure of 1-1.5% of capital value to tender in competition and a further 3-4% to reach financial close. Skilled people able to manage the complexity of PFI design and performance contracting are a scarce resource, adding significant opportunity cost (*the Treasury paper addresses measures to reduce time and cost of bidding*)
- time – although the design and construction phase of projects has been reduced considerably in comparison with conventional procurement, a factor of the ‘time is money’ ethos in the private sector, gains achieved in the ‘business phase’ are often negated by protracted internal NHS Trust consideration of options; the latter often signalling that pre-planning has been too input rather than output focused. Time has a definable opportunity cost not simply financial but directly affecting patients in terms of service access and quality of care.

In a system where innovation is one of the guiding principles, standardisation may seem incongruous. However in process terms it can be beneficial – central negotiation between the PFU and industry representatives to agree a tender process, standard contract and payment mechanism is a good example. However there are also areas where the PFI structure works explicitly against private sector efforts to deliver better value.

### ***Penal Payment Mechanism***

The reasonable principle here is that if space is not made available (or there is non-compliance with service standards) by the PFI consortium then that space, or service, should not be paid for and the Unitary Payment is reduced. Early payment mechanisms are now seen as too soft. With current mechanisms, to provide an ‘incentive’ for the consortium to perform, it is punished by the application of a weighting factor of between 300-600%. The mechanism is downward-only, with no upside for contributing to better hospital outcome performance and flexibility in services. Furthermore, changes in space or service requirement mean a cumbersome and costly change control and contract variations procedure.

### ***The Retention of Employment Model (RoE)***

In response to claims of a two-tier workforce in PFI in the NHS and to ensure staff terms were protected, the Government made a manifesto commitment to keep as many staff as possible ‘within the NHS family’. This resulted in a deal with Unison, the largest representative of NHS Soft Facilities Management services staff, that non-managerial NHS staff engaged in Catering, Cleaning, Porterage, Security and Laundry were to remain employees of the NHS but managed by the PFI partner. An unforeseen complication of the deal was that it was deemed illegal under EU employment protection law where there are Transfers of Undertakings. An ‘opt-out’ mechanic has been introduced but as the legality of this has not been tested in law, complex contract provisions and unwind indemnities have been incorporated in recent project agreements should RoE be successfully challenged in the courts. RoE has introduced a new and unpredictable risk for the PFI service partner managing a workforce of the NHS

employer through who's performance the project company earns the Unitary Payment that pays their wages and services the debt over thirty years.

(NB. RoE is an NHS-only policy. The recent HMT guidance is clear that Soft FM inclusion is optional, but is not clear about the future application of RoE in NHS PFI contracts).

#### 4. Public and Worker Perception

In the UK and Australia the public (and staff) tend to associate PFI/PPP with privatisation. Many, if not most, have not grasped the significance of the policy shift from government 'ownership' of providers to devolution and diversity in the provider system. This lack of understanding can get in the way of introducing beneficial change. There are a number of issues, structural and presentational, that have fed the deeply suspicious nature of the British psyche:

- hospital closures and bed reductions evident in early schemes were put down to meeting the profit requirements of the private sector rather than reflecting underlying systems and planning issues
- 'windfall' profits such as highlighted in the refinancing of the Fazakerly Prison scheme were damaging of public confidence and reinforced the spectre of short term profit taking rather than long term commitment by the private sector
- that pay and conditions of transferred staff had to be cut to subsidise the PFI and sustain private profit
- a tendency for Trusts to cite the PFI as the reason for their structural financial deficits

(whereas the PFI contract cost was defined and fixed for the agreed deliverables, years before commissioning)

- little perception that borrowing by the Government for public investment through the issue of Gilts is just like having a home mortgage where the capital has to be repaid with interest

What is required is transparency in accounting locally for the real time/risk cost of NHS public investment capital (Foundations will be in the vanguard), a new way of engaging the public in owning change and its consequences and an understanding of the mutual benefit that can derive from embracing the principles of PFI/PPP.

#### 5. The Private Sector Perspective

The private sector view of PFI is as a business opportunity. Catalyst has an inherent interest in using the quality and reputation of its hospitals as working assets to generate income to service shareholder equity and loans. Catalyst, in common with other consortia, derives its funds for PFI mostly from institutional investors eg. life and pension funds – the ultimate investor is of course the public, the consumer of hospital services – a theme that this paper will return to later.

##### *The PFI and fulfilling potential*

PFI has achieved a great deal in a short time:

- delivered the first phase of the largest sustained hospital building programme in the history of the NHS
- better time/cost certainty (NAO/HMT reports)

- cost of NHS capital employed is properly valued and accounted for
- quality of maintenance and ancillary services insulated from deprecations of Trusts' annual revenue deficits
- created a new industry
- refreshed the healthcare planning and design capacity available in the UK

Experience gained from PFI hospitals designed over the past six years will pay a public dividend. A vast knowledge base has been established within the PFU, NHS and in a diversity of consortia. Stable groups of experienced consortium sponsors and funders bidding for multiple projects are reducing delivery risk and transaction costs; and their strategic supply chain of designers, engineers, manufacturers and contractors are reducing component cost and driving up quality and reliability.

All this is speeding the adoption of better design and operational practice and will lead to safer, better-built environments. The time-lag effect of applying learning from many lengthy capital procurements will quickly reduce and this new knowledge will increasingly add value, not only in cost terms but also through better procurement and environmental standards contributing to better care.

### ***PFI and 'Hospital' health economics***

At the heart of this case for change is the Pareto principle – the 80/20 rule. PFI investment is invariably measured on the basis of its financial value; in cost terms the Unitary Payment typically represents less than 20% of the total resource consumed by hospitals. Its contribution 'in-kind' to improving health care, other than the opportunity cost savings of lower

building costs, is much more significant but is undervalued. This can relegate the interest of the consortium back to simple economic rationalism again, where the only driving force is presumed to be winning contracts. Good companies have values that if encouraged through some form of 'liberation' of PFI payment mechanisms can promote even greater benefit for patients. There is for example no explicit mechanism for valuing the price differentials of competing PFI solutions that:

- contribute the most to improved clinical effectiveness and better health outcomes (the rationale of the hospital)
- have the most beneficial impact on the remaining 80% of the hospital budget
- build in the cost of flexible structures and adaptable spaces
- provide the greatest contribution to social development and urban renewal, increasingly recognised as having a direct impact on health status

The risk for companies designing these elements into bids is that they will lose on price; bidding cost and risk has already been highlighted as a major disincentive. There are compelling reasons why evaluation criteria should be expanded:

- there is good evidence to demonstrate the beneficial impact of good design on health outcomes, eg. research undertaken by the Karolinska Institute, Sweden – this should be factored into the affordability envelope and assessment process
- the speed of change relating to internal clinical processes and care



standards is accelerating – flexible design principles will be paramount if benefits are to be realised

- design as a contributor to improving clinical practice has yet to realise potential, despite examples such as environmental characteristics contributing to reducing hospital acquired infection
- the balance between ‘refreshment’ investment in technology and the built environment will change with an increasing bias towards technology
- improvements in social infrastructure can contribute to overcoming adverse health determinants particularly those influenced by social inequality

There is little in way of an evidence base (or research) that will currently enable these factors to be valued as part of bid assessment. However, in a remarkable change that recognises the real cost and benefit of new infrastructure and technology that supports organisational change, some complex major schemes where the outline business cases were approved two or three years ago, are now coming to the market with 200-300% increases in the original PSC.

In the wider context, the case for further development of PFI principles and practice is reinforced by policy direction. This introduces the question of how well PFI is positioned to meet the challenges posed by the alignment of factors such as ‘commissioning for choice’, national tariffs and whole systems principles of redesigning health care - all in play and at the top of the modernisation agenda.

## 6. PFI, the case for change

The following trends will all accelerate and increase in intensity during the early lifetime of PFI contracts:

- growth in the numbers of the elderly
- older people will be healthier, then frail and sick with chronic conditions for longer – the average patient of 70 plus will have on average 2.6 DRG conditions (Disease Related Group)
- new ways of tracking and treating illness will arise from developments in genetic science
- more – and more expensive – ‘wonder’ drugs and treatments increasing public expectation/demand
- communications technologies will increase the incidence of diagnosis and treatment delivered from a distance
- chronic shortages of some categories of health professionals will continue

These combinations of factors will profoundly change the health landscape.

An additional driver will be the government’s choice agenda. Choice is aimed at enabling patients to receive care and treatment that offers the best outcomes and quality at the best value, where and when they need it - a central tenet of PCT commissioning. It will demand a new responsiveness from providers, in that:

- the young fit will demand quick access to ‘industrialised’ elective surgery – in Australia for example, small local and specialised private

hospitals are the main providers of many types of elective procedures eg. lens replacement. The UK is following with the imminent arrival of the private DTCs that will provide NHS services under contract

- parents will want their children cared for in an environment dedicated to their requirements – they are not just small adults but have very particular emotional and physiological needs
- the elderly deserve care that maintains their independence and mobility eg. community centres linked with home support programmes are changing the health landscape in many European countries and are dramatically reducing demands on acute beds; these types of investment are now getting underway in the UK
- the chronically ill, now also promised choice, will expect care to be organised on a whole systems basis and benefit from the availability of ‘dispersed’ treatment and support in their home or in their local community

National framework standards are being introduced and will reinforce and accelerate the shift towards designing care more comprehensively around the specific illness related needs of people.

Other factors in play include:

- the continuing drive for value for money in spending public funds
- bringing inter-sectoral ‘health determinants’ into focus in shaping collaborative initiatives and spending priorities between

government departments and agencies

- greater community involvement in the management of local health services (the rationale behind the Foundation Trust movement) will mean more public accountability and thereby greater local influence in reshaping services

Few of the above trends and changes were apparent when PFI was first introduced in the NHS and as we have seen the central construct of PFI has remained largely unchanged. The DoH Private Finance Unit has brought about process improvement and strategies such as ‘bundling’ projects may address short-term capacity restraints and help mitigate the high bid costs of the construction industry; however, a more fundamental reappraisal will be necessary if the capital stock dimensions of health and social care investment are to be sufficient for the changes ahead.

Thinly capitalised, ring-fenced SPC project vehicles have little equity to deal with operational delivery problems and unforeseen cost increases, particularly after refinancing. The current market pricing of total project returns is probably at its low point and market forces and perception of risk on individual projects will most likely see increases feeding through. What is clear is that a proliferation of standalone SPCs, individually funded, with multiple shareholders having no common long-term interest and vision is not sustainable.

