

**Daring to Dream: The Future of Australian  
Health Care**

**Essays in Honour  
of  
John Deeble**

**Edited by  
Gavin Mooney and Aileen Plant**

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## **Acknowledgement**

The Editors are grateful to Mandy Seel, a public health physician working in Aboriginal health in Western Australia. In thinking how best to honour John Deeble's work, it was Mandy who suggested that we edit a book with contributions from various leading figures in public health in Australia.

## Foreword

John Deeble reached three score years and ten in July 2001.

At the start of this year we thought it would be most fitting if the health policy community in Australia were to celebrate his professional life and contributions to Australian health care by writing short chapters for a book in his honour.

John we believe dared to dream and to work to create a better health care system in Australia. We felt that this volume ought to reflect that capacity to dream. We thus asked contributors to think positively of how Australian health care might develop over the next decade. They could do so on the whole institution or some sector such as general practice. They could look at particular disease programs or issues of social justice or better financing systems. We chose not to 'prescribe' areas.

We asked contributors not to write about John's work nor specifically to pay tribute to his work.

We are grateful to all our authors for their contributions and to Linda Browning of Black Swan Press for her generous assistance.

Gavin Mooney  
Aileen Plant

Curtin University of Technology  
Perth  
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November 2001

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## Introduction

John Deeble is an extraordinary person. His contribution to health care around the world has been, and continues to be, enormous. From the beginning John's career has been at the interface between health and economics, with his first 10 years of employment in banking and industry followed by five years as Assistant Manager of the Cancer Institute. Another spell in economics was followed by a variety of positions closely linked to health. His key involvement in the genesis of Medicare was one that gained him both friends and adversaries. Such is his charm, talent and generosity of spirit that in the mid-1990s, I remember that when he was teaching some general practitioners, the lecture series began with barely disguised hostility. Within a few days, the same general practitioners were contacting their colleagues because they were worried about John's health! (It was fine.)

Later in his career he was Deputy Chair of the Health Insurance Commission and, later still, Director of the Australian Institute of Health. Since 1989, John has worked at the National Centre for Epidemiology and Population Health, where his advice is sought by state, territory and national health governments, key national groups, as well as by other countries. John has advised governments and international agencies about health systems in New Zealand, Hungary, South Africa, Turkey and Indonesia. It is difficult to think of another human who has had such a huge impact on the way health services are delivered around the world.

John's expertise lies in being able to think innovatively about big issues, while never losing sight of the humans who are affected. His concern for others is reflected in his work on Indigenous health, his thinking about how people who are poor can best access health services. He is a congenial and collegial man, whose disposition is rarely ruffled. Indeed, I sat in the next-door office for over three years and the only time I ever saw him seriously distressed was when someone wanted to interfere with his beloved Medicare. They lost.

Most of us will never contribute as much as John Deeble has to the health of others. However this book, in honouring him, also acknowledges the importance of thinking about what is possible to achieve, if we just dare to dream of a better world, a better way of doing things. If John were to read this before printing, his response would be 'but I didn't do it on my own you know'. We know that, and we know that John manages to inspire others with his dreams, for the benefit of us all. Thanks John.

Aileen Plant

# The origins of Medibank

**R B Scotton**

Centre for Health Program Evaluation  
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John Deeble's name and reputation are inseparably bound up with the Medibank program and its successor Medicare. John and I enjoyed a remarkably stimulating, productive and cordial intellectual partnership from 1966 to 1976, when circumstances took us on different career paths. Indeed, our joint work was so interleaved that there are many features of our thinking and the panoply of ideas of which some found their way into the Medicare/Medibank programs and others fell by the wayside of which neither of us would be able to claim, or even recall, the original authorship. It is for this reason that I am glad to have the privilege of contributing the first chapter in this series, which has as its centrepiece the hitherto unpublished paper which brought us from obscurity as journeymen academic researchers to a degree of national prominence which we had never imagined.

The origin of this paper was a meeting of Labor Party supporters in Melbourne on 6 June 1967, at which we were invited in order to meet Gough Whitlam, elected federal opposition leader in the previous year. John and I outlined our findings on the failings of the voluntary insurance scheme—notably failure to cover some 15% of the population, primarily at the lower end of the income range—and the increasingly regressive impact of the scheme resulting from the combined impact of tax deductions at marginal tax rates for net medical expenditures and health insurance contributions and increasingly restrictive means testing of patients applying for public status in state public hospitals. According to one witness Whitlam showed only polite interest until we responded positively to his inquiry whether we had any solutions. (Menadue, 2000) At that stage we had not put any of our ideas on paper, and he pressed us to do so, but our other research commitments were such that it was not until February 1968 that we sent him a copy. At the same time we also sent a copy to Dr A J Forbes, Commonwealth Minister for Health, which resulted in an invitation to brief senior departmental officers.



The circulation of this paper was very limited, mainly because we did not consider it suitable for academic publication. A more fully developed and argued article was published in the *Australian Economic Review*, 4th quarter 1968. By this time, the appointment of the Commonwealth Committee of Inquiry into Health Insurance, headed by Mr Justice J.A. Nimmo and Whitlam's public formulation of his "Alternative National Health Programme" had been instrumental in bringing health insurance policy to the forefront of national political policy issues. In view of its seminal importance-both for national health policy and John Deeble's long career in health service research and policy formulation it seems quite appropriate to bring the original paper from archival obscurity by publishing it in this volume. A third of a century has elapsed since it was written, and a great number of pragmatic and not-so-pragmatic changes have been made over that time. Nevertheless (apart from the numbers!), the proposal was widely regarded as very radical at the time yet bears an uncanny resemblance to the present structure of Medicare and the associated arrangements covering public hospital services.

## **A Scheme of Universal Health Insurance**

### **Introduction**

The object of this paper is to set out the authors' proposals for a system of financing medical and general hospital care in Australia. These proposals are the outcome of several years of research in the Institute of Applied Economic Research, some of the results of which have appeared in other articles and reports. Health insurance is only one aspect of the main study, but is the one in which deficiencies in existing arrangements are most obvious and can most easily be remedied.

The scheme outlined here is limited to the financing of services now covered by the voluntary insurance system. However, it could easily be extended to cover other services, especially those of chronic hospitals and paramedical personnel. In its construction, we have attempted to meet three classes of objectives to which any financing scheme must be directed.

These may be described as:

- Consumer objectives, in which doctors only have interests as members of a wider community;
- Joint objectives, shared by both the producers and consumers of health services, and

- The specific professional objectives of the medical and other health professions.

They can be summarized briefly as follows:

1. *Consumer objectives*: that appropriate health care should be available without regard to the income, age, length or type of illness, health status or other personal circumstances of patients, and that the costs of providing this care should be equitable distributed.
2. *Joint objectives*: that the system of financing should be comprehensive, and should promote a high quality of care, the integration of facilities and the most efficient use of resources in the health care 'industry'. It should also be efficient and economical in its own operation.
3. *Professional objectives*: that the system should offer satisfactory rewards, incentives and conditions of practice to health professionals.

We believe that a universal insurance scheme can meet the first two objectives better than a voluntary insurance system, and that it could be structured so as to meet the professional objectives at least as well.

Those who advocate change should accept the onus of specifying their alternative, and for this reason we have set out our proposals in some detail. While we regard them as providing a feasible and practicable system in their present form, we have no doubt that there are many respects in which they could be improved.

### **General outline of proposals**

The basic proposal involves the abolition of the existing system of voluntary insurance and the substitution of a universal compulsory insurance scheme. It also involves the withdrawal of income tax deductions for medical and hospital expenses against which benefits are payable and for voluntary health insurance contributions. The revenue so saved would be transferred to the payment of direct benefits. Our preference would be for the establishment of an independent Commonwealth Health Insurance commission to administer the scheme. The Commission would draw its revenue from a National Health Insurance Fund, to be financed from (a) a health insurance contribution levied as an income tax surcharge at 1 per cent of taxable incomes, (b) a matching Commonwealth Government subsidy, and (c) a levy on compulsory insurers<sup>1</sup> equal to the assessed cost of treatment for which they were liable. In general the proposals involve a minimum

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<sup>1</sup> ie, motor car third party and workers' compensation insurers.

of immediate change, although this does not necessarily involve permanent acceptance of all existing arrangements. The scheme is based on the maintenance of public hospital systems administered by state government authorities, private hospitals, and of general practitioners and specialists practising privately on a fee-for-service basis.

The main feature of the hospital scheme is universal entitlement to free public hospitalisation and the introduction of hospital benefits at a level designed to enable public hospitals to offer this. The same rate of benefit would be payable to accredited hospitals (public and private) in respect of non-public bed days. Medical benefits would be based on a schedule designed to enable doctors in private practice to treat patients substantially free of charge by claiming directly on the fund. Fees charged by doctors and private hospitals would not be directly regulated in any way.

This scheme would remedy many deficiencies in the present system of providing health care while preserving its basic features and protecting the legitimate interests of the health professions. We see it as an evolutionary, not a revolutionary, change, which could combine the benefits of local and private initiatives with those of rational overall planning.

### **The hospital scheme**

The hospital scheme is designed to cover basic care, required on medical and medico-social grounds, in intensive-care hospitals and units (generally, those institutions now classified as 'hospitals' for the purposes of Commonwealth benefit). We are well aware of the problems of financing nursing home and other long-term care, but it is not covered by the present insurance scheme and is thus outside the scope of this paper. It could, however, be accommodated within the proposed system, on any basis considered appropriate. We assume that governments retain their present responsibilities for operating and financing mental, TB and repatriation hospitals. Similarly, we envisage no changes in the present structure of hospital administration or in the supervision which state government authorities now exercise over both public and private institutions. We do, however, envisage a system of accreditation which would apply uniform minimum standards to all hospitals, public and private, which the universal insurance scheme is designed to cover.

Financing would be through two types of grant: general grants from the Health Insurance Fund, payable at a uniform rate per occupied bed day, and claimed direct by hospitals from the Health Insurance Commission; and special grants applied for

and paid through state hospital authorities, but determined by the Commonwealth government.

- (i) General grants would be fixed so as to provide public hospitals with the same revenue as they now obtain from fees after allowing for additional fees for private facilities. In costing our proposals we have assumed additional fees of \$2 per day for 'pay beds' in general wards of public hospitals, \$4 per day in intermediate wards and \$6 per day in private wards. Private hospitals could fix their fees in any way, but in public hospitals these daily charges would be all-inclusive. In the year which we have used for costing—1965-66—a general grant of \$7 per day for all bed days (including pensioner days, and days for workers' compensation and motor car third-party cases) would have compensated public hospitals for the loss of fee revenue. This rate would require periodical revision in the light of cost increases. By now, it would probably be about \$8 per day and the scheme is designed to provide the necessary growth in revenue.

We do not intend to relieve state governments of their present obligations to finance and administer public hospitals. Introduction of the scheme would be conditional on an undertaking by the states to maintain their contribution to at least the same proportion of hospital revenue as applied in the base year. (The proportion would be the average applying throughout Australia, which would have the effect of reducing the state governments share in Queensland and Tasmania and slightly raising it in the other states.)

- (ii) Special grants would be made to meet:
  - (a) drugs (ie incorporation of the present hospital Pharmaceutical Benefits scheme);
  - (b) sessional payments to general medical staff now classified as honorary;
  - (c) salaries and sessional payments to extend public medical services, especially in diagnostic services, surgery, and out-patient facilities;
  - (d) teaching and research;
  - (e) current costs of expanded domiciliary and ancillary services.

Special purpose grants would not be linked with state government subsidies, nor require any matching state contribution. We would expect that the Commonwealth

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government would also seek to influence the development of hospital services by capital grants from general revenue (not the Health Insurance Fund) for desired extensions of buildings and equipment.

These proposals incorporate revenues now received by hospitals through fees and voluntary insurance, and from the Commonwealth government through insured benefits, uninsured benefits, and payments for pensioner patients. They also include existing compulsory insurance payments: no distinction would be made for patients covered by workers' compensation and motor third-party insurance (ie the general daily grant would apply) but insurance companies would be required to pay into the Health Insurance Fund, through a pool, the assessed full cost of treatment for which they were liable. Such bulking of their liability would yield a substantial saving in administration.

A costing of these proposals is as follow. Estimates are for 1965/66 outlays, and are comparable with those shown for the medical scheme.

### **Actual 1965-66**

	\$ million	\$ million
<u>Outlays:</u>		
Hospital fees (including pensioner payments)		133.4
Administration expenses of funds		7.8
Operating surpluses of funds		3.4
		<u>144.6</u>
<u>Met by:</u>		
Contributions to funds (net of tax concessions)		55.0
Levies on workers' compensation and third party insurers		10.0
Patients' fees (net of tax concessions)		22.0
Commonwealth government:		
Pensioner benefits	16.6	
Other hospital benefits	25.0	
Tax concessions	16.0	57.6
		<u>144.6</u>

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**Estimates under our proposals**

	\$ million	\$ million
<u>Outlays:</u>		
Hospitals		137.5
Administrative expenses		2.5
		<u>140.0</u>
<u>Met by:</u>		
Net private patients' fees--		
Private hospitals	10.0	
Public hospitals	8.0	18.0
Health Fund:		
Levy on workers' compensation and third party insurers	10.0	
Health insurance contribution	56.0	
Subsidy from general revenue	56.0	122.0
		<u>140.0</u>

Our proposals would have provided hospitals with an additional \$4.1 million, for an aggregate contribution only \$1 million higher than that actually paid by contributors to benefit funds (after tax), with a reduction of \$1.6 million in Commonwealth contribution, and a reduction of \$4 million in net fees. Direct savings would have arisen from the elimination of \$5.3 million in the administrative expenses of hospital benefit funds and \$3.4 million in their operating surpluses. No attempt has been made to estimate the substantial internal savings which would have accrued to hospitals from the elimination of means testing and patient billing.

We estimate that the additional \$4.1 million available to hospitals would have been sufficient to meet the net cost of the only special grant which would have had to have been initially provided ie the cost of sessional payments to honorary medical staff. The total cost of this would have been about \$10 million, but at least \$6 million should have been provided by internal savings and a compensating reduction in private medical fees due to more public treatment. The proposed system would have resulted in a reduction in fees paid to private medical practitioners and private hospitals for workers' compensation and motor car accident cases. (These would have been almost entirely public, since the general daily rate would have been too low for private hospital admission.) Total payments for medical attention to these patients would not have changed, but they would have been in the form of sessional payments to hospital staffs rather than private fees for service.

### **Medical Benefits Scheme**

The proposed system of medical benefits is designed, like the present voluntary medical insurance scheme, to meet the cost of care provided by medical practitioners in private practice. The intention is to incorporate not only voluntary medical insurance but also the pensioner and Repatriation LMO services and the treatment of persons for whom compulsory insurers are liable. Like the present voluntary scheme it is based on a schedule of services, the content of which may be changed as required. Under our proposals, however, changes in benefit rates would not involve costly re-structuring of tables and transfers of contributors between them, and provision could be made for differential payments to recognized specialists.

The schedule of benefits would be designed to meet 85 per cent of current standard fees, and would be the subject of negotiation on this basis by representatives of the Health Insurance Commission, the Australian Medical Association and the Commonwealth. The Health Insurance Fund would provide a growing source of revenue and benefits would be re-negotiated at regular intervals on the basis of trends in doctors' costs and incomes. Doctors would have the option of:

- (i) charging their customary fees to patients, who would claim the scheduled benefits from the fund, or
- (ii) billing the fund regularly (at least monthly) for the scheduled benefits, in full settlement of their fees.

This option would be open in respect of any patient or any service, but once the option for patient billing had been made, the doctor would have no recourse on the fund in the event of non-payment. The total savings involved in direct claiming on the fund would be large, and we would hope that the vast majority of services would be paid for in this way. Part of the savings would accrue to doctors since the 15 per cent deduction would be less than the costs of preparing patients' accounts and the losses from delayed settlement, concessions and unpaid accounts. As a disincentive to the presentation of many small claims by individuals and as a contribution to the cost of handling them, all claims for benefit lodged by patients would be subject to a deduction of \$2.00. Under the present system more than half of all medical claims are in respect of expenditures of less than \$10,<sup>2</sup> although the cost of handling claims is largely unrelated to their size.

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<sup>2</sup> JS Deeble and RB Scotton, *Health Care under Voluntary Insurance: Report of a Survey*. (Institute of Applied Economic Research, Melbourne, 1968). p. 73.

Most doctors—whether correctly or otherwise—would fear that abuse and consequent loss of control over the content of their practices would follow the introduction of completely free treatment. In fact the relationship between the demand for medical care and its price is more complex and less clear-cut than is generally believed. Demand is determined by many non-economic, as well as economic, factors, although the varied conditions under which medical services are supplied to people in different income groups make it difficult to evaluate their relative importance. In any case patient abuse can only occur in respect of services initiated by patients and outside the control of doctors—ie, general practitioner and unreferral specialist attendances, and not referred specialist, diagnostic or surgical services. Furthermore, financial disincentives sufficient to achieve a significant reduction in abuse may deter the seeking of needed treatment by people lower down on the income scale.

The case for levying charges on patient-initiated services rests at least as heavily on the desirability of concentrating support on those whose needs are greatest. There are more important avenues for expenditure from the health insurance fund than meeting the last fraction of minor medical expenses. General practitioner attendances are not only patient initiated but also more evenly spread over the population: as total expenditure on medical care rises, expenditure on other services increases much more rapidly than expenditure on general practitioner attendances. A substantial improvement in the distribution of benefits can therefore be achieved by subsidizing other expenditures at a higher rate.<sup>3</sup> We would therefore propose the imposition of charges on certain services, as follows:

<sup>3</sup> Data from JS Deeble and RB Scotton, *op. cit.*, in respect of insured contributors with annual expenditures of more than, and less than \$100, and the estimated effect of our proposals on their net costs (assuming doctors bill the fund) are:

		NSW		VIC (excl. HBA)		SA	
		Exp. \$100+	Exp. <\$100	Exp. \$100+	Exp. <\$100	Exp. \$100+	Exp. <\$100
Percentage of contributors:		10.3	89.7	8.9	91.1	10.5	89.5
Av. Exp. on GP attendances	(\$)	47	12.2	40.3	10.7	39.1	10.2
Av. Other expenditures	(\$)	140.9	9.4	135.1	8.8	143.9	8.9
Av. Total expenditures	(\$)	187.9	21.6	175.4	19.5	183.0	19.1
Av. Net expenditure after present benefits	(\$)	61.6	6.9	57.7	6.4	46.7	4.4
Av. Net expenditure under our proposals (est.)	(\$)	9.4	2.4	8.1	2.1	7.9	2.0



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General practitioner attendance (surgery or hospital)	\$0.50—0.80
General practitioner home visit	\$1.00—1.50
Specialist consultation B unreferred	\$2.00—2.50

Where patients were billed by their doctors and claimed on the fund these charges would be deducted from the schedule benefit payable to them. Where doctors claimed direct on the fund for the benefits, they would collect the charges at the time of the consultation, through a pre-paid stamp system, as agents for the insurance fund. The stamps would be attached to their claims on the fund as evidence of collection. Charges would not be payable by pensioners or Repatriation entitles, nor on services for which compulsory insurers were liable. In addition, doctors would be free to dispense with the charges, at their discretion, in the case of patients for whom, by reason of necessary frequent attention and/or poor financial position, payment would constitute hardship.

These arrangements would require some machinery for control. Centralised computer processing of claims would not only produce substantial operating economies but would also provide a method for the supervision of usage. Cases which suggested the possibility of abuse by patients or doctors would be referred by the Commission to a disciplinary committee on which representatives of the organized medical profession constituted at least a majority.

A rough costing of the medical scheme, if had applied in 1965-66 (allowing for some increase in average fee levels and/or usage, but not for savings resulting from the extension of public services) is proved by the following comparison:

### **Estimates of actual 1965-66 outlays and financing**

	\$ million	\$ million
<u>Outlays:</u>		
Doctors' fees		160
Administrative expenses of funds		8.5
Operating surpluses of funds		<u>6.5</u>
		<u>175</u>

Met by:

Contributions to funds (net of tax concessions)		49
Workers' compensation and third party insurance		14
Patients' net fees (net of tax concessions)		35
Commonwealth Government:		
Insured benefit	41	
Tax concessions	17	
PMS & Repatriation	19	
		<u>175</u>

**Estimates of results under our proposals**

	\$million	\$million
<u>Outlays:</u>		
Doctors' fees		157
Administrative expenses		8
		<u>165</u>

Met by:

Patients' net fees (including charges @ 50c, \$1 and \$2)		19
National health insurance fund:		
Levy on workers' compensation and third party insurance	14	
Health insurance contribution	66	
Subsidy from general revenue	66	146
		<u>165</u>

The saving of \$1/2 million on administrative expenses is less than might have been expected from what has been said about the costs of the existing scheme. In the first place, however, the costs of the present scheme were certainly under-stated at \$8.2 million, because of the hidden subsidy from hospital to medical funds. Secondly, the costs of the proposed scheme relate to a far higher volume of payments, and have, on the basis of Saskatchewan experience, been assessed at 5 per cent of payments. Larger scale operation in Australia may well reduce this figure. Our calculations take no account of savings by the Commonwealth government on the administration of Commonwealth benefits and control of the

funds, more of the benefits which would accrue from the greatly increased flow of information and statistics which a centralized system would produce.

The advantages to consumers, in the form of complete security from serious medical expense, are obvious. At the same time doctors would be freed from concern over the source of their incomes, and could treat patients, according to their medical need, without consideration of their financial status. Dissatisfaction with the differential rates of fee paid under the Pensioner Medical Service would disappear, as all services would be paid for the same rate. Review of benefit rates would maintain income standards and growth factor built into the health insurance fund would help to under write the necessary increases. Doctors would not be contractually bound to any method of billing and would be free to withdraw from the scheme if satisfactory adjustments were not made.

There would be many issues to consider in the construction of the schedule, since the availability of free public services and the widespread adoption of direct billing would tend to produce a uniformity of fees at about the standard rates implicit in the fee schedule. One obvious issue would be the extent to which differential benefits for services performed by specialists might be adopted. By and large we should prefer appropriate income differences to be brought about in other ways. The extension of public work would mean that sessional payments would increase as a proportion of specialists incomes, and sessional fees would, as now, be graded according to specialist status. The problems of general practitioners in small localities might also be met by paid part-time or sessional appointments to local hospitals. Other subsidies for, say, diagnostic or other special facilities might be considered.

### **The combined scheme**

We may now assess the proposals as a whole, examining the effects on the Commonwealth budget, the incidence of payments on individuals and the subsequent effects on the structure of medical and hospital practice.

The following table combines the individual costings set out previously, and shows the effects of our proposals in 1965-66, compared with the actual financial results of the existing scheme.

**Present System**

	Hospital \$million	Medical \$ million	Total \$ million
<b>Outlays:</b>			
Hospitals receipts	133.4		133.4
Doctors' fees		160.0	160.0
Administrative expenses	7.8	8.5	16.3
Surpluses of funds	3.4	6.5	9.9
Total	144.6	175.0	319.6

**Met by:**

Contributions to funds (net)	55.0	49.0	104.0
Compulsory insurance	10.0	14.0	24.0
Patients' fees (net)	22.0	35.0	57.0
<b>Commonwealth Government:</b>			
Benefits	41.6	60.0	101.6
Tax concessions	16.0	17.0	33.0
Total	144.6	175.0	319.6

**Our proposals**

	Hospital \$million	Medical \$ million	Total \$ million
<b>Outlays:</b>			
Hospitals receipts	137.5		137.5
Doctors' fees		157.0	157.0
Administrative expenses	2.5	8.0	10.5
Total	140.0	165.0	305.0

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	Hospital \$million	Medical \$ million	Total \$ million
<u>Met by:</u>			
Patients' fees and charges	18.0	19.0	37.0
Health fund:			
Levy on compulsory insurance	10.0	14.0	24.0
Health insurance contribution	56.0	66.0	122.0
Subsidy from general revenue	56.0	66.0	122.0
Total	<u>140.0</u>	<u>165.0</u>	<u>305.0</u>

The basis of costing used in these calculations is generous. The health insurance contribution required to meet the estimated outlays was \$122 million, which represented 1.13 per cent of resident taxable incomes in 1965-66.<sup>4</sup> Our proposal of a contribution equal to 1.3 per cent of taxable incomes, together with the matching commonwealth subsidy, would have yielded an additional \$24 million to meet the cost of other special purpose grants. Even at this rate the Commonwealth governments subsidy of \$134 million, would have been virtually the same as it actually contributed in 1965-66 through direct benefits and taxation concessions. Total payments by individuals would have increased from \$161 million (net contributions and fees in 1965-66) to \$171 million, but the share of fees in this total would have fallen from \$57 million to \$37 million.

