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**WHAT PLACE FOR EVIDENCE IN HEALTH  
REFORM?**

**A CROSS-SECTORAL ROLE FOR THE AUSTRALIAN  
INSTITUTE OF HEALTH POLICY STUDIES (AIHPS)**

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## **Introduction**

Health sector reform has been occurring in many developing and developed countries alike, in recent years. Berman (1995) defined it as “sustained, purposeful change to improve the efficiency, equity, and effectiveness of the health sector”, while Bloom (2000) characterised it more descriptively as “reconfiguration of the major structural features of a health system – finance, provision, and regulation – on a national or state-wide basis”. Within Australia, such reforms have been undertaken across most jurisdictions on a continuing basis for over a decade, and many who work within the health delivery system would probably depict it as almost “continuous change” to the structure and delivery of health services in the name of efficiency, equity, and effectiveness.

This paper contextualises the purpose of creating an Australian Institute of Health Policy Studies (AIHPS) in relation to current health challenges and the nature of health reform debates. The paper acknowledges the challenges of bringing research evidence into health policy but also the importance of continuing to improve the evidence base for health policies. These premises form the basis for describing the AIHPS vision and its proposed agenda and ways of working.

## **Health challenges and health reforms**

The epidemic of health reforms sweeping across the world reflects the continuing pressure on health systems to contain costs, improve access, and raise service standards (Ham 1997), which are sometimes connected to meeting existing and emerging health challenges. Across developed and developing nations there are common issues with a growing burden of chronic disease, ageing populations and relative shortages of skilled health workers. In most developed nations, there are some additional common issues such as the demand for health services exceeding supply because of the increased range and intensity of health care interventions, the increasing scope of what constitutes a medical problem, and increased demand from consumers for more ready access and higher quality services. Across English-speaking OECD countries, there is generally also a recognition of the role of the consumer in health, both in terms of their own health decisions as well as more active engagement in higher level health policy decisions. Pressure groups and industry have recognised and are utilising this capacity in various ways. Health system performance is also increasingly judged on the basis of measures of consumer demand for and consumer experience of the health system.

Despite similar policy pressures, health reforms have proceeded in different ways, which reflect in part, the type of health system in place, the political structures and traditions of each country. While the UK and New Zealand had adopted a ‘big bang’ approach in their initial introduction of ‘purchaser/provider split’, Australia and Canada have taken a more evolutionary, bottom-up pathway, consistent with their decentralised federalist systems. Despite different processes of reform, however, there have been some common themes and tools used internationally – such as ‘steering, not rowing’, contestability, burden of disease analysis, DRGs, cost-effective analysis, de-regulation, report cards, etc. Some of these have been transported across and between countries – such as the centrality of primary care, although their specific meanings and forms vary from country to country.

The stated policy imperatives in Australia are often not dissimilar to many other countries – i.e. how to sustain public commitment to a comprehensive range of health services for all citizens, how to improve the efficiency of health care provision in time of fiscal constraint, and how to devise better approaches to improve population health (Drache and Sullivan 1999). Yet, typically, the main policy themes debated are surprisingly narrow. For example, in Australia, health reform debates have been mainly dominated by the issues of public/private balance and Commonwealth-state relations. Consequently, the reforms across states and territories have largely focused on changing organisational and financial arrangements, particularly for hospitals. There has been surprisingly little debate in Australia about the overall aims of the health system and of the relevance of particular funding models to specific health needs.

While the dynamics of public/private mix and the dual levels of government funding are important in shaping the incentives within the Australian health system, at the aggregate level, Australia does well when compared to other OECD countries – in terms of cost containment as well as health status. Health system performance in Australia is good to high on many measures on a comparative basis, but the comparisons also point to persistent health inequalities, particularly in relation to the health of Aborigines and Torres Strait Islanders, and over-institutionalisation. Looking to the future, and like all other OECD countries, Australia's major health challenges rest with chronic non-communicable diseases, including mental health and other sociopathologies, such as violence, and how to achieve a satisfactory mix of managing, treating and preventing these across the lifespan.