The future challenge for PFI is what direction it should now take?

Whole systems thinking will need to work at least at five levels:

- wide area - local health and social economy planning for property and

technology (Strategic Health Authority bounded?)

- internal - integration of provider Trusts' clinical models, IT, Medical Technology, workforce planning into clinical design, adjacencies and patient flows
- consortium internal - buildings and staff whole-life effectiveness, efficiency, flexibility and cost
- consortium scale – portfolio management and risk spread, specialist management, recycling lessons learnt, economies of scale
- borrowing - frameworks for securing debt finance with flexibility for a mix of NHS Trusts, Foundation Hospitals, Local Authorities and private providers (Foundations could be the 'catalyst' around which this happens).

Add to this urban regeneration and the need for social housing (HM Treasury cites UK backlog maintenance at £19 billion) and there is a compelling case for developing PFI as a more sophisticated and directed tool for modernising and achieving equity in and access to the broader range of public services, within a dynamic market.

## **7. Strategic Property Management in the New Health Economy**

So far, regeneration of the old hospital stock has been the principle consumer of PFI in the NHS. As the means of meeting health needs becomes more diverse, so will the capital stock requirements. There will be:

- increasing need for more rapid changes in the configuration of hospitals – this suggests new

planning concepts eg. incorporating built-in, shorter term obsolescence anticipating the speed with which current clinical processes will be overtaken by new techniques. The Royal Prince Alfred Hospital, Sydney has introduced this principle for part of its new Intensive Therapy Department

- development of campus style hospital sites and hospital network models (already well established in Australia), as examples of provider restructuring
- new style (Trust owned) satellite community units, as Trusts compete with the new generation of Diagnostic and Treatment Centres
- a diverse range of community hospitals and polyclinics (multi-purpose centres) offering a wider range of local care – taking advantage of new 'dispersal' technologies and bridging the gap between the primary and secondary care sectors

This all presages greater volatility as demand levels and priorities change; the inevitable consequence will be the need for health providers to flex in and out of accommodation. The idea of long-term occupation of the current portfolio of facilities in present form does not look sustainable or necessary (nor is the NHS accounting policy of depreciating specialised buildings over 60 years).

These views are reinforced by two recent State Health publications in Australia, the Queensland '20/20 Vision for the Future' and the South Australia 'Generational Review'; both predict the direction of travel indicated in this analysis, both

stress that sustainability of investment in health care depends crucially on greater diversity, both point to the liberating effects of advances in technologies and highlight the growing impact of consumerism but tempered with the reality of a shrinking (supply side) labour market.

The South Australian ‘Generational Review’ also emphasises the need to tackle health determinants in social settings and suggests increasing diversion of resources to resolve inequalities that have an adverse effect on health status. There seems little doubt that difficulties in bridging capital investment between Health and Social Services in a coordinated manner has held back the types of initiatives promoted in the South Australia Generational Review report. The announcement by HM Treasury of extension to the PFI programme to incorporate urban renewal and social housing will create new opportunities for integrated planning and investment aimed at tackling health determinants.

The challenge for PFI developers (constrained by their structures, cost of bidding, procurement rules and probity) is to become immersed in the planning of healthcare processes and to design buildings that outlive current service models and provide ‘agile’ space on flexible terms.

***National Tariff based funding***

There is a further element of asset strategy in which Australia provides relevant and useful knowledge - case mix funding of hospitals and institutions. The introduction of national tariffs in the NHS will have a major impact on Trusts’ approaches to strategic asset investment in the future. Many Trusts will be in different starting positions when national tariffs are introduced. In addition to the wide range of high/low average cost

bases, Trusts will fall into three broad categories:

1. steady state with no foreseeable major capital needs
2. redevelopment schemes at planning stage or under construction
3. new PFI financed facilities and committed to long term contracts

This does not feel like a level playing field and could distort the impact of the choice agenda.

Australian studies show that over a 40-year period capital investment has remained fairly constant. Annual capital spend averages around 8% per annum of total annual health expenditure; this seems adequate to maintain and refresh the built environment and replace major equipment, furthermore this ‘stability’ looks certain enough to predict need well into the future. The new tariff system for the NHS will need to acknowledge this issue of capital loading. There are however further issues; research in the State of Victoria, on the capital dimensions of case mix, shows the dramatic effect diagnostic services have on cost, as illustrated below:

<i>Capital weighted DRG throughput averaged over Victorian Hospitals - the impact of capital cost</i>	
\$666	<i>per case when all services are hospital-provided</i>
\$587	<i>when pathology is contracted out</i>
\$318	<i>when neither pathology nor diagnostic imaging services are rendered by the hospital</i>

The implications of this knowledge may be anticipated; it will inevitably promote new thinking about the establishment of radiological and pathology centres distinct from many individual hospitals, offering network services and with economies of scale in cost and staff terms and with improved generated by concentration of expertise. Collaborative networks of DTCs may be in the vanguard of this movement. This shift has already taken place in parts of the Sydney conurbation and pilot schemes are underway in the UK. PFI should have a vital role in realising this potential benefit.

### ***Portfolio Management of Assets***

The changes in capital need forecast in this paper highlights the requirement for new thinking about integrated strategic asset planning, but wider-ranging than has so far been the case. It will involve multiple-users across multi-sectoral boundaries. Their needs will vary over time. These factors lead to the proposition of considering future asset procurement and management in portfolio terms. This is similar in concept to the NHS LIFT programme but of much greater scale and with broader objectives. The case for reframing PFI to support this approach is developed below.

## **8. Squaring the Tax, Spending and Pensions Circle - A New Funding Principle**

The recurrent themes in this paper are:

- rapid evolution of health provision towards whole system, multi-sectoral principles of care delivery
- consumerism – choice driving diversity in health facilities and capital funding models - PFI hospital rebuilding, PPP Diagnostic and Treatment Centres, LIFT regenerating Primary Care

facilities and Local Authority health related social investment

- the need for multi-site and multi-purpose facility investment
- realising the unfulfilled potential of PFI and the private sector

It is unlikely that PFI in its present form will prove sufficiently flexible to meet these needs. These principles can however be combined effectively by introducing two further strategic aims as the ‘glue that binds’:

- communitarian (inclusive) principles of public engagement in sharing the health agenda, and
- realising new ways of utilising the potential of pension funds – an alternative approach to ‘public ownership’

The proposition carries the principle of Foundation Trusts a step change further and in doing so has the potential to enable the private sector to introduce new property investment and management strategies that support ‘shared and owned’ modernisation of public health services.

The model is based on the creation of ‘Community Bonds’ - in effect retail pension and savings products that could be sold locally and where the funds raised are actively invested in local infrastructure for the benefit of local citizens.

### ***Community Bond Funding for Portfolio Investment***

A managed property Bond would offer an investment vehicle and establish a fund that provides the flexibility for portfolio investment, as opposed to the predominantly single institution focus of PFI. The key principles are:

- investment fund directly geared to health and social investment
- source of flexible capital investment to support changing patterns of care delivery – a health property portfolio principle of meeting needs
- interlinked source of capital to invest in social infrastructure and urban renewal to help overcome health inequalities and support public health initiatives
- opportunities for those working in the service to invest more directly in their future
- ability for local employers to invest their occupational pension funds
- choice for the public to invest their savings directly in the future of their local health service

At a time of acute public anxiety about security of occupational pensions, such a model would help restore public confidence in the wisdom of personal and employer savings for retirement. With sufficient scale in geographical clusters for efficiency and spread of portfolio risk, the fact that bond interest is effectively guaranteed by payments from publicly funded services, then there will be lower volatility in fund returns and therefore greater certainty of income in retirement.

People will find it easier to make a direct connection between their taxes and pension contributions being used to support their children's, their relatives and their own health and retirement – achieving a public consensus on Generational redistribution of resources.

## Conclusion

The introduction of PFI for the provision of health infrastructure has proved a notable success in stimulating the largest building programme in the history of the NHS.

There is qualification: initial (and to some extent ongoing) shortcomings in translating service need into strategic output definition and practice will almost certainly result in the need for mid-stream correction for many new hospitals. For their part PFI consortia have been inhibited by operational factors: high entry costs, penalty (rather than partnership) based contract structures, shortages of staff experienced in this form of procurement and thinly capitalised unconnected SPCs.

If PFI is to facilitate the next stage in the reform of the NHS two factors must come into play:

First is the question of getting the service planning right combined with the capability of defining this more adequately in terms of required outcomes (as the next stage beyond outputs). It is no longer a question of single institution interests but multi-sectoral systems investment and with health determinants rapidly gaining more prominence as the boundaries between health and social services begin to overlap.

Secondly, success depends critically on a dynamic private sector with the capability and capacity to deliver the massive scale of reconfigured and reequipped physical assets. Within a few years a significant volume of controlling equity in PFI concession companies will rest with a reducing number of mainly financial investors. Just as in Australia, there will be increasing consolidation as corporations start to trade investments and contracts in order to rationalise portfolios and pool assets. Economies of scale and

geographical coherence will come into play as determinants of competition, value and future entrants into the market. What is needed is a refreshed PFI strategy to stimulate and encourage a new breed of social infrastructure developers enabled to make a more incisive contribution to the modernisation of services; security for their investment will come from cash flows earned from useful property assets, rather than security of bricks and mortar.

The recent Treasury report should prompt new initiatives; extension of PFI to the wider public service arena and stimulation for urban regeneration and piloting a Credit Finance Guarantee system of PFI funding. This provides an opportunity to create a market for community managed property Bonds and pave the way for new larger scale, lower risk and higher mutual gain portfolio investment strategies. These offer potential pathways for individuals to invest in their future – health and security. Better opportunities for public engagement will generate a new understanding and confidence in the measures necessary to reshape the health and social landscape.

For this to happen there needs to be visionary thinking and strong leadership from HM Treasury; and new models of public private joint ventures with properly capitalised shared-equity development companies prepared to own and operate health and social property portfolios with lease payments geared to usage and volume throughputs across a local economy.

Finally, if PFI investments are well matched to the needs of private sector occupational pension schemes, why not for the currently un-funded, unsustainable NHS pension scheme?

**Context for the Paper -Evolution of the Private Finance Initiative Squaring the Tax, Spending and Pensions Circle?**

Catalyst Healthcare is a PFI consortium that was formed in 1995 by Bovis (now part of Lend Lease Corporation) and Bank of Scotland. Catalyst's purpose was to respond to the Conservative Governments' new policy initiative and compete to build and finance NHS hospitals one at a time, using a combination of small amounts of sponsor equity and large sums of borrowed money.

