Australian Government health advisory groups and health policy: seeking a horse, finding a camel

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ABSTRACT

- Since its election, the Rudd Labor Government has created 10 new advisory bodies in the health portfolio, in addition to the 100 or more that were already established.
- An expansive and devolved advisory system could improve the health policy-making process, but only if it is integrated into the processes of government.
- We outline eight simple and practical measures that, if implemented, would make Australia's health advisory system more transparent and effective.
- Past experience shows that the most important factor governing the impact of health policy advisory bodies is political leadership.

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Since coming to office in November 2007, the Rudd Labor Government has established, ordered or held many committees, reviews and consultations across all portfolios. By one estimate, these include 83 reviews, 17 committees, commissions or boards, 12 inquiries, 11 working groups, 11 discussion papers, seven summits, seven consultations and five audits.[1] In the health portfolio alone, the Government has established 10 new advisory bodies (Box).

This highly consultative and devolved decision-making approach is consistent with the Government's election commitments. If it is genuinely and broadly consultative, coordinates and integrates the efforts of multiple advisory bodies, and is accompanied by strong leadership, there is a real chance it will produce a definitive and sustainable reform agenda for Australia's health system. However, if it is an excuse to delay bold decision making, then the promised reforms will not materialise.

A multiplicity of advisory bodies is not new. In the mid 1980s, under a previous Labor Government, then Minister for Health Neal Blewett commissioned a review that found at least 240 committees operating in the health portfolio.[2] The review was primarily concerned with community participation in the decision-making process, but made some important recommendations on the advisory system in general. It recommended that the then Department of Health "keep an up-to-date directory of groups it consults with", "review the relevance of all committees and working parties", and, in consultation with community groups, "agree on procedures for nominating … representatives to advisory committees and working parties" and "develop guidelines for appointment and consultation on committees and working parties".[2]

Twenty years later, it is still not possible to find out how many committees, councils, authorities, statutory agencies, advisory groups and working parties exist in the health portfolio. Our research shows that there are over 100, and this number would easily double if subcommittees and delegated working groups were counted.[3] Some of these may now be considered defunct, and we have no way of knowing how many we missed.

These groups, along with the health bureaucracy, have generated a huge number of strategies, action plans, reports and evaluations. If these were readily available and accessible, they could provide data, insights and guidance on most current health initiatives to interested parties, including concerned citizens.

Criteria for outsourcing decision making and advice

To make this elaborate system for outsourcing decision making and obtaining expert advice more effective, we propose several criteria.

The system should be more obvious and transparent. There should be a single location on the Department of Health and Ageing website where all operational commissions, taskforces, advisory groups, committees and other such bodies are listed. For each body, this site should provide its terms of reference, who it reports to (and how frequently it does so), the authority under which it was established, and its functions organised by category (eg, regulatory, management, disciplinary or advisory). Currently it is impossible to accurately compile such a list.

Information on advisors and decisionmakers (eg, who they represent and how they are appointed) should be publicly available. A consequence of a small population and a plethora of bodies needing specific expertise is that the same expert individuals and organisations are utilised repeatedly. These individuals and organisations will inevitably have better access to information that may provide an advantage with professional activities and funding applications.

The role of each body and its relation to other bodies with similar responsibilities should be explicit. Currently, the National Health and Hospitals Reform Commission, the Preventative Health Taskforce and the National Primary Health Care Strategy External Reference Group have overlapping responsibilities and deadlines. It is not clear how they will work together or incorporate work done elsewhere in mental health, Indigenous health and the large number of cross-government groups reporting to the Council of Australian Governments and the Ministers for Health.

Whether and when action based on advisory body recommendations is required, as well as the rationale for ignoring such advice, should be explicit. The requirements of governments, government departments and ministers to act on advice needs to be made clear. Also, although we recognise that they are entitled to override or ignore policy advice, a stated commitment to evidence-based policy making should require justification of why expert advice is rejected or ignored.

How and when each body will be decommissioned should be clear. At present, the Pharmaceutical Health and Rational Use of Medicines Committee is fading into obscurity. It has not met since February 2006,[4] but there has been no suggestion that its work (in implementing the National Strategy for Quality Use of Medicines at the consumer level) is complete or no longer needed.

Findings and recommendations of each body should be publicly available and actively disseminated. When there is a change of government, new advisory bodies are inevitably created and others are retired. As many reports from advisory bodies are not publicly released, and do not elicit a formal response, changes in government cause "institutional amnesia", and new advisory bodies repeat previous work. Currently, the only way that most of these "lost" reports can become public is through the expensive and time-consuming Freedom of Information process.

