How sick is our health system?

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At first sight we're travelling well. Along with Japan and the Nordic countries we have high life expectancy and generally low levels of morbidity, and most indicators are showing improvement over time. With a mixture of government, individual and private insurance funding we achieve these outcomes with outlays just below 10 per cent of GDP - around the OECD average and significantly below the 15 per cent the Americans spend (for much poorer outcomes).

Behind these indicators, however, lie a number of problems. There are pockets of severe disadvantage, particularly among Indigenous and other remote communities, and in many country and outer metropolitan regions. Mishaps in hospitals dominate the tabloid press, and there is evidence of poor management in some hospitals. There are signs that demand is exceeding capacity, with long hospital waiting lists, stressed emergency wards, and with workforce shortages in many professions. And our expenditure is rising rapidly, having risen from 8 per cent of GDP to 10 per cent over just 10 years.

In short, it ain't broke, but it's under stress. And it's under stress because it doesn't fit together as a system.

In fact, we don't have a health system.

In Australia we have a number of loosely connected programs, some delivered by the Commonwealth, some by the states, and some by the private sector. It's too much of a mess to be dignified by calling it a "system".

Even within the two big Commonwealth programs, administering pharmaceutical benefits (the Pharmaceutical Benefits Scheme) and medical benefits (Medicare), there is little co-ordination. We have fragmented funding and delivery, without any consistent underlying policy.

If the reader's patience allows, consider the following partial guide to health funding:

> We have free public hospitals, but have to pay $30.70 for pharmaceutical prescriptions. If we have private insurance, generously subsidised by the government, some "ancillary" services such as dentistry are covered (only up to a capped amount), but if we choose to rely on our own savings for our ancillaries or private hospitalisation, we get no support. The safety net scheme for medical benefits is on an individual basis; for pharmaceutical benefits, by contrast, the safety net is on a family basis. Then, while safety nets operate calendar years, there is a 20 per cent tax rebate for medical expenses above $1,500 in a financial year, with different definitions of what qualifies as a medical expense.

That's not to mention provisions for certain disadvantaged groups, such as concession card holders. And after the election there may be new arrangements: Labor is promising a state-based dental program, while threatening a Commonwealth takeover of hospitals, while the Coalition is on track to bring at least one hospital, the Mersey Hospital, under Commonwealth control.

Different programs have different legacies. The Pharmaceutical Benefits Scheme (PBS), for example, was developed in the postwar period when new "wonder drugs" such as antibiotics were prohibitively expensive. Medicare has its origins in the Whitlam Government's Medibank, which met with strident opposition from interest groups and which has been whittled back by successive Coalition Governments and boosted by Labor Governments.

State hospitals have an even longer history; by now they are funded roughly equally by the Commonwealth and state governments, with a great deal of bickering in the process. Coalition governments have been generous to private insurers, allowing private hospitals to separate themselves from the public hospitals, thereby adding to fragmentation.

There is no locus of responsibility for health care as a "system". The Commonwealth is obsessed with the rapidly rising budgetary cost of the PBS, and with retaining membership of private insurance. The Commonwealth's Intergenerational Report looks at the components of Commonwealth health care funding, but does not consider state funding or private outlays. While the Commonwealth panics about projected PBS expenditure, it does not take a broader cost-benefit approach, for pharmaceuticals, if wisely used, can reduce hospitalisation and can allow people who would otherwise be incapacitated to lead productive lives.

The Commonwealth's concern is only for its own budget, rather than the nation's total health outlays and what can be achieved with those outlays. State governments are focused almost entirely on hospitals, and miss no opportunity to shift blame and costs onto the Commonwealth. The Commonwealth has had no health workforce policy; thanks to misguided tertiary education policies Australia faces severe shortages of health professionals.

With such neglect and fragmentation it's surprising that we do as well as we do. Credit goes to health professionals, who are generally overworked (and over-managed). And while professionals keep each clinic, pharmacy, or hospital ward operating well, the whole is certainly less than the sum of its parts.

There is no consistency in health policy. We may reasonably expect some difference between Labor and Coalition policies, perhaps with Labor more supportive of "free", tax-funded health care and the Coalition more in favour of market forces, but no such division is evident.

Labor has gone along with increases in PBS co-payments, while, on the other hand, vigorously defending medical bulk-billing.

The Coalition has introduced an extremely generous and expensive open-ended safety net for medical consultations, and has diverted about $4 billion a year to supporting private insurance, thereby diverting resources away from public hospitals, and, contrary to its own ideology of "self reliance", encouraging over-use of services which are free at the time of delivery. (Those who criticise Medicare as a manifestation of the "nanny state" conveniently forget that private insurers are "nanny corporations".)