Catalyst has two large "first wave" PFI District General Hospitals that were designed in 1997/8 and have been in use since 2001/2, and a rural general hospital designed in 2001 that opened in 2003. Catalyst is currently designing and bidding for 7 schemes to replace or redevelop 14 hospitals having a capital value of £1.6 billion, requiring funds of circa £2.0 billion with a resulting commitment by the NHS to pay index-linked Unitary Charges of some £300m pa for 30-35 years. As a project-based business, Catalyst is progressing towards a corporate model capable of developing and managing portfolios of health and social services infrastructure investments, harnessing institutional funds on a significant scale.

In July 2003, HM Treasury published "*PFI: meeting the investment challenge*", an important analysis and end of first term report on PFI. It provides evidence of what has and has not worked drawn from experience since 1995/7 to date and looks in a pragmatic way at what needs to improve.

In summary, HMT believes that PFI has delivered on time and to budget and the operational experience is positive; it has worked well for [large] hospitals and delivered value for money; the DoH

projects 55 PFI deals by the end of 2005 with a total capital value of £6.5 billion; the price of the risk premium on private sector debt finance (0.3-1%) is good value; a significant proportion by value are on the public sector balance sheet.

The Treasury further propose:

- PFI should no longer be used for IT provision and transactions below £20m
- 'Soft FM' services do not have to be included in the scope of PFI
- employees' terms and conditions including new recruits, have to be broadly comparable to [NHS] rates
- the Public Sector Comparator will be subject to more rigorous early economic appraisal

In terms of ongoing development:

- PFI is to be extended to urban regeneration and social housing
- PFI is only one means of funding public service investment and it does not matter whether projects are on or off the Government balance sheet if they represent best value
- The Government will consult and pilot a Credit Finance Guarantee system of PFI funding where HM Treasury will buy "wrapped" senior debt in PFI projects by issuing Gilts, and paying the private debt risk margin



# The Role of Private Health Care in Australia: Where to From Here?

Helen Owens

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## 1. Introduction

The private sector plays an important role in Australia's health care system, both in terms of delivery and to a lesser extent, financing of health services. Its role in service delivery takes a number of forms: the treatment of fee paying private patients in private hospitals; the delivery of services to public patients under contractual arrangements with State and Territory governments; and, through private contracting, the provision of various clinical and non clinical services to public hospitals. In some instances private hospitals have co-located with public hospitals, sharing facilities but operating at arms length.

However the position of private health care in our overall system is somewhat ambiguous. It sits alongside a universal, tax-financed public system (Medicare) that is available to all. It is also constrained by government regulation designed to pursue broad social objectives relating to universal access, quality and pricing of services.

Governments at all levels have pursued a range of policies to promote the private sector in Australia's mixed public-private system. In the early Medicare years the Commonwealth government subsidised private hospitals directly, while more recently other measures have been directed instead at supporting private health insurance. Meanwhile, over the past decade, State and Territory governments

have been building public-private partnerships through contractual arrangements with private companies to finance, build and operate public hospitals.

Questions arise as to the underlying rationale for these measures, whether they contribute positively to Australia's health system performance and whether more should be done to build private capacity in the Australian system.

## 2. A significant role for private health care

The private sector is involved in Australia's health care system at various levels.

- private suppliers of hospital and medical services
- voluntary private hospital and ancillary insurance
- privately provided and funded dental care, physiotherapy and ancillary services
- manufacture, wholesale and retail distribution of pharmaceutical drugs
- private construction companies

Private health insurance is a \$4 billion industry (net of government premium rebates and tax expenditures) accounting for about 7 percent of total health care expenditure in 2000-01 and nearly

12 percent of hospital funding. (AIHW, 2002a) However its shares of total health expenditures and hospital expenditures have declined significantly since the mid 1990's (Figure 1) despite government measures to support the industry introduced in 1997 (see below).

In 1999-00 there were 509 private hospitals, representing 41% of all acute hospitals, with a large increase in numbers since the early 1990's. The biggest increase was in private free standing day hospitals which almost doubled in number over the last decade (from 111 to 207). Private hospitals account for a third of acute bed supply and 43% of same day separations (AIHW, 2002b) and a higher proportion of surgical than of non-surgical cases.

There are many examples of private hospital co-locations with public hospitals in most states. In theory, these co-locations - which have largely evolved since 1995 - reflect complementarities and economies of scope in the provision of public and private health services. They have been expected to reduce duplication of services and facilities; help the public sector to retain medical specialists; and offer specialists a back up in the public hospital in the event of complications. (PC, 1999a)

In addition to the provision of traditional private hospitals, the private sector has been increasingly involved in entering into contracting arrangements with State and Territory governments to help finance and/or operate public hospitals. A survey undertaken by the Steering Committee for the Review of Commonwealth/State Service Provision in 1998 identified a wide variety of such arrangements across all States and Territories, except for the ACT. In total 14 competitive tendering-type arrangements were identified, involving both private for-profit and private not-for-profit hospitals. (Steering Committee, 1998)

A number of different contracting models have been applied across states.

#### **BOO/BOOT/O/OO:**

BOOT contracts (build, own, operate, transfer) have been used in NSW, Queensland and WA to develop public hospital facilities. BOO contracts (where the private company or consortium retains ownership of the facilities) have been used in NSW and Victoria. O contracts (operate only) have involved the South Australian and Tasmanian governments contracting out the entire management of the public hospital (Modbury and Latrobe hospitals respectively) to private companies in a franchising-type arrangement. In addition, the Commonwealth Department of Veterans Affairs (DVA) has competitively tendered the ownership and operation (OO) of three Repatriation Hospitals which were not previously integrated into the State public hospital systems.

Private providers also contribute to the Australian health system in other ways. Many public hospitals contract out non-clinical services such as catering, cleaning and IT support and private companies supply clinical services such as pathology to the public sector.

In addition, more than 20 religious/charitable hospitals, including 7 major teaching hospitals provide about 3000 beds for public patients. There are many similarities to BOO arrangements in that the owners finance construction and operation of the facilities and governments pay them to treat public patients. But unlike BOO contracts, the private hospital component is operated as a separate entity within the complex.

### **3. Private health care as part of an interactive system**

The private sector is an integral part of Australia's health system, performing multiple functions, some in partnership

with governments and others in direct competition. It is a part of a complex system comprising numerous intersecting arrangements, many ad hoc and opaque. Interactions of the private sector with the broader health system spread well beyond those between private hospitals and governments (as providers of subsidies or contractors), or between private hospitals and public hospitals (as potential competitors or co-locators). They extend to interactions between private hospitals and private health insurers, nursing homes, primary care providers, the medical workforce and Medicare arrangements relating to pharmaceutical and medical services.

Hence the successful functioning of the private sector will be influenced by, and cannot be divorced from, what happens elsewhere in the system. But there are many structural features which make it a rather unorthodox environment in which to operate and may create traps for the unwary. The most significant of these is the historically complex and changing set of subsidies and tax transfers between the Commonwealth government, state governments and insured aimed in part at containing public expenditures.

Other examples include:

- given the existence of a universally available, publicly-funded system (Medicare) which is 'free' at point of delivery, the incentive to use private hospitals or purchase private health insurance depends to a significant extent on the (actual and/or perceived) availability of public beds.
- private hospitals do not operate in a competitively neutral market when competing with public hospitals for private patients (public hospital charges are set by government whereas private charges must reflect underlying costs).
- reduced levels of bulk billing (involving no out of pocket cost to the patient) by general practitioners over recent years may result in a switch of demand to public hospital emergency departments.
- governments regulate the behaviour, standards and entry of public and private providers, the costs of which are reflected in private health insurance premiums.
- governments also regulate medical workforce supply, the availability and price of pharmaceuticals, and the higher cost medical technologies.
- budget caps provide an incentive for governments to limit public hospital capacity and contract out the financing and/or provision of public services.
- little or no (public) coverage for many services (notably dental) creates incentives for privately funded care.

#### **4. Ambiguity in the role of the private sector**

There is little consensus at any level concerning the role of the private sector in this complex mosaic. Consequently, its proper role in the context of Australia's universal health care system has been the subject of considerable uncertainty and policy debate. Participants in the Industry Commission 1997 inquiry into private health insurance expressed diverse views as to its role – and, in particular, the role of private health insurance in funding privately provided services. (IC, 1997)

A number of participants (including consumer groups) saw private health insurance as funding *supplementary* services to those provided in the public system (additional comfort, choice of doctor). Others (including medical and private hospital interests) saw the private

sector as providing a desirable *alternative* to public funding and provision. Some also recognised private health insurance as *supplementing* public funding in regard to public hospital care.

The Commission has expressed the view that in practice it plays both roles – providing additional services and amenities, as well as displacing the need for public funding and service provision under Medicare.

## **5. Government intervention in the market**

Governments' approaches to interacting with the private sector, through regulation contracting and (possibly) subsidy arrangements, will be largely dictated by how they interpret the role of the private sector.

If private funding (and provision) is merely a top up there would be little need for intrusive regulation of private health insurance. If private funding and delivery replace some public responsibilities (taking pressure off budgets) there is more justification for strong regulation, consideration of public-private partnerships and possibly financial support. The latter interpretation is the rationale for the Commonwealth government imposing a range of conditions on funds relating to lifetime community rating, pre existing ailment rules etc and approving premium rises.

It also is the rationale for the original bed day subsidy for private hospitals (removed in 1986-1987) and also the reinsurance pool (also phased out). In order to encourage private insurance membership the government introduced in 1997 a package of means tested rebates and levies, in 1999 a universal 30% premium rebate (largely to relieve the pressure on public hospitals) and in 2000 lifetime community rating designed to induce

higher levels of insurance among younger people.

The incremental reforms introduced in recent years were a means of ensuring the ongoing viability of private health care as well as promoting a broader role for the private sector in public provision and financing. They have to date resulted in a slight shift along the public – private mix spectrum. Underpinning them is an assumption, at least implicit, that the private sector plays both roles and is an intrinsic part of our health system. They reflect a general desire to retain the current mixed model rather than take a big step either towards a private market – based model or alternatively a fully public system.

Taken together with the perceived need to constrain public spending, governments at federal and state levels will be addressing the questions of whether there is scope to develop further the capacity of the private sector to deliver and/or finance a greater share of Australian health services, and the extent to which this is or is not desirable?

