REPORT ON OVERSEAS STUDY VISIT TO ENGLAND AND FRANCE

APRIL, 2004

Dean Brown
Deputy Leader of the Liberal Party
Shadow Minister for Health
Member for Finniss
**Purpose of Study Visit**

The British Government, through the Foreign and Commonwealth Office (FCO), invited me to visit England to study the British Health System. In particular the British Government wanted to highlight changes in the structure and objectives of the health service, and the subsequent improvement in performance. As a result the FCO organised the visits based on fifteen specific objectives I submitted for the visit. Several visits were organised independently of the FCO, still aimed at gaining a better understanding of the British health system.

The visit to France had three specific objectives. These were:

- to examine initiatives being taken by the French Government to foster the biotechnology industry;
- to discuss with a representative of the wine industry its assessment of the Australian wine industry; and
- to visit and understand the role of Australian troops in France in the First and Second World Wars

**British Health System**

1. **Groups and People Visited**

The visit was organised on the basis of meeting key representatives of the Department of Health to discuss the central organisation of the health system and the monitoring of its performance. This included funding, financial management, funding of areas on a population basis, the use of information technology especially for patient information systems, and the provision of primary health care. The structure of the health system was discussed in great detail, including recent changes to structure to make a system more responsive. This segment included how the Department reported to both the Minister and the Prime Minister.

I met with the King’s Medical Research Fund, an independent highly respected research organisation.

To understand the delivery of health services at a local level I visited the Dorset and Somerset Health Authority, which is regarded as having the best performance in Britain. This included meeting various local boards and a visit to a National Health Service (NHS) Hospital and a Primary Care Trust.
Other visits included:

- Dame Briget Ogilvie, University College London and Chair of various medical committees;
- Child Protection Division of the Department of Education and Skills, London;
- The Houses of Parliament and meeting with members of Parliament and the Commonwealth Parliamentary Association;
- The Conservative Party Headquarters;
- The South Australian Agent General;
- A University medical research laboratory at Sheffield; and
- Department of Trade and Industry concerning approval criteria for wind farms to generate electricity.

### 2. General Findings

#### 2.1 Structure of health system.

In the past the British health system had centralised control through the National Health Service (NHS) with regional boards covering large areas having control over both primary care (general practitioners and other primary care workers) and acute care (hospitals). That structure has now been abolished, because it did not deliver the health services required. It performed poorly, partly because of the conflict for funds between primary care and acute hospitals.

Most international comparisons showed the previous system was under-funded and had some of the worst outcomes for patients. There were long waits for surgery and in emergency departments of hospitals, and it was often difficult to see a general practitioner.

Five year survival rates for various cancers were very poor compared to other countries, such as Australia.

The modernisation of health care has resulted in the large regional health authorities abolished and replaced with regional offices. The old regional authorities each controlled all primary care and numerous hospitals.

Under the new structure there are 303 primary care trusts (PCT) which are directly funded by the central office of the NHS to provide primary health care. There are about 200,000 people in each PCT.
Each hospital now has its own board which is referred to as a General Hospital Trust. Each hospital is funded to perform required amounts of service.

Some hospitals that have achieved a 3 star rating are referred to as Foundation Hospital Trusts. This concept is a move towards individual hospital status. These hospitals have their own board, have complete independence, are able to raise their own outside finance, and can carry out extensions up to 25 million pounds without central office approval.

The performance of the individual PCT’s and hospitals within a region is monitored by a regional office, which then reports back to central office. There are 28 regional offices.

Private hospitals, such as the Nuffield Foundation Hospital and especially contracted orthopaedic and ophthalmic hospitals are now being contracted to deliver services for the NHS.

Therefore the large bureaucratic boards and structures have been dismantled in favour of smaller individual units with much greater autonomy. This is the exact reverse of what has been proposed for South Australia through the Generational Health Review. In South Australia new large regional boards with control over numerous hospitals and community health services have been established. The people in Britain with considerable experience of their previous system said the move by South Australia was likely to fail in delivering better health services, with hospital performance expected to decline. They stressed the South Australian move was counter to the trend elsewhere. The South Australian model was unlikely to see a focused improvement on primary health care.

Britain has increased funding for health care by almost 10 per cent a year for three years. Now spending on health care represented about 8.2% of GNP (compared to about 9.8% in Australia).

A number of people, including the King’s Research Fund, stressed the importance of keeping separation between primary care and hospital care.

Walk-in Treatment Centres, run by nurse practitioners, are used to reduce the wait to see a general practitioner. There is a shortage of GP’s in Britain. These Walk-in Treatment Centres attempt to triage people and reduce the number of people needing to see a GP. The wait to see a GP can be 3 to 4 weeks.