What a health "system" would look like

At the Centre for Policy Development (CPD) we gathered a group of health care experts to come up with their suggestions on what a health system for Australia should look like. There was a strong convergence of views, and a strong belief, supported by basic calculations, that a properly integrated health care system could deliver significantly improved services without

the need for any more funding. (The full report *A health policy for Australia* can be found at the Centre's website) Our main conclusions were:

> First, there should be one locus of responsibility for health programs. There are arguments as to whether this should be at a state or Commonwealth level. The states, in general, are more proficient at program delivery than the Commonwealth, are much closer to the people, and are better placed to handle regional needs. Whichever level of government provides services, funding should remain a Commonwealth responsibility, and the Commonwealth should have a role in establishing standards of care, providing shared services, ensuring interstate transferability, and providing shared services such as pharmaceutical evaluation and price negotiation.
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> Second, there should be integration of programs. If program division is required, it should be on user lines, rather than provider lines. To illustrate, at present there are three major programs - pharmaceuticals, hospitals and medical services. These divisions are based on providers, and reflect the legacy of old practices; for example, pharmacies were kept separate from medical clinics because they were essentially small chemical laboratories. User divisions could be on demographic groups (for example, aged care, adolescent, youth etc), on groups with special needs (for example, aboriginal health), on conditions (mental health, reproductive health), or on types of care (for example, occasional, acute and chronic care).
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> Third, there should be a consistent policy on health funding and allocation to replace the incoherent mess of funding arrangements. The basic question on funding is the extent to which we should pay for health care from our own pockets, as opposed to the extent to which we pay for health care from pooled funding. There are arguments for more use of market forces and for a completely free system, but whatever way we go there should be consistency.
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> Wherever the division occurs, private insurance should have no role, for in providing "free" services at the point of delivery it distorts incentives and muzzles market signals, and, as a means of pooling funds, it is administratively expensive, fails to achieve the equity of tax-funded pooling, and fails to keep service providers' costs under control (which is why health care in the USA is so expensive).
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> In relation to funding, government policy should be concerned with the community's total costs, rather than the present narrow fiscal focus. Governments have a role beyond looking after their own budgets; they should be concerned with total community costs, including not only direct out-of-pocket costs of health services, but also the costs of accidents, illnesses, poverty, environmental degradation and other factors which add to the community's burden of poor health.
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> Fourth, health care programs should be universal. At present, thanks to the link between private insurance and private hospitals, we are developing "two tiers" of provision. Rather, all Australians should have access to the same high quality services. That does not mean all services should be free; to the extent there are co-payments these should be based on ability to pay. And a universal system is not necessarily a public system; even if, as is likely, the majority of funding is from the public purse, the majority of delivery could remain with the private sector, as at present.

Fifth, there needs to be a re-allocation of resources towards the "front end" of health care - public health and primary care. Well-resourced primary health care centres can take a significant load off public hospitals and can provide an integrated services including general practice, nursing, pharmaceutical services, diagnostic services, physiotherapy, some basic specialties etc, providing users with the convenience, efficiency and safety of "one stop" health care. Such a re-allocation is likely to occur when responsibility for health care is more focussed, and when programs are no longer divided along service-provider lines.

Can it be done?

Only an extreme optimist would expect any fundamental policy proposals in the current election campaign. As in previous campaigns, most proposals from both main parties are cautious and incremental, often dealing with specific high profile problems and often targeted at marginal seats. Thanks to "reforms" introduced by the current government, particularly the so-called *Costing of election commitments*, the cards are stacked any opposition party proposing fundamental policy re-direction.

It was refreshing, therefore, to see a press release from Kevin Rudd on September 25 in which, in reference to the Mersey Hospital intervention, he said:

> We believe that what Tasmania needs and what Australia needs is a national approach, an integrated national approach to dealing with health and hospital services, not just one plan for one hospital in one seat in the country.

Labor has also made some promising statements on the need for greater integration of aged care and hospital care, on health promotion, and on the importance of primary care. Health centres, as proposed by the CPD, may become a reality under a Labor Government. (The Whitlam Government did establish some community health centres, but rather than being universal they tended to be targeted to disadvantaged regions.) On the other hand, Labor has no unifying health policy proposal, and has promised to retain budgetary support for private insurance.

If Labor wins office will it be seeking a national integrated approach to health policy, or will it slip into the comfortable, incremental approach which tinkers only at the margin - the approach preferred by lobbyists and bureaucrats, fearful of change and lacking in imagination?

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