The answers to these questions rest in part on how well the private sector, given its public competition, has performed within Australia's mixed system to date. They also depend on how the private sector itself views its future prospects in this challenging and volatile environment.

## **6. Private sector performance**

Containment of costs to the budget has been a powerful factor motivating governments to promote private sector participation in the health system. However in recent years there has also been a perception that private involvement will lead to higher quality, more competition and greater efficiencies (both technical and allocative). But many of these preconceptions may not stand up to scrutiny.

So how well has the private sector performed within Australia's mixed system?

I would like to say that I could answer this question unequivocally but I can't. Its impact has not been well documented so at this stage there are many unanswered questions.<sup>1</sup>

For example, the presumption that private hospitals are relatively more efficient than their public counterparts was the subject of a study undertaken by Duckett and Jackson which provided limited evidence to the contrary. (Duckett and Jackson, 2000) To date no comprehensive Australian study has been undertaken to benchmark the two sectors properly. Ideally, a technique such as data envelope analysis could be used. This tool, which is used to measure relative productivity (or technical efficiency), is able to capture the main sources of difference – including those arising from scale of the operation and factors relating to other characteristics, such as hospital type and location.<sup>2</sup>

The fact that there are very little reliable publicly available data on the quality of care across the sectors is another source of difficulty in comparing the sectors. The Steering Committee for the review of Commonwealth/State service provision noted the limited availability of indicators of quality outcomes for public hospitals. (Steering Committee, 2003). It records piecemeal information for the public hospitals relating to accreditation rates, patient satisfaction, unplanned readmission

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<sup>1</sup> A partial and now somewhat dated picture is provided in inquiry and research reports undertaken by the Productivity Commission and its predecessor, the Industry Commission (IC (1997), PC(1999a), Steering Committee (1998))

<sup>2</sup> The Productivity Commission has successfully applied this technique in an international benchmarking study of railway performance (PC, 1999b).

rates and hospital acquired infections. Much of these data are supplied on a voluntary basis to the Australian Council of Health Care Standards and are not strictly comparable. This problem is compounded in the private sector.

The rapid growth of day surgery centres and elective surgery in the private sector has been interpreted by some as evidence that the private sector is 'cherry picking' the more profitable patients. It has also been accused of refusing entry to elderly medical patients and transferring complex cases to the public system. (Victorian DHS, 2003) This behaviour – to the extent that it exists – may simply be a reflection of the sector responding rationally to the current incentives and payment schedules, which may favour particular services over others in terms of the profit they can generate (Bloom, 2002). If so, it could be an indication of allocative inefficiencies in the system.

Another question relates to how much competition exists in the private hospital market. It would be expected that because of the large number of private hospitals there would be a significant degree of competition. But as the Productivity Commission indicated in its report on private hospitals in Australia (PC, 1999a) competition can occur at a number of levels so the answer to this question is not straightforward.

For example, competition can occur:

- **between private hospitals for private patients**, but this is largely dependent on the hospital's ability to attract doctors and secure contracts with private health insurers so there is little price based competition.
- **between private and public hospitals for private patients**, but they may operate in largely different markets (with public hospitals admitting the

more urgent, seriously ill and/or chronic cases, while private hospitals treat less urgent elective patients).

- **between private hospitals for doctors** based on the quality of facilities and equipment, which may lead to a hospital ‘arms race’ and have adverse impacts on public hospitals in the context of doctor shortages.
- **between private hospitals for contracts with private health funds**, but the development of genuine market in this respect is inhibited by the regulatory environment and concern that the funds have ‘excessive’ bargaining power.
- **between private companies for State and Territory government contracts** to build, own and/or operate public hospitals, that is competition for the market.

Another unanswered question is whether the mode of ownership (for-profit or religious/charitable) delivers different outcomes in terms of efficiency, quality of care and competition. Perhaps of most interest is whether the modality of private sector involvement in delivering and/or financing public hospital services leads to different outcomes. To my knowledge no comprehensive research into the comparative efficiency gains resulting from various contractual arrangements and co-locations has been undertaken but there are some partial case studies which are of interest (for example, Hawkesbury Hospital (Steering Committee, 1998)).

Perhaps the most visible failure was the NSW Port Macquarie hospital BOO contractual arrangement, one of the earliest in Australia (the hospital opened in November 1994). The contract was with Health Care of Australia, a for-profit group ran by the Mayne Group. Significant problems arose in relation to the

specification of the contract and allocation of risk. The contract involved the NSW government paying all finance charges, including for areas devoted to private patients; separate charging for diagnostic and medical services; and limited external accountability.

The outcome is a hospital with among the highest per patient costs in NSW, largely borne by government. The NSW government learnt from this experience when establishing its contract for the Hawkesbury hospital in 1997. The Wentworth Area Health Service chose only to tender with not for-profit groups to deflect community opposition to a non-government operator after the Port Macquarie experience. The experience also influenced the structure of the contract and level of scrutiny of the contracting process. An attempt was made to allocate risk to the party best able to bear it. For example, Fletcher Construction accepted most risk relating to design and construction; the operator (Catholic Health Care) assumed most of the operating risk; and the government accepted the risk for non emergency, elective public patients and any changes to interest rates or government policy. However, competition for the market was limited to just two tenderers.

Other contractual arrangements had more serious repercussions on the private contractor. In the case of the Latrobe hospital in Victoria, the contractor, Australian Hospital Care (AHC), entered into an unrealistic casemix-based BOO contract in 1998. It had unrealistic expectations of what could be delivered at the contract price, possibly reflecting a misjudgment about the relative ability of a private operator to achieve economies in treating public patients. The upshot was the company faced major financial problems and has since been taken over by Health Care of Australia (which in turn has been experiencing major financial

difficulties in its overall operations and is likely to be sold off by its parent company, the Mayne Group, in the near future).<sup>3</sup>

These negative experiences are reflected in similar accounts from California. (Gardner and Scheffler, 1998). Underpinning these experiences are cultural and other differences between the sectors. The public sector has often demonstrated a lack of skills in developing and monitoring contracts, whereas the private companies bidding for contracts have often had limited experience with certain disease classes of public patients.

Apart from the potential adverse impact on governments, private companies or both, there is a danger that such arrangements could lead to the erosion of professional altruism in public hospital care. But such altruistic behaviour forms an important source of social capital (on which the public sector in part relies), which as a result could be diminished.<sup>4</sup>

A final question is whether government financial support for the private sector (in particular through the 30% rebate) has taken pressure off the public hospital system. Again the answer is unclear. Existing research has produced conflicting results. (For example, see Butler, JRG, 2002; Access Economics, 2002; Healthcover, 2003) While not entering into this debate I would like to make just three observations which reflect the difficulty of answering this question unequivocally.

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<sup>3</sup> Mayne's poor financial performance appears to partly reflect a lack of management understanding of the peculiarities of the health market, especially the central role of the medical profession in its hospitals. Other factors include a blow out in nursing and medical indemnity insurance costs.

<sup>4</sup> Social capital is an evolving concept that can be defined as relating to social norms, networks and trust that facilitate cooperation within and between groups. (PC, 2003)

First, we do know that the initial response – largely encouraged more by lifetime community rating – was a reversal in a long term decline in private health insurance coverage (from 30.1% in December 1998 to 45% by June 2001). The health funds experienced an improved risk profile as the young and healthy joined and many private hospitals have experienced high levels of demand and relatively high occupancy rates. However, more recently we are observing a slight reversal in net private insurance uptake and the experience of the funds has worsened as the first year waiting periods expired.

In addition, it is interesting to note that the net contribution of private health insurance to total health expenditures and hospital expenditures continued to fall steadily after the introduction of the government measures, although the decline may have halted in 2000-01 with a slight reversal observed (Figure 1). The medium and longer-term outcomes of the change are yet to be experienced.

Second, there have been some reports of problems of access to private hospitals. According to a Commonwealth Department of Health and Ageing discussion paper (2002) there have been complaints about:

- older, medical patients unable to access private hospital beds
- local private hospitals having no contract with private insurers
- a lack of private providers in some rural areas
- private emergency departments on regular ambulance by pass
- private hospitals allocating more beds to particular surgical procedures.

Any perception that patient choice is limited could contribute to discontent with the private insurance product and the drop out that is now being observed.

Finally, recent hospital separation data from Victoria indicate that between 1996/97 and 2001/02 private hospital activity increased by 36% but public hospital activity also rose 20% and the increase in the absolute number of public hospital separations was relatively larger in the same period (Victorian Department of Human Services, 2003). Thus, use of public hospital treatment in that state has not diminished but the counter-factual is unclear, that is what it would have been without Commonwealth intervention.

## **7. Future prospects for private health care**

The current disjunction between public and private sector funding and service provision has been identified by Scotton as one of four features of the current Australian system imposing barriers to greater efficiency and potentially offering positive incentives for inefficiency. (PC, 2002)<sup>5</sup> Without major reform of the system these factors will contribute to ongoing instability and pressure for continuing incremental change.

This implies that the private sector will face a high degree of sovereign risk from such changes to government policy which could impinge on it directly or indirectly. Its market share is at the whim of governments – especially the

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<sup>5</sup> The other features contributing to inefficiency are:

- program multiplicity and fragmentation
- funding and service overlaps between Commonwealth and State governments
- remuneration arrangements usually unrelated to outputs and outcomes.

Commonwealth's policy position regarding the 30% rebate and states' positions on contracting out. It also faces uncertainty regarding the future uptake of private health insurance, which in turn reflects whether it is perceived as an attractive product (particularly by the young) and cyclical fluctuations in the economy.

Private hospitals may also be vulnerable to structural changes in the private health insurance market. Currently they deal with 44 largely state-based insurers (although the market is dominated by a few large funds in each state). There are signs that many small funds are facing low profits and possible takeover by the larger funds such that in future private hospitals could face an even greater power imbalance in negotiating contracts in a far more concentrated industry.

The private sector also faces risks from a changing public perception about privatisation and its role within the economy generally. While the Australian public generally values choice and accessibility and tends to support the existing public/private mix in health services, a backlash would be likely if there were to be a significant shift towards a market based, privately focused system. A recently conducted survey relating to privatisation and government subsidies found increased scepticism among Australians of all political persuasions about further privatisations (Sikora, 2003). 54% of respondents objected to more privatisation and only 9% fully supported more. Instead there was a significant level of support for government subsidies of health services (71% of respondents), far higher than for any other goods and services.

Thus any further contracting out of public hospital services would need to be handled with great care.



