Health policy: a different perspective

Introductory presentation to SIDS and Stillbirth Symposium

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Introduction

It isn't often that I get a chance to talk to a symposium convened by an organization which has been as effective as SIDS and Kids. Looking at the reductions in SIDS deaths over the last ten years, and borrowing a phrase coined by a recent Prime Minister, I think it can truly be called "a lovely set of numbers", and it is certainly a testimony to the work of SIDS and Kids.

Others will be speaking today about this progress with SIDS, and about the issues surrounding perinatal deaths. Jan Carey asked if I could say a few words about health policy in Australia generally, and where movements like those represented here fit into it.

I hope I can do justice to Jan's request. I will present some observations on health policy – its successes and its shortcomings. And how we might re-consider some arrangements we have tended to take for granted.

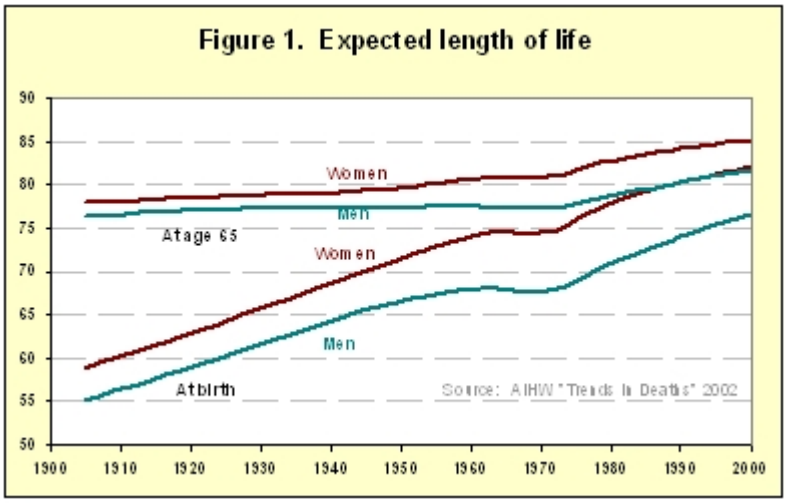
My intention isn't to use this platform to present an "ideal" health policy, but I do want to show how some re-shaping of our arrangements may make it easier for public health issues to capture more policy attention. While there have been tremendous success with SIDS, do we have the sort of health policies which would allow such successes to be replicated in other areas?

Health care – reason to celebrate

Hardly a day goes by without a newspaper story about a failure in health care. "Chaos", "crisis", "out of control" are the usual descriptors to be found in headlines.

It's fashionable to ridicule any activity in which the public sector is the dominant player, but the reality is that there has been outstanding progress over the last hundred years. An Australian born in 1900 could expect to live to about 57 (63 if they made it through the first year of life). An Australian born in 2000 can expect to live to almost 80, and the first year of life is far less hazardous. Some diseases and conditions which were commonplace just two or three generations ago are now relegated to medical history. (We hope future generations will similarly relegate SIDS to history.)

By international standards we are doing reasonably well. In terms of life expectancy at birth we rank 6 out of 30 OECD countries; Japan is the only country that does significantly better. On infant mortality, however, while we have made progress, we are still only mid ranking.[1]



Only some of this gain is due to health care – education, nutrition, public sanitation, safer transport, better food hygiene and inoculation have all played their part. And of course community-based organizations like SIDS and Kids should take their well-earned share of credit.

But we could do better

While this progress is impressive there remain severe health disparities. These are mainly between rich and poor, there being a two-way causal relationship between poverty and poor health. There are sharp disparities between city and rural dwellers; these are particularly marked among aboriginal people in rural areas. We know that those who have control over their own lives enjoy much better health than those who are relegated to the lower rungs of the pecking order.[2] Some of these disparities will also be the subject of this symposium; there is still a concentration of SIDS among the most socially disadvantaged.

In 2003 Professor John Dwyer of the University of New South Wales convened a National Health Summit. At that conference clinicians, administrators and economists pointed out how much better we could do with our existing resources, or with a modest expansion of those resources.