These shifts in the shares of the various sources of finance are not dramatic, but they conceal considerable changes in the incidence of benefits, fees and contributions, with respect to both incomes and health status. On the outlays side, all Commonwealth subsidies and health insurance benefits would be distributed according to need. Fees would consist either of small residual charges on patient-initiated consultations or discretionary expenditures on private hospital and medical care. The incidence of the insurance contribution would be proportional to income, in comparison with the regressive impact of tax-subsidized voluntary insurance contributions. In the following table, the net cost to various income groups which would result from the proposals is compared with the present net costs (after tax) of

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<sup>4</sup> The calculation of resident taxable incomes for 1965-66 is as follows: Taxable incomes 1965-66: \$10,441m (Commonwealth Income Tax Statistics 1968, p.4), plus 3% allowance for late and supplementary returns \$313 = \$10, 754m.

obtaining the highest medical cover now available, and hospital cover appropriate to the fees likely to be charged to each income group.<sup>5</sup> The figures represent an average of New South Wales and Victorian costs in 1966-67.

**Net cost of family cover for medical and hospital care  
(\$ per year)**

As percentage of average earnings	1966-67 equivalent actual income	Income		Our Proposals	
		Hospital	Medical	Total	
75	2362	22.37	22.46	44.83	21.84
100	3150	32.18	21.25	53.45	28.80
150	4725	27.73	18.31	46.04	44.70
200	6300	25.22	16.66	41.88	62.40
300	9450	28.20	13.66	41.86	97.80

The comparison above does not precisely reflect the differences in incidence between the proposed scheme and the existing arrangements. A charge on taxable incomes would be payable on the incomes of husband and wife whereas the present scheme provides for a working wife to be covered under a family contribution. A transfer from single to married persons is also involved; under these proposals both would pay the same rates of contribution whereas single insurance rates are now half the family rate. The virtual elimination of net patients' fees (except those incurred voluntarily) would increase the transfer to heads of families, who now incur much higher average net fees than single persons.

In general, the lower the income, the larger the number of dependants, and the greater the need for medical and hospital care, the greater would be the benefit conferred.

### Summary

The primary purpose of the proposed scheme is the financing of health care, but the relationships between financing and the production and distribution of services are both close and direct. Like similar schemes now operating in Canada and the Scandinavian countries, our proposals are not aimed at disturbing the present

<sup>5</sup> The basis on which the hospital fund calculations are made is set out in RB Scotton, Voluntary insurance and the incidence of hospital costs, *Australian Economic Papers*, Vol. 6, no. 9, page 183.

institutional structures, ie, state run hospitals, private hospitals and doctors in private fee-for-service practice. They do not restrict or distort the important freedoms of choice which both doctors and patients now enjoy, nor do they seek to eliminate genuine voluntary health insurance. With universal coverage of basic services the scope for medical insurance would be small, but there are many ancillary and paramedical services for which private benefit funds could provide cover. In the hospital field, a considerable market for voluntary insurance would remain.<sup>6</sup> Freed of the restraints which must be imposed on them in their present role of contractors to the Commonwealth in provision of an essential social service, one would expect the funds to develop new benefits and provide new services which a basic insurance scheme should not aim to cover.

The scheme does, however, have some implications for a different balance between the public and private sectors, and was designed to facilitate changes which have occurred in other countries and appear to improve efficiency and the quality of care. By simplifying and rationalizing financing methods, it would free resources now absorbed in simply collecting and distributing funds for the more important tasks of assessing performance, improving resource allocations and maintaining and reviewing standards.<sup>7</sup>

The scheme also involves an extension of public treatment by hospitals, and development of the role of the public hospital as the centre for organizing comprehensive care in the community which it serves. This development does not imply the subordination of domiciliary to institutional medicine, nor accentuation of the divisions between them. Indeed we would hope that general practitioners would be closely associated with hospitals, both by paid appointments and in their private practices for in-patient and outpatient treatment, and that they should have ready access to domiciliary nurses, social workers and other ancillary staff of public hospitals. One of the objects would be to prevent both the partition of the profession which has occurred in Britain and the market-induced disappearance of

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<sup>6</sup> In the costing of our proposals we have suggested a sum of \$20 million for private fees in 1965-66, but this was a conservative estimate, adopted mainly to show that even with minimal additional revenue, the health fund contributions of both individuals and the Commonwealth government would be similar to their expenditures under the present scheme. In fact, private fees might well amount to between \$30 million and \$40 million and we would expect the benefit funds to continue to offer insurance cover for these fees.

<sup>7</sup> We do not suggest that the last function can be performed other than by the medical profession.

the general practitioner in the United States by improving the material conditions and professional integration of domiciliary practitioners.

In general, we wish to achieve centralized management in areas where it contributes to increased efficiency and lower costs, whilst retaining autonomy in areas where flexibility and regional or private initiative are important. The cost arguments appear to be unanswerable. A substantial improvement in equity and security for consumers could be achieved without significant additional outlays, simply by a restructuring of the present volume of payments. The scheme outlined here does not automatically remedy all of the deficiencies in Australian health services administration—the problem of caring for the aged is not specifically dealt with, for example—but it does provide a framework within which these problems might be approached.

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May 1968

### **Looking back**

The program set out in the foregoing paper underwent a series of modifications before it emerged on 1 July 1975 as Medibank, an even more radical set of revisions and final abolition during the incumbency of the Fraser government, and further modifications since its resurrection as Medicare in February 1984.

The course of events to October 1976 has been covered in a great detail in Scotton and Macdonald (1993), which covered the many changes of detail in some depth. When reflecting on changes which had a significant effect on the eventual shape of the program, I can think of three in particular.

First, the idea of a statutory Health Insurance Fund, which would be funded through a hypothecated health insurance levy and a proportional grant from consolidated revenue, was successfully opposed by the Commonwealth Treasury and the levy itself was later abandoned altogether when the relevant legislation was defeated in the Senate by the opposition parties. Although it was reintroduced with Medicare in 1984, the whole idea of a variable levy rate directly related to the proportion of income absorbed by medical and public hospital costs had long been abandoned. The result has been to eliminate a potentially valuable test of public willingness to



pay for government-funded health services, and to reduce the Medicare levy to a more or less meaningless (except for its greater progressivity at the lower end of the income scale) supplement to personal income tax.

The second issue, which caused even greater problems for the program, was the formula for Commonwealth payments for public hospital services, which were required to replace the loss of fee revenue from public and private patients and from the prospective increase in the proportion of public patients, and the increased costs due to the substitution of paid for honorary service by hospital doctors. The difficulties arose from the lack of any useful measure of hospital output, such as the medical benefits schedule provided in the case of doctors' services. Hence there was no objective measure of how much should be provided, how it should be allocated between states and/or hospitals, and how the amount(s) could be adjusted over time. The potential costs of perverse incentives involved in any payment formula were considerable. The original proposal of daily bed payments to public hospitals incorporated undesirable incentives to prolong inpatient stays. The authors of the "Green Paper" agonised over a suitable formula, and the Whitlam government decided, on pragmatic grounds, on a simple 50-50 cost sharing arrangement with the states, which effectively broke any link between output and payment.

Since that time, a succession of arbitrary grant arrangements under the Fraser government, and subsequent Commonwealth-State agreements under Medicare have introduced ever-increasing complexity into the hospital payment arrangements and effectively severed them from other health financing programs. The fact that the method of payment bears no direct relationship to the services delivered has had the consequence of channelling a great deal of administrative effort into cost shifting and its prevention.

Another issue which has never been resolved satisfactorily is the role of private insurance in the Australian health system. The Medibank program was launched with the specific promise of choice between public or private care, and a measure of subsidy through lower fees in public hospitals, Medibank benefits for in-hospital medical services to private patients and bed-day subsidies to private hospitals. Subsequent amendments have alternately increased and reduced the levels of subsidies to private care, with consequent effects on the proportion of people covered by private insurance. The massive tax rebates on private health insurance contributions, costed at over \$2 billion annually, have massively changed the generally downward trend in private health insurance coverage. Its full effects on the broader health system have yet to be felt.

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## Looking forward

The issues of universality of access to services and equitable incidence of health costs remain as central to health policy in the 21st century as they were in the 1960s. Given the inverse relationship between health status and socioeconomic status, rising real costs of state-of-the-art health care, growing inequality of incomes and the increasing proportion of the population in the upper age groups, there is no reason to believe that the enormous need for cross- subsidisation will diminish. Nor is it possible that the requisite degree of cross-subsidisation

- (a) would be forthcoming from any conceivable set of private arrangements based on the voluntary choices of individuals, or
- (b) could be effected by categorising potential beneficiaries *ex ante* by reference to income and health status. The potential financial risks are not confined to an identifiable group of very poor and/or chronically ill.

The level of income at which the occurrence of major health problems would cause serious financial difficulties is well above the poverty line, and those at risk form a significant (and perhaps growing) proportion of the population. Either government has to remain in the cross-subsidisation business in a very big way, or the access of the less healthy and the poor to health services will be seriously curtailed.

Further, the only means by which this can be done is a public program in which in which all members of the population are automatically covered. In other words, the case for universal coverage under a national program in which the cross-subsidisation is undertaken by government agencies funded through the budget is as compelling as it was 33 years ago.

In fact, the increasing inequality of incomes and wealth and the reduction in employment security resulting from globalisation and microeconomic reform have, if anything, increased both the need for universal health coverage and the voting public's valuation of the security which it offers. Quite apart from the valuation placed on it by individuals, universal coverage has an immense social value, at a stage in our history when many other institutions which have mediated the impact of markets on income distribution in the past are perceived to have disappeared or to be under threat. Social cohesion may have little bearing on short-term GDP growth but its erosion will generate very large long-term costs. In this context there is no doubt that Medicare and the other universal components of our health system are increasingly important elements in our social cement.

In fact, there is no serious alternative to the maintenance of a substantial public program, funded and administered at the national level, as the means of achieving

these objectives. Fortunately, the clearly expressed level of electoral support for this proposition has resulted in a belated consensus by political parties at the federal level that Medicare should be maintained. Equity outcomes are no longer at risk through the abolition of Medicare but the increasing diversion of health outlays to the support of private insurance is contributing to erosion of the capacity of public hospital systems to deliver services to people in lower income groups with serious health problems.

What has changed in the last 33 years is the sustained increase in the real cost of state-of-the-art health care largely as the result of enormous advances in new medical knowledge and technology, which have provided treatments which were both more clinically effective and, on balance, more expensive. Since the mid-1970s onwards governments have increasingly-and with a good degree of success-moved to contain total costs directly through budget and capacity ceilings with the resulting emergence of lengthy waiting lists and other symptoms of explicit rationing. The increasing scale of the health sector has raised the priority which has to be accorded to the objective of **efficiency** with which health services are produced and used. In this respect global budget ceilings and capacity limitations are blunt weapons, consistent only in a loose sense with allocative efficiency. In fact, over time, the increasing complexity of medical practice and health care organisation have greatly diminished the capacity of government agencies to make efficient allocation decisions. As a result, among OECD countries, there has been a growing advocacy—to some extent carrying over into implementation—of reforms involving a greater use of market and quasi-market relationships and incentives, with the objective of introducing a degree of self-regulating capacity **within** a framework of universality.

In the Australian context, the most obvious path towards increased efficiency would be to restructure Commonwealth government health programs so as to focus on improving efficiency **within the framework of universality**. In the model which I have set out elsewhere, this would involve the amalgamation of all publicly funded programs into a single program and the devolution of service organisation and management to competing private and public budget holders. (Scotton, 1998) In this regime of managed competition, the direct role of the Commonwealth government would be limited to supervising the rules governing the resulting market and making risk-adjusted capitation payments to these agencies, who would in turn contract with service providers and/or intermediaries for the provision of all covered services to the people enrolled with them. The economic incentives flowing from these arrangements would result in profound changes on the supply side and in the choices available to patients.

This proposal is necessarily complex and cannot be explained in any detail here. However, it does (uniquely, in my view) constitute a framework for resolving—or at least managing—many problems which are intractable in the context of the present system.

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# **The challenges of the changing researcher — policy maker interface**

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Both the academy and the policy making environment have been subjected to intense pressures to change in recent years. Important components of these changes are that the academy has been pushed to be more “relevant” in both commercial and policy making terms and that the policy making environment has been pressed to dispense with in-house content knowledge and to rely heavily on outside expertise.

These movements have made researchers and policy makers more reliant on each other, but the quality of the relationship has been quite variable and often far from harmonious. How can the changed environment be harnessed to greater mutual benefit and satisfaction and, more importantly, to produce research and policy which are most advantageous to society?

One aspect of the relationship that has not been systematically examined or addressed is differences in world views and interests of researchers and policy makers. Understanding and accommodating these differences can greatly enrich the experience of working together. On the other hand, an underlying cause of conflict is often a lack of appreciation of these differences.

What follows is a brief analysis of world views and interests as they impact on the researcher-policy maker interaction. It is easier to write about this with an emphasis on how differences can cause conflict, but in the conclusion I focus on how differences can be turned into strengths.

### **Harnessing the differing world views of researchers and policy makers**

World views or mental models are the assumptions that underlie our thinking and behaviour. In any given situation, they determine which aspects of the people and environment we attend to, how we interpret events and behaviours and, therefore, how we react. Paradoxically, mental models are both essential for allowing us to deal efficiently with the complexities of life, but also constrain our thinking and provide blocks to effective collaboration.

The assumptions that comprise world views tend to be most problematic when they are unrecognised or when the assumptions are thought to be fact. One common unrecognised mental model that often leads to problems is the assumption that others hold the same values and beliefs that we do and that these shape their behaviours in the same way that they shape ours.

Three areas where mental models are important in researcher-policy maker interactions are: those based on group characteristics; those about the nature of research; and those about how researchers and policy makers should work together.

#### **Mental models based on group characteristics**

To a greater or lesser extent, we all use stereotypes in our interactions with people from other groups. While such mental models can be useful in alerting us to likely characteristics that will affect the interaction, some aspects can be unhelpful. In terms of useful attributes, it can be beneficial, for example, to assume that researchers have a detailed understanding of their subject and of key players in the area and that policy makers are adept at manoeuvring ideas into action—although these assumptions will need to be tested. On the other hand, if policy makers assume that researchers are unrealistic, impractical, arrogant know-alls and researchers think that policy makers are interested only in political expediency and care nothing about research quality, the relationship is likely to be fraught with problems.

#### **Mental models based on the nature of research**

Both researchers and policy makers can have firmly-held views about what should and should not be classified as research, what constitutes quality in research and what should be given priority in resource allocation. These influence the areas of enquiry deemed to be legitimate, the theoretical frameworks that govern the approach, the evidence collected, as well as what is and is not accepted as evidence, the methods that are considered appropriate and sound, and how the results are

presented and interpreted. For example, some are suspicious of any quantitative survey, others of qualitative research, others of modelling or of economic analysis.

Policy makers may also have little understanding of the limitations of any one piece of research. In addition, the time needed to build a convincing body of evidence may be incompatible with the needs of policy makers, who may have a window of funding opportunity or be faced with short-term pressure to modify policy. This incompatibility can help foster negative stereotypes.

A particularly problematic assumption that some people hold about research is that it can produce an uncontested set of "facts". This supposes that research can proceed as a mechanical data gathering exercise, where the interpretation simply "falls out". Researchers as well as policy makers can hold this view. On the contrary, the formulation of the research questions, the data collected, the population groups studied, the methods of analysis and the emphases given in interpretation are all influenced by the researchers' values, perceptions and experience, as well as the social and cultural climate in which the research is conducted. Neither researchers nor policy makers yet have an agreed way of dealing with the fact that all research is grounded in a personal, social and cultural context.

This lack of resolution has had some far-reaching consequences for collaborations between researchers and policy makers. First is a general lack of understanding of, or often even interest in, the ways in which the quality of the research, in terms of the rigour of the methods used, can ameliorate bias. It is common for all methods to be seen as equally flawed, particularly in social research. This in turn has meant that allegations of bias are used indiscriminately in order to discredit research findings when they challenge particular beliefs or interests. It has also led to a desire on the part of research funders, especially government departments commissioning research to inform policy decisions, to have control of whether and how research findings are made public.

Another problematic consequence is that policy makers tend to focus on personal rather than social and cultural factors and often attempt to control the possibility of personal bias. This is commonly done by assuming that experience equates with personal bias. Thus it is often thought that researchers with less specialist knowledge and experience are less biased than those with long standing in the field. Researchers who have taken a position on an issue in their area of expertise are particularly assumed to be biased. In fact just the opposite may be the case. They may be more aware than others of the ways in which the position they have taken

can be scrutinised and may be quite willing to conduct further investigations to test out the weaknesses.

Nevertheless, in practice these assumptions have meant that policy makers often prefer to commission studies from consultancy firms rather than university-based researchers. An additional benefit from the point of view of the funder is that consultancy-based researchers are more likely than university-based researchers to agree to give the funder full control of how the research is used.

### **Mental models about the nature of the researcher-policy maker collaboration**

There are still no widely accepted models of what collaboration between researchers and policy makers entails and views can vary greatly. This is not only relevant to the practicalities of the collaboration, but also to issues of control and responsibility. Problems can arise when some members of a collaboration assume it will be an equal partnership and others that there will be dominant and subordinate partners. The issue of the independence of the researchers in designing the research and reporting the results is also relevant here.

The extent to which the tasks of the researcher and the policy maker are seen as separate or overlapping is also important. Policy makers generally see research as providing the foundation on which they build, with their role being to consult, develop consensus and build a constituency for the policy arising from the research. Policy makers do not usually see the research process itself as an effective way of consulting, developing consensus and building a constituency, although it can effectively fill these functions. Certainly policy makers rarely see themselves or their role as being a legitimate component of the research process.

The model of research that I am interested in sees policy makers as one of the interest groups that need to be included in order to develop a comprehensive understanding of a problem and possible solutions to it. In such a model, the exclusion of policy makers would skew research outcomes.

Another contentious area can involve different assumptions about where the responsibility for the application of research lies. For example, who should be responsible for the translation of research findings into policy-relevant recommendations? Who is responsible for ensuring that those who can implement a recommendation are aware of it? Policy makers often see this as a role of researchers and vice versa, with the result that application of research findings is often poor.



### **Harnessing the differing interests of researchers and policy makers**

Interests are what motivate us. They are our needs, desires, concerns and fears. It can also be useful to think about the professional or specialist interests of researchers and policy makers. These are generally what led them to engage in their profession in the first place. The boundaries between personal and professional interests are not distinct.

In good researcher-policy maker partnerships a way will be found to accommodate the range of interests of both sides. Problems often arise because interests are not met and this is commonly the result of either not considering the interests of partners or of incorrect assumptions being made about individual interests.

Finding ways to accommodate interests can be challenging because they are often poorly articulated. One reason for this is that they can be deeply ingrained, so that people are not conscious of them. Interests can also be taken for granted, so that people do not appreciate that they are not evident to others. Finally interests are often private and people may fear lack of understanding or even ridicule or censure if they make some of their personal needs explicit. For example, some people may be reluctant to talk openly about their ambitions while others might not wish to disclose their desire for a more balanced family life. One way of considering interests that may be useful is to think of them as formal, informal and idiosyncratic.

We can begin to understand formal interests through a basic understanding of the activities of researchers and policy makers that receive official rewards and recognition within those professions, and what these rewards are, as well as those which are officially punished and what the punishments are.

Informal rewards are often the by-products of formal rewards. The difference is that they are not usually taken into account in formal assessments for promotion, job renewal and so on. These can include national and international travel, a public profile, being a confidant or source of advice for powerful people, flexible working hours or independence in working habits, a luxurious office, an opportunity to face new challenges and so on.

Idiosyncratic rewards are generally unpredictable and will often only be known if there is a close relationship between collaborators. For example, a person may welcome an opportunity to meet a childhood hero, to visit overseas relatives, to engage in an activity for which opportunities might otherwise be limited, such as accompanying police in their duties, and so on.

For any collaboration to work, the interests of collaborators must be engaged. It is also important, however, not to make assumptions about what the interests of any individual collaborator might be. For example, even formal rewards may not be strong motivators for some people. In addition, in terms of informal rewards, what is attractive to one person can be anathema to another. Thus, some might welcome opportunities to travel or a high public profile, but for others these will be a disincentive.

### **Turning differences into strengths**

It is easy to see how different mental models and interests can produce conflict, but how do we promote harmonious relationships? Making the mental models and interests explicit is the key. How this can best be done is an area that requires considerable development.

Most thinking in this area has been in the context of team building, which generally involves exercises that can be undertaken in either a formal or informal procedure. However, neither researchers nor policy makers currently consider engagement in team building as part of the partnership, so that it may not be possible to arrange such a process. Time pressures can also mitigate against team building and if such processes are forced on busy people who think they are unnecessary, it can stultify rather than open up the relationship.

Another possibility is to have a broker, who can gently and progressively mentor the parties into building a greater understanding and producing more fruitful outcomes. At present most partnerships are hit-or-miss and their success depends on the insights and experiences of the particular partners. My current research involves exploring the possibilities of a recognised role for experienced brokers.

There is, therefore, a real need for further research into the best ways of building partnerships between researchers and policy makers that not only produce useful research and good policy, but that do so in ways that are stimulating, creative, fruitful, practical, satisfying, rewarding and fun.

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# **We the people: citizen's opinions and values in future health policy in Australia**

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## **Introduction**

Love him or hate him, John Deeble showed us how to challenge entrenched barriers in health in Australia and to develop policy in health that enabled all Australians to access health services. It is this sort of courage that can inspire all of us who choose to hang off the edge of the status quo and dream to make a difference in health in this country. John Deeble's work says it can be done; it asks each of us to have a go.

Australia is a democracy. We are proud it is so. There can be little doubt that democracy is the best way to govern our country. We would not have it otherwise. Australians, however, like the people of many democratic countries, do not stop to think very often about the democratic process. Is democracy working well in Australia? Can we improve or enhance the process of democracy in this country? While not attempting to answer these questions comprehensively this paper looks at their potential relevance to health and health care in Australia.

The views expressed here are those of a clinician working in general practice who sees the need for change in the way we configure and fund our health services. Saying that immediately raises the question of who the "we" and "our" are. Having thought that through there seems no one better or more eligible than the community of Australian citizens ("we the people"). After all and as a clinician it is important and salutary to recognise anew that it is the Australian citizens' health care system when we talk or write of 'our' health services. That is the starting point for this paper.

## **Democracy in Australia**

Is democracy working well in health in Australia? We each vote for health and the allocation of the health dollar. We do so for both State Government and Federal

Government. It is here in terms of the particular form of democracy and its operations that we have the first dysfunction in health service delivery for the people of this country. Both Governments have a supposedly clear demarcation of their responsibilities in health. Each at the same time has an entrenched mistrust of the other. Much intellectual effort that could be devoted to the bettering of our health care system and the bettering of the health of the Australian population goes into trying to assess whether this policy change or that policy change will mean more or fewer dollars for health care in NSW or Western Australia or wherever. Decisions about an equitable allocation of resources across the states and deliberations on what would be fair and just given the relative needs of the state populations are clouded by accountants' arithmetic as to which state wins and which loses not in terms of health but of solely dollars. It could be different. Cost shifting takes on a special art form leading to all sorts of manipulations for the sake of a few more dollars. Explicitness and transparency are not to be encouraged as these result in openness and knowledge of what is going on and thereby scope for public debate. Cost shifting requires the shifty opaque world of smokescreens in the interests of obtaining more money. It is a system that discourages concerns for the national good and the health of one's neighbour state. If the spilt of powers and responsibilities between Commonwealth and state were rational then the funding problems would be lessened. They are not and thereby the problems are enhanced.

The second dysfunction in the democratic process in relation to health, is brought about by who and what influences health policy and spending between elections. "The People" often rate health policy as important when casting their votes. They are dismayed that the crisis-to-crisis health service delivery style continues unabated, even when they succeed in changing the Government. This style of health delivery is perhaps due less to the inadequacy of funding levels as is often claimed and more to the maldistribution of the funds available.

This latter problem seemingly follows the response of the health system to the (undue) influence of pressure groups in our society. Unions, professional associations, politicians, political ideology, pressure groups with a narrow health focus, consumer groups, pharmaceutical companies and the like bring to bear influences which create or at least result in this maldistribution. One difficulty here is who owns the maldistribution and indeed in this context there is a need to recognise that not all will accept that the current funding does result in maldistribution. The distribution of resources results in employment for various groups within health care and it is often those employed in health care who seem to have a large say in how the monies are spent. Since they have a vested interest in that distribution they are more likely to be happy with the distribution than will be

others including the community at large. Within the community at large one might speculate that the extent of any maldistribution might be seen as greater by rural and remote communities than metropolitan Australia, by Aboriginal people and by the elderly. The distance one perceives any distribution to be from optimal is not independent of where one sits oneself. Any stand that each of us might take on equity and the distribution of resources is a function of where we sit .