Finally, like the public sector, the private sector must also address the challenges associated with rapid technological advances and an ageing population.

Understanding this challenging and volatile environment is essential for the future prosperity of the private sector. Meanwhile, governments need to be alert to the potential dangers of greater inequities and inefficiencies if inappropriate regulatory, contracting or financial reforms are adopted.

### Postscript

Providing a reliable assessment of the relative performance of the public and private health sectors within Australia is an almost impossible task. Whatever assumptions are applied, one cannot compare like-with-like. They face different financing structures and incentive systems and perform defined roles within the overall health system. Public hospitals are more likely to treat the more seriously ill cases and provide a “safety net” or residual role (Duckett and Jackson, 2000) whereas private hospitals can be efficient “surgical mills”, treating elective cases with greater amenity. Medical research and training are mostly undertaken in public hospitals. Public hospitals face constrained budgets, whereas private hospitals are less constrained in terms of patient throughput and medical and pharmaceutical use.

The study by Feachem, Sekhri, and White (2002) comparing the British National Health Service and the US Kaiser Permanente health maintenance organisation was able to overcome to obstacles to compare like-with-like. Despite delivering a different service mix and facing different factor costs, both operate in similar environments based on rational incentives (in turn based on constrained budgets and responsibility for the care of a defined population). One can

therefore have some confidence in the overall results which showed per capita costs within ten percent of each other.

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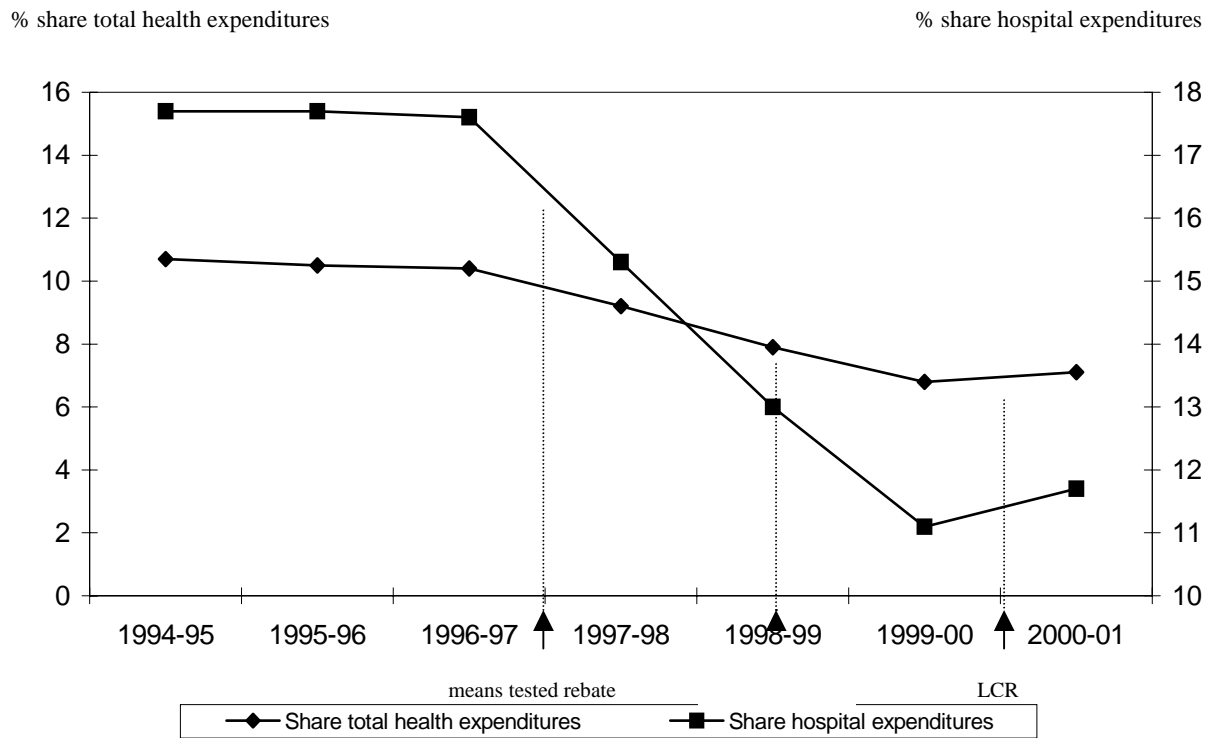
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**Figure 1**

**Private health insurance share<sup>a</sup> of total health expenditures and hospital expenditures, 1994-95 to 2000-01<sup>b</sup>**



**a** Net of 30 per cent premium rebate; includes taxation rebate. **b** Preliminary estimate.  
*Data source:* Australian Institute of Health and Welfare (AIHW 2002a).

## Participant and Biography Listing

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### Participant Listing

#### Australian Delegation

Mr Alan Bansemer  
Professor Bruce Barraclough  
Mr Jim Birch  
Mr Craig Bosworth  
Ms Joanna Davidson  
Mr Philip Davies  
Ms Anne De Salis  
Mr Ron Donato  
Associate Professor Judith Dwyer  
Mr Robert Griew  
Professor Jane Hall  
Ms Jane Halton  
Dr Diana Horvath  
Mr Gavin Jackman  
Mr Mark Metherell  
Dr Louise Morauta  
Ms Mary Murnane  
Mrs Helen Owens  
Dr Sue Page  
Mr Russell Schneider  
Mr David Webster  
Dr Tarun Weeramanthri  
Professor Judith Whitworth  
Mr Roger Wilkins

#### United Kingdom Delegation

Sir John Coles  
Sir Nigel Crisp  
Mr Michael Davis  
Professor Peter Donnelly  
Ms Pam Garside  
Mr Scott Greer  
Mr Justin Jewitt  
Dr Graham Lister  
Mr Dave McNeil  
Ms Claire Perry  
Professor Ray Robinson  
Mr Simon Stevens  
Mr Stephen Thornton  
Mr Nicholas Timmins  
Mr Derek Wanless  
Mr John Wyn Owen CB

#### Support Staff

Ms Lynette Glendinning (rapporteur)  
Mr Tony Kingdon  
Mr Bob Eckhardt  
Ms Libby Camp

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## Biography Listing

### Chairs

**Jane Halton** was appointed Secretary of the Australian Government Department of Health and Ageing in 2002. Prior to this, Ms Halton was Executive Co-ordinator, Department of the Prime Minister and Cabinet (PM&C), responsible for advising on all aspects of Australian Government social policy including health, social security, employment, education, immigration and indigenous policy. In addition, she was responsible for the Office of the Status of Women and for advising the Minister Assisting the Prime Minister for the Status of Women. Prior to joining PM&C in July 1998, Ms Halton was national program manager (First Assistant Secretary) of the Australian Government's Aged and Community Care Program in the Australian Government Department of Health and Ageing, with responsibilities for long-term care. She was responsible for the development and implementation of the Australian Government's Aged Care Structural Reform Package. She has held the position of Principal Adviser, Corporate Development Group in the Australian Government Department of Human Services and Health and Assistant Secretary, Community Care. Ms Halton has also had experience in the Department of Finance, Social Security, Australian Bureau of Statistics (ABS) and the Research School of Social Sciences at the Australian National University (ANU).

**Stephen Thornton** has been Chief Executive of The Health Foundation, an independent charity that aims to improve health and the quality of healthcare for the people of the United Kingdom (UK), since the beginning of 2002. Mr Thornton was previously Chief Executive of The NHS Confederation, the membership body for

all National Health Service (NHS) organisations. He has over twenty year's

experience of management in the UK's NHS, having worked at hospital, community health, health authority, regional and national levels of the service. Mr Thornton has extensive experience of promoting the NHS overseas and has been a member of the Governing Council of the International Hospital Federation. He is currently a member of the Commonwealth Fund of New York's International Programme in Health Policy Coordinating Committee. Mr Thornton is a member of the Governing Council of the Open University and a trustee of two charities operating in the developing world: Christian Blind Mission (UK) and Aquaid Lifeline Fund. He was a member of the NHS Modernisation Board 2001-2 and has recently been appointed a Commissioner of the Commission for Health Audit and Inspection (CHAI). Mr Thornton is a Fellow of the Royal Society of Medicine and was appointed a Commander of the Order of the British Empire (C.B.E.) in the 2001 New Year's Honours List.

**John Wyn Owen** took up the post of Secretary, the Nuffield Trust, on 1st March 1997, having previously been Director-General of NSW Health in Australia and, until 1994, Director of NHS Wales. His career has spanned public and private sectors and is based on a commitment to research, education and training as a foundation for effective management. Mr Owen is: an Honorary Fellow of the Faculty of Public Health; Honorary Member of the Royal College of Physicians; Fellow of the University of Wales Colleges, of the Australian College of Health Service Executives, of the Royal Society of Arts; and an Honorary Doctor of the University of Glamorgan. He is a member of the Institute of Medicine of the National Academy of Sciences and was

made a Companion of the Order of the Bath in the Queen's Birthday Honours in 1994 and an honorary member of the Gorsedd of Bards in 2000.

### Participants

**Alan Bansemer** is an independent consultant. His background includes extensive experience as a senior health administrator, with special expertise in State-Federal funding processes and health policy.

**Bruce Barraclough AO** is Chair of the Australian Council for Safety and Quality in Health Care, and Chair of the NSW Institute for Clinical Excellence. He also Chaired the Expert Advisory Group Inquiry into Claims Related to 'Hepatitis C Transmission through Blood Products in 1990' for the Federal Health Minister in 2002. Professor Barraclough is a member of the Australian Medical Council and the Medical Services Advisory Committee, and a Past President of the Royal Australasian College of Surgeons. He is the Medical Director of the Australian Cancer Network and is Professor/Director of Cancer Services, Northern Sydney Health and Sydney University. Professor Barraclough has a special interest in the field of endocrine surgery.

**Jim Birch** has been employed as Chief Executive of the Department of Human Services since March 2002. Immediately before taking up this appointment, he was Deputy Chief Executive in the Attorney-General's Department and the Department of Justice. He completed a Bachelor of Health Administration in 1983. During his career Mr Birch has held a number of Chief Executive Officer (CEO) positions within the public health sector, including at the Whyalla Hospital, the North Western Adelaide Health Service and, more recently, at the Women's and Children's Hospital. Over the last decade he has also served on a number of Boards

with a focus on improving health service quality and health services reform. He has held senior Board posts on Women's Hospitals Australia, the Australian Health Care Association, the Australian Council on Health Care Standards and the Australian Association of Paediatric Teaching Centres. He has also lectured in Health Services management at the University of South Australia and is currently a Council Member of the University.