Their messages will be familiar to this audience. Our health policies and programs are focussed on curing or ameliorating illness rather than on promoting health and preventing illness. And in public policy we compartmentalize "health" into a set of programs which stand apart from other areas of public policy.

This compartmentalization of health care comes at a huge cost – what economists call an "opportunity cost". We devote huge resources to research on new drug therapies (around $500 million to develop a drug which may provide no more than a marginal improvement on existing therapies), but we fail to learn about simple and low-cost interventions that could improve health outcomes. Sometimes we know what should be done, but we lack the institutional framework for implementation.

There are of course breakthroughs. SIDS and Kids provides a fine example. Often these breakthroughs are based on empirical research which precedes the more theoretical research into the causes of disease. When in 1854, John Snow removed the handle from the Broad

Street pump and halted the spread of cholera in London, he was acting on sound statistical evidence, but it was many years before we had a sound understanding of the etiology of cholera. Similarly with research on sleeping position.

We don't know what other simple messages are out there waiting to be discovered. We do know of many low-cost, effective interventions that aren't being implemented. The use of bednets in combatting malaria is one that comes readily to mind.

We do know that our present arrangements tend to favour medical solutions. Medical practitioners are conditioned to prescribe medical solutions (drugs, operations), and consumers are conditioned to expect them. Our public and private insurance systems are built around payment for medical solutions.

These issues will resonate among those who read Ivan Illich's *Medical Nemesis* thirty years ago.[3] Illich's solutions were straightforward – a Marxist revolution which would ensrue elimination of the profit-inspired medical establishment and the multinational drug companies.

I don't want to ridicule Illich – for example, Cuba for all its problems, does offer an excellent example of the benefits of a low-cost public health system. But Illich did not give credit where credit was due, and he really didn't help those who seek solutions without starting a Marxist revolution. Medicalization is a problem, but it stems from the incentives and institutional arrangements we have implemented through public policy decisions, rather than from any intrinsic problem in capitalism. We can change these policies without demolishing our institutions; the analysis of our problems and opportunities and suggestions for change that follow are a little more practical than starting a revolution.

And, unlike Illich, I do not suggest that we should have a dramatic shift in resources away from medical therapies. Rather, the point is that if we get our public policy right there would be less need for medical therapies, and we could deploy our scarce medical resources more effectively.

I will start with the strong claim that while we are achieving a great deal, we are doing so without really having a sound health policy. I will suggest five basic reforms which may go towards achieving a more effective health policy.

Problems and opportunities

1. The need to separate out health services

The claim that we do not have a sound health policy would bring immediate denials from nine Commonwealth and state health ministers. They would draw our attention to Medicare, the Pharmaceutical Benefits Scheme and public hospitals. They would point out that every year they enter into combat with their respective treasury departments for appropriations for these programs – and that they succeed in gaining funds. Fifteen percent of Commonwealth budgets and a quarter of state budgets are absorbed in health programs. About two thirds of all health expenditure is met from government budgets.

I do not want to belittle these efforts and achievements, but I suggest that our public policy is primarily concerned with *health care*. This isn't to say other areas are neglected, but they do have a tough job competing for funds in government health budgets, which are dominated by personal health care services (medical, hospital and pharmaceutical programs), expenditure on which is growing at about five percent annually, in inflation adjusted terms. In 2002-03, out of total recurrent public sector health expenditure of $46 billion, $41 billion or 88 percent was spent on personal services. (See Table 1.)

Table 1. Recurrent health expenditure 2002-03 $m

	Personal services	Community health	Total health care	Research	Public health	Total
Government						
Commonwealth	31 084	338	31 422	771	763	32 956
State and local	9 431	2 660	12 091	201	589	12 881
Total government	40 515	2 998	43 513	972	1 352	45 837
Private						
Individuals	14 477	0	14 477	0	0	14 477
Other	8 036	8	8 044	388	0	8 432
Total private	22 513	8	22 521	388	0	22 909
Total	63 028	3 006	66 034	1 360	1 352	68 746

Source: AIHW *Health Expenditure 2002-03* (AIHW 2004). I note there is no recorded amount for private contributions to public health – presumably a classification matter.