Rudd Labor Government announcements of new policy advisory bodies in the health portfolio

Name	Purpose	Established	Reports to	Additional information
Cognate Committee on Organ and Tissue Donation and Transplantation	Advise governments on implementation of the recommendations of the 2007 National Clinical Taskforce on Organ and Tissue Donation final report	7 December 2007	Australian Health Ministers' Conference (AHMC)	Replaces Inter-governmental Committee on Organ and Tissue Donation and Australians Donate
Council of Australian Governments (COAG) Working Group on Health and Ageing	Improve the health of all Australians and sustainability of the Australian health system; plan implementation of election commitments	20 December 2007	Prime Minister and COAG	Chaired by Minister for Health; implementation plan for election commitments delivered at COAG meeting in March 2008; group scheduled to meet four times in 2008 to report on progress of this plan
National Health and Hospitals Reform Commission (NHHRC)	Advise on performance indicators and short- and long-term practical reforms for the Australian health care system	Election commitment; members announced 25 February 2008	Prime Minister, COAG and AHMC, via Minister for Health	Funded until July 2009; advice on framework for next Australian Health Care Agreements (AHCAs) and performance indicators delivered in April 2008; Australian Institute of Health and Welfare performance indicators delivered in July 2008; interim report due in December 2008; final report due in June 2009
Pharmaceuticals Industry Working Group	Provide policy advice on pharmaceutical industry development in Australia	Members announced 8 April 2008	Minister for Health and Minister for Innovation, Industry, Science and Research	Revival of earlier group formed in 1998
Preventative Health Taskforce	Develop a National Preventative Health Strategy, prioritising issues regarding tobacco, alcohol and obesity; provide a framework for Preventative Health Partnerships between federal, state and territory governments	Election commitment; members announced 9 April 2008	Minister for Health	Funded until July 2012; discussion papers released October 2008; draft strategy to be ready for comment by March 2009; final strategy due in June 2009
National Primary Health Care Strategy External Reference Group	Support the government in the development of the National Primary Health Care Strategy	Election commitment; members announced 11 June 2008	Minister for Health	Work on the National Primary Health Care Strategy will link with current related health reform processes, including the activities of the COAG Working Group on Health and Ageing and the NHHRC, development of the AHCAs, and the National Preventative Health Strategy
National Advisory Council on Mental Health	Provide independent advice on mental health and assist with the coordination of mental health services across federal, state and territory governments	Election commitment; members announced 12 June 2008	Minister for Health	Funded until July 2011
Ageing Consultative Committee	Improve government consultation with aged care industry, workforce and consumer representatives	Members announced 25 June 2008	Minister for Ageing	Merges former Aged Care Advisory Committee and Community Care Advisory Committee
Ministerial Council on Ageing	Help initiate, develop and monitor policy reform; facilitate consultation and cooperation between federal, state and territory governments	Election commitment	Prime Minister and COAG, via Minister for Ageing	Funded until July 2012
Australian Suicide Prevention Advisory Council	Identify community needs and priorities for the National Suicide Prevention Strategy	10 September 2008	Minister for Health	Minister for Health also announced a reinvigorated National Suicide Prevention Strategy Workplan ◆

Time and money invested in each body should be explicit and justifiable. All the bodies that we have identified require time and commitment from their membership; impose travel and secretarial costs; and require keeping of minutes, analysis of data, circulation of paperwork and writing of reports. These activities have financial and human-resource opportunity costs. The annual administration costs of the current health advisory bodies are likely to amount to hundreds of millions of dollars.

Before a new commission, committee, advisory group or working party is established, the need for it should be questioned. Questions to be asked include: Is this really necessary? Does this information already exist in the reports that the Department of Health and Ageing has received? Could this work be done by some other group or one of the 17 statutory agencies and authorities attached to the Department?

Committees can be substantial, critically important and durable — examples are the Pharmaceutical Benefits Advisory Committee (PBAC) and the Medical Services Advisory Committee. Here the question is how to get the best from them. They should not be hindered by excessive workloads and underfunding. If the PBAC was to be funded by fees from industry, as has been mooted,[5] who would pay for it to deliberate in breadth and depth about future issues?

Although not perfect, the health policy advisory system in the United Kingdom provides an example of how this can be done. The UK Department of Health's website details a current list of operational advisory bodies. Information such as terms of reference, membership, meeting schedules, agendas and minutes, along with current and past reports, is provided.[6]

Conclusion

Although it is difficult to create and manage a functional, devolved advisory system and translate advice into action, past experience reveals that it is possible. The Hospitals and Health Services Commission, established by the Whitlam Government when it introduced Medibank and expanded community care, was a judicious blend of study and action that was highly successful. It demonstrated the value of creating a federal entity capable of analysing data, developing appropriate policy proposals, translating them into programs that were implemented by federal, state and territory governments, and implementing rigorous evaluation mechanisms.[7]

During the 1980s, Neal Blewett successfully used the work of two major committees to develop a national set of goals and targets in preventive health that were implemented through the National Better Health Program, which was jointly funded by the Australian and the state and territory governments.[8] He did this while simultaneously introducing Medicare, tackling HIV/AIDS, initiating the first Indigenous health and women's health policies for Australia, and establishing the Australian Institute of Health and Welfare to measure the impacts of these initiatives.

These examples demonstrate how previous health ministers have harnessed the expertise of advisory bodies to implement substantial and long-lasting reforms in Australia's health system. They highlight that political leadership and adequate resources, together with responsibility for implementation and evaluation, are critical to delivery of substantive reform. Advisory bodies are only as effective as political leaders allow them to be. The current challenges in health policy are difficult and diverse, and they demand that the expertise and institutional memory of the existing advisory network are fully utilised. We have outlined criteria to help achieve these goals.

Competing interests

None identified.

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