**Craig Bosworth** is an Adviser to Federal Minister for Health and Ageing, Senator the Hon. Kay Patterson on access and financing policy. He has responsibility for the Pharmaceutical Benefits Scheme and pharmaceutical subsidy reform, diagnostics and technology, pharmacy ownership, private health insurance, private hospitals and information technology/management issues. He was formerly the Health and Social Policy adviser to the Victorian State Opposition Leader. Craig is a qualified Manipulative Physiotherapist and is currently undertaking his Masters in Business Administration.

**John Coles** retired as Permanent Under-Secretary of State in the Foreign and Commonwealth Office (FCO) and Head of the Diplomatic Service in November 1997, after a 37-year career. Overseas postings included as High Commissioner to Australia for three years from 1988. From 1991 he was Deputy Under-Secretary of State for Asia and the Americas in the FCO in London, and Permanent Under-Secretary of State from 1994 until his retirement. From 1981-84, Sir John served as Private Secretary to the then Prime Minister, Margaret Thatcher, advising on foreign affairs and defence policy. Sir John is also Chairman, Sight Savers International.

**Nigel Crisp** is a Cambridge graduate in Philosophy. He has a background in

community work (where he worked for some years in Liverpool and Cambridgeshire) and in industry, prior to joining the NHS in 1986. He became the General Manager for Learning Disabilities in East Berkshire and moved in 1988 to become General Manager (and later Chief Executive) of Heatherwood and Wexham Park Hospitals which provided a wide range of general hospital and mental health services in East Berkshire. He moved to Oxford in 1993 to become Chief Executive of the Oxford Radcliffe Hospital, which incorporates the John Radcliffe and Churchill Hospitals and is one of the largest academic medical centres in the country. He became South Thames Regional Director of the NHS Executive in February 1997 and London Regional Director on January 1999. Sir Nigel took up his new role as Chief Executive, Department of Health and NHS on 1 November 2000. He was awarded a KCB in the New Year's Honours 2003.

**Joanna Davidson** is currently head of Social Policy Division in PM&C, with responsibility for policy advice and development on social policy issues including health, education, employment services, community services, income support, immigration and Indigenous policy. Prior to this Joanna had a broad range of experience working for government departments, including Health, Social Security and Finance, on policy and program administration.

**Philip Davies** joined the Australian Government Department of Health and Ageing as a Deputy Secretary in August 2002. He is a member of the Department's Executive, and has specific responsibility for the Acute Care, Primary Care, Health Services Improvement and Medical and Pharmaceutical Services Divisions. He brings to the role almost 25 years' international experience in health care policy and management. After graduating in Mathematics, Mr Davies spent five

years working with the British Department of Health and Social Security in London followed by 14 years as a specialist health care management consultant with Coopers and Lybrand in the UK and New Zealand. In 1997 Mr Davies joined the New Zealand Ministry of Health as a Deputy Director-General. He left at the end of 2000 to spend 18 months as a Senior Health Economist with WHO in Geneva before taking up his current position.

**Michael Davis** became Chief Executive of Catalyst Healthcare Management Limited (a subsidiary of Bovis Lend Lease) in 2000, and in 2003 was also appointed Chairman of Lend Lease Europe's new health development business. Catalyst's two founding and principal sponsors are Bovis Lend Lease and the Bank of Scotland. Mr Davis leads Catalyst's policy development and relationships with NHS Trusts, the Department of Health and a wide network of other agencies.

**Anne De Salis** has a diverse career spanning both the public and private sectors. Ms De Salis is currently the Group Executive Corporate Culture and Communications in Medical Benefits Fund of Australia Limited (MBF). She is responsible for spearheading the development of a performance culture for the health insurance mutual, as well as covering government relations and advocacy, human resources and board relations. Prior to joining MBF she worked for nine years at AMP, starting in 1994 as Head of Government Affairs before becoming a line manager responsible for sales in AMP's Corporate Superannuation business in 1996. In 1999 she moved on to create a new retail financial services start-up business called AMP Direct. Before moving to the private sector, Ms De Salis enjoyed several years as a Senior Adviser to the then Prime Minister, Rt. Hon. Paul Keating, covering issues as diverse as immigration policy, the republic debate and the operations of



government. She joined the Keating office from the Commonwealth Treasury, where she had worked for many years as an economic adviser. In 1991, she became the first woman to join Treasury's senior executive service since Federation. Ms De Salis has held and continues to hold a number of Board appointments, including the NSW Financial Institutions Commission, the Association of Superannuation Funds of Australia, the Technical and Further Education Board of NSW and AMP Superannuation Ltd, one of Australia's largest trustee companies.

**Ron Donato** is an economist in the School of International Business and at the University of South Australia. He also has lecturing interests at Flinders University of South Australia, where he delivers a health economics course to masters students in health services administration. His field of research is in health economics, and he has lectured, consulted and published extensively in this area. Mr Donato has consulted to State and Australian government health agencies in the area of health program evaluation and on health policy reform issues. He has also provided health economics training workshops for health professionals from developing countries under government and World Bank funded aid programs. His current research interests centre on the economics of health care financing reform. In particular, recent research has been in relation to the application of diagnostic-based risk adjustment methodology in the Australian context and the economics of contracting in health care. Mr Donato was also a key participant in the workshop on Managed Competition conducted by the Productivity Commission in 2002.

**Peter Donnelly**, a graduate of Edinburgh Medical School, joined Lothian Health as Director of Public Health and Health Policy in April 2000. In addition, since 2002 he has held an honorary Chair in Public Health at the University of

Edinburgh. Before returning to Edinburgh he was Director of Public Health for four years with Iechyd Morgannwg Health in Swansea. Prior to that he spent four years as a Senior Lecturer at the University of Wales College of Medicine. Although focussed on service appointments, Professor Donnelly has remained academically active, and his doctoral thesis was on the topic of CPR training. He has trained in management at a number of institutions including Harvard Postgraduate School of business administration where he completed the programme for management development in 1994. He has published widely on Public Health and related matters. Professor Donnelly is the elected Vice-President of the UK Faculty of Public Health Medicine. He is a former President of the UK Association of Directors of Public Health.

**Judith Dwyer** is the Head of the Department of Health Policy and Management at the La Trobe School of Public Health. She coordinates the Masters in Health Administration at La Trobe, and her major research and consulting work is in the areas of health governance and policy and management reviews. Dr Dwyer is a former CEO of Southern Health Care Network in Melbourne, and of Flinders Medical Centre in Adelaide. With her colleague Dr Sandra Leggat, she edits *Australian Health Review*. Dr Dwyer chairs the National Board of the Australian Resource Centre for Hospital Innovations, is a member of the Health Advisory Committee of the National Health and Medical Research Council (NH&MRC) and is a Director of Yarra Valley Water. At the national level, she has experience as a member of the Board of the Australian Institute of Health and Welfare (AIHW), as well as serving on an AHMAC sub-committee, and on the national Executive of the Public Health Association. She was a member of the Australian delegation to the World Health



Assembly in 1992, and has served in numerous policy and governance bodies at State government and institutional levels. Most recently, she chaired the Governance and Funding Task Group for the South Australian 'Generational Review' of the health system. Dr Dwyer works in China (teaching health care managers) and has recently acted as a consultant to the Australian government on a project in Thailand. In 1998, she was awarded the inaugural AMA Women's Health Award for her sustained contribution to the development of health services for women in Australia, and in 2000 was appointed Adjunct Professor at the Institute for Health Services Research at Monash University.

**Pam Garside** has her own management consultancy, Newhealth, specialising in organisational strategy and development in health care. She is a member of the visiting faculty at the Judge Institute of Management Studies (the business school of the University of Cambridge) where she is Co-director of the Cambridge International Health Leadership Programme. She began her professional life in management in the NHS and subsequently spent 10 years studying and working internationally based in the USA. Since the mid-1980s she has worked as a management adviser and consultant concentrating on the reform of healthcare systems, and leadership and management development. Ms Garside is a member of the Board of Quality and Safety in Health Care, a *British Medical Journal* publication, Chairman of the Board of Governors of the Royal College of Nursing's Institute of Higher Education, and a Board Director of the International Women's Forum Leadership Foundation in Washington DC. She is co-owner and Vice Chairman of the International Health Summit, USA and a Senior Associate of the Nuffield Trust. She holds a BSc from the University of Durham and a Masters Degree in Hospital and Health Care

Administration from the University of Minnesota.

**Lynette Glendinning** is a founder and principal of P.A.L.M. Consulting Group, a consultancy practice in 1989. P.A.L.M.'s mission is to provide high quality management consultancy services to organisations to improve organisational, workgroup and personal performance. Originally a psychologist leading residential rehabilitation programs, Lynette then became a lecturer in organisational psychology in tertiary institutions. She holds a Bachelor of Arts in Psychology and a post-graduate Diploma in Education from Sydney University and is a member of the Institute of Management Consultants of Australia, the Australian Institute of Training and Development, the Australian Human Resources Institute and the Institute of Public Administration of Australia.

**Scott Greer, PhD** is a Research Fellow with the Constitution Unit, University College London, where he is responsible for the Devolution and Health project. This study of health politics and policy in England, Northern Ireland, Scotland, and Wales includes interviews, partnerships with Northern Irish, Scottish and Welsh researchers, a survey of health elites, and participant observation of health meetings. A report will be published in 2004, *Territorial Politics and Health Policy* (Manchester and New York: Manchester University Press). He has also organised the international seminar series *Decentralisation and Democracy*. The Constitution Unit specialises in constitutional reform and comparative constitutional studies. It is independent and non-partisan, and the centre of a wide network of national and international experts. The Unit is funded by charitable trusts, research councils and government departments.

**Robert Griev** has worked for over 20 years in the Health and Community Services field. He started work in Children's Services and then in Child Care Policy, having in the process joined the Commonwealth public service as a graduate trainee. In the various Australian Departments of Health and Community Services he worked across Aged Care, Public Health and Aboriginal health, running that last program for two years when it had just transferred to the Health Department. Mr Griev has also maintained academic and community sector links and was CEO of the AIDS Council of NSW during the latter part of last decade. He has also served as Deputy Director General of the NSW Department of Ageing, Disability and Home Care. Mr Griev was appointed CEO of the Northern Territory Department of Health and Community Services in January 2003.