Government health departments, particularly the Commonwealth's, are essentially large health care operations. In the language of public finance, we would say they are essentially providing or funding *private goods*. That is, they are providing goods and services (hospital care, pharmaceuticals, medical services) that primarily benefit individuals.

There are sound economic reasons for public funding of health care, but this isn't the place to argue whether governments should be more or less involved in funding and providing these programs.

Rather, I want to draw attention to other programs – community and public health and research. These have many characteristics of *public goods*. These are goods and services that generally will not be funded by private markets. Unless private firms can capture a return in the form of a sellable product, these goods and services will not be provided. That's why most health research is done by pharmaceutical firms; they can gain returns through sales of their products. By comparison, other health research gets neglected. Similarly with promotion; there's a financial return in promoting pharmaceuticals, but there's none in promoting sleeping position.

Of course there is always philanthropy, but corporate philanthropy is an unstable source of funding, and even in a generous society individual philanthropy has its limits.

In order to escape this poor cousin status of public and community health and research, a rearrangement of government "health" departments would be in order. Health services could be provided in specialized agencies with their own budgets. Other functions with public good characteristics – community health, public health and research – should have their own budget. There are many possible institutional arrangements which could serve the purpose of quarantining "public good" aspects of health from the ever-growing demands of health care programs.

Also important is that the department responsible for these "public good" services have a strong voice in government. As we know, public policy influences on people's health emanate from almost every government activity – economic, regional, environmental, transport, consumer protection, welfare etc.

Such seniority could ensure that health considerations become a feature of all government policies. Just as, at present, no policy can escape the scrutiny of treasury departments, so too should health be in a similar role. And if health programs could be handed to a separate agency, health ministers and their departments may be able to devote more policy attention to policy integration and public health.

2. The need for integration

Bringing government health care programs into one administration would still not address problems within those programs themselves.

We tend to talk about the health care "system", but as anyone in this room would understand, it is better described as a loose set of government programs and private services, with some level of coordination but nothing which could be called "integration". This disintegration of services is particularly stark in maternal and early childhood health.

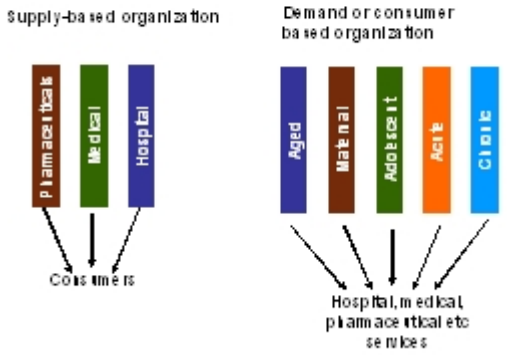
Sometimes I ask people to contemplate a world in which we have to go to one establishment for same-day car servicing, another for longer periods of service, another to obtain spare parts, and where it would be common practice to receive separate bills from a mechanic and from the garage providing the service.

From a consumer's perspective, what I call the "front end" of health care, there is no system. Our arrangements are based on "back end" or supply-driven divisions – pharmaceuticals, hospitals and medical services being the three main divisions. Bob Carr and many others have called for health to be brought under one tier of government, but such proposals don't get to the nub of the problem, for even at the Commonwealth level there is no significant integration of its two main programs – pharmaceuticals and medical services. Systems of subsidies and co-payments are based on different criteria, there is no integration of user records, and budget appropriations are separate. The Commonwealth is forever raising alarm about the cost of the Pharmaceutical Benefits Scheme, rather than considering it in its context as a program which is part of health care delivery.

Many years ago, corporations learned that the best way to arrange divisional responsibilities was along consumer lines, rather than provider lines. A firm like Coles Myer, with its Coles supermarkets, Myer department stores, K Mart low price shops, and Harris Technology division for computer enthusiasts, is arranged on consumer lines. (Many of Coles Myer different divisions carry similar merchandise, but their divisions serve customers with different needs.)