When these health challenges are considered, it becomes clear that there is a large gap between the dominant health policy debate in this country and the nature of health problems that require attention across Australia. Although there are attempts at programmatic innovations, including mental health and Aboriginal health, there is often little connection between the systemic issues and the particular health challenges. This gap between the health challenges and the health policy debate points to an absence of an agreed upon national vision of what the health system should achieve, as well as the lack of a sufficient evidence base for identifying pathways and options for national health improvement.

### **Can the evidence base for health reforms be improved?**

Globally, there is wide acknowledgement that there should be a better link between health policy and practice and an evidence base about effectiveness and performance. Since Archie Cochrane's reflection on effectiveness and efficiency of health care, there has emerged a global movement for evidence-based medicine. While active strides are being made in the realm of clinical interventions, the application of this concept (and rhetoric) is less evident in the health policy arena, despite some modest individual initiatives to form policy-research partnerships (see November 2003 issue of *Journal of Health Services and Policy Research*).

Case studies of Australian health policy point to mixed success (see Lin and Gibson 2003), with challenges apparent in both the nature of evidence as well as the policy process. Some Australian systems for evidence-based health policy development (such as pharmaceutical subsidy decisions) are internationally well-known. Other Australian reforms are strongly underpinned by research evidence (such as the introduction of case mix funding) although once introduced, the impact of such reforms is usually not assessed fully. Still, other bodies of evidence in relation to program impact are often not transferred into systemic reforms, for example, the recent study on the return on investment from prevention.

There are many reforms for which there has been little serious assessment of impact and outcome. This is particularly the case with organisational re-arrangements and legislative and regulatory changes. The evidence base for the diverse health reform strategies are often difficult to establish, in part because of the multiple and simultaneous nature of many reforms. The short-term focus of political cycle and the incomplete information that is collected on aspects of the system, particularly in ambulatory and community settings, also pose other challenges.

The lack of a substantial evidence base for health reforms is not surprising. Policy-making is often driven by political or other imperatives, and cannot wait for research and evaluation to occur. Policy-making and delivery organisations seldom have the luxury of being learning organisations. Policy-making also requires a wide range of ‘evidence’, not all of which are necessarily fall within the understanding of ‘evidence’ by conventional researchers. At the same time, researchers often do not comprehend the imperatives of policy decision-making sufficiently to be able to engage successfully with policy-makers, and to assist with answering questions such as what type of evidence is useful for what kinds of decisions, and when. Where research evidence is available, it is usually not made available in a form or in a language which is digestible by health decision-makers.

Despite all of these barriers to improving the quality and quantity of evidence available to health leaders, there is an undoubted increased international commitment to improving the evidence base for health policy. The Agency for Health Research and Quality (AHRQ) in the US and the Prime Minister’s Strategy Unit in the UK are amongst the notable government entities, while the Canadian government has funded the establishment of a chair in research transfer in health. These governmental efforts complement the efforts in the philanthropic sector in the US and UK (e.g. Nuffield Trust, Commonwealth Fund, Robert Wood Johnson Foundation, Pew Trust, etc.).

The substantial challenges in effecting evidence-based health policy as a means to improved health reform can only be tackled if there is shared commitment across the various sectors – public, private, academic, community – to do so. Researchers can work more effectively with the policy arena by drawing together the available evidence and interpreting that evidence base within a decision-making context. Researchers can also provide a constructive and critical eye to promote policy learning; researchers can also assist in providing a ‘safe’ environment for frank discussion of policy dilemmas across sectoral interests. A longer term investment in independent analysis, built on partnership between researchers and decision-makers in the public, private and community sectors, can offer one pathway to evidence-based health policy.

### **Why is AIHPS needed?**

There is currently no national, independent body devoted to the study of health policy, such as those established for other important areas like housing, family studies, and Aboriginal and Torres Strait Islander policy. An independent body is vital if Australia’s health policy is to be underpinned by balanced consideration of stakeholder interests, community interests, and good scientific research and practice. The need to enhance Australia’s capacity for policy relevant health research, particularly in relation to the translation of research into policy, has been recognised by the Wills Report, the more recent NHMRC Investment Review, and many other reports in Australia over recent years.