**Jane Hall** is a health economist whose current research interests include the investigation of individual decision making, valuation of health and health care benefits, and social welfare measurement. Professor Hall is the founding Director of the Centre for Health Economics Research and Evaluation (CHERE) and Professor of Health Economics in the Faculty of Business, University of Technology, Sydney (UTS). Among her current research projects are studies of media reporting of health policy issues, the evaluation of genetic testing, and the role of private health insurance. Her previous research includes economic evaluation studies in many areas of health services and public health. Professor Hall is involved in health policy and planning issues both in Australia and internationally, and has served on numerous advisory committees and working parties.

**Diana Horvath** is Chief Executive Officer, Central Sydney Area Health Service. She graduated in Medicine from

the University of Sydney in 1968. For two years Dr Horvath was a member of the Faculty at the Johns Hopkins Hospital, Maryland, USA, which led to involvement in the development of community health services in Australia. After completing a Masters Degree at the University of NSW, she was involved in the management of Royal Prince Alfred Hospital for some 20 years. Dr Horvath was the President of the Australian Hospital Association 1993-1995 after 20 years as national councillor and office bearer. She had a major role with the NH&MRC and became its chairman in the early 1990s. She held the position of Commissioner with the Health Insurance Commission (HIC) when it was both Medibank Private and responsible for the running of Medicare. She was appointed an International Fellow of the King's Fund College, London. From 1996 to 1999 she served on the Trade Policy Advisory Council (TPAC) of Australia the peak advisory trade policy body to the Federal Minister for Trade. Her extensive knowledge of health issues—operational and policy involvement—has placed her on numerous working parties and committees at State, Federal and international levels.

**Gavin Jackman** is the Chief of Staff to Federal Minister for Health and Ageing, Senator the Hon. Kay Patterson. He is her chief political and policy adviser and manager of Parliamentary business. He was formerly the Senior Adviser to Senator Patterson and, prior to this, had responsibility for health and community services policy in the Department of the Prime Minister and Cabinet. He has also been a policy adviser within the Australian Government Department of Health and Ageing. Gavin has a Masters Degree in Public Policy from the Australian National University.

**Justin Jewitt** is Chief Executive of Nestor Healthcare Group plc, a FTSE 250 Company and the UK's largest

independent sector provider of personnel and services solutions to the fast-growing UK healthcare market. Mr Jewitt joined the Group in May 1994 as Managing Director of BNA and was appointed to the Board in July 1996, becoming Chief Executive in December 1997. He was previously Managing Director of two of BET's business services companies, prior to which he worked for Thorn EMI and Mobil Oil. Amongst other activities, Nestor is responsible for looking after 25% (20,000,000) of the UK's population for primary care after surgery hours.

**Graham Lister** is Chair of the College of Health charity that operates the Patient Involvement Unit for the National Institute for Clinical Excellence (NICE) and the Access and Choice Unit for the DoH. He is also Senior Associate of the Nuffield Trust and Advisor to the Netherlands School for Public and Occupational Health, working on health reforms in European Union (EU) accession countries. Dr Lister has advised on health care management and policy in the UK, Kenya, Cambodia, Hong Kong, Spain, Sweden, Italy, Denmark, the Czech Republic, Lithuania and Hungary. Publications include international reviews of: health reforms, information management, primary care, patient involvement and self care. Recent work includes input to the White Paper 'Making Globalisation Work for the Poor', the National Scoping Study for NHS Direct and health futures projections for WHO and the Wanless Review. His Nuffield Trust programmes include: Globalisation, Women's Development and Health, Information and Communications Technology for Health, the Commonwealth Forum on Globalisation and Health, The Global Health Award and the UK Strategy for Global Health. Dr Lister was formerly the partner responsible for healthcare management consulting at Coopers and Lybrand UK. He gained a doctorate for work on public sector

management and has a master's degree in management science.

**Dave McNeil** has an honours degree in Psychology. He has worked in the private sector as manager of a retail outlet and as a musician, but the bulk of his career has been in the civil service. He is active in his local community as a school governor and as a non-executive director on the management board for Citizens Advice. His civil service career has covered operational as well as policy responsibilities. In 1996, he was asked to lead a multi-agency project to co-ordinate a yearlong anti-fraud campaign. In 1998, he was asked to assist in the setting up and development of a new agency to scrutinise the work of local authorities in their payment of benefits. He led a number of inspections aimed at improving efficiency and offering best practice models. In 1998 he joined the Department of Health as assistant director of policy and communications in the new counter fraud and security unit. This included chairing regular meetings with his opposite numbers from Scotland, Northern Ireland and Wales. In 2001, he moved into the mainstream of the department as private secretary to the Parliamentary under Secretary of State for health (Lords), moving to become Senior Private Secretary to the Permanent Secretary and Chief Executive of the NHS in 2002.

**Mark Metherell** writes, from Canberra, on national health policy for the *Sydney Morning Herald*. His interest in the area tracks back to the early 1980s, when he covered the establishment of Medicare as a medical reporter for *The Age*, Melbourne. He held news executive positions with *The Age* and the *Canberra Times* before joining the *Herald*, and returning to the health round four years ago.

**Louise Morauta** is currently First Assistant Secretary, Acute Care Division in the Australian Government Department

of Health and Ageing. In this role, Dr Morauta has responsibility for financial relations with the States and Territories on public hospitals. She also has responsibility for private hospitals, private health insurance, blood and fractionated products and medical indemnity. From 1970 Dr Morauta spent a number of years in Papua New Guinea where she taught in the Department of Anthropology and Sociology at the University of Papua New Guinea. Since coming to Australia, Dr Morauta has worked in two other Australian Government Departments: the Australian International Development Assistance Bureau and the Department of Finance.

**Mary Murnane** became Deputy Secretary with the Australian Department of Health in May 1993. After an early career in school teaching, university tutoring and research, Ms Murnane became Deputy Director of the Tasmanian Department of Community Welfare in 1978. Joining the Australian Government in 1985, she became First Assistant Secretary of the former Office of Child Care. Before taking up her current position, she was First Assistant Secretary of the Department's Community Programs and Aged and Community Care Divisions. Ms Murnane oversees the Department's Ageing and Aged Care Division, Population Health Division, Office of Aboriginal and Torres Strait Islander Health, the Commonwealth Rehabilitation Service, the Department's Offices in NSW, Tasmania, Queensland and the Northern Territory, and portfolio interests in the NH&MRC. Her responsibilities encompass ageing and aged care, population health including drug policy, food policy and regulation, communicable diseases, health protection and biosecurity, Aboriginal and Torres Strait Islander health services and infrastructure and research. In her work, Ms Murnane actively promotes a social policy perspective and maintains high level

networks with consumer and industry groups.

**Helen Owens** was appointed to the Productivity Commission as a full-time Commissioner in 1998, following 5 years as Commissioner on its predecessor organisation, the Industry Commission. Prior to that Mrs Owens was Associate Professor in Health Economics at the Centre for Health Program Evaluation, Monash University. At the Productivity Commission Mrs Owens has special responsibility for matters relating to the social effects of economic adjustment and social welfare service delivery. She holds a Bachelor of Economics (Hons.) and a Master of Economics from Monash University. Mrs Owens is currently the presiding Commissioner on the national inquiry into the *Disability Discrimination Act 1992*. She recently presided on a government commissioned study investigating general practice compliance costs associated with Commonwealth programs, as well as an international benchmarking study of pharmaceutical prices. Mrs Owens has led a number of other health-related government inquiries, including into the Pharmaceuticals Industry, Medical and Scientific Equipment Industries and Private Health Insurance. She has also directed a number of other research projects in the health area including: private hospitals, public hospital contracting, hospital casemix funding, the cost of alcohol consumption and supplier-induced demand. In 2002 she facilitated two Commission roundtables on health policy and managed competition. She has conducted many other major Commission inquiries over a wide range of areas, including Research and Development, International Air Services Agreements and Cost Recovery by Government Agencies.

**Sue Page** is a senior academic at the University of Sydney's Department of Rural Health and President of the NSW Rural Doctors Association. She is

involved in rural health advocacy, policy and planning through a variety of multidisciplinary bodies including the NSW Rural Health Action Group and the NSW Aboriginal Maternal and Infant Health Strategy Committee, and is a Ministerial appointee to the NSW Rural Health Taskforce and the NSW Mental Health Sentinel Events Review Committee. At a Federal level, she has represented the Rural Doctors Association in the Red Tape Taskforce, Medicare Attendance Item Restructure, and at the national Indemnity meetings organised by PM&C. A rural GP from the far north NSW coast, her practice includes primary health care within an Aboriginal community. She is a Fellow of both the Royal Australian College of General Practice and the Australian College of Rural and Remote Medicine, and is a registrar Supervisor and Examiner. She also has post graduate training in Psychiatry (eating disorders), Obstetrics, and the early management of severe trauma.

**Claire Perry** is Chief Executive of University Hospital Lewisham NHS Trust, a role she commenced early in 2002. UHL is a busy 3 star District General Hospital providing a deprived population with the full range of acute services plus some tertiary specialties for a wider catchment. Prior to this post Ms Perry led the development of the London Patient Choice Project, introducing choice for elective patients through the rapid expansion of capacity to achieve waiting time reductions. For two years before this she was Project Director modernising professional self-regulation systems for nurses and midwives. Ms Perry was Chief Executive at Bromley Health Authority for seven years until 2000 delivering primary care services to a population and commissioning community, acute and specialist services. Ms Perry is recent past Chairman and a founder Trustee of the New Health Network, an organisation that

aims to improve services to patients by sharing good practice, supporting open debate and influencing policy. She was awarded the Order of the British Empire in 1998.

**Ray Robinson** is Professor of Health Policy at LSE Health and Social Care, London School of Economics, and Senior Fellow at the European Observatory on Health Care Systems. From 1993-98 he was Professor of Health Policy and Director of the Institute for Health Policy Studies at the University of Southampton, and from 1990-93 he was Deputy Director of the King's Fund Institute, London. Earlier in his career he worked as an economist in HM Treasury and was a Reader in Economics at the University of Sussex. He has also held visiting posts at a number of universities in North America and Australia. He has acted as a consultant to health authorities, government departments and international organisations such as WHO, OECD and the World Bank. He has also carried out assignments for management consultants in Britain and overseas. From 1990-95 he was a health authority non-executive director and from 1993-95 vice chair of East Sussex Health Authority. Professor Robinson's work at LSE is concerned with various aspects of health finance, economics and management. He has published over 150 articles and seven books on health and social policy. His most recent publication is *Completing the Course: Health to 2010*, The Fabian Society, 2003 (with A. Dixon).