There is a critical shortage of nurses. Up to 30 per cent of nurse positions in London are vacant, and higher in some country areas.
A 24 hour telephone advice service, called NHS Direct, is used to give immediate advice on location of medical services and to reduce inappropriate attendances at hospitals. NHS Direct appears to be effective in achieving its objectives.

The health system is also establishing Diagnostic and Treatment Centres which are specialist medical centres for X-rays, diagnosis and day surgery. These are separated from hospitals and have a very limited number of overnight beds for one night stays only.

The British Government is decentralising health care, providing greater flexibility, specialisation and autonomy. In many regards their system is moving towards the Australian system with its greater use of private health providers, especially in specialist medicine. The benefit appears to be more efficient services and better quality care due to greater specialisation.

This trend appears to be counter to the government-controlled national health scheme proposed by the Australian Labor Party at a national level in recent publicity. The British experience of past years should be a classic lesson not to follow such a model.

2.2 Information Systems
The NHS is investing vast amounts of money in developing a national patient information system which can be accessed by all health providers. This patient information will be transmitted through a dedicated network called the Integrated Care Record Service.

The information will be held centrally. An extra 600 million pounds a year, on top of the existing information technology budget of 850 million pounds a year, is being spent to develop and rollout this information technology system.

The approach taken reflects similar thinking to the Information Technology outsourcing contract adopted in South Australia.

Improving information transfer is seen as a key means of improving quality of treatment of patients and reducing medical mistakes.

The new system provides the following:

- Electronic booking of patients for specialist appointments or hospitals by the GP;
- Electronic transmission of prescriptions;
- A network to transmit patient information; and
• Patient care records providers on a local basis, with six regions across England.

When completed it will be the world’s largest and most complex IT system.

2.3 Improved Care of Chronic Illnesses
To improve care of chronic illnesses, National Services Frameworks (NFS’s) have been established for coronary heart disease, cancer, mental health, older people, children and diabetes.

For example in cancer treatment, the framework sets out to screen more women to reduce the time for people with suspected cancer to be seen by a specialist, to increase the number of cancer care specialists, and to establish cancer care networks to improve service.

For improved coronary heart disease treatment, there are many more defibrillators installed, more heart operations are performed, the number statins prescribed increases by about 30% per year, and a free fruit scheme has been introduced for school students.

It was found that 3 per cent of patients use 35% of hospital bed-days. For those patients over 65 years of age who are admitted to hospital more than twice in one year, coordinated care is being provided. This coordinated care is based on managed care from the United States of America.

Kaiser Permanente and United Health Care, two managed care providers from the USA, are working with 18 primary care trusts in England on delivering coordinated or managed care.

Functions of a typical managed care organisation are to:

• Monitor and coordinate care for specific people for a fixed annual fee;
• Monitor and coordinate all care from primary to tertiary care;
• Emphasise prevention and health education;
• Encourage the provision of care in the most appropriate setting by the most appropriate provider; and
• Promote the cost effective use of services through various means.
2.4 Accountability of Performance

There is a big effort to reduce waiting times for elective surgery and reduce the waits in Accident and Emergency Departments of hospitals. Strict standards have been set and each hospital is expected to operate within those standards.

There is weekly reporting to the central office of the Department of Health from the regional offices. Once a month there is reporting to the office of the Prime Minister.

Waiting times for elective surgery have apparently decreased, although the public seemed sceptical about the degree of improvement.

The hospital visited in Dorset (about 600 beds) had better standards of performance on waiting times than major hospitals in Adelaide. This hospital was classed as one of the best performers in the country. The ratio of patients to nursing staff was about double the ratio that would apply for an Adelaide hospital. No doubt this reflects the shortage of nurses. The impact of such low nursing levels could not be determined in the time available.

3. General Conclusion on Health Care

My general conclusion of health care in Britain is that the NHS is attempting to reform and modernise itself. The level of success varies greatly across the country.

The NHS is huge (second biggest employer in the world) and that is probably one of the biggest barriers to rapid improvement. However, significant improvement has been made where there is flexibility, decentralisation, and competitive pressures from outside private providers to the NHS.

The best performing region, that of Dorset and Somerset, was the most aggressive in introducing contracted private medical providers and providing greater autonomy to the clinicians and local managers. It focused strongly on better health care for patients, including healthier lifestyles.

This dominant conclusion must be a clear message to Australians not to adopt the proposal for a national health commission, which would manage and control all health care (Federal and State) through a centralised bureaucracy.
Child Care and Protection

National responsibility for child protection and care comes under the Department of Education and Skills, as the emphasis is on achievement for these children. The Department determines the national policy and national framework, and about 70% of the funding. The local authorities are responsible for providing the care and for being guardians of the children.

A Child Protection Order from the courts must be obtained before removing a child from the family home. All parties are represented legally before the courts.

