



THE REFORM AGENDA | VICTORIAN HEALTH CARE ASSOCIATION

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John Menadue AO

Chair, Centre for Policy Development\*

Health ministers around Australia must be very frustrated. They are all spending a lot more money on health, but the situation only seems to get worse with almost daily bad news about some new crisis.

More money is clearly not solving the problems. The real problem is health care design. and that is what I want to talk about today.

Health spending is increasing dramatically. In the 10 years to 2004/5, health expenditure grew at 8% pa, more than double the GDP growth rate. In the same decade real growth of health expenditure has been 4.8% pa, compared with population growth of 1% pa. At the state level, health budgets are taking a higher and higher proportion of total expenditure, often over 30%. Ten years ago, health costs represented 8.1% of GDP. It is now 9.8%. The total cost is \$90 b. This growth in health expenditure is driven by unrealistic community expectations, ageing, high technology costs, but more importantly some fundamental design problems. There is a huge amount of waste in the health 'system'. I estimate that poor design and systemic failures cost us well over \$10 b pa and perhaps nearer \$15 b pa.

What then are the key design problems health care faces?

First, there are 19th Century workforce structure and practices. Health care is riddled with demarcations and restrictive work practices. For example, only 10% of normal births are delivered by midwives in Australia. In the Netherlands it is 70% and in the UK 50%. There are only about 300 nurse practitioners in Australia as a result of opposition by doctors. There should be thousands of them across the country. There are severe shortages in some specialties, eg geriatrics and emergency, and locums are used widely to fill the gaps. Steps are being taken to increase training places but the great mistake would be to train people to do the same jobs in the same way that we have done for a hundred years. They are a major economic burden.

Health is our largest industry, with almost 600,000 employees or 7% of our civilian workforce. About two thirds of health expenditure are labour costs. The problems of workforce dysfunction arise not because of individual failure but because of

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\*Note: For elaboration of some of the points made above, see 'Obstacles to Health Reform' by John Menadue, <http://cpd.org.au>

unwillingness to address the systemic problems. Our archaic work practices deny career opportunities especially for nurses and allied health workers. The Productivity Commission estimates that a 5% improvement in the productivity of health services would deliver resource savings of about \$3 b each year. I think this is a very conservative estimate.

We need role renewal and the creation of new types of health workers. We need up-skilling, multi-skilling, broad-banding and team work. Blue collar workers in other industries have had to undergo substantial workforce change. It has improved productivity. But there has been little or no attempt to address the dysfunctional nature of workforce structure and practices in health.

Expanding the role of existing health professionals could include radiographers taking on a role in reporting X-rays, ultrasounds and other images; pathology technicians being involved in the reporting of routine pathology; nurses taking on a role in procedures such as endoscopy and minor surgery; and podiatrists involved more in foot surgery. Ambulance officers could play a significant role as primary care providers, particularly in homes and rural areas. We could establish new types of health workers, eg nurses undertaking greater responsibility for prescribing, diagnosis and triage in hospitals; nurse anaesthetists complementing and substituting for medically qualified anaesthetists; enrolled nurses taking on some of the tasks of registered nurses; midwives substituting for obstetricians; practice nurses undertaking more of the work currently performed by GPs including some prescribing, screening and triage. We should consider task substitution in the establishment of new generic health classification that cross professional boundaries. Why couldn't we create a new broad banded job of health practitioner which would include junior doctors, registrars and nurse practitioners in hospitals?

The government has announced increased training places and the funding of practice nurses to visit the elderly and veterans. These are useful steps. The ALP has yet to make any announcement on workforce reform. It should be a key feature of any re-negotiated Australian Health Care Agreement, and I do not mean AWAs. The problems are much more fundamental than that.

A second design problem is evident in the quality and safety problems that are widespread in health care. Little effective action has been taken. Bundaberg, Hawkesbury and Royal North Shore in Sydney are only the tips of a very large iceberg. Based on the 1995 Report by Wilson et al on hospital admissions in NSW and SA, the national cost of avoidable mistakes in health care is \$5 b plus per annum. About 10,000 Australians die each year in health care as a result of avoidable mistakes.

We are not dealing with performance issues by individual doctors and nurses, but rather the 'system'. The responsibility lies clearly with those that are responsible for 'the system' – ministers, clinicians, bureaucrats and managers. There is a conspiracy of silence to keep it out of the public domain. This is a public health, ethical and financial problem of large proportions. It is a scandal.

The clear evidence in aviation safety is that the worst thing is to cover up safety problems and scapegoat those involved. There must be a culture of openness and transparency. Health is very different. There is a major cultural problem whereby health practitioners, highly professional in their own specific areas, have little

knowledge or experience of other industries and different ways of thinking and doing. Health does not have a healthy culture. Problems are hidden.