If health care were arranged along consumer divisions, rather than provider divisions, we may perhaps see a "division" responsible for the needs of those with chronic illnesses, another for the aged, and of course one concerned with maternal and early childhood health. All divisions would provide a mix of services – pharmaceuticals, medical services etc. There would be much better integration of services, and much more consumer convenience.

Figure 2. A consumer-friendly system of health care



An even more important, long-lasting benefit, would be the opportunity for more rigorous quality management and research. Our present arrangements do not make for easy quality control. When people get pharmaceuticals, medical services, hospital services, allied health services and post-natal care from different agencies, establishment and maintenance of protocols for data capture and evaluation are extremely difficult. SIDS and Kids has done a wonderful job in developing standard protocols, but we may ask why we have health care arrangements which make it so difficult. I wonder how many other simple lessons – similar to those relating to infants' sleeping positions and exposure to smoke – remain unlearned because we lack the capacity for systemic consumer-based quality management.

It's not that health care providers resist quality management; health care professionals are passionate about quality. Rather, it's that they work within organizational arrangements which don't make for good quality management.

A fundamental rearrangement of services would of course meet with resistance. All change brings forth anxiety, and the present "back end" divisions have a long legacy. But once established, under whatever jurisdiction, and under whatever mix of public and private services, there have to be gains in effectiveness and efficiency.

3. We need to see health as a benefit, as well as a cost

Because so much health care is funded from public budgets, because outlays are growing, and because public servants, particularly those in state and Commonwealth treasuries, are concerned with outlays, there is a strong budgetary focus on the cost of health care.

In 2002-03 we spent $72 billion on health[4] – that's almost ten percent of GDP. In terms we can relate to a little better, it's about $3600 a head, or $9000 a household.

Is this huge outlay indicative of a problem? I don't know, but let's put it into perspective. It's just a little over half of what we spent in the same year for our financial services.[5] As our population ages and as new treatments and technologies come to hand it is probable that we will be spending more on health care, a trend confirmed in various projections.

This doesn't mean, as some imply, that health care will become unaffordable, however. Even a modest rate of economic growth will allow us to accommodate much higher expenditure on health care without compromising our capacity to enjoy higher consumption of other goods and services.[6] Whether we choose to fund health care from public budgets or from our own pockets, it should still be affordable. (Ivan Illich's notion that we should divert resources away from care to provide public and community health makes good sense in a poor society, but we are fortunate in not having to make such a choice.)

This isn't an argument to avoid scrutiny; we should all be thankful that our treasury departments do have such guardians. Whatever we spend, in the public or private sector, should be spent wisely. But we may need to change the popular notion that we are spending more and more with little to show for our outlays.

Turning around such a perception is a challenge in many areas of public policy. Performance indicators relating to crime, road safety, literacy and many other areas have shown tremendous improvement in our lifetimes, but unless we correct the false public perception that things are getting worse, cynicism and a sense of powerlessness will erode public support for ongoing improvement.[7]

4. We should beware of accepting any condition as "normal"

On July 2, 2002, in southern Germany there was a mid-air collision between a Boeing 757 freighter aircraft and a Russian Tupelov 154 airliner of Bashkirian Airlines. All 71 occupants of the two aircraft were killed.

The sense of tragedy was heightened by the fact that 44 of those killed on the Russian airliner were children, bound for a holiday in Spain. It is hardly surprising that even when such misfortunes occur to people on the other side of the world, we see tragedies involving children as more painful than similar tragedies involving adults.

We gain no comfort from the knowledge that air travel has become so much safer over the years. We don't consider accidents like this to be "normal".