Apart from possible inequities that thereby arise, this situation leads to inadequate planning for the future because we have to resource the crisis of the day. In so doing we perpetuate today's crisis into tomorrow's crisis.

In brief then, democracy is working but not well. The people do have some say, but are often less influential than many of the players from within the industry. It can be argued that that is how the people want it. Not to test whether that is true however is paternalistic and patronising. It behoves us if we seek some genuine democratic decision making to establish the community's preferences for the use of the community's preferences.

This is already happening both overseas (for example Shackley and Ryan 1995 and Mullen 2000) and in Australia (Nord et al 1995 and Jan et al 2000). What this chapter deals with specifically is the use of and future potential for the use of Citizens' Juries to bring a greater element of democracy to health care decision making.

### **Citizens' Juries**

Can we improve or enhance the process of democracy in health in this country? Internationally there has been a significant focus on processes that can bring the informed opinions and values of the people into the health service debate. Citizen Juries, Citizen forums, Citizens workshops, deliberative panels and other similar processes have all been successful in enabling "the people" to have an influence on their health services (Coote and Lenegham 1997; Davies et al 1998; and McIver 1998). The features of these processes are similar:

1. Randomly selected citizens.
2. Working under a code where they agree to consider what is best for all not best for them or their particular interests.
3. Carefully informed by experts to give a balanced representation of the issues on which they are being asked to deliberate.
4. Time to deliberate and revisit some of the information given.

5. Facilitation to make decisions on the evidence given. To answer the questions that need to be answered on behalf of the community at large.

There are options for improving the process of democracy in health in this country. For governments to travel this road will not be easy, at least not at first. There is genuine scope for establishing social priorities for health care spending. It seems only right that we the people of Australia should be involved in making these sorts of decisions or at least having our values used to inform these decisions. It can readily be argued that citizens are the only group who can and should make this type of decision. It is of course possible that the citizens themselves as suggested above might choose to have some of these decisions made by experts or by others of their choosing. Such community autonomy is easily incorporated into this democratic process. However, it requires asking the community in which decisions they want to be involved and in what way. We must not assume that health care decision makers know this. While it is less of a problem given the starting point, it is in principle just as much an issue to force decision making on to people who do not want it as it is to deny them that responsibility when they seek it. Informed citizens can make these decisions where health professionals, health managers and politicians cannot and should not.

Citizens' juries/workshops have been the subject of experimentation in Western Australia under the auspices of the Medical Council of WA. The Council has commissioned the only two such events to occur in this country. The values expressed by the informed citizens have been quite simple and very clear.

From the first Citizens' Jury (Proceedings "*Health and Economics—Bridging the Abyss*" 17th March 2000, Western Australian Medical Council) the following preferences and opinions emerged:

- While there was genuine support for universal access under Medicare the citizens expressed the opinion that there should be a focus on equity of access.
- We need to look at our objectives for the future and work backwards to achieve them. This should be done with a focus on health promotion and prevention, especially on children through education.
- To add to this the opinion of the jury was that there needed to be an emphasis on multisectorial action to achieve health gains eg. nutrition programs in schools, improved footpaths by local government. "It is important to fix the footpaths first, before we agree to fund another orthopaedic unit."
- Substitution of, and innovation in, models of care and in the health workforce are needed to achieve health gains.

- The citizens were very supportive of community input to health care decision making. They thought the informed citizens process a very good model to achieve this.

Given the citizens' preferences for equity and for prevention and public health it was decided that the second Citizens' Jury should focus on equity.

From the second Citizens' Jury (Proceedings "*What's Fair in Health Care?*" Thursday 22nd and Friday 23rd February 2001—Medical Council of Western Australia) the following preferences and opinions emerged:

- Equity in health is important.
- The citizens see equity in terms of equal access for equal need. Where two people have a similar need, the barriers that face them (age, culture, rurality, etc) should be overcome to give them equal access.
- When asked to deliberate on how they would allocate extra funds made available for health, the citizens arrived at a principle "those with the greatest needs should benefit first and most."
- Given their definition of equity the citizens agreed that there are inequities in Aboriginal health. From their deliberations they arrived at the following principles of addressing these inequities:
  - We can't treat Aboriginal health in isolation—it must be considered with other issues such as employment, justice, environment, education etc.
  - Greater consultation on cultural issues is needed to achieve health gains in Aboriginals.
  - Aboriginals have special health needs due to complex issues which must be considered.
  - Given the citizens principle "those in most need should benefit first and most", greater investment in indigenous health was advocated.

Out of the mouths of informed citizens of Western Australia have come some very clear ideas as to directions for reconfiguring our health system. These are early days in developing this technique of eliciting community values. Already in WA we have departed from some of the models used in other countries. We are confident however that what the Medical Council has achieved in WA can be replicated across the country. It will then be interesting to see if the results are reproduced. It is not the case that Citizens' Juries are the only way to elicit community preferences. There may be a case for wider larger community surveys. The idea of a constitution for health services and a constitutional convention for



health care might be worthy of consideration (Mooney and Wiseman 2000). What is clear is that the citizens' voice needs to be heard.

It also seems likely that that voice if listened to will be telling a somewhat different story from that which is reflected in resource allocation in health care today. In WA, for example, if the voice of the citizens was to be a basis for resource allocation we would see many more resources moving to Aboriginal health and to rural and remote parts of the state and with greater emphasis on aged care. A greater emphasis on prevention, health promotion and public health would be advocated. It is not suggested that health care decisions on resource allocation should be made on the basis of the small examples we have to date and that these should lead to detailed strategies for implementation. There is however a need to see whether further exercises of this ilk confirm these directions as seems most likely and whether it is possible to elicit better the relative weights that might accompany distributions adopted to foster equity. There is further a need to extend beyond concerns for equity and examine the values that are attached to other principles such as efficiency and choice.

### **Conclusion**

At a time when health services seem troubled and constantly trying to prioritise and sort out where they are going, the search for reconfigurations holds little hope if the same influences are allowed to continue to have the same input. The challenge to entrenched policy makers is to break from the traditional influences of pressure groups in health, not to ignore them but to add value to the process of reconfiguration and priority setting by listening to the informed opinions and values of the citizens of Australia.

The drive for reorganisation of administrative structures which seems to be where health services turn when in trouble is no solution until there is a clearer idea as to where we want to go. There is no point in choosing to develop a car or boat or plane until we know where the destination lies and whether by land, sea or air is the best way to travel. Health services are first and foremost social organisations. Recognising that and the legitimacy of the citizen's voice is a major step to reform and to allow the social in health care to become more influential. To achieve this will require other powerful groups to accept the legitimacy of the informed citizen's voice. It may be here more than in the principle per se where the most serious barrier to change lies. There is a need to have courage and to believe that this is the right road to travel. We have John Deeble's example to encourage us.

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# **Australian women's health: from margins to mainstream?**

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Beginning in the 1970s, innovation in Australian women's health care was driven by vigorous political advocacy and practical action by the feminist women's health movement. For twenty years, feminist pressure was sustained despite constraints and political reversals. An internationally recognised National Women's Health Policy was endorsed by all health ministers in 1989. In the late 1990s, however, the emphasis—both national and international—shifted and the future became unclear. This paper maps this history, briefly introduces the innovative National Women's Health Policy, and identifies several contemporary challenges to women's health in this country.

## **The women's health movement and renascent feminism**

In the 1970s, a number of left and liberation movements were emerging. Concern about damage to the environment, national liberation in a number of developing countries, opposition to the Viet Nam war, anti-racism and gay rights movements were all flourishing, as was the renascent women's movement which promoted considerable activity on women's health (Broom, 1991; Ruzek, 1978). Although not all interest arose from the political left, most of the first two decades of explicitly politicised women's health action came from or was closely related to the feminist movement and other generally liberal social initiatives of the time. Many of those involved also participated in organisations oriented toward other social issues, leading to a cross-fertilising of strategies, conceptual vocabularies and networks.

During this same period, a number of developments were occurring in the health field. The 'new public health', community health movement and health consumerism all contributed to the articulation of a critical orientation to biomedicine (Milio, 1988; Nettleton, 1996; Petersen & Lupton, 1996). Lay people were encouraged to ask questions and inform themselves, and to take more

responsibility for their own bodies and health. The women's health movement worked in concert with these activities, often as the advance guard.

Drawing on the broad array of political action at the time, themes of oppression and liberation permeated women's health. The term 'sexism' appeared, and analogies were drawn to racism. Academic women's studies supplied conceptual and analytical tools that helped activists formulate perspectives on the problems they faced as well as strategies for response. The women's health movement was a focus for a range of activity, from private discussions about dissatisfaction with doctors to feminist consciousness-raising to public meetings, lobbying, advocacy and community-based service provision. Beginning with amateur pamphlets and extending to highly professional publications such as *Our Bodies Ourselves* (Boston Women's Health Book Collective, 1971), women seized the initiative of defining their own health priorities and generating their own sources of information.

Action and information on women's health were framed initially in terms of a vocabulary of resistance to something called *patriarchy* and a conception of biomedicine as male-dominated (Broom, 1984; Broom, 1995). The language of the women's health movement referred to discrimination and injustice, notions around which it was easy to mobilise a vigorous and diverse constituency in the activist 1970s. The election of the Whitlam Labor Party government in 1972 created a national political environment of innovation and responsiveness particularly in the health field, with such significant initiatives as the national public health insurance scheme and the Community Health Program which funded a number of the first women's health centres.

From the vantage point of the new millennium, it is difficult to imagine the sense of excitement when Australia's first Women's Community Health Centre opened in Flood Street, Leichhardt on International Women's Day, 8 March 1974. Women came from all over Sydney, country NSW and even Tasmania for the centre's medical, counselling, and health education services. The urgent need for Leichhardt is symbolised by the fact that their first client had arrived in desperation several weeks before the official opening and was examined on a kitchen table. During the next four years, a dozen similar centres were established, and after a 5-year hiatus (under a conservative federal government), funding improved again and another 25 opened in the subsequent 15 years. Of course women's community health centres are not Australia's only activity on women's health, and although we may have more such centres per head of population than any other country, the majority of women never attend one.

Nevertheless, the centres have played an important role in shaping the changing face of women's health services and policies in this country. They have deployed a 'dual strategy' of supplying specific services to women and working with the 'mainstream' in order to advance the diverse agenda of the movement. While there was considerable overlap, Indigenous women and those from non-English speaking backgrounds emphasised somewhat different priorities from those advanced by Anglo-Australian women. For example, Aboriginal women were more concerned about the coercive imposition of fertility control than access to abortions (Goodall & Huggins, 1992). And NESB women sought improvements in occupational health and safety and mental health services with particular urgency. Women of all racial and ethnic backgrounds were united, however, in their call for a voice in personal health care decisions and in the formulation of health policy.

### **The National Women's Health Policy**

Government eventually responded to these claims by developing Australia's National Women's Health Policy (NWHP) which—in a rare bipartisan coup—was endorsed by all health ministers and released in 1989 (Commonwealth Department of Community Services and Health, 1988; Commonwealth Department of Community Services and Health, 1989). The Policy was developed through a long and democratic process of consultation in which more than one million women throughout Australia participated (Broom, 1991; Gray, 1998).

Getting women's health squarely on the political agenda for the Commonwealth and all States was a major accomplishment for the women's health movement. The national policy was a watershed because it signified that the Commonwealth was encouraging governments to innovate, promote and expand women's health initiatives, rather than mainly respond to community initiatives. It also gave women's health an ongoing national significance.

### **Seismic shifts**

The climate that produced this visionary Policy has been transformed by elections of more politically conservative governments with a strong emphasis on containing public spending. One way to trace the changing climate for women's health in Australia is by following the role of successive Commonwealth governments in the four National Women's Health Conferences. The Prime Minister Gough Whitlam addressed the first National Women's Health Conference in 1975 (Commonwealth Department of Health, 1975). Senior government politicians and bureaucrats participated in the second and third conferences in 1985 and 1995 (Davis et al., 1996; Kerby-Eaton & Davies, 1985), but the Howard government was entirely

absent from the fourth (in 2001), suggesting that it viewed women's health as either passe or as politically hazardous or maybe, paradoxically, both.

After all, in recent decades, more women have gone into medicine, many family planning clinics have opened, and we have had the NWHP and two programs for its implementation. Yet research conducted in the 1990s showed that most of the concerns that had motivated the foundation of Leichhardt and later prompted the NWHP were still very much alive (Broom, 1998a; Brown & Doran, 1996). The fact that most women's health centres are booked weeks in advance is ample evidence that women still seek an approach that is difficult or impossible to obtain from other sources. From their earliest beginnings, the centres have sought to be particularly accessible to women who are disadvantaged in their access to conventional facilities (Broom, 1997).

### **Into the mainstream?**

In this changing environment, what is the fate of women's health policies and programs? From 1985 until 1998, Australian women's health initiatives (including the NWHP and programs) were guided nationally by the Australian Health Ministers' Advisory Council (AHMAC) Subcommittee on Women and Health which consisted of the women's health advisers from the Commonwealth and all jurisdictions, plus representatives of several NGOs and professional bodies (Broom et al., 1993).

With the end of special purpose funding for the National Women's Health Program and broadbanding of public health funding in the late 1990s, the Subcommittee was dissolved and, except for continuing national oversight of breast and cervix screening programs, women's health activities have effectively become the responsibility of the States and Territories. There is no longer any Commonwealth (or national) dimension beyond that contained in Public Health Funding Outcome Agreements which bear little resemblance to the issues and priorities identified in the NWHP or by research with women (Redman et al., 1988). A recently restructured Office of the Status of Women (OSW) lists 'optimal health and well being' among the four goals in its 2001-2003 Strategic Directions (Office of the Status of Women, 2001). While the Directions paper does not refer explicitly to the NWHP, the OSW website summarises it, and the Strategic Directions document can be construed as shaped by the Policy. For example, another goal is 'the elimination of violence in the lives of women' which is one of the Policy's priority health issues. However, there is an awkward contradiction between the Office's commitment to equitable access to care, and the government's investment of \$1.5B per year to fund rebates on private health insurance premiums, a scheme whose

incidence is clearly regressive (Gray, 1999-2000). The Office is explicit in announcing an intention to 'enhance gender mainstreaming' in women's health. Whether mainstreaming is a defeat or an accomplishment, it has become very popular both nationally and internationally (Rees, 1999).

### **Toward a woman-friendly mainstream**

How might women's health advocates contribute to mainstreaming at a national level? Australia has a National Public Health Partnership and numerous National Public Health Strategies (like HIV/AIDS or nutrition) all of which supply opportunities to make inputs, as might the several National Health Priority Areas (for example injury, heart disease or diabetes) or indeed any policy or program area. But if the mainstream is to advance women's health, all major national activities in the government and community sectors must incorporate a gender perspective explicitly, systematically and consistently.

Because of the 'dual strategy' in women's health, collaboration with mainstream agencies has been occurring for some time on certain issues. For example, feminist organisations supplying services to women experiencing domestic violence and sexual assault have developed successful cooperative programs with police, the criminal justice system and hospitals. Within State health departments, there is considerable strategic development designed to support mainstreaming of women's health. For example, in 2000, the State health departments in both NSW and SA published women's health frameworks to guide planning and practice for their departments (Gay & Dwyer, 2000; NSW Health Department, 2000a; NSW Health Department, 2000b). There are also various women's health initiatives at different stages of formulation and implementation in several other jurisdictions, including the NT, ACT, and Victoria.

It is too early to say how fully these initiatives will be implemented, or with what overall effects. The balance of this chapter reviews briefly several continuing challenges arising from the interaction between past and present.

### **Unfulfilled promises, unintended consequences and continuing challenges**

Many of those writing on women's health in the biomedical and popular presses still do not appreciate that women's health is more than sexual and reproductive health, or that the women working in the health sector are not all nurses. The *Australian Family Physician's* 1998 theme issue on women's health concentrated entirely on gynaecological and reproductive themes. Searching the

Commonwealth's Healthinsite on 'women's health' produces a lineup of the usual suspects, plus diet and weight, infant feeding, and mental health. The big women's magazines tend to adopt the same view. Even contents of the mass-distribution magazine *Women's Health* are much like a regular fashion and beauty glossy, plus an extra large serve of fitness, healthy nutrition and new-age advice.

There is also now a magazine on *Men's Health*, confirming interest in men's health in both the public and private sectors. In addition to commercial establishments that cash in on men's sexual insecurities, and a national research centre in male sexual and reproductive health announced in 1999, assorted men's health inquiries, projects and programs have been instigated by governments and NGOs. A draft national men's health policy never became government policy, but there have been four national conferences (1995, 1997, 1999 and 2001) and a consultancy on research priorities in men's health. NSW has published a men's health strategy (NSW Health Department, 1998; NSW Health Department, 1999), and there is now some worthwhile research being conducted in the field (Cameron & Bernardes, 1998; Lyons & Willott, 1999; Sabo & Gordon, 1995; Watson, 2000). These initiatives can yield opportunities for mutually beneficial collaborations, and some links are being formed between women's health activists and the pro-feminist men's movement (Pugh & Caleidin, 2001).

Initiatives on men's health are related to increased interest in gender differences. Textbooks on health studies now routinely include a chapter on gender, and gender disaggregated statistics are no longer viewed as remarkable, even if they are still not consistently collected or reported (Charney & Morgan, 1996; Siang, 2000). Whether the issue is women or gender remains uncertain in many instances. 'Gender' is still more likely to be political code for 'women' than a detailed analysis of the way various forms of masculinity and femininity affect health, health-related action, access to services, exposure to risks, or the behaviour of service providers and researchers. Sometimes gender now means men too, or even instead of women. Indeed, a concern among some women's health activists is that the political palatability of the term 'gender' is being used to restore a male-centred approach through superficially feminist language.

Disputing early claims about women's health, some people are trying to promote attention to men's health by positioning men as the really needy sex when it comes to health. While this is ultimately a futile quarrel (Broom, 1998b), it may have some surprising benefits. Assertions that men are sicker might just work to destabilise the usual deficit model in which women are usually figured as lacking something (careers, self-esteem, labour-force attachment, good health). Unlike



employment rates, occupational segregation or income, where the statistics—although occasionally complicated—generally tell a clear gender story, health is much more diverse and difficult to measure, so disputes about the ‘facts’ are likely to resist resolution (Macintyre et al., 1996). However one interprets the statistics, when the defects of masculinity are emphasised as they are in this way of arguing, such assertions may work inadvertently to weaken the traditional basis of male privilege. Besides, any focus on masculinity as such (rather than the fictional sexless standard) can undermine the long history of the male norm with its deleterious consequences for women and men both (Broom, 1996; Broom, 1999).

### **Hidden hazards**

In focussing on women’s health services and policies, we must not lose sight of apparently unrelated processes that may have implications for women’s health. One is at least semi-obvious: the preservation of our universal medical insurance scheme funded by progressive taxation (Medicare). As the most economically vulnerable sector of the population apart from Indigenous Australians (about half of whom are, of course, women), and as the guardians of the health of other vulnerable people such as children and elders, women will lose disproportionately if publicly funded health services and Medicare are further eroded.

A final example comes from Australia’s own Bob Connell (Connell, 2000) who observes that the harms arising from globalization, growth in financial markets and overall weakening of welfare states are liable to fall particularly heavily on women. Because of women’s low average income, limited power and contingent participation in the market, they are more likely to rely on the state for services (including health services) and income transfers. Consequently, women’s health and well-being could be an accidental casualty of international forces that seem on the surface remote from such concerns. To people who subscribe to the social model of health, that will come as no surprise.

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# Policy change and private health insurance: did the cheapest policy do the trick?

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## Abstract

From the introduction of Australia's national health insurance scheme (Medicare) in 1984 until recently, the proportion of the population covered by private health insurance declined steadily. Following an Industry Commission inquiry into the private health insurance industry in 1997, a number of policy changes were effected in an attempt to reverse this trend. The main policy changes were of two types: "carrots and sticks" financial incentives that provided subsidies for purchasing, or tax penalties for not purchasing, private health insurance; and lifetime community rating, which aimed to revise the community rating regulations governing private health insurance in Australia.

This chapter argues that the membership uptake that has occurred recently is largely attributable to the introduction of lifetime community rating which goes some way towards addressing the adverse selection associated with the previous community rating regulations. This policy change had virtually no cost to government. However, it was introduced after subsidies for private health insurance were already in place. This chronological sequencing of these policies has resulted in substantial increases in government expenditure on private health insurance subsidies, with such increases not being a *cause* but rather an *effect* of increased demand for private health insurance.

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## **Introduction**

From the introduction of Medicare until recently, the proportion of the population covered by private health insurance in Australia declined steadily. Following an inquiry by the (then) Industry Commission into the private health insurance industry in 1997 (Industry Commission 1997), a number of policy changes were effected in an attempt to reverse this trend. The main policy changes were of two types: financial incentives that provided subsidies for purchasing, or tax penalties for not purchasing, private health insurance; and lifetime community rating.

The success of these measures depends upon the extent to which they address the underlying causes of declining private health insurance membership. While private health insurance premiums have been increasing, this may have been due to the problem of adverse selection associated with the community rating regulations. These regulations required a uniform premium to be charged for any given policy regardless of health risk, with the result that private health insurance was more attractive to higher risk groups. The reduction in demand for cover by lower risk groups places upward pressure on premiums, making private health insurance even less attractive to lower risk groups. As a result, private health insurers were left with an increasingly adverse selection of risks, and the downward spiral in membership may have been symptomatic of an adverse selection death spiral.

Both the efficiency and equity aspects of the recent policy changes are important. This chapter is concerned with the efficiency aspect.<sup>1</sup> Within that, one particular issue is considered—what was the effectiveness of the various policy changes in increasing private health insurance coverage, and what was their cost to government? The chapter concludes with some speculation on what the future might hold for private health insurance in Australia.

## **Overview of three policy changes**

### ***Policy A: The Private Health Insurance Incentives Scheme (PHIIS)***

This scheme was introduced with effect from 1 July 1997. The scheme was based on a ‘carrots and sticks’ approach in that it provided tax subsidies for lower income groups that purchased private health insurance and imposed tax penalties on higher income groups that did not. The scheme operated on the basis of three annual taxable income bands (see Table 1). Medicare-eligible single persons and families

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<sup>1</sup> Some recent papers that comment upon the equity aspect are Hall *et al* (1999) and Smith (2000).

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with annual incomes falling within the first (lowest income) band received a subsidy for any eligible ancillary and/or hospital policy. Those in the second band neither received a subsidy nor incurred a tax penalty regardless of their private health insurance status. Those in the third (highest income) band incurred a tax penalty if they failed to purchase an eligible hospital and/or ancillary policy. The eligibility criteria for policies were specified in terms of minimum annual premiums.

The subsidy component of the scheme was introduced under the Private Health Insurance Incentives Act 1997 and was administered by the Health Insurance Commission (HIC).<sup>2</sup> Individuals could opt to take the subsidy in one of three ways: an immediate reduction in the premium; a direct payment from the HIC; or a tax offset at the end of the financial year. The tax penalty component of the scheme was introduced as a Medicare levy surcharge.

***Policy B: The 30% Rebate***

The original Private Health Insurance Incentives Scheme was amended on 31 December 1998 with the subsidy component of the scheme being replaced by a 30% rebate on private health insurance premiums. This amendment extended the subsidy for private health insurance in three ways:

- the original subsidies specified in absolute amounts were replaced with an ad valorem subsidy that delivered larger subsidies for most individuals and families;<sup>3</sup>
- the eligibility criteria required for policies to qualify for a subsidy, originally defined in terms of minimum premiums, were removed;<sup>4</sup> and
- all Medicare-eligible individuals or families could receive a subsidy regardless of income.

Individuals could again opt to receive the subsidy in one of three ways as under the PHIIS.

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<sup>2</sup> See Sidorenko (2001 section 2.7.1) for a discussion of the legislative amendments necessary to introduce the scheme.

<sup>3</sup> The only losers in terms of the value of the subsidies were some families previously receiving the \$450 subsidy for combined (hospital + ancillary) cover.

<sup>4</sup> Presumably the reason for this is that, when the subsidies were specified in absolute amounts, the subsidy represented a greater proportion of the premium the lower was the premium.



**Table 1**  
**Subsidies and tax penalties under the**  
**Private Health Insurance Incentives Scheme 1997**

Annual taxable income band		Subsidy/tax penalty	
			<i>Subsidies<sup>(a)</sup></i>
Single	\$0-\$35,000	Ancillary policy	\$25
		Hospital policy	\$100
		Hospital + ancillary policies	\$125
Family	\$0-\$70,000 <sup>(b)</sup>	<u>Without children:</u>	
		Ancillary policy	\$50
		Hospital policy	\$200
		Hospital + ancillary policies	\$250
		<u>Other:<sup>(c)</sup></u>	
		Ancillary policy	\$100
		Hospital policy	\$350
		Hospital + ancillary policies	\$450
		Single	\$35,000-\$50,000
Family	\$70,000-\$100,000	No subsidy or tax penalty	
			<i>Tax penalties<sup>(a)</sup></i>
Single	> \$50,000	Medicare levy surcharge	1%
Family	>\$100,000 <sup>(d)</sup>	Medicare levy surcharge	1%

**Notes:**

(a) To attract a subsidy or avoid the Medicare levy surcharge, a policy must have satisfied the following constraints on annual premiums:

Ancillary premiums: ≥ \$125 Single; ≥ \$250 Family  
 Hospital premiums: ≥ \$250 Single; ≥ \$500 Family.