In addition to these cultural issues, there are a whole range of organisational issues that must be addressed: rigorous peer review; accreditation; reliable and efficient recording; better hospital systems; consolidation of clinical services. But above all else, we need transparency.

In this election campaign, neither the Coalition nor the ALP has addressed these quality and safety problems.

A third major design problem is that we have constructed a sickness model of care rather than a health model. The Australian Institute of Health and Welfare identified 14 preventable health risks. The top five, were tobacco smoking, high blood pressure, high body mass, physical inactivity and high blood cholesterol. The identified 14 preventable health risks accounted for 32% of the total burden of disease and injury in 2003. Yet only 2% of health funds are spent on prevention and public health – keeping people well. The rest is spent on medical services in treating sickness. Our health model is fundamentally flawed in design. It needs redesigning to focus on keeping people well – as well as treating their sickness. Ministers could be more aptly described as Ministers for Sickness rather than Ministers for Health!

The Coalition and the ALP in recent months are beginning to address this major issue, particularly obesity, with perhaps the ALP being more committed with a range of relevant policies. Unfortunately it has backed off recently from its modest proposal to ban junk food advertising and the use of cartoon characters.

A fourth major design problem is our preoccupation with hospitals when the future focus of health delivery should be in primary care – in the home and in the community. Our public debate is all about hospitals – waiting lists and emergency departments. The fact is that for the long term, we have too many hospitals and too many hospital beds when we need to build health resources in the community.

All the international evidence is that a health system oriented towards primary care achieves better health outcomes, lower rates of all causes of mortality, for overall lower cost and greater equity than a health system centred on hospitals. At the Centre for Policy Development, we published in June this year a proposal to roll out 200 multi-disciplinary primary health care centres across Australia at an average capital cost of \$20 m per centre. We envisaged that most of these centres would be privately run. Some would be a mix of public and private and there would be a mix of remuneration, both fee for service and salary. Such a roll out would be part of a universal scheme and not focused just on disadvantaged areas or marginal seats.

The ALP's proposal for general practice super clinics has the makings of a major redesign of health care in Australia. The Coalition's proposals are much more limited. Their purpose is to take some pressure off hospital emergency departments. That is only part of the problem.

The fifth design problem is well-known – the fragmentation of health services, particularly as a result of the commonwealth/state divide. There is clearly a lack of integration of the commonwealth's major programs, MBS and PBS, with the state

run hospitals. But there is also a lack of integration within the commonwealth's own area of MBS and PBS. It is very clear that modern drugs can reduce the need for some medical and hospital services.

The ALP has outlined a more realistic proposal to ensure more national leadership and integration. Like almost all major issues in health, this will involve political will. How national responsibility for funding, standards and direction of health services will be reconciled with 'subsidiarity' – delegating priority setting and delivery as much as possible to the local level – will be a key issue to be addressed. The Coalition's proposal on the Mersey Hospital and on hospital boards will make integration much more difficult. The Coalition however rightly insists that in the next Australian Health Care Agreement there must be improved accountability and governance in hospitals.

The sixth design problem, and a really dangerous sleeper, is the steady undermining of our universal health system and the development of a two-tier alternative. The subsidy to private health insurance (PHI) is approaching \$6 b per annum. Every country that has a large PHI sector has associated high costs. The US is the standout example. Countries that have pioneered public health insurance, such as the UK and Scandinavian countries have much lower health costs with comparable and sometimes better health outcomes. Private health insurance favours the more wealthy, it is inefficient, with numerous competing bureaucracies, and high cost because private insurance companies are largely price takers in the market and do not adequately seek to control costs as Medicare does.

The trend to a two-tier health care system in Australia is a serious threat. If only a handful of us want to jump the health care queue it is probably manageable. But when the government subsidises wealthier people to jump the queue, we are on the way to crippling Medicare. We now learn that NSW Health takes into account persons with private health insurance in the region in deciding the allocation of funds to the Royal North Shore Hospital. It is a worrying trend.

At the Centre for Policy Development, we do not suggest that a single public insurance payer should fund only free services or fund only public institutions. We believe that Australians can afford to pay more directly for their health through rationalised co-payments. Further, private hospitals would be much better off if public funds from Medicare went directly to them rather than via inefficient, financial intermediaries, the private health insurers.

In the three years of the next federal government, \$18 b will be spent on subsidies to private health insurance. Just think how new priorities could be tackled with that money – mental health, indigenous health, primary care, prevention and dental care. What an opportunity to reshape health care in Australia!

Unfortunately, both the Coalition and the ALP are committed to corporate welfare to prop up inefficient private health insurance. This is not surprising given the Coalition's long-term scepticism about Medicare. I am not sure that the ALP quite appreciates what is at stake.

Medicare has been successful in funding the demand side of health care. What have been ignored are the gross inefficiencies on the 'supply side'. We need a re-design of the way we deliver health care.