But when deaths occur in ones and twos, throughout the year, the pain is not of great public concern. Two thousand perinatal deaths and a further twelve hundred deaths of children under one year may not make the headlines of the tabloids, but to put these figures into perspective, using a little back-of-the-envelope mathematics, those deaths represent about 250,000 years of potential life lost each year (3,200 deaths x 80 years expectancy). That's the same order of magnitude as the 190,000 potential life years lost from diseases of the circulatory system (heart disease, stroke etc).[8]

Circulatory diseases achieve prominence because of the demographics of their incidence. We can all name people who have died of circulatory diseases. In a family with four grandparents, on average, we could expect two to die of stroke or heart attack. We are far less likely to have such personal awareness of children's diseases.

The achievement of SIDS and Kids has been to shift our perception of normality; 500 infant deaths a year were not "normal". And, to the credit of the movement, they don't accept the current death rate of 70 a year as "normal".

5. Health care is not only about ageing

It is well-known that as we age we use more health care resources. But does this mean that public policy on health should be so heavily focussed on the aged?

In the 2004 election campaign Labor launched its Medicare Gold proposals. Medicare Gold had merit, in bringing an integrated package of services for those aged over 75, and eliminating the costly intermediary of private health insurance. But it could have diverted health care resources from where they could be more effective in terms of saved life years.

Similarly the Coalition proposed, and subsequently implemented, incentives for even heavier subsidies for private health insurance for older Australians. Where the insurance dollars go, so too do the resources.

Both policies can be seen in the context of swinging or holding the gray vote; older people are heavily concentrated in particular electorates, and have a strong loyalty to the Coalition. It is strange that both main parties paid so much attention to voters whose loyalties are hard to dislodge. In terms of political leverage young parents should have far more influence, because younger people are far less likely to have rusted-on loyalties to one party. This would seem to be an opportunity waiting to be exploited.

Conclusion – health from the consumer's end

It would be preposterous for me to suggest to this audience how people may go about achieving their objectives. To see a model of effectiveness one need look no further than the work of SIDS and Kids. If we are at risk of letting SIDS slip from our awareness, we will be reminded again on Red Nose Day in just three months; in terms of capturing policy attention, SIDS and Kids has been extraordinarily successful.

I do want to stress, however, that we have a set of health policies which make it hard to achieve change outside the established health care programs, and which leave public health as a poor cousin of health programs. SIDS and Kids, through tremendous effort, has achieved change outside those programs, but does it always have to be so difficult? In overcoming the difficulties in working around this program structure SIDS and Kids has reminded us that we may need to be directing some of our advocacy to the basic design principles underlying our health policies.

Providers, be they pharmaceutical companies or suburban GPs, tend to take a medical perspective on health. Unlike Illich, I don't make that statement in any accusatory way;

university lecturers tend to take a pedagogical perspective on education. But we should ask whether we should have such a medicalized structure of our health policies. We may achieve more for our contributions – both those from our own pockets and those from our taxes – if we work towards a re-design from the front end. If we can convince governments that they could save some money and get some kudos in doing so, they might even listen to us.

Endnotes

1. OECD Health Data 2004.

2. Michael Marmot *The Status Syndrome: How social standing affects our health and longevity.* (Times Books 2004).

3. Ivan Illich *Medical Nemesis: The expropriation of health* (Calder and Boyars 1975).

4. AIHW *Health Expenditure Australia 2002-03* (AIHW 2004). That's $3 billion more than is shown in Table 1 because it includes capital expenditure.

5. In 2002-03 "Value added" of the Finance, insurance, property and business services sector was $137 billion. (ABS National Accounts Cat 5206.0.)

6. Even if annual per-capita GDP growth were only 0.2 percent, we could accommodate a doubling of per-capita health care expenditure by 2050 without any loss in other production or consumption.

7. For a thorough treatment of this divergence of public perception and reality, Derek Bock "Measuring the Performance of Government" in Joseph Nye, Philip Zelikow, David King (eds) *Why People Don't Trust Government* (Harvard University Press 1997).

8. For data on years of potential life lost, see Table 1.10 of the ABS publication "Causes of Deaths" (ABS 3303.0). These statistics are collated on the basis of cause, rather than age; so the two figures I use are from different categorizations – used for illustration rather than direct comparison.