In addition, to avoid the Medicare levy surcharge, an individual or family must have purchased a hospital policy with or without an ancillary policy (purchase of an ancillary policy alone was insufficient to avoid the surcharge).

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- (b) Annual income ceiling increases by \$3,000 for each child after the first. Dependent children include children under 18 years of age and full-time student children under 25 years of age.
  - (c) Single parent families and families with at least one dependent child. Dependent children are defined as in note (b).
  - (d) Annual income threshold increases by \$1,500 for each dependent child after the first. Dependent children are defined as in note (b)

There were no changes to the tax penalty arrangements with the introduction of the 30% rebate on 1 January 1999. However, two factors operating together since then gave rise to a change in the regulations governing the eligibility of policies to avoid the surcharge. The first factor was the extension of the subsidy to all individuals and families regardless of income. This meant that individuals with annual taxable incomes of \$50,000 or more (or, for families, \$100,000 or more) now *both* qualified for a subsidy *and* avoided a tax penalty by purchasing private health insurance. For example, a family with taxable income of \$100,000 purchasing a family policy with an annual premium of \$1,800 would receive a subsidy of \$540 and avoid the Medicare levy surcharge of \$1,000.

The second factor was a change in the range of insurance products offered by the health funds to include policies with larger front-end deductibles (or annual excesses). As with any insurance product, a larger excess results in a smaller premium. When coupled with the first factor just discussed, it became possible for health funds to offer products with a net premium (i.e. gross premium minus rebate) that was less than the Medicare levy surcharge.<sup>5</sup>

To address this situation, a new criterion governing the eligibility of policies in terms of avoiding the surcharge was introduced with effect from 24 May 2000, *viz.* hospital policies with front-end deductibles greater than \$500 for singles or \$1,000 for families did not enable purchasers to avoid the surcharge. The new criterion was not retrospective—those who had purchased such policies prior to the effect date would continue to be exempt from the surcharge while maintaining continuous membership under that policy.

### ***Policy C: Lifetime Community Rating***

The third policy change allowed lifetime community rating in the setting of private health insurance premiums. For many years, the community rating regulations

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<sup>5</sup> An example of this using data from the Government Employees Health Fund is given in Hall *et al* (1999, Table 4).

governing private health insurance required funds to charge a uniform premium for any given policy regardless of health risk. Lifetime community rating introduces a degree of risk discrimination into premiums by allowing funds to vary premiums according to the age at entry into the fund and the number of years of continuous membership of any fund. This initiative was proclaimed on 29 September 1999 and introduced with effect from 15 July 2000.<sup>6</sup> This allowed a period of around nine months during which private health insurance cover could still be purchased before the new regulations came into effect.

The main characteristics of this initiative were as follows:

- those over 30 years of age who did not have hospital cover by 15 July 2000 would pay a uniform but higher premium over the remainder of their lifetime;
- the increase in premium is calculated as 2% of the base premium for each year of age above 30;
- the maximum increase in premium is 70% which applies to people aged 65 years and above;
- people aged 65 years or more on 1 July 2000 are exempt from lifetime community rating; and
- transfers of membership between funds do not affect continuity for the purposes of lifetime community rating.

The degree of risk rating allowed in setting private health insurance premiums under lifetime community rating is considerably less than full risk rating. In a recent study of the price elasticity of demand for private health insurance in Australia, Butler (1999, Table A.1) found that hospital benefits per privately insured person increased considerably with age. The highest benefits per capita were paid to the 80+ age group while the lowest benefits per capita were paid to the 5-9 and 10-14 age groups. For those aged 20 and above, the ratio of the highest to the lowest benefits per capita varied by State but was at least 6.8:1 for females and 14.6:1 for males. The ratio of the highest to the lowest premiums under lifetime community rating is 1.7:1.

### **Tax Expenditures and Direct Expenditures**

Of the three policy changes outlined above, two (A and B) give rise to Commonwealth government expenditures on subsidies for private health insurance.

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<sup>6</sup> The original effect date of 1 July 2000 was extended because of the large number of people wishing to purchase cover in the run up to the effect date, causing extensive queues and waiting times to lodge applications.

As will be evident from the foregoing discussion, these expenditures take the form of either direct expenditures through the HIC to individuals or health funds, or tax expenditures through tax offsets at the end of the financial year.

Table 2 presents the expenditure estimates through each of these avenues of subsidisation for the three years 1997-98 to 1999-00. Under the tax expenditures category, the Medicare levy surcharge is treated as a negative tax expenditure, representing revenue obtained from high income individuals who chose not to purchase private health insurance. The 30% rebate accounts for most of the expenditures on private health insurance over this period. Overall, total expenditures have increased rapidly each year, reaching \$2,191 million in 1999-00.

Treasury forecasts indicate that tax expenditures on account of the 30% rebate will increase to \$1,130 million in 2003-04, while the negative tax expenditures attributable to the Medicare levy surcharge will fall from \$140 million to \$25 million over the same period. This suggests that, on current trends, total expenditures on private health insurance subsidies will exceed \$2,300 million in 2003-04.

**Table 2**  
**Direct subsidies and tax expenditures for private health insurance**  
**1997-98 to 1999-00 (\$million, current prices)**

	1997-98	1998-99	1999-00
<b>HIC payments</b>			
Cash claims by individuals - 30% rebate	---	6.4	5.9
Payments to health funds - PHIIS	251.6	128.2	---
Payments to health funds - 30% rebate	---	771.9	1391.0
<i>Total HIC Payments</i>	251.6	900.1	1391.0
 <i>Tax expenditures<sup>(a)</sup></i>			
PHIIS	160.0	60.0	---
30% rebate	---	500.0	910.0
Medicare levy surcharge	-105.0	-140.0	-110.0
Total Tax expenditures	55.0	420.0	800.0
<b>TOTAL</b>	<b>306.6</b>	<b>1,320.1</b>	<b>2,191.0</b>

**Note:**

(a) In the source document for tax expenditure estimates, the estimates are reported for the year in which the claim affects the Commonwealth Budget rather than the year in which the claim accrues (which is the preceding year). In this Table, the tax expenditures are reported for the year in which they accrue. The figures for 1999-00 are projections.

**Sources:**

HIC Payments: HIC Annual Reports (various years)

Tax expenditure: Commonwealth of Australia (2001, Table 5.1)

**Effectiveness of Subsidies**

How has private health insurance coverage reacted to the three policy changes discussed above? Figure 1 shows the proportion of the Australian population covered by a hospital table over the period from June 1984 to June 2001. The implementation dates of policies A and B, and the announcement and implementation dates for policy C, are also shown in the Figure.

It appears that policy A (PHIS) had little effect on the long-term decline in hospital coverage. To be sure, the counter-factual scenario is not known—coverage may have declined even further in the absence of the policy. However, this appears to be unlikely as the trend rate of decline appears the same before and after policy implementation. Policy B (30% rebate) does appear to have had some effect. Coverage reached its nadir of 30.1% in the December 1998 quarter, and rose to 32.2% in the March 2000 quarter—a 7% increase in coverage.<sup>7</sup> This time period does overlap with the time period following the announcement of lifetime community rating, but the promotional activities of the government and the health funds regarding lifetime community rating were concentrated in the March and June quarters 2000. Policy C appears to have a dramatic effect on private health insurance coverage. Over the period from announcement to implementation of lifetime community rating, coverage increased from 31.0% to 43.0% (a 39%

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<sup>7</sup> If this entire increase was attributable to the 30% fall in premiums, it suggests a price elasticity of demand of  $-0.23$ . This compares with the estimate provided by Butler (1999) of  $-0.44$  for hospital cover with or without ancillary cover and  $-0.35$  for ancillary cover with or without hospital cover, suggesting that some of the increase in coverage after March 2000 may still have been attributable to the 30% rebate.

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increase). While some of this increase may have been attributable to the 30% rebate as already discussed (see also note 5), the empirical evidence on price elasticities of demand suggests that the bulk of the increase was caused by the looming implementation of lifetime community rating. The 'announcement effect' of premium increases up to 70% after 1 July 2000 gave rise to a sharp increase in coverage, particularly in the June quarter 2000.

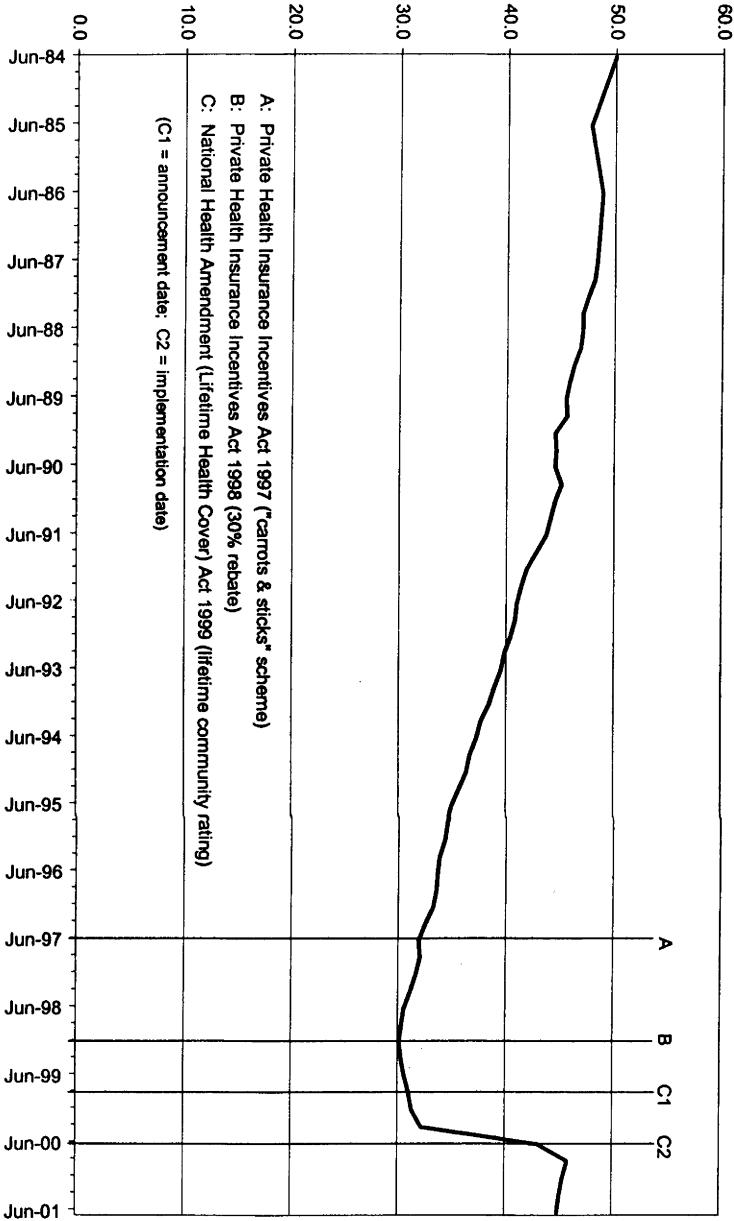
### Conclusions

The Australian experience of private insurance subsidies in recent times provides some interesting lessons on the timing and sequencing of policy changes. Of the three sequential policy changes examined in this chapter, the two involving a cost to government through subsidies for private health insurance premiums were introduced before the policy with no cost to government (lifetime community rating). Yet those two policies with a cost to government appear to have had either no impact on private health insurance (PHIIS) coverage or a modest impact (the 30% rebate), while the third policy appears to have induced a major response at virtually no cost to government. Ironically, a government-funded reduction in premiums appears to have had a much more muted effect on private health insurance uptake than an unfunded announcement of an increase in premiums.

Given the experience of the last 20 years, it is interesting to contemplate what the future holds for private health insurance in Australia. One consequence of the sequencing of policy changes discussed in this chapter will be that government expenditures on health insurance subsidies are likely to increase substantially. This is not because the subsidies have actually induced a major uptake of private health insurance but because lifetime community rating has induced a major uptake and these insurance policies now qualify for a subsidy. In other words, the large increases in expenditures on subsidies will more likely be an *effect* rather than a *cause* of increased demand for private health insurance in Australia.

Another potential consequence is the re-emergence of a downward drift in the proportion of the population covered by private health insurance. This may seem paradoxical, as the introduction of lifetime community rating appears to have addressed an important underlying cause of the decline in private health insurance coverage. This policy change introduced an age gradient into private health insurance premiums and apparently stimulated uptake. Indirectly, this suggests that adverse selection induced by the original community rating regulations was an important cause of the downward spiral in membership. The Industry Commission inquiry also suggested this was the case. Yet the data for the December 2000 quarter and the March and June quarters 2001 each show a fall in the proportion of

the population covered in comparison with the September 2000 quarter (see Figure 1). Will this decline continue?



Consider the following two hypotheses as to the cause of this decline. First, it may be due to a failure on the part of some new members of private health funds to honour their first premium payment, with the result that their policy lapsed. Having applied for cover before the effect date for lifetime community rating (16 July 2000) and been counted as policyholders in the September quarter 2000 statistics, these policies lapsed when the premium payment fell due. If this explains the fall in coverage after the September quarter 2000, then coverage may well stabilise in the future in excess of 40% of the population. Non-payers will disappear from the statistics, and the fall in coverage will be a temporary phenomenon reflecting this 'once off' effect.

A second hypothesis is that the decline in coverage since the September quarter 2000 is due to the re-emergence of an adverse selection death spiral. While lifetime community rating has introduced some degree of risk discrimination into private health insurance premiums, the gradient of premiums by age at entry into insurance is somewhat less than that necessary to achieve full risk rating, as shown earlier in this chapter. As a result, there remains a considerable degree of cross-subsidisation of older members by younger members. This may lead younger members to begin dropping out again, with consequent upward pressure on premiums inducing even more lower risk members to drop out. Hence, while the current version of lifetime community rating may have caused an immediate lift in coverage, there may be sufficient residual cross-subsidisation for an adverse selection dynamic to reappear.

The challenges facing policy-makers in the future depend upon which of these two hypotheses is correct. If the first, and coverage stabilises, then the challenge will be to achieve political acceptability of large government expenditures on private health insurance subsidies which will approach \$2,500 million per year by the middle of this decade. If the second, and coverage continues to fall, then the challenge will be to move further towards full risk rating of private health insurance premiums (e.g. by increasing the penalty on age at entry to 3% per year or more). Failure to do this may lead to another policy challenge—managing the demise of the private health insurance industry.

But the challenges ahead are not confined to policy-making. Further research is needed to deepen our understanding of the interactions between private and public health insurance, and of the role of adverse selection in private health insurance in a system where coverage by a national health insurance scheme is mandatory. While adverse selection appears to be an important cause of the malaise that has afflicted private health insurance coverage, this proposition is not uncontested. For example,



a recent paper by Vaithianathan (2001) has argued that the consequences of adverse selection may have been exaggerated because insurers can design plans to separate risks and hence achieve risk discrimination through self-selection of insureds into different plans. Hence the empirical importance of adverse selection in private health insurance in Australia remains a vexed issue.

In the meantime, to answer the question posed in the title of this chapter, it does seem that the cheapest policy (in terms of cost to the government) really did do the trick—but with a fiscal sting in its tail!

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# **Electronic health records as essential building blocks for the Public Health Information System**

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## **Abstract**

As we develop a national system of electronic health records aimed at improving the efficiency of individual patient care, these records should also be the building blocks for a national health information system that can monitor and inform public health action for the whole population.

The new system must meet high ethical standards and use innovative approaches to the issues of privacy, ownership and access. Because the system must serve the needs both of individuals and the community at large, an exclusive preoccupation with the privacy needs of the individual cannot be allowed to drown out the urgent need for improved data on population health.

We will thus need to reassess the way personal health records are prepared, maintained, stored and accessed. The recent initiative by Australian health ministers to develop a national health information network provides the opportunity for much needed improvement in our public health information capacity. Current health information systems are quite inadequate to the needs and challenges of modern health care

## **Introduction**

Health is both a private and a public matter. No longer is the provision of health care exclusively a private arrangement between a doctor and his or her patient. The state contributes substantially to the costs of the decisions jointly reached in the general practice consulting room, and to what follows from it. The community has a legitimate interest in the consequences of those decisions. Whether the patient is incubating a new strain of influenza, suffering an adverse reaction to a newly released drug, or developing a stress response to their work environment, there are

public health implications for families, neighbors, work colleagues and fellow consumers. (1)

At last we have begun in Australia, to harness the capacity of modern information technology to the needs of individual patients and their practitioners. The development of a system of electronic personal health records, that can be accessed instantly by whoever is authorized by the patient to use them, is now feasible, and planning for them is well under way. (2, 3) At this early stage in the developmental process, we need to re-examine the way our health system uses and manages information, and to look afresh at the information needs of patients, health providers, managers, researchers and the community at large.

### **Two sides of one coin**

Public health is about the health of the whole community. It is axiomatic that the health of the community as a whole is influenced by, and also a consequence of, what is happening to the individuals within it.

For public health practitioners to contribute to improvements in public health, they need greatly improved information systems about the populations under their care. The ad hoc mixture of registers, administrative and financial data-sets, surveys and retrospective morbidity collections on which they depend at present, are inadequate. (1)

Health administrators and public health practitioners do not at present have the essential data on which to understand what is going on, to develop public health interventions, or to manage risk. We should no longer tolerate the huge delays that are routinely associated with the recognition and causal understanding of epidemics such as the recent Legionnaire's Disease outbreak in relation to a Melbourne museum. Nor should we pretend that public health action can be developed responsibly in an information vacuum.

Information that is pertinent to public health action should be available at the earliest possible time to public health researchers and administrators. Every diagnosis of Legionnaires Disease should be instantaneously notified to a central agency so that the circumstances surrounding the event can be immediately explored. Our current indirect systems of notification, many of which depend upon intentional human actions, are slow, laborious, incomplete and relatively ineffective. The information needed by the clinician to manage the individual patient is very often identical to that required by the public health administrator to avert threats to the broader community.

The information entered into the health record of an individual patient by their general practitioner includes much of the same data as that required by the public health practitioner. Individual and public health information, are two sides of the one coin.

### **Ownership**

Who owns my medical record? I certainly have a substantial ownership stake in it, as does the person who maintains it for me (eg my GP). So also does the agency which pays for its storage and ensures its accessibility to others in the health care system whom I may consult in the future.

Other groups besides these three major actors will have an interest in gaining access to my record, although they may not be thought to be the principal owners of it. But if it is properly assembled, consultants, pharmacists, allied health professionals and others will be contributing pieces of information to it, into which they may be investing some of their own intellectual property.

Ownership in the legal sense is thus not clear-cut. The development of the shared electronic record poses entirely new questions about ownership, and we need to recognise that this is a major shift from the situation which obtained when health care was an exclusively private arrangement between one patient and one doctor. With the advent of the electronic age and the many players now involved in health care, we need new thinking about the way we manage issues of privacy, confidentiality and access.

### **Privacy and confidentiality**

Confidentiality and privacy worry us all. There are aspects of my medical history that I may not be proud of, and I may not wish them to be accessible to anyone. Also, we must not permit commercial, insurance or employer interests to exploit information that derives from personal information, and might be used in ways that are inimical to individual interests.

On the other hand, where something in my medical experience can be used to benefit others, without invading my personal space, and without compromising my own privacy or welfare, it should proceed with a minimum of constraint. The new system must clearly be capable of auditing access, and monitoring theft and abuse. It is now possible to achieve this with a high degrees of confidence, and protective systems are already widely used in the finance sector. (3) No electronic systems are, however, absolutely foolproof and imperfection does not justify inaction.

The need to develop perfection in the protection of privacy and confidentiality of individual patient histories should not drown out the need for a well-constructed and protected national information databases that can inform public health action. It is as important that public health practitioners have “real time” data on which to base public health action, as it is for a clinician to have measured the blood pressure before prescribing hypotensive drugs.

### **The vision**

We need a broadly shared vision of the kind of health information system that will best serve both individuals and the Australian community at large. (4, 5) That vision needs to be understood widely in the community, and endorsed by both state and federal governments. The operating philosophy should be that information that is pertinent to the health of the community as a whole, and that resides in individual health records should be accessible in de-identified form to those managing various elements of the Australian Health Care System.

The system design should be the responsibility of the national government. We must at all costs avoid the state “rail gauge” problem, while recognising that the States will be closely involved. The system must include checks and balances to ensure that access to identified data is under the control of the individual whose health it describes (6), and that there is a secure mechanism for authorising access to various parts of the record. The new system should employ a uniform identifier (eg the Medicare number) to link all of the parts of an individual’s electronic record that are distributed in various data warehouses attached to the various elements of the Health Care System.

Individuals need to be able to review all aspects of their own electronic record (6), and should be able to partition parts of it, making them inaccessible to specified categories of health worker or even particular individual’s, but they should not be able to alter it. Simple reports of encounters with various elements of the health care system should contain basic detail of reasons for encounter, new developments, actions taken and expected outcomes.

There will be occasions when, those with access to the de-identified data, will need, in the interests of the individual or the community, to contact the individual, and therefore, be able to access elements of the individual’s identified data file. At this point, there must be rigorous access protocols and audit trails, and mechanisms for detecting and punishing abuse. (1) These mechanisms need to be widely understood in the community, which will need to be reassured that no-one can

“trawl” through their personal records without detection and without appropriate sanction.

### **Political feasibility**

The rancorous debate over the Australia Card in the late eighties, made politicians very wary of issues relating to personal confidentiality in relation to large databases, and rightly so. A consequence for health care has been, however, a preoccupation with individual protection, and protection of data ownership, that has often drowned out considerations of public good. As a result we now have in Australia, inadequate health information systems, that are out of date, and relatively unhelpful by the time they become available to decision-makers.

Fortunately, the bipartisan House of Representatives Committee on health information management grasped this nettle (4), and made some far-sighted recommendations about the way forward. The committee clearly recognised the two sides of the health information coin, and the need to chart new directions in the health industry that is seriously lagging in its application of electronic methods to the management of information.

In the meantime, the banking and tourism industries have moved rapidly to exploit the potential of the internet and the benefits of electronic information storage and security. The Australian public is rapidly coming to understand and accept the benefits of these modern information methods. Moving ahead with an integrated health record and information system (2, 5, 7), that is carefully designed to deliver benefits on both sides of the coin, is, in my view, now politically feasible. But it will be essential that there is open discussion of the methods by which privacy and confidentiality will be protected.

### **Conclusion**

Modern health care is now extremely complex, and has moved a long way from the simple relationship between a physician and his patient that characterized the system only fifty years ago. To ensure that we use scarce resources efficiently and effectively, Australia needs now to make full use of the new capacity offered by information technology. We need to do this as a nation, and to plan carefully the way we address the two sides of the information coin. We have a remarkable opportunity to get it right.

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# Rationalising roles in public hospital funding

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A critical issue for health policy is the way in which hospitals are funded, and especially who funds public hospitals. In 1997/98, recurrent expenditure in the hospital sector in Australia was about \$16.9B, about 36% of total health expenditure and about 2.9% of GDP. Of this expenditure 76% was on public hospitals with the balance on private hospitals. About 47% of public hospital expenditure is by State governments, 45% by the Commonwealth, and the balance by consumers, either out-of-pockets (0.6%) or through health insurance (2.4%), or through third party insurance (5%).

Commonwealth policy on hospital care is principally effected through the Australian Health Care Agreements which essentially provide funding support to States for hospital services with broad accountability in terms of:

- the nature of barriers to access for patients (all patients are to be given the right to elect to be treated as public patients on admission); and
- overall levels of activity, where the Agreement specifies state-specific targets in terms of separation rates.

The current Agreement, signed in 1998, expires in 2003 and this provides an opportunity to revisit what might be the appropriate hospital funding arrangements for the 21st Century.

## **Options for new roles**

Revisiting hospital funding arrangements enables one to revisit whether existing divisions of responsibility are appropriate. There are three broad options for Commonwealth and State roles in relation to hospital funding: pooling, clear separation of funding responsibility and single level of government.

## **Pooling**

The current funding arrangements could be described as a form of funds pooling.