Given the internationalisation of health systems policy, through such influential institutions as OECD and the WHO, Australia needs to regain its position as a leader in research and development in health policy so that it can influence directions (as it did with case mix funding) rather than merely following the directions set elsewhere. There is scope for an Australian contribution beyond the issues of financing, provision and regulation of health care, given the Australian successes in many important public health areas (Allin et al 2004). Furthermore, given the health challenges confronting Australia, there is a need for a body committed to health policy that can work across and outside the health sector, particularly in terms of how a strong orientation towards prevention may be secured.

The vision for the Australian Institute of Health Policy Studies (AIHPS) is to establish Australia's first collaborative (and virtual) national institute devoted to health policy research with the capacity to better inform long-term decision-making in order to improve the Australian health care system and the health of the Australian people. In light of the health challenges, and in the interest of engagement across the health system, the following five areas as being the Institute's 'core' research program:

1. *Engaging consumers in health* – encouraging informed, shared decision-making about available treatments and policies, and examining what constitutes effective health consumer participation;
2. *Getting the most from prevention* – supplementing research on prevention strategies with research on prevention policy that will have implications beyond the health sector;
3. *Improving chronic disease outcomes in a rapidly ageing population* – examining the management of chronic disease and the barriers to better integrated care;
4. *Priority setting in healthcare policy and planning* – exploring methods for priority setting in the face of rising demand and the need for tough decisions about resource allocation; and
5. *Workforce for the Australian healthcare system in the 21st century* – planning and training a workforce to meet Australia's future healthcare needs.

The core activities of the Institute will be policy-oriented research synthesis, through critical evaluation of existing research in Australia and overseas. With a major emphasis of the Institute being on knowledge transfer, the collaborative research programs will focus on:

- Encouraging national debate about new approaches to chronic disease management and health improvement, and the interface between prevention and reduction in healthcare demand;
- Facilitating improvements in health policy by examining new approaches to demand management in health care and inter-generational dynamics in health; and
- Facilitating improvements in the health system by exploring strategies for transcending the traditional care model and offering new options for health policy.

Additionally, the Institute will commission and conduct research and foster exchange between research groups and decision-makers. Amongst the deliverables planned for the Institute are:

- Bulletin-style updates and industry-specific analyses
- Bi-annual reports on 'best practice'
- Annual report on health system costs and performance
- Policy templates for improved prevention
- Hosting meetings that bring diverse perspectives together

### **Some proposed priority areas for work and debate**

In line with the above nominated areas of work, and for the purposes of stimulating debate, AIHPS<sup>1</sup> nominates the following as the initial questions for exploration.

- Consumer engagement – do current models work or have they lasted beyond their 'best by' date? Can they truly act as impetus for patient-centred care or do we need to extend beyond communication and information? What would a consumer-centred health system look like? In a system which is largely government funded what does consumer-driven mean?
- Prevention across the system – how can population health programs work in concert with secondary and tertiary prevention? Can prevention programs and health care be effectively planned and governed from within the same organisational framework? At what scale do these programs need to operate to achieve population-level impact? What is the infrastructure and capacity needed at the local level to tackle health inequalities in a realistic and serious manner?
- Health workforce – have professional boundaries led to structural inefficiencies in the system? Do changing technologies require a different interface between consumers and healthcare professionals? Do training and educational programs need a major shake-up and move away from control by professional bodies? How do we retain the strengths of the existing workforce training structures for example in relation to standards while achieving more flexibility?

### **Conclusion**

Despite the general recognition that the Australian health system performs relatively well compared to other nations, there is still considerable room for improvement. The current dominant themes for policy debate, while important, are unlikely to result in improved health outcomes. The AIHPS vision for health reform is that it becomes an evidence-based rejuvenation of cultures, structures, and approaches to the provision of health services in the community that maximises health gain, inclusion, wellbeing, quality of care, and consumer rights and participation, and minimises bureaucracy, waste, and needless complexity.

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<sup>1</sup> More information on each of the foundation researchers and details on AIHPS are available in *A Strategic Framework for the Establishment of the Australian Institute of Health Policy Studies*.

## References

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