**Russell Schneider** is a political journalist, media administrator and author. Since 1983 he has been Chief Executive of the Australian Health Insurance Association, which probably makes him the longest serving health lobbyist in Canberra. Mr Schneider has worked as an adviser to Federal Governments and Opposition, and worked closely with Ministers, Shadow Ministers, Backbench Members of



Parliament and senior public servants. For five years he wrote a weekly column on politics in *The Australian* newspaper. He is currently Chair of the International Federation of Health Plans' Panel on Public Affairs. As a representative of the Australian private health insurance industry, Mr Schneider has had responsibility for developing and promoting policies on health financing for adoption by government. A number of changes to health financing arrangements have come about as a direct result of his efforts.

**Simon Stevens** is Prime Minister Tony Blair's Health Policy Adviser at 10 Downing Street. He previously served as the policy adviser to the last two Health Secretaries at the Department of Health, where he co-authored the 'NHS Plan' and 'Delivering the NHS Plan'. He has worked in the NHS and internationally, including as a health authority director, general manager of a psychiatric hospital, and group manager at Guy's and St Thomas' hospitals in London. He studied at Oxford and Strathclyde universities and was a Harkness Fellow at Columbia University and New York City Health Department. He is a board member of the Health Equity Network.

**Nicholas Timmins** is Public Policy Editor of the *Financial Times* and author of *The Five Giants* (HarperCollins) a history of the British welfare state from Beveridge to the present day. At the FT he works with a team of journalists covering health, welfare, education, employment and home and legal affairs, and defines the job as watching the boundaries between the public and private sectors. He previously worked for *The Independent*, *The Times*, the Press Association and the science journal *Nature*. He has worked as a political, employment and health correspondent and won a number of awards for journalism and books. He is

also a former distinguished visiting fellow at the Policy Studies Institute.

**Derek Wanless** worked for NatWest for 32 years and was its Group Chief Executive from 1992 until his retirement in 1999. He advises Governments and companies and is currently a director of Northern Rock plc and of Business in the Community, a Commissioner with the Statistics Commission and a Trustee of the National Endowment for Science, Technology and the Arts. He graduated with a first class honours degree in mathematics at King's College, Cambridge. He qualified as a member of the Institute of Statisticians and of the Chartered Institute of Bankers, of which he was President in 1999-2000. In 1999, he was President of the Institute International D'Etudes Bancaires. In 2001, he was asked to review the long-term trends affecting the UK health services over the next 20 years. His final report 'Securing Our Future Health: Taking a Long Term View' was published in April 2002. In April 2003, he was invited to provide an update focussing on population health, prevention and reducing health inequalities. He also advised the Welsh Assembly Government's Review of Health and Social Care in Wales (published in July 2003).

**David Webster** is currently First Assistant Secretary, Portfolio Strategies Division in the Australian Government Department of Health and Ageing. One of the Division's priorities is to assist the process of 'whole of portfolio', strategic policy development. A vehicle for driving this is the recently established high level Policy Outcomes Committee. The division also covers international health issues and takes the lead in planning and co-ordinating the Department's contribution to the government's annual budget process. Mr Webster has worked on health and other social policy issues since 1988. For much of that time his work, in PM&C,

focused on headline health issues with a Commonwealth/State relations dimension. Mr Webster's earlier work in the public service was on foreign affairs and defence. Before that he taught at a number of TAFE colleges and universities.

**Tarun Weeramanthri** works as a Community Physician with the Northern Territory Department of Health and Community Services. He has had a long-term involvement with Indigenous health issues as a specialist physician, policy maker and researcher. He completed his PhD in social medicine at the Menzies School of Health Research in Darwin, before playing a key role in the development and implementation of the NT Preventable Chronic Disease Strategy. Dr Weeramanthri is a member of the National Diabetes Strategies Group. In January 2004, he will take up the position of Principal Medical Adviser in the NT.

**Judith Whitworth** is the Director of the John Curtin School of Medical Research and Howard Florey Professor of Medical Research at the ANU in Canberra, and heads the High Blood Pressure Research Unit. Professor Whitworth is Co-chair of the WHO/ISH Guidelines for Management of Hypertension and a member of WHO's Global Advisory Committee on Health Research, an Ambassador for Canberra and an Ambassador for Women. She was 2002 Telstra ACT Business Woman of the Year. Professor Whitworth graduated from the University of Melbourne, which awarded her the degree of Doctor of Medicine in 1974, a PhD in 1978 and a Doctor of Science in 1992. Professor Whitworth is a Fellow of the Royal Australasian College of Physicians. She has practiced medicine and research extensively in Australia and overseas; she chaired the Medical Research Committee of the NH&MRC and is a Past-President of the Australian Society for Medical Research, and the High Blood Pressure Research Council of Australia. Professor Whitworth's previous appointments were

Australia's Commonwealth Chief Medical Officer and Professor of Medicine at St George Hospital, University of New South Wales. She was made a Companion in the Order of Australia in 2001 for service to the advancement of academic medicine and as a major contributor to research policy and medical research administration in Australia and internationally.

**Roger Wilkins** holds the dual positions of Director-General of The Cabinet Office in NSW, and Director-General of the New South Wales Ministry for the Arts. He was appointed as Director-General of The Cabinet Office in 1992, and Director-General, Ministry for the Arts, in early 2001. Mr. Wilkins came to the Premier's Department in 1983 from an academic position at Sydney University Law School where he also undertook postgraduate studies in law and philosophy. He studied Administrative Law at London University. He has played a leading role in areas of reform in administration and law, in corporatisation and micro-economic reform, and in Commonwealth-State relations. He is New South Wales' representative on the Senior Officials Committee for the Council of Australian Governments (COAG). Mr. Wilkins is also a member of the Cultural Ministers' Council Standing Committee.

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## Program

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**Sunday 14 September 2003**

**Location: Members' Dining Room, Old Parliament House, Canberra**

<b>4.00pm</b>	<b>Registration</b>
<b>4.30pm</b>	<b>Afternoon Tea</b>
<b>5.00pm</b>	<b>Welcome, Introduction and Scene Setting – Federal Minister for Health and Ageing, Senator the Hon Kay Patterson and Mr John Wyn Owen</b>
	<b>First Plenary – Policy Imperatives for the United Kingdom and Australia</b>
	<b>Presentation of Papers:</b>
	<ul style="list-style-type: none"><li>• <b>United Kingdom – Mr Simon Stevens</b></li><li>• <b>Australia – Ms Jane Halton</b></li><li>• <b>Discussant – Mr Nicholas Timmins</b></li></ul>
	<b>Plenary Discussions</b>
<b>6.45pm</b>	<b>Summary and Close of Session – Ms Lynette Glendinning</b>
<b>7.00pm</b>	<b>Welcome Reception – Members' Bar, Old Parliament House</b>
<b>7.30pm- 9.30pm</b>	<b>Welcome Dinner – hosted by the Australian Government Department of Health and Ageing, Members' Dining Room</b>

**Monday 15 September 2003**

**Location: Members' Dining Room, Old Parliament House, Canberra**

<b>8.45am</b>	<b>Second Plenary – Changing Health Economies – Design and Management</b>  <b>Presentation of Papers:</b> <ul style="list-style-type: none"><li>• <b>United Kingdom – Professor Ray Robinson</b></li><li>• <b>Australia – Mr Philip Davies</b></li><li>• <b>Discussant – Dr Graham Lister</b></li></ul> <b>Plenary Discussions</b>
	<b>Group Work</b>  <i>Groups will be asked to draw on their experiences, and the presenters, to identify the 'lessons' or advice they would give when it comes to designing and managing a mixed health economy</i>
<b>10.45am</b>	<b>Summary and Close of Session – Ms Lynette Glendinning</b>
<b>11.00am</b>	<b>Morning Tea</b>
<b>11.15am</b>	<b>Third Plenary – Federalism and Health and Health Care</b>  <b>Presentation of Papers:</b> <ul style="list-style-type: none"><li>• <b>Australia – Mr Roger Wilkins</b></li><li>• <b>United Kingdom – Mr Scott Greer</b></li><li>• <b>Discussant - Mr Alan Bansemer</b></li></ul> <b>Group Work</b>
<b>12.35pm</b>	<b>Summary and Close of Session – Ms Lynette Glendinning</b>
<b>12.45pm</b>	<b>Lunch</b>

**Monday 15 September 2003**

**Location: Members' Dining Room, Old Parliament House, Canberra**

<b>1.30pm</b>	<b>Fourth Plenary – Public Health</b> <b>Presentation of Papers:</b> <ul style="list-style-type: none"><li>• <b>United Kingdom – Professor Peter Donnelly</b></li><li>• <b>Australia – Mr Robert Griew</b></li><li>• <b>Discussant – Professor Judith Whitworth</b></li></ul>
	<b>Group Work</b>
<b>2.50pm</b>	<b>Summary and Close of Session – Ms Lynette Glendinning</b>
<b>3.00pm</b>	<b>Afternoon Tea</b>
<b>3.15pm</b>	<b>Fifth Plenary – Financing and Delivering Services</b> <b>Presentation of Papers:</b> <ul style="list-style-type: none"><li>• <b>United Kingdom – Mr Mike Davis</b></li><li>• <b>Australia – Mrs Helen Owens</b></li><li>• <b>Discussant – Mr Derek Wanless</b></li></ul>
	<b>Group Work</b>
<b>5.15pm</b>	<b>Presentation of synthesised feedback from group reflections – Ms Lynette Glendinning</b>
<b>6.15-7.30pm</b>	<b>Reception - hosted by Sir Alastair Goodlad, British High Commissioner, Westminster House</b>
<b>8.00pm</b>	<b>Dinner – hosted by The Nuffield Trust at The Lobby Restaurant, Parkes</b>

**Tuesday 16 September 2003**

**Location: Members' Dining Room, Old Parliament House, Canberra**

<b>8.45am</b>	<b>Country Working Groups</b> <ul style="list-style-type: none"><li>• <b>Discussion of issues and recommendations for the UK and Australia and for bilateral working</b></li></ul>
<b>10.30am</b>	<b>Morning Tea</b>
<b>11.00am</b>	<b>Sixth Plenary:</b> <ul style="list-style-type: none"><li>• <b>Report of discussion, country group recommendations and recommendations for bilateral consideration</b></li></ul>
<b>12.45pm</b>	<b>Concluding Remarks – Mr Stephen Thornton</b>
<b>1.00pm</b>	<b>Lunch</b>