Normally, decisions about which patients to admit are taken at the hospital level and decisions about volume of services at individual hospitals by the State health authority as part of the budget setting process. There is however a significant financial Commonwealth contribution to hospital funding and in 1997/98 Commonwealth funding accounted for about 45% of total public hospital expenditure. Obviously, this type of pooling could continue but there is little accountability to the Commonwealth for the level of hospital expenditure by States. There has been evidence that additional Commonwealth funding does not necessarily lead to additional hospital services, that is, States may reduce their expenditure as Commonwealth expenditure increases.

A second pooling option is for there to be a more explicit pooling and development of rules about joint decision making. Commonwealth and States would agree as to the quantum of money available each year (or over a five year period) in a hospital "funds pool". They would also establish joint decision making processes about the use of funds in the pool. Elements of joint decision making might include the rate of growth of funding over a defined period or rate of growth of activity to be funded from the pool.

Although there has been much advocacy for the creation of a funds pool, the critical policy issue is not what funds go into a pool but how disbursements from the pool are made including the criteria for decision making (i.e. what is the maximand or objective of policy). Decision making rules for the pool might include the use of capitation (and to whom) or the use of casemix funding. Pool rules could specify how the two levels of government might share in changes in productivity and improvements in efficiency. Formalised arrangements about different service mix could also be contemplated in the pool. For example, shifting responsibility for outpatient services from State to Commonwealth could be facilitated by these arrangements as the new Commonwealth expenditure of outpatients would substitute for other Commonwealth expenditure within the pool rather than this change simply being seen as cost shifting.

A major benefit of this sort of funds pooling approach is that it enables increased flexibility of service delivery and deemphasises the boundaries created by the divide of Commonwealth and State responsibilities in the health sector. It would weaken accountability and enhance the likelihood of buck passing as neither party would be clearly responsible for determining the overall level of funding.

### **Separate funding**

The second broad cluster of options relate to separate funding responsibility where

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*either* the Commonwealth *or* the State takes predominant responsibility for funding one component of care. There are four broad options for separate responsibility for hospital care.

The first option, advanced by Scotton and Owens (1990), is for State governments to maintain their funding responsibility for infrastructure and the base level of inpatient activity of hospitals, described in shorthand as the fixed component of care. The Commonwealth, however, would have responsibility for the variable component, including being at risk for changes in inpatient volume. The Scotton and Owens' approach has a number of strengths. For example, it recognises the historical role of the States in provision of hospital care and would assign to States the responsibility for hospital planning and ensuring that the distribution of hospitals is responsive to population need and demand. This is because the capital and infrastructure would remain a State responsibility. Assigning responsibility for variable costs and changes in volume to the Commonwealth government recognises that, when Scotton and Owens proposed their model, the Commonwealth was the predominant level of government with access to growth tax through income and excise taxes. The main weakness of the approach is that the dividing line between fixed and variable costs would need to be clearly negotiated.

A second option for clear separation of responsibilities is to assign responsibility for funding of day stay and ambulatory care to the Commonwealth and for overnight care to the States. Day stay and ambulatory care is growing rapidly as more and more procedures can be undertaken on that basis. Assigning responsibilities for these services to the Commonwealth recognises the Commonwealth responsibilities for medical services outside hospitals and for pharmaceuticals. There is an unclear dividing line as to what services require a hospital admission and what can be done on an ambulatory, non admitted basis and so assigning responsibility for non admitted services to the Commonwealth and overnight services to the States would facilitate links with the existing Commonwealth responsibilities. Further, many same day cases are admitted for delivery of pharmaceuticals and again assigning responsibility for these to the Commonwealth recognises the Commonwealth's responsibility for the Pharmaceutical Benefit Scheme. One weakness of this arrangement is that it might encourage earlier discharge than is clinically desirable (or discouragement of an admission at all) to shift costs from the State to the Commonwealth by avoiding an overnight stay.

A third option to separate responsibility is for elective and maternity care to be assigned to the Commonwealth and responsibility for emergency services to remain

with the States. The virtue of this arrangement is that the Commonwealth has clear responsibility for private health insurance and private hospitals and the predominant reason for consumers taking out private insurance relates to elective surgery needs, given the very small role that private hospitals still play in emergency care. Responsibility for emergency services requires closer links with ambulance services, which are a State responsibility. States also have a closer political involvement because of ambulance bypass and the like.

A fourth option would be to divide responsibility for parts of services rather than on the basis of the nature of treatment. For example, the Commonwealth could assume responsibility for medical and pharmaceutical services provided to inpatients in public hospitals paralleling their responsibility for similar services in private hospitals. The main weakness of this approach would be that it would encourage provision of services by medical practitioners even where people with other qualifications have a more appropriate mix of skills to meet the needs.

A major weakness of all of the separation arrangements is that they weaken intra-hospital integration, that is, the internal coherence of hospitals would be weakened because parts of the hospital, either in terms of components of hospital care or different classes of patients, would have different funding sources. Most hospitals already have multiple funding sources. However, the divisions of responsibilities of the kind outlined in the separation arrangements outlined above would yield a significant increase in those activities of the hospital which would require accountability to different funding sources.

### **Single level of government**

The third main option for allocating responsibilities for hospital care is to assign financial responsibility for hospital services to a single level of government. The immediate question is: which?

Although the new tax system which came into effect on 1 July 2000 will essentially maintain Commonwealth dominance, in that the GST is a Commonwealth collected tax, the arrangements provide for all the GST revenue to be passed to the States. This means that, for the first time, the States have access to a growth tax. The fact that States now have a growth tax means that it is possible to contemplate a greater State role in hospital funding.

There are strengths and weaknesses of either level of government assuming responsibility (see Table 1) which need to be addressed in the event of changed roles.

**Table 1: Summary of factors in assigning responsibility to a single level of government for public hospital funding**

<b>Impact</b>	<b>State responsibility</b>	<b>Commonwealth responsibility</b>
Continuity of care	<ul style="list-style-type: none"> <li>• Link with ambulance services.</li> <li>• Links with non-medical State-funded primary care and public health activities (although the potential for these links has not currently been realised).</li> </ul>	<ul style="list-style-type: none"> <li>• Potential to improve links with primary medical care and aged care services.</li> </ul>
Access to growth funds	<ul style="list-style-type: none"> <li>• GST revenue may provide adequate access to growth funding.</li> </ul>	<ul style="list-style-type: none"> <li>• Commonwealth traditionally seen as having greater potential for growth funds.</li> </ul>
Responsiveness/ Planning	<ul style="list-style-type: none"> <li>• States probably more responsive to inadequacies within system (e.g. waiting times, ambulance bypass).</li> </ul>	<ul style="list-style-type: none"> <li>• Commonwealth typically has stronger planning orientation but weak ability to respond quickly to changed demand patterns.</li> </ul>
Tradition	<ul style="list-style-type: none"> <li>• States traditionally have had responsibility for operational decisions</li> </ul>	<ul style="list-style-type: none"> <li>• Commonwealth <i>modus operandi</i> is dealing with private and non-government sectors.</li> <li>• Commonwealth has track record of funding residential aged care so could feasibly fund public hospitals on casemix basis.</li> <li>• Commonwealth officers have extremely limited experience in dealing with operational issues of the kind typically raised in hospital policy (e.g. ambulance bypass)</li> </ul>
Experimentation	<ul style="list-style-type: none"> <li>• Eight State/ Territory jurisdictions with responsibility allows experimentation</li> </ul>	<ul style="list-style-type: none"> <li>• Commonwealth has funded a number of 'demonstration' projects relating to hospital care</li> </ul>
Economies of scale	<ul style="list-style-type: none"> <li>• No economies of scale but administration costs for hospital system direction are typically low</li> </ul>	<ul style="list-style-type: none"> <li>• Commonwealth responsibility would allow economies of scale in administration</li> </ul>

### **A way forward**

Each option has strengths and weaknesses. None stands out as being unequivocally superior. The options put forward are not necessarily alternatives and so it is possible to think of a mixture of strategies. Although tidy, the single level of government option appears to be off the political agenda (see discussion at the Roundtable conducted by the Senate Community Affairs References Committee as part of its Inquiry into Public Hospital Funding, July 2000; (<<http://www.aph.gov.au/hansard/senate/commtee/comsen.htm>>—Public Hospital Funding 18.08.00 accessed 11.4.2001).

The optimum solution for new roles in the short term would certainly involve a greater level of consultation between the Commonwealth and States. A more explicit consultation framework than exists currently would seem to be essential to allow clearer identification of roles, and more local or regional flexibility in funding arrangements, rather than covert cost shifting as a solution to changes in technologies.

Pooling options are superficially attractive, in part because there is still vagueness about precisely what services are to be pooled and what limitations or commitments might apply to participants. As pooling options are clarified, they may lose their political attractiveness.

The 'rules of engagement' for creation and management of funding pools have real potential for conflict. A critical issue here will relate to funding rules, in particular what will be the arrangements about forward commitment of funds. Will both parties be expected to 'grow the pool' equally? Will the Commonwealth attempt to equalise base funding (including funding for private medical practitioner services which varies significantly across Australia and is not currently subject to Grants Commission equalisation)? What is the objective of pooling i.e. is it about access, efficiency or improving health? What is the nature of the pool?

Financial risk (of growth) is not the only risk to be shared. Commonwealth and states will need to agree on political risk sharing (who can claim credit for what? Who gets to announce openings? Who is to blame for what?).

Issues of risk sharing in part will be affected by the scope of the pool (e.g. what services to be included: hospital care, specialist care, pharmacy services, home and community care). However, determining scope may also create interdepartmental conflict within a jurisdiction if more than one department has policy responsibility in a given area (e.g. for home and community care). Larger states may support sub-

state or regional pools which will be more complex to manage because of cross-boundary flows.

The greatest benefits from pooling options will arise with a larger scope of the pool (maximising opportunities for flexibility and substitution). However, the greater the scope of the pool, the more complex will be its management. Design of pooling policies will thus need to ensure that the benefits to consumers and care-design from pooling are not outweighed by increased transaction costs.

Finally, it is important to note that pooling options may lead to a weakened national commitment to Medicare. The more flexibility that is available within each pool, the more common national principles of access to Medicare may be called into question.

In summary, although widely supported, politically attractive, and superficially 'rational', pooling options entail significant choices and risks. These choices and risks need to be worked through before the first pooling proposal can be implemented. As with the Coordinated Care Trials, it would probably be worthwhile ensuring that the experiences of these first 'pools' be documented and evaluated.

### **Beyond pooling**

Pooling by itself is unlikely to address all of the frictional problems caused by the current division of Commonwealth/State relations. Further, at least in the short to medium term, not all parts of Australia will be covered by pooling arrangements.

A new division of responsibility might also involve increasing the Commonwealth's responsibility for inpatient care by adopting one of the separation options, the most viable being assigning it responsibility for elective and maternity services. This has a number of advantages. The Commonwealth currently has responsibility for private health insurance which, essentially, is about access to elective surgery and/or maternity care. A better targetting of Commonwealth support for elective surgery and maternity care to those in greatest need would obviously be an appropriate policy direction.

The development of casemix funding means that it is now possible for the Commonwealth to fund hospital care without becoming involved in detailed, intrusive regulation of hospital administration or assuming ownership of public hospitals. An elective surgery/maternity care scheme could be implemented by the Commonwealth through the Health Insurance Commission paying hospitals or

states on a casemix adjusted basis, for maternity care and all elective surgery meeting agreed treatment thresholds. The casemix payment would cover medical, pharmaceutical and hospital care.

The Commonwealth, in collaboration with medical practitioners and consumer groups, would develop an agreed priority setting system for elective surgery similar to those in the N.Z. and Canada (Hadorn and Holmes 1997; Feek 2000: see also [www.wcwl.org](http://www.wcwl.org)) as the basis for the treatment thresholds.

The requirement for the Commonwealth to establish clear treatment thresholds would have a number of benefits, including providing additional opportunities for citizen debate about health care priorities. This should allow citizens to be involved in discussion of the tradeoffs between criteria such as pain and function, children versus adults, life extending versus life enhancing treatments etc. Wider debates about allocation of resources, such as the priority for inpatient services vs prevention, could also evolve.

Thresholds and criteria will be published which should reduce the scope for idiosyncratic or discriminatory implementation. Because government subsidies will be tied to care meeting the thresholds, timely access to care will be more related to need rather than income and the over-provision of some surgery would be reduced if not eliminated.

### **Conclusion**

It is obviously desirable for the health care system to address properly the frictional problems it faces and to ensure incentives are appropriately aligned. As a minimalist first step there needs to be some strategy for greater consultation such as that involved in the pooling options.

Our system has not made the progress it should have since Medicare was introduced, on issues of allocative efficiency and hospital links to primary care, access to hospitals (both in terms of elective surgery and emergency care) and appropriate arrangements for teaching and clinical research. This failure is in part because our financing approaches divert attention and political and bureaucratic effort from addressing these issues to unproductive Commonwealth/state conflicts. They also divide our expertise.

Further, an important and worrying development is that the corporate growth in the hospitals sector in the 1980s was succeeded in the 1990s by acquisition of pathology and imaging businesses. The last few years has seen further vertical

integration by large chains with take-overs in primary medical care. Corporatisation is going to change the nature of the health sector. Managing this is not traditional expertise/territory for the states. It will require national responses.

Medicare is a Commonwealth policy—not a state one. All this leads to a conclusion that despite the possible political difficulties of a major realignment of responsibilities, it may be necessary for the Commonwealth to assume direct responsibility for hospital care.

As John Deeble would testify, the introduction of Medibank was highly contested (Scotton and Macdonald, 1993). The next round of reforms may not have the same colourful players nor be characterised by the same level of vindictiveness, but challenging the *status quo* will always be difficult and noisy. The returns, in terms of policy coherence and the capacity to frame sensible policy and program arrangements for the sector as a whole, will however, be great.

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# Securing the future of the Pharmaceutical Benefits Scheme

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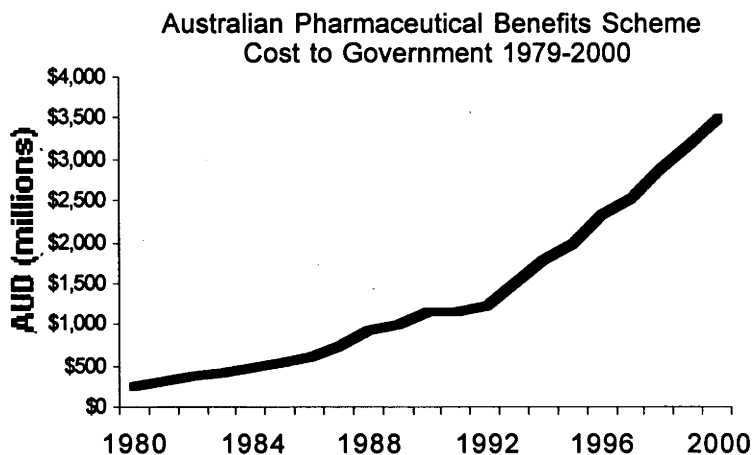
A funding crisis is developing in the Pharmaceutical Benefits Scheme which poses the greatest threat to its existence since the scheme's beginnings more than half a century ago. In response to a growing debate on PBS costs, somewhat crude cost-cutting measures have been proposed which would curtail access to necessary drugs and create substantial equity and medical problems without achieving long-term sustainability of the program. Instead, systemic reform is needed to meet the crisis and secure the survival of the PBS for future generations. We propose a co-ordinated package of changes aimed at ensuring, so far as possible, all drugs on the PBS Schedule are priced and prescribed according to the health benefits likely to be achieved by the patients actually taking them. This would ensure not only large and ongoing cost savings but also the economic and political defensibility of the program.

## **Development of the PBS**

The Pharmaceutical Benefits Scheme (PBS) was introduced amid political furore by the Curtin government in 1944, again enacted by the Chifley government in 1947 after High Court challenge and a constitutional amendment, then confirmed and extended by the Menzies government in 1953. For around 50 years, the PBS has delivered effective, efficient and equitable medicinal care and in the 1970s and 1980s it became an essential component of the comprehensive Medicare program designed by John Deeble.

In 1948/49, Commonwealth expenditure on the PBS was \$298,074. It took until 1987/88 to reach its first billion. It took only another eight years to pass \$2 billion and three more to reach \$3 billion. The current annual *increase* is \$500 million—an amount equal to the annual operating costs of three or four public teaching hospitals. If annual percentage increases continue at these levels, the cost will reach \$15 billion within a decade and will then be rising by \$2 billion a year.

Further threats will emerge with an ageing population and the emergence of gene-based and other new, expensive therapies.



*(Source: Department of Health and Aged Care)*

Various measures have been introduced to control costs but these have not reduced the rate of increase to a level that is sustainable in the long term. Patient contributions have increased substantially and in 1999/2000 raised \$651.8 million. But because the annual rise in co-payments is indexed to the CPI, which is rising far less rapidly than the cost of pharmaceuticals, the co-payment is quickly becoming less significant as an offset of government expenditure. Under the present government, Therapeutic Group Pricing was introduced, by which limited numbers of drugs with similar uses were put into groups, with the PBS setting reimbursement at the cost of the cheapest. While this policy had a significant one-off impact on overall costs, it has been limited to a relatively small number of therapeutic areas and has not fundamentally changed the trend in PBS costs.

In 1987, the government amended the *National Health Act 1953* to require the Pharmaceutical Benefits Advisory Committee (PBAC) to consider cost effectiveness when assessing drugs for listing on the Schedule of Pharmaceutical Benefits. A comprehensive process of assessment was fully in place by 1993. It was a world pioneer and has been a model for similar schemes being introduced in other countries, particularly in Europe. Despite claims from the international pharmaceutical industry, it has not endangered the viability of pharmaceutical

companies operating in Australia and has not prevented important medicines from reaching consumers.

Drug companies lobbied the 'pro-industry' Coalition government, and this culminated in the dissolution of the PBAC on 31 December 2000. A new PBAC was established in early 2001 with a representative of the pharmaceutical industry amongst its members. This marked the end of an important period of eight years in which Australia operated what was widely regarded as the most rational and effective program in the world for using evidence to set and maintain the prices of medicinal drugs.

### **The PBAC and how it works**

The PBAC is required by the *National Health Act 1953* to consider the comparative benefits and costs of therapy when making its recommendations on listing of drugs. By law, the PBAC cannot list new drugs that are more expensive than existing agents unless they offer additional clinical efficacy or reduced toxicity.

Because of the secrecy provisions of the *National Health Act*, a serious lack of transparency surrounds the PBAC processes. The committee finds it almost impossible to say anything meaningful to doctors, pharmacists, consumers, parliamentarians and the public about the reasons why any decision has been made. A company, on the other hand, can say anything it likes about a decision on its own drug.

The placement of a member representing industry interests on the new committee was a particularly inappropriate act. The position for an industry member could crucially determine a tight vote, brings no needed expertise to the committee, and may inhibit committee discussions, particularly if they subsequently become the subject of a court challenge.

Relationships between the PBAC and the medical profession have at times been difficult. Doctors may act legitimately in writing to the PBAC or engaging in stakeholders meetings, but should not act on behalf of pharmaceutical companies, particularly in their negotiations over PBS listing. In a number of instances the financial relationship between some doctors and companies appears to have affected the attitude of individual practitioners and professional bodies. Similar criticisms can be made of some consumer organisations. Media coverage has also been orchestrated to increase the pressure on PBAC to make positive recommendations, sometimes raising unrealistic community expectations.

### **The impact of PBAC decisions**

Are the methods used since 1993 producing the most economically efficient drug purchase and supply system? Are drugs listed on the Pharmaceutical Benefits Schedule genuinely cost-effective?

These questions were addressed in detail in a recent report by pharmaco-economics consultants, the Medical Technology Assessment Group (M-TAG), which derives most of its work and income from the pharmaceutical industry (Davey 1999). The authors examined the performance of the PBS by the classic measures of economic efficiency: technical efficiency (the cost of achieving specified outcomes); allocative efficiency (the ability to allocate resources where they will do most good); and dynamic efficiency (the flexibility to respond to changing circumstances). In all three, the PBS was found to be preferable to all other funding models, including private health insurance.

While the Australian system has made considerable advances toward a genuinely cost-effective PBS, this goal has not yet been achieved. This is important, not only because it inflates government health budgets and prevents money from being spent elsewhere, but because it seriously compromises the political and social case in support of the PBS. As costs rise, that case will need to be articulated with ever greater strength, energy and conviction by those who believe in the efficiency, equity and plain good sense of a drug funding system which is centralised, evidence-based, good value, universal and fair to all.

Although the PBS provides effective pricing control, we do not have control over the dramatic and often unforeseen rises in the use of drugs which are already on the list. The main driver of unsustainably high costs has been a general enthusiasm for these new (and more expensive) rather than older (and cheaper) drugs. In part, this has been a consequence of aggressive promotion of newer and highly profitable pharmaceuticals and the lack of real incentives for doctors to prescribe in a cost-effective manner.

### **Cost control**

With a small number of exceptions, the prices of medicinal drugs in Australia being newly listed on the Schedule of Pharmaceutical Benefits reflect a fair assessment of their worth, and generally have been lower than OECD averages. The problem arises when these drugs, once listed, are used in ways the PBAC did not intend.

The estimates of cost made by manufacturers at the time of listing are often unrealistically low and in practice can be outstripped many times over. Price-

volume agreements have become an increasingly common mechanism for attempting to control post-listing costs. Under these arrangements, a drug which is expected to be heavily marketed and widely prescribed might be subject, as a condition of listing, to a written understanding between the company and the Commonwealth by which, for instance, the second half-million prescriptions in a year carries a lower price than the first half-million. Where 'leakage' (supply to patients in whom cost-effectiveness has not been proved) is thought to be likely, an agreement might be used to strike a lower price for prescriptions that do not comply with the PBS indication.

Presently no adequate mechanism is in place by which formal pricing reviews can be initiated. A mechanism is needed to bring scheduled drugs into such a process and to update existing arrangements where these prove to be inappropriate or inadequate. A degree of legislative muscle would be needed. It would in theory be possible to obtain a lower price or a price-volume agreement by threatening to remove a drug from the schedule but, in practice, removal of drugs which have an established place in clinical practice and which have no direct equivalent is seldom a practical option.

The rewards from the determined implementation of cost control and anti-leakage measures are potentially huge. Hundreds of millions of dollars would be saved by bringing the entire schedule within accepted parameters of cost-effectiveness. Just as importantly, the inevitable increases in cost would become far more defensible, both economically and politically.

### **Reforming the Pricing Authority**

Concerns about price reviews currently conducted by the Pharmaceutical Benefits Pricing Authority (PBPA) and the Department were noted in the 1997 review of the PBS by the Australian National Audit Office. In almost all cases, the auditors found, price reviews were initiated by requests from the companies and were aimed at maintaining or raising prices, not lowering them. (ANAO 1997). The Department agreed with the ANAO, without qualification. But the situation appears not to have changed. The process still does not result in lower prices overall: the PBPA's latest annual report notes that the price adjustments for 1999-2000 add \$7.12 million to the cost of the PBS in a full year. (PBPA 2000). Price review mechanisms remain limited and rely on sponsor companies taking the initiative. This is not satisfactory. The lead suggested in the 1997 ANAO audit report needs to be followed.

### **Prescribing practices**

A truly cost-effective and economically defensible PBS cannot be achieved while the present largely unrestrained prescribing practices of many doctors continue. A substantial degree of flexibility in approaching the problem of 'leakage' is desirable. No system should try to stamp out all prescribing outside the approved PBS indication. But the evidence-based restrictions are being flouted so widely, with such great implications for overall cost and cost-effectiveness, that the future integrity of the PBS is being jeopardised. The other arm of a cost control policy is reform of the organisations addressing prescribing practice. Doctors must be persuaded that high levels of cost-ineffective prescribing pose a serious threat to the entire PBS and are not therefore in the long-term interests either of patients or the profession.

Many organisations are charged with oversight of prescribing policies, including the Health Insurance Commission, the Pharmaceutical Health and Rational Use of Medicines Committee (PHARM) and the National Prescribing Service (NPS). They have made considerable efforts to modify prescribing behavior but they are fragmented, under-resourced, sometimes in conflict with each other, lacking a coherent mandate and tackling an industry with promotional budgets measured in hundreds of millions of dollars. Some of their main techniques—newsletters, feedback of prescriber data—are known to be weak strategies. Because of the legislated secrecy of PBAC decision-making, it has not been possible to coordinate effective prescriber programs with the release of new drugs. Bodies such as the NPS are therefore inhibited in drawing on cost-effectiveness information in framing messages to doctors and consumers.

If the growth in costs is to be contained in the long term, a more aggressive policy of cost control will be required. Inescapably, this must involve prescribing doctors much more actively in taking responsibility for their prescribing costs. There needs to be a much clearer link between the measurement of cost-effectiveness and initiatives aimed at improving prescribing practice.

