

Learning from past commissions

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*History doesn't repeat itself; at best it sometimes rhymes —
learning from the past to secure future success*

In the light of Australia's current health challenges,¹ the new Labor federal government has established two commissions to review existing health services and advise about reform — one expressly to concentrate on what might be achieved through prevention. Two former national commissions deserve attention to see what lessons can be learned that could help ensure the success of the new initiatives.

Before 1972, the Australian federal government's role in health had essentially been to subsidise private health care services. During the Whitlam era, the Hospitals and Health Services Commission (HHSC), created under legislation passed in late 1973, produced a wide range of initiatives with its most important innovation being the Community Health Program, which was intended to make primary care more accessible, and prevention more popular, across Australia.²

The HHSC was inextricably connected with the policy ideas and political skills of the chair, Sidney Sax, former Director of Research and Planning in the New South Wales Department of Health. The HHSC was well resourced, with three full-time and six part-time Commissioners, but faced several familiar but serious constraints.³ The difficulties arising from the fast pace at which policy development was pursued were compounded by

Key propositions

- If the two new commissions established by the federal government are to have lasting impact, their recommendations will require appropriate and sustained funding.
- Political leadership and commitment are essential.
- Professional capability and adequate expertise, both on a commission and available to it through its secretariat, are necessary for bringing about meaningful outcomes.
- Non-government and civil society networks must be consulted — a commission's recommendations need to strongly reflect prevailing community understanding and values. ◆

the division of responsibilities between Medibank and the Ministry of Health. However, the HHSC was able to pursue a deliberately conciliatory course. It emphasised primary health care and established the Community Health Program, which included the Family Medicine Program, the Hospitals Development Program, health services planning and research, a review of the School of Public Health and Tropical Medicine at the University of Sydney, diagnostic services, rehabilitation, Abori-

ginal health, rural health, health transport, nursing personnel, health careers, and occupational health.³

The legacy of the HHSC is mixed. Not only was it unclear whether prevention should be emphasised at the individual or population level, but many general practitioners were uneasy about the multidisciplinary, team-based approach of the community health centres and use of salaried doctors. However, a national corps of health professionals was imbued with the idea that community-based health interventions were achievable, while health promotion received unprecedented recognition.⁴

Another step for the nation away from the “sickness” model of health was the Better Health Commission (BHC), established by federal Health Minister Blewett in 1985. Noting the nationwide failure to advance prevention, it committed adherents to reorient their systems towards health promotion, and urged the creation of a national health promotion body.

In 1987, after receiving the report of the BHC, the Australian Health Ministers’ Conference set up the Health Targets and Implementation (Health for All) Committee (HTIC), chaired by one of us (SRL).⁵ The HTIC produced a comprehensive set of eight national health goals and 65 targets in the proposed National Better Health Program (NBHP), with priority given to prevention.

In 1988, the Australian Health Ministers accepted the NBHP and approved 3-year federal–state funding of \$40 million for its implementation. This was the first national plan employing health promotion to be endorsed at such an elevated political level. Evaluators of the NBHP in the 1992–93 financial year noted observable progress in the HTIC’s priority areas, although major progress would clearly require efforts beyond a limited-life initiative like the NBHP.⁶

The BHC’s approach of using measurable outcomes, health priorities and cooperative leadership at the national level enjoyed a degree of popularity, and this has persisted, with current interest in measurable accountability owing something to this parentage. Notably, this includes renewed interest through the recent proposal for a National Prevention Agency.¹

What can we learn from these commissions?

- First, both the HHSC and the BHC enjoyed considerable influence, though some sceptics judge that neither made any lasting impact. Such a dismal view of history overlooks incremental change, especially in the domain of political and social attitudes.⁷ By comparison with other commissions and inquiries whose recommendations go absolutely nowhere and whose reports are never read, at least these two were taken seriously, received multimillion-dollar funding and had an impact that lasted over several years.
- Second, the commissions enjoyed the patronage of competent federal ministers. Without strong political leadership,⁸ and political commitment, nothing happens. If the minister (or prime minister or premier) does not want a commission to do anything, it won’t. Consequently, a wise commission will keep in mind the political risk that the minister has taken in establishing it. This is “Politics 101”, but commissions have been known to be so dazzled by the brilliance of their recommendations that they lose this critical insight.
- Third, the commissions were led by individuals with professional status, congenial temperaments and political capability. Dull, politically inept people appointed to positions of leadership lead nowhere.
- Fourth, a commission needs to be well resourced to work.

- Finally, both commissions had strong links to non-government and civil society networks. A commission detached from the people will fail.

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