All people working or dealing with children must be screened, which includes an assessment of the suitable character of the worker or volunteer.

Foster parents receive 250-300 pounds per week per child (half for living expenses and about half as a skills payment). Some private agencies charge 500-600 pounds per week to care for children. Foster parents of children with special needs receive up to 3,000 pounds per week. Foster care of children is seen and paid as a carer, rather than a community service.

Costs of providing foster care or alternative care have been increasing by 10-12 per cent a year. However, in England it is becoming increasingly difficult to find foster carers.

Wind Farms for Electricity Generation

The Department of Trade and Industry is responsible for the approval process for wind farms over 50 mega watts. Many of the wind farms are well off-shore to minimise the visual effects and overcome problems with noise to neighbouring residential areas.

An EIS must be carried out before extensive public consultation.

Key objectives are noise, visual effects, and bird strikes. Off-shore wind farms are 8 to 10 km off-shore.

It has been found that birds of prey are very susceptible to strikes by the blades of wind tower. As a result wind farms cannot be located in areas frequented by birds of prey. Apparently birds of prey focus on the ground for prey and are oblivious to the rotating blades, hence the high mortality.
French Biotechnology and Other Visits

1. Groups, People and Places

The main aspect of the visit to France was to assess support given to develop and commercialise the French biotechnology industry. The following occurred:

- A visit to Genopole, which is a National Centre for Sequencing the Human Genome and for Gene Research;

- A visit to the Imagery and cell Biology Platform of the Plant Sciences Institute, Centre National de la Recherche Scientifique (CNRS);

- A meeting with the staff of BioRet, a small start up biotechnology company;

- Breakfast organised by France Biotech for its member to hear from the co-discoverer of HIV/AIDS of the last 20 years research on the disease; and,

- Meetings with the Australian Ambassador to France and the Senior Trade Commissioner.

A meeting was held with the Business Development Director of Moet and Chandon to discuss the company's policy towards the Australian wine industry.

To understand the role of the Australian troops in France during the First World War a visit was made to the Somme, including Villers-Bretonneux, the major Australian War Graves. For the Second World War I visited the Memorial pour la Prix, Caen, which is a massive Museum to Peace which records the history of the War in France.

2. General Findings

The French Government has the objective of developing a significant biotechnology industry, which will interface with medical research. The greatest concentration of biotechnology is at Genopole, about 30 kilometers south of Paris. Genopole is a Biotechnology Park involving public and industrial research, and supported by private and public organisations.
In Attachment 1 of this report is a presentation which highlights the key objectives and features of Genopole. The significance of Genopole is that it symbolises the very large commitment to support biotechnology research and to assist its commercialisation.

Much of the government funded research is carried out by the CNRS, Universities, the Atomic Energy Commission (CEA) and other research institutes. These have a close affiliation with Genopole. Many private companies have established research laboratories in Genopole. The largest research facility is the combined National Genotyping Centre, the National Sequencing Centre, and the Gene Therapy Centre.

The largest private funding comes from the French Muscular Dystrophy Association, which raises huge funds each year from a national Telephon. It then uses these funds for the following:

- To understand the genetic origin of diseases;
- To develop innovative therapies on gene-based therapies; and,
- To learn more about muscles.

The national business incubator for biotechnology is based in Genopole. It attracts small start-up companies, helps to fund them with small grants, provides business advice and support, and assists the businesses to raise private funding.

Pre-seed venture funding of 50,000 – 100,000 Euros is provided. The start-up businesses are provided with office and laboratories facilities for about two years.

The French Government offers one year grants, covering wages and on-costs, for French post-graduates working outside France to return to France and work for either a university or private company.

France Biotech carries out on a national basis a role similar to Bio-Innovation in South Australia.

The French claimed that USA, UK, and German Governments all put much more funds into biotechnology start-up companies. In addition many governments provide tax deductions for investments in start-up biotechnology companies.

I was surprised how highly regarded the biotechnology research and industry in Australia was regarded by the French. They rank Australia 6th in the world.
The key lesson to learn is that commercialisation of biotechnology is very slow, difficult and with high financial risks. It needs greater government support and for a longer period to succeed. The extent of the financial value of commercial biotechnology is still very uncertain.

3. A Tribute to Australian Troops

My visit to the Somme and Caen to understand the role played by Australian troops in the two World Wars left an indelible impression.

It is hard to comprehend the personal hardship and trauma the troops in WWI experienced. So many were lost in honouring Australia and preserving our democratic values. The price they paid was massive.

They were highly respected and appreciated. Their bravery and commitment is still respected by the French today.

The loss is symbolised by the Australian War Grave, while their honour and memory lives on in the Australian Museum in Villes-Bretonneux.

As Australians we must never forget their sacrifice.

Attachment.