Company marketing and promotion can greatly increase cost-ineffective prescribing and is often designed with this in mind. Pressure on governments to approve direct-to-consumer marketing must be resisted. At present, companies can advertise and promote any use for its product which is within the terms of its TGA registration, even where this use has been found by the PBAC not to be cost-effective. As this has obvious implications for the PBS, strong consideration should be given to restricting the promotion of prescription medicines to those medical conditions listed in the PBS.

## **Conclusions and recommendations**

In order to ensure a viable future for the PBS we believe that a number of changes need to be made to the operations of the PBAC and PBPA. We have framed these as a series of recommendations:

### **1. *'Love it or lose it'***

- (a) As a matter of priority, the government should re-articulate to the Australian people the central principles of universality, equity and economic efficiency underlying the PBS.

### **2. *Ending the secrecy in PBAC decision-making***

- (a) The legislatively-enforced secrecy surrounding the PBAC's processes and decisions should be ended. The *National Health Act* should be amended to allow the public release of detailed accounts of the PBAC's deliberations on individual drug submissions.
- (b) The revised legislation should include legal protection for committee members and public servants releasing information within the limits of agreed guidelines.

### **3. *Membership of PBAC***

- (a) The position recently established for an industry member on the PBAC should be eliminated.
- (b) Provision should be made for two additional members, taking the total membership to 14. This would provide the Minister with the flexibility to appoint individuals with skills that may be under-represented at any particular time.
- (c) No member of the PBAC should have enduring and serious potential conflicts of interest, such as employment by a pharmaceutical company or related organisation, membership of industry advisory panels or boards, financial retainers, shareholdings or infrastructure support from industry.

### **4. *Relationship between the PBAC and the Government***

- (a) While not intervening in individual listing decisions, the government should communicate clearly its general expectations of the PBAC. In particular, government expectations of overall cost control need to be spelt out.
- (b) There should be much more regular contact between the government and committee chairs.
- (c) The government and the Minister should recognise that the primary responsibility of the PBAC is to the public health, and that requests to

consider the welfare of pharmaceutical companies are incompatible with this primary role and should be the responsibility of the Department of Industry, Science and Resources.

**5. *Cost control***

- (a) A rigorous and continual process of cost-effectiveness review should be extended to drugs already on the Schedule, to ensure they remain appropriately priced despite changing usage patterns.
- (b) Following the enactment of enabling amendments to the *National Health Act*, responsibility for price-setting for new drugs and the review of already-listed drugs should be transferred to a pricing review sub-committee of the Pharmaceutical Benefits Advisory Committee. The Pharmaceutical Benefits Pricing Authority should be relieved of these responsibilities.

**6. *Improving prescribing practice***

- (a) The various committees and organisations responsible for prescriber education and the quality use of medicines should be rationalised, properly resourced and given a new mandate.
- (b) The research, evaluations and decisions which form the PBAC's deliberations should be promptly released to these bodies to help link their prescribing initiatives with the PBAC's economic and clinical information.
- (c) The government should reject attempts to introduce direct-to-consumer advertising of prescription medicines.

**7. *Media policy***

- (a) In line with a more open approach to decision-making, there is a need to develop a more active media strategy, which should involve education of journalists, regular briefings and development of detailed and timely media releases to accompany all PBAC recommendations.

**8. *Relationship between doctors and the pharmaceutical industry***

- (a) There should be an investigation of the influence of industry marketing and promotion activities on the medical profession and on the appropriateness of prescribing practice.
- (b) Professional bodies, such as the medical colleges and societies, should be encouraged to produce guidelines for these relationships and to accept responsibility for their implementation and success.



**9. *Relationship between consumer organisations and the pharmaceutical industry***

- (a) Similarly, the financial relationship between consumer organisations and the pharmaceutical industry should be investigated to determine whether undue industry influence is taking place and whether more appropriate financial support for the consumer sector can be envisaged.

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# Maybe if I were white

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Aboriginal people have been part of this continent's life for 40,000—60,000 years, since time began. That gives Aboriginal people a claim of enormous moral and spiritual power. The exercise of that claim has found voice in different forms over the past 213 years. Whether it was Pemulwy in the east or Yagan in the west, resistance was the response to the encroachment of the colonies on our social and cultural mores, our land and our family lives.

Finding common ground on which alternatives to resistance might be based was difficult. Aboriginal people and colonisers approached life from different perspectives. Conflict flowed from the inability of settlers and Aboriginal people to understand and accommodate the value and belief systems each had inherited over many centuries. One of the earliest recorded instances of cultural misinterpretation occurred in 1791 around the Rose Hill settlement. Convicts and settlers maliciously destroyed the canoe and traded goods of Ballooderry, a local Aboriginal man. Governor Phillip punished the offenders. Ballooderry's personal right under Aboriginal law to punish the offenders however had not been served. He sought further retribution, was subsequently declared an outlaw, was wounded, captured and died in 1796.

As their numbers and settlements grew, the reach of the colonisers became paramount and subjugated the culture and population of Aboriginal Australia. Unlike other British colonies, Aboriginal people had no Treaties with the Crown. Colonial authorities did not recognise Aboriginal people as a valued symbol of the uniqueness of this continent. If Aborigines could not be subsumed as colonial trappings, then they were obstacles to be overcome or fodder to be harvested in the production of goods and services.

The forced separation of Aboriginal people from their identity continued even to the extent that the links between people, country and culture exemplified by names and cultural nationalities were stripped away and re-badged. The ability of Aborigines to live their culture was all the time more limited. Even the more liberal minded administrators were “disappointed” when Aborigines seemed to rebut ‘generous’ offers for them to take up a life any white man would appreciate.

**Maybe if I were white ...**

British expansion into the Australian continent brought with it the view that natives would be controllable so long as they feared the military. The subjection of Aboriginal religion to Christian teachings, the denigration of traditional medicines in favour of western methods and the assumption that Aboriginal people were savages incapable of sustaining social order reflected not the facts but the self serving needs of the colonials.

The fundamental belief that Aborigines were inferior was driven in part by the ethnocentric attitude that European man was at the top of the evolutionary ladder. As Aborigines were lesser beings, colonisers were relieved of the requirement to respect their humanity. In the 1830s however a House of Commons report, critical of the treatment of Aborigines, forced the colonial authorities to look to new strategies. Church and government reserves, that were to increasingly quarantine Aboriginal people for ‘protection and care’, were introduced. In the years following, the Aboriginal population dropped significantly, languages disappeared, culture was decimated and Aboriginal people died. The colonialists had established the ground rules—who Aboriginal people were, how they would be described, where they would live and what their expectations of life would be.

Major changes in absolute and relative population sizes of Aboriginal people and the colonisers brought with them a further shift in the relationship between the two. The colonies were now starting to position themselves to take nationhood for themselves and with it the notion that a moral and temporal attachment to this country as an absolute right flowed from their absolute majority. The rights they sought to garner in nationhood ignored those Aboriginal people claimed.

In 1890, speaking at the Australasian Federation Conference, Alfred Deakin proclaimed: “in this country, we are separated only by imaginary lines ... we are a people one in blood, race, religion and aspiration.” Even as the colonies decided to join together as a nation, “[f]or the first time, a nation for a continent and a continent for a nation”<sup>1</sup> as Barton proclaimed, the drafting of the new Australian

Constitution denied citizenship, franchise<sup>2</sup> and the right to military duty to Aboriginal people.

There was no debate at the 1891 Sydney Convention about the words proposed by Sir Samuel Griffith that would preclude the Commonwealth from making laws in respect of the Aboriginal race in any State. Those words became the discriminatory Section 51 (xxvi) of the Australian Constitution. During the 1897 convention debating what was to become Section 127 of the Constitution<sup>3</sup>, fewer than 195 words were uttered by only five speakers on whether Aborigines should be reckoned in the count of the population. The notion of a non-Aboriginal majority rule came to be the basis on which the colonies formed the Commonwealth and in doing so the basis on which Australia dishonoured Aboriginal people's claims. The drafting of the Constitution failed Aboriginal people.

Aborigines were left to ponder the majority's newfound national identity and exclusive sovereignty. The exclusivity of the participating majority and its continuing denial of Aboriginal moral, spiritual or practical claims were to become the refined tools of oppression against which Aboriginal people would fight. The rule of the majority had become the force of oppression that would replace the military and technological means used by the colonies.

The stated view that Aborigines were a dying and subordinate race and therefore did not need to be considered continued after Federation. During a debate on voting rights Isaacs, the member for Indi in Victoria declared that "the aborigines have not the intelligence, interest, or capacity to enable them to stand on the same platform with the rest of the people of Australia". Early policies continued to group together often disparate groups of Aborigines, often with different languages, different social norms, different behaviours and declared them protected.

The first meeting of Commonwealth and State Aboriginal Authorities was convened in Canberra in 1937. That meeting quickly set about declaring as the first issues to be recorded that "the destiny of the natives of aboriginal origin, but not of the full bloods, lies in their ultimate absorption by the people of the Commonwealth."<sup>4</sup> The distinctiveness of Aboriginal culture was to be eliminated therefore eliminating the Aboriginal problem.

### **Maybe if I were white ...**

Confinement to reserves and church missions continued well into the 20th century. By the 1960s about one third of all Aborigines remained living on reserves. Non Aboriginal managers, rationing and appalling physical conditions made life

unacceptable to most and, despite fears of discrimination and doubts, many sought alternatives outside.

When however Aboriginal Australia did seek to extend and enrich their existence, a new dimension to the relationship between Aboriginal and non Aboriginal people was introduced. Aboriginal people were no longer over there, confined; they were reasonably quickly here, next door. This often brought confrontation and discrimination.

The Aboriginal future had started to shift. Aboriginal people were looking at our lot and asking why is ours so much poorer, so much bleaker, so much sadder. Patten, Ferguson, Cooper and others in the 1930s organised the incredulous disbelief of Aboriginal people into the beginnings of a social change movement that continues today.

Aboriginal people were concerned for our place in Australia as citizens, for education, housing, employment and health services. Aboriginal people wanted to catch up; to have status and access to services that provided an outcome that was equal to that realised by the citizens of Australia; to be treated as Aboriginal people, fairly. But there was a price to be paid.

Citizenship, health, education, housing and other human services they could access were those that were designed for the majority and generally gave no recognition to Aboriginal cultural values. While surrendering the justification for control based on the notion that Aboriginal people were dying out, Australia reinforced another: majority rule i.e. if the majority of Australians were happy with the services on offer, so should Aborigines be.

Non Aboriginal Australia, however, even when they sought the mantle of moral and cultural superiority, found it difficult to accept that Aboriginal people might in fact turn up in some of the same services as they used. In 1949, the matron of King Edward Memorial Hospital in Perth said “[i]t is all very well to talk about the rights of the natives, but I do not think that people who talk in this way would like to be in the next bed to some of these women”.<sup>5</sup>

The contrast between the domestic course of action, so overtly dehumanising, that Australia was pursuing after the conclusion of the second world war and its involvement in establishing with nations across the globe international standards for the protection of Human Rights is striking. In 1948 the United Nations, with an Australian, former Attorney General H.V. Evatt in the chair, adopted the

Convention of the Prevention and Punishment of the Crime of Genocide and the Universal Declaration on Human Rights and established the World Health Organisation. Some in Australia did raise their voices at these double standards. Hasluck, later Governor General, said in the House of Representatives in 1950: “when we enter into international discussions, and raise our voice, as well we should raise it, in defence of human rights and the protection of human welfare, our very words are mocked by the thousands of degraded and depressed people who are crouched on the rubbish heap throughout the whole of this continent.”

The Australian majority continued with policies that maintained their determination of Aboriginal destinies. In NSW in the 1960s when the Minister for Health attempted to force hospitals to cease discriminatory practices against Aboriginal people, he received a reply from the chairman of the hospital board that such change would “lead to trouble”<sup>6</sup>. The AMA acknowledged<sup>7</sup> the immorality of doing nothing but affirmed that Aborigines should be assisted to change themselves, so that they would become part of the non Aboriginal community, “so that they may be in it and of it.” The consistent message was: share in our society, become like us and you and your people have a future, if you don’t, then...

### **Maybe if I were white, Living would be all right ...**

In the 1960s and 70s, the contemporary policy of assimilation did not change the basic premise that the majority culture of Australia should be the only culture of Australia. The special measures taken to assist Aboriginal people were not based on any cultural recognition or distinction but simply on the notion of welfare for a group of disadvantaged people<sup>8</sup>. The physical needs of Aboriginal people had been acknowledged as requiring justified attention. However, the majority again showed us the price for such gains. Hasluck would have had us living as members of a single Australian community “enjoying the same rights and privileges, accepting the same responsibilities, observing the same customs and influenced by the same beliefs, hopes and loyalties as other Australians.”<sup>9</sup>

Notwithstanding that we should become white, many of the discriminatory legislative provisions that adversely affected Aboriginal people were repealed in the 1960s, some would suggest to further encourage assimilation. This decade did however saw the culmination of the work of many Aboriginal and non Aboriginal people to repeal the discriminatory provisions of the Australian Constitution. In 1967 Sections 51 and 127 of the Constitution were altered by the most successful referendum in Commonwealth history. Thereafter the issue of the protection of Aboriginal culture was increasingly raised, but the nature of the discussions and

actions tended to focus on only those aspects of culture that you could hold in your hand or touch, relics and sacred sites.

South Australia and Queensland passed problematic sites protection legislation in 1967. While largely focused on the physical conditions of Aboriginal life, some came to share the views of many Aboriginal activists that culture was more than songs, dancing and paintings; it was a political and human process that sustained people. Nugget Coombs saw the importance of this in 1972 when he advocated the establishment of programs that “makes the maintenance of their cultural traditions a reality”<sup>10</sup>.

The election of the Whitlam government in 1972 brought a reform agenda that clearly supported the best of the changing times but introduced more deliberately and perhaps for the first time a national recognition that the unique qualities and value of Aboriginal culture also needed to be upheld if change in areas of social and economic deprivation were to occur. The passage of the Commonwealth Racial Discrimination Act in 1975, giving effect to Australia’s obligations under the United Nations’ Convention of the Eliminations of All Forms of Racial Discrimination, declared unlawful discrimination on the basis of race, colour, descent or national or ethnic origin. This move provided a basis in law for Aboriginal people to reject the harsh and discriminatory practices and service that had been imposed by some elements of society and to say that Aboriginal culture could no longer be dismissed as irrelevant.

Accompanying this policy shift in the 1970s to Aboriginal self-determination and later to self-management, cultural appropriateness emerged as a fundamental aspect of policy. Over recent years however cultural awareness has increasingly been seen as a soft option. Aboriginal people continue to complain about the inappropriateness of services offered from mainstream health services<sup>11</sup> 25 years after cultural awareness took root as public policy.

These various changes of this nature did not always guarantee that the circumstances and experiences of Aboriginal people would improve. The Tent Embassy erected in 1972 was a sign of how slow the pace of change was, the walk off by the Gurindji at Wattie Creek a sign of their frustration. The first raising of an Aboriginal flag in Adelaide in 1971 led to widespread adoption across the country as a rallying point of Aboriginal activism. Police forcibly evicted the residents of Mapoon in the middle of the night from their homes and them burnt them to the ground. The Yirrkala people took the Commonwealth and Nabalco to the Supreme Court as a sign of their frustration over land rights negotiations. The creation of

community controlled Aboriginal Medical Services was a sign of Aboriginal people's frustration with racist or otherwise unacceptable health services.

Efforts to improve health services to Aboriginal people had until then drawn heavily on government- or church-run Aboriginal specific services. Aboriginal enrolled and registered nurses and other liaison staff worked in some hospitals and community health services. These environments however did not provide the opportunity for Aboriginal people to set the ground rules and to change the cultural paradigm and value base on which services and the notions of quality were based. The practice of medicine even in these services had historically accompanied policies of assimilation and integration and for this reason was viewed with suspicion by many Aboriginal people. The continuing failure of health systems and practice to take into account living Aboriginal cultural values did little to assuage the fear held by Aboriginal people.

The early 1970s saw the establishment of the first Aboriginal community controlled service organisations. The Aboriginal Legal Service and Aboriginal Medical Service emerged from Aboriginal dissatisfaction with their treatment before the law and in health care. These organisations however were dedicated to more than serving Aboriginal people in these specific contexts. There were Aboriginal advancement societies and associations in every jurisdiction across the Commonwealth. What was different was that Aboriginal people controlled these agencies through elected boards of management, they delivered services to Aboriginal communities and most importantly brought together the political and cultural elements of reform in Aboriginal affairs. In the face of a history that subordinated Aboriginal interests and needs to those of the non-Aboriginal majority, Aboriginal people said:

“Why is it they continue to receive the massive funds for hospitals, doctors, aeroplanes and training? Why is it our people here are mostly sick and homeless with no tucker, no water, no roof over the heads, no work and finally no recognition? This sad tale goes on day by day, year upon year ... Where will it end? In spite of this we retain our Aboriginality and our struggle; it is all we have.”<sup>12</sup>

**Maybe if I were white, Living would be all right, But why should I hope for that ...**

Aboriginal people believe recognition of culture is important to health and many other human service endeavours. Culture and identity are central to Aboriginal perceptions of health and ill health. At the service interface these perceptions and



the social interaction surrounding them influence when and why Aboriginal communities use services, their acceptance or rejection of treatment, the likelihood of compliance and follow up, the likely success of prevention and health promotion strategies, the client's assessments of the quality of care and views of health care providers and personnel<sup>13</sup>.

The direction taken by this paper is one postulating a future where a combination of immutable rights are framed. These must firstly, guarantee the protection generally of the fundamental cultural rights and values of Aboriginal people from the predominance of majority rule. History has shown that the majority's will can be applied to minorities unfairly and harshly. We need strong safeguards against this continuing. Respect for cultural rights should not be dependent on the extent of the majority's good will, but on their respect for the law and justice.

Secondly, the right to health care for all citizens should be recognised so that the exigencies of serving the whole population are not used to diminish unfairly or covertly the access to services on grounds of geography, culture or any other distinction. Equitable access to health resources and services is fundamental to the nation's health and self respect.

Without these rights being guaranteed, as Aboriginal people we may well continue to find ourselves in a less advantageous position than other citizens, with little hope that our rightfully different needs will see the light from under the tremendous burden of the majority. With them, Aboriginal people will be empowered to participate fully in Australian life and at the same time encouraged to maintain their cultural outlook, we will be able to be who we are.

**Maybe if I were white, living would be all right**  
**But why should I hope for that when I'm proud to be black**  
Aborigines must be free to control our destiny

## Endnotes

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<sup>1</sup> Barton's Campaign Slogan in favour of Federation

<sup>2</sup> Aboriginal people had voting rights in South Australia at the time of Federation, and Aboriginal people who served during World War II also were able to vote.

<sup>3</sup> Before its repeal by the 1967 Referendum, s127 said, "In reckoning the numbers of the people of the Commonwealth, or of a State or other part of the Commonwealth, aboriginal natives shall not be counted."

<sup>4</sup> Aboriginal Welfare, Initial Conference of Commonwealth and State Aboriginal Authorities, Canberra 21 - 23 April 1937.

<sup>5</sup> Comments were made in 1949 and are cited in Biskup 1973.

<sup>6</sup> Reported in Rowley, 1971.

<sup>7</sup> *Medical Journal of Australia* 1952.

<sup>8</sup> Hasluck, 1988 *Shadows of Darkness*, Aboriginal Affairs.

<sup>9</sup> Reported in *Aboriginal Health and History*, E Hunter.

<sup>10</sup> H.C. Coombs, evidence to the Senate Standing Committee on Social Environment, 1971-76.

<sup>11</sup> *Health is Life*, report on the Inquiry into Indigenous Health, House of representatives Standing Committee on family and Community Affairs, 2000.

<sup>12</sup> Leo Williams, President Central Australian Aboriginal Congress, reported in *Health Business*, Pam Nathan & Dick Leichleitner Japanangka, 1983.

<sup>13</sup> *Cultural Security, A Background Paper*, Health Department of Western Australia, 2000.

# **The Genome Drafts. A book of life or another book of Leviticus?**

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The recent publication of initial drafts of the human genetic code is one of those achievements that change peoples' views of themselves and their existence on this planet. But the genome drafts are more than metaphysical mutations, to use Houellebecq's (1999) term. Looking at the International Human Genome Sequencing Consortium's (2001) colour coded maps printed in Nature on 15 February 2001, the likeness to a global atlas becomes apparent. An accompanying commentary gives the impression that the genome maps are developed to a stage equivalent to the regional and global charts of Mercator, the 16th century cartographer, and contain errors, a few major gaps and large amounts of detail to be added. A more realistic analogy would be with the 2nd century map of Ptolemy which was a very incomplete guide to moving around the world. Global maps reveal the results of innumerable human movements, conquests and colonisations. Genetic maps are a consequence of the scientific drive to understand how living organisms work and to construct new ways of averting harm to, or enhancing, human existence. Common to both is the capability to control; on the one hand through power over geographically defined human societies and on the other through power over individuals acquired by possession of life-altering biological information. It follows that the potential embodied in genetic advances will be exploited within the political, economic and social milieux of the times. But this is not what is implied by all the gene-hype, triumphalism and utopian predictions that accompany the discoveries. Genetics does not operate and never has operated in a societal vacuum. Indeed, it is well to recall that genetics has some parallels with the development of atomic physics.

Until the late 1970s genetics was where atomic physics was in the mid-1930s. Both had a distinguished scientific past, strong theory and a string of Nobel Prize winners, two of whom—Lord Rutherford, physicist in 1936 and Max Perutz, molecular geneticist in 1963—foresaw no practical applications for their respective

sciences. Each was seen as valuable for gaining enlightenment on theoretical issues but not in a manner that would influence human lives. In 1945 atomic physics burst on the world with two bombs that killed nearly 200,000 Japanese. In 1978 genetics erupted from university and biotechnology company laboratories into the world's stockmarkets with recombinant DNA technology (genetic engineering—the transferral of a known gene sequence into the genome of a living organism to yield a specific protein product). Generation of electricity by nuclear reactors (“Atoms for Peace”) and genetic engineering both commenced with almost universal public support and predictions of limitless energy on the one hand and living creatures designed to optimise their value for human well-being on the other. Each vision soured. Nuclear power industries became seen as too closely linked with weapons production, environmentally irresponsible with radioactive wastes and, after widespread fallout from the damaged Chernobyl reactor, as a dangerous way of generating electricity. One major branch of recombinant DNA technology, the genetic modification of food, initially welcomed as a global saviour has become widely condemned as potentially hazardous to human health, ecologically destructive and disruptive to Third World agricultural practices (Anderson 2000).

The dark side of atomic physics led to the consequences of the A-bombs in Japan, Armageddon scenarios during the Cold War, reactor accidents and the prospects of nuclear terrorism. For genetics it has been eugenics—the principle of encouraging those people regarded as having superior qualities to reproduce and discouraging from breeding those deemed to be inferior. Conceived by Francis Galton in the late 19th century before Mendel's work on heredity had been discovered, eugenics subsequently became intertwined with genetics when some early Mendelians, mainly in the USA, mistakenly assumed that complex human traits were inherited in a simple manner. So the eugenic statutes of modern times commenced with the sterilisation of “undesirables” (mostly fertile intellectually handicapped people) in the USA and Scandinavia. This gave the Nazis justification for their increasingly ferocious eugenics program, which culminated in the well-known genocidal slaughter.

Viewed in this manner genetics has not evolved in the seamlessly beneficial way we are often led to expect for future medical applications. Moreover, the most spectacular achievements in atomic physics and genetics were not obtained through the single-minded pursuit of scientific goals. They resulted from ideologically grounded competition between large groups of scientists and technologists. Those in the Manhattan Project were engaged in a race with the Germans to construct a nuclear weapon. The Human Genome Project ended in another race between the publicly funded groups who were committed to making their drafts freely available

and the private sector Celera Genomics who intended to sell the information. There is no reason to assume that the further development of genetics will not be similarly shaped by the cross currents and pressures of future times.

The Consortium's report concluded "Finally it has not escaped our notice that the more we learn about the human genome, the more there is to explore". What needs to be explored for medicine is how genes relate at the molecular level to the development of specific diseases in individuals. A major challenge is to understand the precise nature of genetic predisposition to common serious diseases so that interventions to control harmful effects may be designed.

There is a possibility, most forcefully expressed by the Harvard evolutionary biologist Richard Lewontin (2000) that complete answers to such challenges may never be found. From the instant an egg is fertilised to the day we die genes interact with other genes and a host of environmental factors. One has to account for the ontological process of developing a biological shape and structure, a mind and myriad functional capabilities. What is required is a multi-dimensional understanding of the role of genes in the spatial and temporal development of human structure and function—a far cry from the starting point of a one-dimensional genome map. Lewontin believes that such an understanding will never be achieved because of a high probability of random events resulting from chance associations between all the interacting determinants of human development.

Despite this caveat the genetic determination juggernaut rolls on with scientists well advanced into the post-genomic era. There are strategies for understanding the mechanisms of gene interactions with other genes and environmental factors (functional genomics) and for building a library of the construction details of proteins, the gene products (proteomics). The latter task will probably involve another multinational consortium of scientists because detailed knowledge of protein variants involved in disease will lead not only to more precise diagnostic tests but also to identifying targets for specifically designed drugs and vaccines. Rewards for success will be great.

There is a general acceptance that progress towards practical solutions will be slow because of immense complexity. This view is supported by evidence from studying the simply inherited single-gene (monogenic, Mendelian) disorders. Human haemoglobin variants were the first group of inherited disorders to be investigated at the molecular level (Weatherall 2000). There are around 600 mutations known to affect haemoglobin. Among those carrying identical mutations there are widely varying clinical consequences ranging from rapidly fatal anaemia to no detectable

effects. Such clinical differences are found among affected members in the same family. Similar clinical variation exists between groups of people from different parts of the world who all carry the identical mutation. This has been demonstrated to result from varying adaptive responses to infection by *Plasmodium falciparum* malaria. It all adds up to a complex picture of genes interacting with other modifying genes and environmental factors.

Twin and family studies have found variable but generally low rates of heritability for conditions such as insulin dependent diabetes, asthma and ischaemic heart disease. Most probably these diseases result from varying susceptibility to a wide range of environmental factors determined by many different genes. These genes will each have their own set of modifiers. For cancer the prospect seems to be that many pathways lead through oncogene mutations to common forms of malignancy. If this remains the case, most individual cancers could have different causal mechanisms and thus could be prevented or suppressed only by tailor-made interventions.

There are grounds for being optimistic about eventual practical solutions. The recent history of molecular genetics has been marked by scientific goals reached well before they were predicted, culminating in completion of revised human genome drafts five years ahead of the original schedule. Progress is spurred by huge investment, a highly talented workforce and fierce competition. Spectacular advances continue with high throughput laboratory technology including mass identification of genes and their products by microchips and gene expression arrays and with increasingly powerful bioinformation systems for interpreting the exponentially expanding databases.

Medicine is fast becoming attuned to genetic advances with increasing use of diagnostic gene probes for single-gene disorders, more precise molecular identification of infective agents, and with attempts to develop gene therapy. In its traditional imperialistic and trade demarcating manner the profession tends to see molecular genetics as just another developing specialty (molecular medicine (Semsarian and Seidman 2001)) when in reality all physicians of the future will view disease as subtle molecular variations in cellular mechanisms rather than in terms of pathological effects on bodily systems and organs.

So far genetic advances of clinical utility have been incorporated into screening, diagnostic and therapeutic systems for specific single-gene diseases. It has long been apparent that detection of a harmful mutation for which there is no effective remedy is fraught with problems. Because single-gene disorders are uncommon

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those who suffer from them have been accommodated within the various medical specialities. If and when it becomes possible to fully interpret genetic predispositions to common diseases and to construct effective interventions a health policy threshold will have been crossed in economically advanced countries. Widespread availability of pre- or early post-conceptual predictive tests followed by appropriate action would have to be considered. Accompanying this capability would be a more exact understanding of the interaction of environmental factors with genes. Prudence will be needed to guide applications. For instance, there seems to be little point in attempting to identify the involvement of genes in the destructive effects of smoking on multiple bodily systems for the purpose of constructing a large set of specifically tailored remedial responses. Indeed, a more precise knowledge of predisposing genetic interactions will probably involve as much if not more manipulation of environmental factors than of genes.

A sizeable parallel industry has arisen to consider the ethical, legal and social implications of genetic advances. Building on experience over the last thirty years with genetic and related reproductive achievements, philosophers, ethicists, sociologists and some thoughtful scientists and clinicians have, in general, expressed concern about the probable loss of individual autonomy, threats to privacy, stigmatisation of and discrimination against those regarded as genetically "different" and the potential for inequality in benefitting from the new procedures. Barely considered is how useful advances may be integrated in health policies for whole populations rather than for individuals.

Any planning on a population basis is rendered difficult by the extreme variability of gene effects and the complexity of causal mechanisms. Methods of genetic epidemiology as applied to categorical observations (e.g. normal, abnormal) and genotype-phenotype associations can provide some general guides on the distribution and frequencies of harmful effects (Kaprio 2000). But as demonstrated by experience with BRAC1 and other breast cancer genes (Hopper 1996) and with the relatively common mutations for haemochromatosis (Yapp et al 2001) such information is too imprecise for committing large resources for screening and patient management purposes, nor can it predict the effectiveness of current non-molecular treatments. What is required are whole-population studies on molecular processes such as are being conducted by deCode Genetics on the stable and genealogically well-documented population of Iceland (Gucher and Stefansson 1999) or being planned for the UK Population Biomedical Collection, prospectively involving 500,000 people (Kaye and Martin 2000). In this way a much more informed basis for useful population strategies can be obtained.

Incremental addition of genetic procedures to existing services has occurred in most of the medical specialties and especially in paediatrics and oncology. But any genetic explanations of chronic disease susceptibilities are a different matter covering all ages and most aspects of health. Some gene-influenced diseases such as senile macular degeneration and several forms of dementia typically appear among the expanding numbers of aged persons. There is a paradox with new solutions for serious disease in that they are presumed to reduce costs by removing the need for expensive care but at the same time the enabling technology *sui generis* accounts for the major component in increasing the annual real costs of health care delivery. So it will be for any break-through genetic applications. These will be extremely costly not only in terms of scientific, technological and clinical inputs but also because of the demonstrated need for support services. It is clear from experience with single-gene disorders that most people have little knowledge of fundamental genetic principles and do not understand the probabilistic nature of available options (Kerr 1996). As a result it is difficult for them to make informed choices. Sustained public education is needed along with individual counselling for those contemplating an intervention. This task will not be made any easier by the media-driven high expectations for genetic progress.

It is not clear how people will respond to any new predictive or remedial procedures. Superficially a high acceptance of genetic testing and manipulation could be expected, given the urge for perfection in offspring (an ethically contentious doctrine (Appleyard 1997)) and living in societies where testing for quality is increasingly taken for granted (Nelkin and Lindee 1997). But if innovations are introduced prematurely, without careful planning (which is likely due to commercial pressures), the public response could become adverse. Such has occurred with the genetic modification of food. The issue is important because public demand will influence the nature of investment in genetic technology. Almost everywhere, neoliberal economic policies are reflected by governmental unwillingness to pay for a continually expanding medical sector. It is likely that most if not all useful genetic advances will be covered by patents (Rifkin 1998). Already the high costs of diagnostic tests in the USA are limiting access only to those who can afford them. There should be time to consider other alternatives to using governmental revenue or user-pays principles—say, an additional income tax levy or a superannuation type of health insurance together with safety net access for the disadvantaged. In fact, the oncoming possibilities for genetic applications provide an excellent reason for at last constructing a sustainable and affordable national health policy.



At the very least, efforts to apply expanding genetic knowledge will lead to interesting times, in the sense of the famous Chinese curse, for those with responsibilities for organising health services. It remains to be seen whether the human genome drafts will turn out to be an introduction to the Book of Life, to use the excessive term beloved by journalists. Alternatively, the drafts could end up as another Old Testament Book of Leviticus, that strange, prescriptive and only partly useful set of directions on how to conduct one's life.

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# Three moral imperatives for Australian health care

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John Deeble's contributions to Australian health care provoke reflection about the values that they express.

Medibank was a method of health service financing whereas Medicare concerns service provision as well. The development of both signified several values. These include, high on the list, commitment to equitable access to health care independently of ability to pay at the time of need and commitment to comprehensive service reach and equity.

On a different track, Deeble and colleagues' research into the financing of health care for Indigenous Australians has served as an example of fine scholarly health economic commitment to this high priority area. Their research reflects, above all, humane concern for Australia's least privileged community.

This essay describes three moral imperatives that I propose should shape our future efforts in relation to health care: humaneness, outreach and Indigenous health. Each is visible in the work and concerns of John Deeble: each persists as a challenge in contemporary Australia (and beyond).

## **Humaneness**

Miles Little, founding director of the Centre for Values, Ethics and the Law in the University of Sydney, to whom I owe much as a colleague, has published a book entitled *Humane Medicine*, the central thesis of which is that we stand at substantial risk of losing sight of the humane mission of medicine (Little 1995). This potential loss has all sorts of structural determinants, some of which are obvious, such as the steady intrusion of sophisticated and effective technology into every branch of medical practice. Some determinants are less easily seen. For example, even in quality assurance, *techne* has come to dominate. In our justifiable search for ways

of ensuring that medical and surgical care are safe, we are now flooded with examples from the aviation industry of how to do this. Despite its undeniable virtues, such quality control does not put the captain and the passengers, especially those travelling in Economy, in personal touch with one another. There are things to be learned from the world of technical simulators that have immediate applicability to the development and maintenance of surgical technical competence. To allow these to become dominant means of guaranteeing the adequacy of medical and surgical care is to take a road leading away from the main game of humane care.

Health outcomes have a commendable relevance to the mission of health care; however, we must be clear that the outcomes from care we define as desirable, are consonant with those of the people for whom we are caring. At a recent conference Little (2000) said the following:

In 1995, I was a member of a group in Western Sydney tasked with the task of working out how outcomes might be used as measures of effectiveness and efficiency in the treatment of a number of chosen cancers. The group of about 25 people included most of the legitimate stakeholders in cancer treatment—patient[s] ... doctors, nurses, administrators, health bureaucrats, health economists were all there. After twelve months, we reluctantly agreed that we had reached no useful conclusions. More to the point, we were compelled to admit that we had not even reached a satisfactory understanding of what each group meant by outcomes. For doctors, it had to do with survivals, mortalities and morbidities. For patient[s] ... a satisfactory process of management was part of the outcome. For administrators and bureaucrats, numerical outputs were essential. For economists, cost-benefit practices and equity of distribution of scarce resources were defining parameters.

Little offers several constructive suggestions on how progress might be made. He argues for an ethics of discourse, where clarity in the use of terms is a pre-requisite, along with sensitivity to the legitimacy of the experience, and accounts of that experience, of others involved in the discussion. We must guard against the deceptive familiarity of some words. Care may mean one thing to a patient, another to a doctor. Outcomes, unless explored as a word, may easily lead to separate discussions that then collide as people use the word in different ways. The kinetics of collision generate anger, resentment and disenfranchisement and the end-point of discussion is null.

Some inhumane tendencies operate without our noticing. For example, we celebrate our success in the management of cancer, and for conditions such as childhood leukemia gains have been impressive. Often, though, we do better at delaying recurrence than definitively curing. This is without serious dispute a great achievement, but it creates a new category of need among survivors. Much of Miles Little's energy and that of his colleagues has been directed recently to survivorship. He and his coworkers have found a huge, unmet need among survivors who find themselves without voice and without company.

In *An Intimate History of Humanity*, Oxford historian Theodore Zeldin advances the view that as humans, we have much growth yet to achieve in the use of conversation (Zeldin 1995). Zeldin's central assertion is that it is in meeting new people and speaking with them that we fulfil the greatest potentiality available to us as humans. It is in intimacy nourished through conversation that new knowledge and new ways of understanding open to us.

Through conversation, Little and his coworkers are seeking, even in the shadow of cancer, a new and energising vision of the future for people whose trust in their own bodily future has been shaken to the core. This must take full account of the cancer event. As Zeldin puts it, 'to have a new vision of the future, it has always been necessary to have a new vision of the past'.

There is a terrible price to be paid if we forget the humane purpose of health and medical care. Such forgetfulness can be induced by our dazzling success as much as by our wanting not to think about our failures. Unless medicine continues to be seen as a humane enterprise, with human well-being as its goal, then a most valuable means of expression of societal altruism will be lost.

## **Outreach**

Professor Jeffrey Sachs is director of the Centre for International Development and professor of international trade at Harvard University and an eloquent advocate for a humane approach to the global destruction of human assets such as health. He writes, 'In our Gilded Age, the poorest of the poor are nearly invisible'. Seven hundred million people live in the 42 Highly Indebted Poor Countries where 'extreme poverty and financial insolvency marks them for a special kind of despair and economic isolation' (Sachs 1999).

Sachs compares the 42 Highly Indebted Poor Countries with the 30 highest income countries in the world, among which Australia is numbered. Most of the wealthy countries are in the temperate and snow zones. Among the Highly Indebted Poor

Countries, 39 are tropical or desert societies. Among them malaria, hookworm, sleeping sickness and schistosomiasis run rife. Sachs writes:

All the rich-country research on rich-country ailments, such as cardiovascular diseases and cancer, will not solve the problems of malaria. Nor will the biotechnology advances for temperate-zone crops easily transfer to the conditions of tropical agriculture. To address the special conditions of the Highly Indebted Poor Countries, we must first understand their unique problems, and then use our ingenuity and co-operative spirit to create new methods of overcoming them.

Inequalities of wealth in the world are exceeded by inequalities in scientific advance. Rich countries drain off the research brains of the less developed countries and then apply them to their own purposes.

Australia, by any international reckoning, does well with regard to health. Our health status (measured as Disability Adjusted Life Expectancy) is ranked second, behind that of Japan, of 191 countries by the World Health Organization in its recent report on the world's health systems, although 17th in terms of variation in health across areas and groups (WHO 2000).

Unfortunately, our scientific advance does not easily cross the ecological divide. Sachs uses malaria as an example. There have been advances recently in mapping the genome of the malaria parasite, and so a malaria vaccine might be considered technically feasible. Big vaccine producers, however, lack 'the bottom-line motivation' because of the high costs and likely patent piracy that would deny them profitable returns. There are about 100 million clinical cases of malaria in the world each year. Deaths from malaria are between 1 and 2.5 million per annum worldwide (no-one has an accurate count). The disease is concentrated in tropical and sub-Saharan African countries, South East Asia and the Melanesian countries in the Pacific. Tropical countries cannot be turned into malaria-free zones as has occurred in temperate zone countries because of the intractable environment.

Closer to home, if one has a genuine concern about the unequal spread of health in Australia, it is essential first to listen to what the people say in understanding and addressing its causes. Ten years ago in western Sydney, a visiting Swedish epidemiologist interested in nutrition and Dr Karen Webb, a public health nutritionist, spoke with people in their homes about what they ate. They ate little fruit and few vegetables. So would you if you were a young mum, at home with three children, with no private transport and the fruit shop is much further than the

instant food store. If your menfolk believe that a meal without meat is no good, you're in trouble serving pasta. If you've never tasted lowfat milk and found that it is palatable, you won't buy it. If you've not been shown how to add beans to mince to make a cheap, delicious and hifibre meal, you won't cook it. Have some sympathy for those families who told us that they cannot afford alcohol, and so they use cigarettes which can be a comfort several times a day for the same price.

Giving the people more of what they want may not be good medicine, and what people want by way of harmful lifestyle may be a want because they have never had options sympathetically presented. So there are some things we can do. For example, most of the smokers we surveyed in western Sydney realised they were hooked and wanted to quit. As former UK chief health officer Sir Donald Acheson says, if nicotine replacement were available free on prescription through general practitioners who spent five or ten minutes with the patient to whom the script is given discussing quitting, UK data show we could help 10% of smokers to stop (Independent Inquiry into Inequalities in Health Report 1998). At the moment, many people in the less advantaged groups cannot afford the outlay for nicotine replacement. It is cheaper to keep smoking.

### **Indigenous health**

No discussion of moral imperatives in Australian health care today could legitimately avoid this topic. Rates of severe otitis media are extremely high in many Indigenous communities, particularly in remote areas of Central and Western Australia. In some communities more than one-third of young children have ear drum perforations (Morris 1998). So of the relatively small proportion of Indigenous children attending school, many are profoundly deaf. Yet, in other places and communities, this is a problem easily treated and which is much less common in the first place.

Is this a moral challenge? Certainly it is a social challenge. It is also a technical challenge as dedicated research workers set out to develop the appropriate anti-bacterial vaccines that might prevent this problem. It is a health service challenge as equally dedicated nurses and Indigenous health workers establish antibiotic regimes of high compliance for those children already suffering and in whom prevention no longer remains a possibility. It is a challenge to the patience and tenacity of the teachers who have to add teaching the profoundly deaf to their armamentarium.

Why should Indigenous health be seen as a moral challenge? Because the social changes, the financing of the research and service, the commitment of people's

lives to the cause of improving Indigenous health are all challenges to our society about the extent to which we value our Indigenous people. In that regard some extremely positive things are happening within our society. No one who participated in the various marches for reconciliation in 2000 could fail to notice these.

The University of Sydney's Year 2000 graduating medical students were fortunate to have Mr Chris Sidoti, Human Rights Commissioner, speak to them in the graduation address (Sidoti 2000). He was one of the authors of the report *Bringing them home*, the document that detailed many of the stories of the stolen generation. He made the point that failure of national political leadership had helped make reconciliation a grass roots movement.

The word 'conciliation' comes from Latin via French and shares origins with other words including 'council'. Its root means such things as uniting, gaining good will by friendly acts, soothing, winning, placating. It is a positive word, and 'reconciliation' carries all the gifts of goodness and light implicit in it but as well seeks to restore these qualities, to move from a fraught circumstance to one where conciliation can do its healing and building work.

As Chris Sidoti said to our students, reconciliation is in large part a matter of social justice. He quoted Mick Dodson, former Aboriginal and Torres Strait Islander Commissioner, who has said this about social justice:

Social justice must always be considered from a perspective which is grounded in the daily lives of Indigenous Australians. Social justice is what faces you in the morning. It is awakening in a house with an adequate water supply, cooking facilities and sanitation. It is the ability to nourish your children and send them to a school where their education not only equips them for employment but reinforces their knowledge and appreciation of their cultural inheritance. It is the prospect of genuine employment and good health, a life of choices and opportunity, free from discrimination.

There are many elements in reconciliation that we could explore with great benefit, but at the root of it is the need for us, as non-Indigenous Australians, to recognise our role in the shambles that exists at present and seek a new way of living with Indigenous fellow-citizens. No-one should expect this to be a miraculous event: complex problems are rarely solved except by complex solutions and these take time. The seeking of forgiveness for our part, however, can release healing powers that are unlikely to come from other actions. There is a convergence in the fundamental ideas of many of the



world's great religions, and the notion of penitence and forgiveness is written deep in most of them. This is because of the nature of the human condition where we all make mistakes. The question is how we learn from them and move on.

In health we have the opportunity to do things that could continue to inform and reform the social ethic of this country. By addressing ourselves to the health agenda, we can avoid many of the conflicting ideologies and dysfunctional interpretations of Indigenous life that prevent effective action. Health offers an opportunity for reconciliation through working together toward the common goal of improved Indigenous health. We should take it, hoping all the while that as we work at it, we will establish such competence for reconciliation that the present hostility, meanness and misery will slide quietly into a poorly-lit space alongside other memories of nightmares.

### **Conclusion**

Medicine and health care are profoundly humane enterprises. The linkage among these three moral imperatives is clear. How much technology we use, how fast we get patients home after surgery, how we pay for health care (and this perhaps even less than the others) are matters of secondary significance. What really matters is the extent to which we are meeting people humanely in their moment of need. It is when the humane mission of health care is clearest that we create thought-space and political energy for important consequences other than more care. Without that priming activity, we whistle in the wind.

If we maintain a clear focus on humane care, if we acknowledge the imperative of outreach, if we can then come home and see what needs to be done to bring our Indigenous fellow citizens home as well, we will be on the path to addressing some of the major moral problems that present themselves in clinical practice in Australia today.

### **Acknowledgment**

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# **Dystopia—an examination of the future of Australian health care and medicine**

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My view of the future for Australian health and medicine is a bleak one. Having long since abandoned utopianism, I find myself more and more envisioning a dystopian future. A future, that is, in which utopian dreams have been turned into the kind of dysfunctional reality that humankind seems to produce when it puts its dreams into practice. A lot of well-meaning people will have invested huge effort to create a fair and equitable world, in which peace and justice will prevail. The reality will be quite otherwise. The gaps between rich and poor, between their health, wealth, welfare, access to justice, education and pleasure, will widen. The burgeoning technology that promises so much will prove to be of inestimable benefit to those who can afford it, and in many ways least need it. Commercial interests will prevail increasingly over moral commitments, and multinational companies will increasingly replace nation-states as the centres of political and economic power. Global issues, such as pollution, environmental destruction and global warming, will be endlessly discussed, and endlessly dismissed. Spiritual and aesthetic issues will decline in importance still further, and money will become almost the sole criterion of worth. Universities, health systems, churches and cults will be judged, and will appraise themselves, by their capacity to make profits rather than prophets. All these things will happen in Australia and in most other Westernised countries. Indeed, this pattern of development is seen to be the criterion of successful development. Those countries that cannot make it in such an environment will be marginalised, and seen as 'opportunities for investment' or as 'sources of cheap labour'.

I think that these things are happening now, and I cannot see anything that is likely to change this joyless and destructive progression. At the root of much of this is the science of economics (if it is a science) and the colonisation of values by money (Simmel 1990; Buchan 1997). Economics defines itself as the branch of knowledge

which deals with the distribution of wealth on one hand,\* and (in its more idealistic moments) as 'the study of how men [sic] and society end up choosing, with or without the use of money, to employ scarce productive resources ... It analyses the costs and benefits of improving patterns of resource allocation' (Samuelson 1976, p. 5). The difficulty in practice is that these definitions represent conflicting priorities. The distribution of wealth ties economics to money, to a utilitarian calculus, and to commercial values. The domain of scarce resources is communitarian and socially oriented. I argue that the dominant paradigm is that of handling wealth and managing the monetary economy, a 'neo-classical' paradigm. It is economists of this persuasion who advise and influence the heads of states, who determine whether interest rates will inflict 'necessary pain' in order to adjust the national inflation figures or 'limit the blow-out in the balance of trade'. There are, of course, economists of the communitarian or socially conscious persuasion. John Deeble (Deeble 1999), John Butler (Butler 1999), Norman Daniels (Daniels 1985; Daniels 1996), Robert Evans (Evans 1990) and Gavin Mooney (Mooney 1992) are examples in their different ways. But they work for social change at the margins of mainstream politics. They have their victories, as John Deeble did with Medicare in Australia. At the end of the day, however, some form of 'economic rationalism' dominates, because it is money management which influences politicians.<sup>1</sup>

The problem of money is the primary one. Money presumably began its life as a convenience, as a portable means of trading that meant that an exchange medium could be used in place of barter. Instead of offering goods and services for other goods and services, the direct exchange of materials or actions judged to be of equivalent value by those making the exchange, money became a symbolic medium whose exchange value was set by powers external to the transaction. This was a conception of breathtaking originality. The extent to which money would develop a life of its own could not have been foreseen by the unnamed geniuses who first proposed its use.

Money is far more convenient than exchange of goods and services, and its role as a symbol of value has largely been forgotten. It has become an end-in-itself. It has also become a surrogate for power. It can buy almost anything for those who have no skills themselves, except the skill of making money. To have money confers a greater likelihood of making more. Deploying money in strategic ways brings more money. In financial circles, goods and services have disappeared from the monetary equation. Money circulates. It can be moved electronically because it

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\* This is the basis of one definition listed in the *Shorter Oxford Dictionary*.

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has become a notional entity, an intellectual construct. It can be traded into the future, before anything has even been created which might confirm its value. It began life as a symbol of value, and has become an abstraction against which value is measured.

This abstracting process has reached the point where we think in terms of 'value for money' rather than 'quality of goods or services'. When our motor car breaks down, we are angry because of its cost, because we paid 'good money' for it. Our anger, furthermore, is likely to be more or less proportional to the amount we paid. Our relationship to the workmen who produced the car, to the labour conditions under which they worked, to the philosophy behind the product, are all distanced by the existence of money. Money distances us from each other in our daily interactions, and from the systems we live with in our social lives.

Money thus colonises moral space. It has also colonised political space almost completely. In Australia, there is effectively only one viable political party. We might call it the Economic Realist Party. Like the recognised parties, it has its factions. Just to the left of centre is a faction which insists on emphasising a (heavily qualified) social awareness. To the right, a counter-faction espouses a (qualified) free-market philosophy. Both factions woo the corporate sector, both make gestures toward social welfare. Both temper their ideals with appeals to the central reality of economic restraints.

What has this got to do with health and medicine? Alas, it has a great deal to do with any public services, whether they be in education, transport, housing, roads, defence or health. Levels of services are determined by what we can afford, rather than what we can transact between each other. This is a reality. It is scarcely realistic to suggest going back to some kind of barter system in any Westernised country. But we do need to understand how money alienates us from the sustaining, foundational values which underlie the provision of any services.

The effective colonisation of morals and politics by money and commerce has far-reaching consequences. Commercial values and the notion of the legally binding contract have replaced trust in many relationships, including those between patients and doctors. The ideal of service has been replaced by the legally nuanced 'duty of care'. Our adversarial legal system has entered the space of health services more and more intrusively, so that 'defensive medicine' is now an established (and very expensive) part of health care practice (Tancredi and Barondess 1978; Summerton 1995). The costs of health services have inevitably demanded that commercial and economic ideas, such as 'best practice', 'efficiency', 'cost-effectiveness',

'outcomes' and 'evidence-based medicine' have become more important than human relationships and the nature of the processes of health care. Compassion and time to talk return no dollars that can be easily identified on a balance sheet.

Yet health services are essentially moral endeavours. Governments and other agencies are obliged to provide them because people generally value human life in both quantity and quality (Little 1995). Each person wants to be protected from illness, and, when illness strikes, to be looked after. Each wants some sort of bulwark against the risks and sufferings that illness threatens. If we did not value human life to a significant extent, societies would not permit the expenditure that governments put into health services. Huge amounts of money are committed. Individuals and corporations can become immensely wealthy by supplying goods and services within the health sector. Science and technology continually promise more and better ways to diagnose and cure disease. Life expectancy in Australia was 78.2 years in 1997 (Australian Institute of Health and Welfare 1998). It has increased by more than 20 years in the United States in the last 100 years (Maloney 1981). The last gains have been the hardest and the most expensive, and that is a common pattern of technological advance (Landes 1983).

It is time to recognise that we are in the phase of diminishing returns (Maloney 1981), and to re-examine what we can achieve. And what we can achieve is determined by the availability of money. Although we are told by some that economics is the science of distributing scarce resources, it is really not the resources which are scarce in themselves. It is the scarcity of money that is the problem. If there were more money, we could train and employ any number of doctors, buy CT scanners for every suburb and town, and replace more hips and coronary arteries. We could provide sophisticated services for outback towns, and public health programmes for indigenous communities. Whether this increased expenditure would translate into better public health is another question. It would probably make little difference. The public health parameters for Australia, the UK and the USA are very similar, despite differences in expenditure from more than 14% of GDP in the USA to about 7% in the UK (Australian Institute of Health and Welfare 1998).

It is quite likely we could achieve greater health gains by concentrating on improving the health of those with the greatest health needs—the poor, the elderly, the unemployed, the indigenous groups—but it is far more likely that medical research will continue to be funded for the advancement of high-end technology, such as molecular genetics and gene therapy. These technological wonders *may* produce some benefits, but it is extremely unlikely that they will produce the

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revolutions confidently predicted by scientists at the start of the human genome project. Further, we must ask ourselves who might reap those benefits. The already wealthy (and statistically more healthy), or the poor and needy? Because the medical technology companies inevitably think in terms of profit rather than public service or morality, each advance will come at a price that will be beyond the reach of the disadvantaged, and beyond the reach of governments to subsidise.

I am not predicting the end of society as we know it, nor the end of Western civilisation. What I foresee is something insidiously progressive, a steady and unstoppable drift toward a mode of life anchored firmly in the simple equation of values and money. This *is* the direction of social evolution in Western societies. Levinas's construction of ethics as the responses made necessary by each person's recognition of the vulnerabilities of others (Levinas 1989) will become embarrassingly *passé*, to be replaced by a hard (and eventually dangerous) social Darwinism. The criterion for inclusion in the privileged, surviving group will be the possession of money, and those who cannot buy services will have to do without. Public medical services will, however, linger for a long time, because there are votes still to be had by conceding that they are needed. That lingering, however, will become increasingly painful as the services are constrained and allowed to decay. The basic services available to public patients will indeed be basic.

There may be some good things to come from this attrition. Those who continue to staff the public system (and there will always be some prepared to do so) will need to be remarkably well motivated. They may actually care about others, and about relieving their suffering.

This is a bleak picture indeed, but I believe that something like it is already happening. My only hope is that humankind still values human life in quantity and quality. Public discourse and public action just may be both angry enough and powerful enough to produce something good from the inevitable changes (Habermas 1992). It is hard to see what a reconstructed system of health services might look like within a society which has minimised the moral, spiritual, interpersonal and aesthetic in its life, in favour of the value of money. Unfortunately, I think the axiological void is already developing. Its progress may have been relatively slow, but there are signs that it is gathering speed. The planet is warming, the ozone layer is diminishing, and the gaps between rich and poor, within and between countries, are widening. And while some people seem to care about these things, the people who call the shots are resisting change in the name of economic necessity.

John Deeble, says the letter inviting me to contribute to this volume, 'dared to dream and to work to create a better health care system in Australia.' It invites me to 'Feel free to dream.' This I have done, and my dream is a (qualified) nightmare, from which I would like to awake. Like Karl Popper (Popper 1971) and the sociologist Zygmunt Bauman (Bauman 1995), I believe that wholesale social engineering produces unintended consequences that may be far removed from the ideals which prompted reform. But I still approve of dreaming and still salute John Deeble for his vision and his daring. At a time when our values have been subsumed by commercialism and the market, we need dreamers to free us from the moral resource constraints that are at least as threatening as the monetary resource constraints which dominate our lives. As Bauman writes (Bauman 1995, p. 240)

If anything does matter, it is the redemption of moral capacity and, in the effect, remoralization of human space. To the likely objection 'This proposition is unrealistic', the proper response is: 'It had *better* be realistic'.

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<sup>1</sup> I am aware that the term 'economic rationalism' causes serious cardiac irregularities in the bosoms of some economists, particularly that of Gavin Mooney. It seems to have been an Australian invention, but it has gained international currency as a label for a style of political economy which believes in the wholesomeness and ultimate wisdom of free-market forces. The Australian Broadcasting Commission runs a monthly programme called *Money, markets and the economy*. On 11 February 2001, Barry Clarke hosted a session entitled "The rise of economic rationalism". Introducing the subject, he said:

'Economic rationalism' is a term that's often used in Australia, and sometimes in other countries, to describe a range of economic policies which aim to reduce the extent of government intervention in the economy and to rely more on markets to organise economic activity.

Some of the policies which have come to be associated with 'economic rationalism' include reducing government spending, privatisation and deregulation.

The term 'economic rationalism' was first used by economic journalists in the Australian press in the early 1970s.

It was used when criticising government policies on tariffs to protect Australian industry. They argued the use of tariffs was irrational and that reducing tariffs was a rational policy. In this sense, the term 'economic



rationalism' was used approvingly by those arguing for less government intervention on specific policy issues.

However, economic rationalism was not confined to the tariff debate and came to be used more broadly to argue for a reduction in government intervention per se. This policy shift was particularly noticeable within the Australian Treasury, although the Treasury was not alone in that approach.

Source: Transcript on Internet website -  
<http://abc.net.au/money/vault/programs/prog11.htm>

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# John Deeble: “The Boy Dun Well”

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## **Introduction**

Australians and “Poms” are linked by more than cricket and a penal system which condemned largely poor felons to be pioneer settlers as a result of trivial offences. They share a democratic culture in which the ebb and flow of political debate creates health care reforms which are social experiments. (Campbell (1971)) John Deeble has been at the forefront of such social experiments, driven by a strong “collectivist” perspective to improve health care access and health for disadvantaged groups in countries as different as Australia and South Africa. After seventy years of toil, his efforts can be nicely summarised in Cockney, a species of Londoners who populated many convict ships: “the boy dun well!”

## **Competing social perspectives**

For Deeble’s generation the dominant social value in health care policy was collectivist: a belief that access to care should be determined by need rather than willingness and ability to pay.

Demand, in the market sense, is a desire to have a good or service and having the means to pay for it. However willingness and ability to pay (demand) is distributed unevenly, reflecting often gross inequalities in the distribution of income and wealth. As a consequence its relevance to the determination of access and use of health care is debated, or in the case of Deeble, rejected.

Instead of market criteria as the determinant of health care access and utilisation, collectivists favour the use of the concept of “need”. Need can be either a demand or a supply concept. A patient may seek health care because she feels she will benefit from it (demand side need). A physician may conclude that such a patient’s demand would generate no health benefit for the patient (zero supply side need). In collectivist systems such as Australia’s Medicare and the UK-NHS the usual

principle by which access and utilisation is determined is supply side need, or ability to benefit.

In such systems rationing is determined by the patients ability to benefit per unit of cost. Rationing can be defined as depriving patients of care which will be of benefit to them and which they want to have. Whilst it is easy to define rationing it is less easy to operationalise although the Australian Pharmaceutical Benefits system completed this task nicely until undermined recently by the Government. Such opposition to efficient rationing based on 'need' is, of course, paralleled with opposition to the collectivist system of health care. The recent Government in Australia has pursued its opposition of this ethic by subsidising private health insurance inefficiently (Hall et al (2000)).

Health care policy is about these conflicting paradigms, let us call them the libertarian and the egalitarian. During the early part of the Thatcher-Reagan revolution and the growth of the influence of the libertarian perspective, Alan Williams and I described the attitudes typically associated with the competing viewpoints (Williams and Maynard (1984)). These are set out in table 1 and they remain the currency of contemporary political and policy debates in Australia, Britain and the rest of the world.

These differing perspectives create, in the minds of the protagonists, different idealised health care systems. The idealised characteristics of these systems in terms of how they consider demand, supply, the adjustment criteria to match supply and demand, and the success criteria are set out in table 2.

Usually this idealised structure is what all libertarian and collectivists respectively adhere to. However, in political debate they assert their idealised system's superiority and compare it with the "sad", actual failures performance of their rivals' system. Thus collectivists assert the superiority of their position by advocating their ideal system (table 2) and comparing it with the actual characteristics of the libertarians' model (table 3). The libertarian advocate their ideal system (table 2) and comparing it with the actual characteristics of the libertarians' model (table 3). The libertarians advocate their ideal (table 2) and comparing it with the actual characteristics of the collectivist system (table 3).

Such exchanges are often the kernel of political debate. However they divert the attention of the competing ideologues away from the improvement in the performance of their system, public or private. This requires focused research and policy investment in the micro-economic characteristic of alternative systems and

how incentive systems influence behaviour, both positively and negatively in relation either to the ability and willingness to pay goals of the market—libertarian system or to the need goal of the NHS—egalitarian system.

Deeble has always been clear about his social values ie. the egalitarian viewpoint and the advocacy of the public health care system as a means of achieving these goals. This approach is epitomised in the Australian Medicare system and in Deeble's proposals for the reform of the South African health care system after the downfall of Apartheid.

### **System creation and system performance**

Many health economists put considerable effort into advocacy of the egalitarian or libertarian perspective. This is essential activity because of the continuing political debate and the fluctuations in the dominance of the competing paradigms. However this work often obscures the issues which are essential for the achievement of good system performance. Williams (2001) has noted that health care systems face seven strategic policy choices:

1. How much should be spent on public health care compared with other health interventions not directed at health but which improve the population's health status?
2. What should be the balance between public and private care? No system is solely public or private eg. in the former communist countries, informal, under the table, private payments were extensive.
3. What should be the balance between primary and secondary care? Is the advocacy of a "primary care led NHS" evidence based or mere political rhetoric?
4. treatment, rehabilitation and social support? Is this balance evidence based?
5. How should resources be rationed or, in other words, how should particular treatments be given priority over others? Rationing is ubiquitous, covert, chaotic and unprincipled, with its practitioners not being accountable to Medicare or private insurers.
6. On what basis should finance be distributed so that provider organisations are incentivised to achieve social goals?
7. How should health care workers be remunerated so that their returns are both fair and efficient as a means of rewarding achievement?

Answering such questions requires explicitness about values (social goals) and evidence about how organisations and individuals behave. Often objectives are not explicit and are rarely ranked eg. how much efficiency will you forego to achieve

equity goals, however defined? Usually, even though health care reform is social experimentation which can damage patient and population health just as much as thalidomide or some other dangerous pharmaceutical, policy change is neither evaluated nor evidence based. Health care policy makers do not want to be “confused” by facts.

### **Concluding remarks**

Groucho Marx reportedly said “the secret of life is honesty and fair play. If you can fake that, you have made it”! Honesty and fair play are increasingly threatened by commercial corruption in cricket and in politics. In the latter extensive investment in ‘spin’ usually fails to hide what we all anticipate in that market place: skulduggery and manipulation to achieve and retain power! Globalisation is driven by profits with a similar degree of self-interest and as epitomised in the high price of drugs to poor countries: why are some drugs more expensive in Bangladesh than in Australia?

Honesty and fair play in academia are threatened by these forces. The role of the academic is to challenge power and complacency by logic and evidence. The practitioner has a very privileged position and temptations to depart from honesty and fair play include political favour and riches from the pharmaceutical industry. In the health care policy field some clinical and economic researchers have succumbed to such temptations: there is a market for corruption, with academic and for profit consultancies willing and able to produce poor science and, in doing so, corrupt the evidence base and meet the demands of the purchasers of corruption, the pharmaceutical industry often too intent on wealth rather than health creation!

Deeble has resisted such temptations and robustly advocated the egalitarian approach and accountable public health care systems. Hopefully his efforts will be undiminished for many years to come. The challenge for the next generation is to strive to achieve his accolade: “the boy dun well”!

**TABLE I**  
**ATTITUDES TYPICALLY ASSOCIATED WITH VIEWPOINTS A AND B**

	<b>Viewpoint A (Libertarian)</b>	<b>Viewpoint B (Egalitarian)</b>
<b>Personal Responsibility</b>	Personal responsibility for achievement is very important, and this is weakened if people are offered unearned rewards. Moreover, such unearned rewards weaken the motive force that assures economic well-being and in so doing they also undermine moral well-being, because of the intimate connection between moral well-being and the personal effort to achieve.	Personal incentives to achieve are desirable, but economic failure is not equated with moral depravity or social worthlessness.
<b>Social Concern</b>	Social Darwinism dictates a seemingly cruel indifference to the fate of those who cannot make the grade. A less extreme position is that charity, expressed and effected preferably under private auspices, is the proper vehicle, but it needs to be exercised under carefully prescribed conditions, for example, such that the potential recipient must first mobilise all his own resources and, when helped, must not be in as favourable a position as those who are self-supporting (the principle of 'lesser eligibility').	Private charitable action is not rejected but is seen as potentially dangerous morally (because it is often demeaning to the recipient and corrupting to the donor) and usually inequitable. It seems preferable to establish social mechanisms that create and sustain self-sufficiency and that are accessible according to precise rules concerning entitlement that are applied equitably and explicitly sanctioned by society at large.

**Viewpoint A (Libertarian)**

**Viewpoint B (Egalitarian)**

Freedom

Freedom is to be sought as a supreme good in itself. Compulsion attenuates both personal responsibility and individualistic and voluntary expressions of social concern. Centralized health planning and a large governmental role in health care financing are seen as an unwarranted abridgement of the freedom of clients as well as of health professionals and private medicine is thereby viewed as a bulwark against totalitarianism.

Freedom is seen as the presence of real opportunities of choice; although economic constraints are less openly coercive than political constraints, they are nonetheless real and often the effective limits on choice. Freedom is not indivisible but may be sacrificed in one respect in order to obtain greater freedom in some other. Government is not an external threat to individuals in the society but is the means by which individuals achieve greater scope for action (that is, greater real freedom).

Equality

Equality before the law is the key concept, with clear precedence being given to freedom over equality wherever the two conflict.

Since the only moral justification for using personal achievement as the basis for distributing rewards is that everyone has equal opportunities for such achievement, then the main emphasis is on equality of opportunity; where this cannot be assured, the moral worth of achievement is thereby undermined. Equality is seen as an extension to the many, of the freedom actually enjoyed by only the few.



**TABLE II**  
**IDEALISED HEALTH CARE SYSTEMS**

	<b>PRIVATE</b>	<b>PUBLIC</b>
Demand	<ol style="list-style-type: none"> <li>1 Individuals are the best judges of their own welfare.</li> <li>2 Priorities determined by own willingness and ability to pay.</li> <li>3 Erratic and potentially catastrophic nature of demand mediated by private insurance.</li> <li>4 Matters of equity to be dealt with elsewhere (e.g. in the tax and social security systems).</li> </ol>	<ol style="list-style-type: none"> <li>1 When ill, individuals are frequently imperfect judges of their own welfare.</li> <li>2 Priorities determined by social judgements about need.</li> <li>3 Erratic and potentially catastrophic nature of demand made irrelevant by provision of free services.</li> <li>4 Since the distribution of income and wealth unlikely to be equitable in relation to the need for health care, the system must be insulated from its influence.</li> </ol>
Supply	<ol style="list-style-type: none"> <li>1 Profit is the proper and effective way to motivate suppliers to respond to the needs of demanders.</li> <li>2 Priorities determined by people's willingness and ability to pay and by the costs of meeting their wishes at the margin.</li> <li>3 Suppliers have strong incentive to adopt least-cost methods of provision.</li> </ol>	<ol style="list-style-type: none"> <li>1 Professional ethics and dedication to public service are the appropriate motivation, focusing on success in curing or caring.</li> <li>2 Priorities determined by where the greatest improvements in caring or curing can be effected at the margin.</li> <li>3 Predetermined limit on available resources generates a strong incentive for suppliers to adopt least-cost methods of provision.</li> </ol>

	<b>PRIVATE</b>	<b>PUBLIC</b>
<b>Adjustment mechanism</b>	<ol style="list-style-type: none"><li>1 Many competing suppliers ensure that offer prices are kept low and reflect costs.</li><li>2 Well-informed consumers are able to seek out the most cost-effective form of treatment for themselves.</li><li>3 If, at the price that clears the market, medical practice is profitable, more people will go into medicine and hence supply will be demand responsive.</li><li>4 If, conversely, medical practice is unremunerative, people will leave it, or stop entering it, until the system returns to equilibrium.</li></ol>	<ol style="list-style-type: none"><li>1 Central review of activities generates efficiency audit of service provision and management pressures keep the system cost-effective.</li><li>2 Well-informed clinicians are able to prescribe the most cost-effective form of treatment for each patient.</li><li>3 If there is resulting pressure on some facilities or specialties, resources will be directed towards extending them.</li><li>4 Facilities or specialties on which pressure is slack will be slimmed down to release resources for other uses.</li></ol>
<b>Success criteria</b>	<ol style="list-style-type: none"><li>1 Consumers will judge the system by their ability to get someone to do what they demand, when, where and how they want it.</li><li>2 Producers will judge the system by how good a living they can make out of it.</li></ol>	<ol style="list-style-type: none"><li>1 Electorate judges the system by the extent to which it improves the health status of the population at large in relation to the resources allocated to it.</li><li>2 Producers judge the system by its ability to enable them to provide the treatments they believe to be cost effective.</li></ol>

TABLE III: ACTUAL HEALTH CARE SYSTEMS

	<b>PRIVATE</b>	<b>PUBLIC</b>
<b>Demand</b>	<ol style="list-style-type: none"> <li>1. Doctors act as agents, medicating demand on behalf of consumers.</li> <li>2. Priorities determined by the reimbursement rules of insurance funds.</li> <li>3. Because private insurance coverage is itself a profit-seeking activity, some risk-rating is inevitable; hence, coverage is incomplete and uneven, distorting personal willingness and ability to pay.</li> <li>4. Attempts to change the distribution of income and wealth independently are resisted as destroying incentives (one of which is the ability to buy better or more medical care if you are rich).</li> </ol>	<ol style="list-style-type: none"> <li>1. Doctors act as agents, identifying need on behalf of patients.</li> <li>2. Priorities determined by the doctor's own professional situation, by his assessment of the patient's condition and the expected trouble-making proclivities of the patient.</li> <li>3. Freedom from direct financial contributions at the point of service and absence of risk-rating enables patients to seek treatment for trivial or inappropriate conditions.</li> <li>4. Attempts to correct inequities in the social and economic system by differential compensatory access to health services leads to recourse to health care in circumstances where it is unlikely to be a cost-effective solution to the problem.</li> </ol>
<b>Supply</b>	<ol style="list-style-type: none"> <li>1. What is most profitable to suppliers may not be what is most in the interests of consumers and since neither consumers nor suppliers may be very clear about what is in the former's interests, this gives suppliers a range of discretion.</li> <li>2. Priorities determined by the extent to which consumers can be induced to part with their money and by the costs of satisfying the pattern of 'demand'.</li> <li>3. Profit motive generates a strong incentive towards market segmentation and price discrimination and tie-in agreements with other professionals.</li> </ol>	<ol style="list-style-type: none"> <li>1. Personal professional dedication and public spirited motivation likely to be corroded and degenerate into cynicism if others, who do not share those feelings, are seen to be doing very well for themselves through blatantly self-seeking behaviour.</li> <li>2. Priorities determined by what gives the greatest professional satisfaction.</li> <li>3. Since cost-effectiveness is not accepted as a proper medical responsibility, such pressures merely generate tension between the 'professionals' and the 'managers'.</li> </ol>

<b>PRIVATE</b>		<b>PUBLIC</b>	
<b>Adjustment mechanism</b>	<ol style="list-style-type: none"> <li>1. Professional, ethical rules are used to make overt competition difficult.</li> <li>2. Consumers denied information about quality and competence and, since insured, may collude with doctors (against the insurance carriers) in inflating costs.</li> <li>3. Entry into the profession made difficult and numbers restricted to maintain profitability.</li> <li>4. If demand for services falls, doctors extend range of activities and push out neighbouring disciplines.</li> </ol>	<ol style="list-style-type: none"> <li>1. Because it does not need elaborate cost data for billing purposes, it does not routinely generate much useful information on costs.</li> <li>2. Clinicians know little about costs and have no direct incentive to act on such information as they have – and sometimes quite perverse incentives (ie cutting costs may make life more difficult or less rewarding for them).</li> <li>3. Very little is known about the relative cost effectiveness of different treatment and even where it is, doctors are wary of acting on such information until a general professional consensus emerges.</li> <li>4. The phasing out of facilities that have become redundant is difficult because it often threatens the livelihood of some concentrated specialised group and has identifiable people dependent on it, whereas the beneficiaries are dispersed and can only be identified as statistics.</li> </ol>	
<b>Success criteria</b>	<ol style="list-style-type: none"> <li>1. Consumers will judge the system by their ability to get someone to do what they need done without making them 'medically indigent' and/or changing their risk-rating too adversely.</li> <li>2. Producers will judge the system by how good a living they can make out of it.</li> </ol>	<ol style="list-style-type: none"> <li>1. Since the easiest aspect of health status to measure is life expectancy, the discussion is dominated by mortality data and mortality risks to the detriment of treatments concerned with non-life-threatening situations.</li> <li>2. In the absence of accurate data on cost-effectiveness, producers judge the system by the extent to which it enables them to carry out the treatments that they find the most exciting and satisfying.</li> </ol>	

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## **A health system which cares about health (will be effective, efficient, equitable and loud)**

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There are two main features of health systems which we care about: goodness and fairness. A good system will be effective in improving the health of the population as well as responding to public expectations. Economic efficiency will be optimised by a single insurer. Fairness demands that effective services be available equitably (according to need) and funded progressively (by ability to pay). The twin goals of goodness and fairness are linked: for any given level of investment, those populations which have great inequalities in health and its determinants also have lower life expectancy overall. That is, the health of the worst off in society can act as a barometer of the success of the system in achieving both goodness and fairness goals.

Australia has achieved a reasonably successful health care system, as judged by most goodness and fairness criteria. The Medicare system remains hugely popular and is seen by the public as providing good quality care with high levels of equity of access.

But what does this mean in practice? Through Medicare, Australia has had some success in achieving financial efficiency and fairness goals. In the 1970s, the introduction of Medibank, then Medicare and the Pharmaceutical Benefits Scheme reduced price barriers at the point of medical service delivery and offered a subsidy for prescription drugs for most of the population. Health spending has been kept below 9% of GDP. Attempts have been made to improve access for under-served populations in rural and remote areas and those who face cultural and other barriers. The system as a whole is predicated on a belief in the effectiveness of doctors and drugs as the mainstay of health care, and if equity of good access to these can be achieved, then outcomes will improve.

This health care model is based on an acute infectious disease paradigm, where most loss of life and disability is caused by acute illnesses which the health system can either prevent with vaccines and better public nutrition and hygiene or cure with antibiotics or surgery. The effectiveness of modern medical science against infectious and other acute diseases was responsible for much of the huge extension of life expectancy worldwide in the second half of the 20th century (WHO, 2000). It is this success which now fuels the epidemiological transition where chronic diseases, including cancer, heart disease, diabetes, depression and substance abuse, account for the vast bulk of the burden of disease worldwide, particularly in wealthy countries (World Health Report, 1999). In Australia, death and disability from heart disease, cancer, depression and diabetes now overwhelmingly dominate the ill-health landscape (Mathers, Vos, Stevenson, 1999).

Modern medical science, however, has few cures for these disorders. Instead, sufferers face, at best, a lifetime of symptom control with drugs, with the aim of extending the period between hospitalisations, where expensive treatment buys little health gain.

The world has undergone a late-20th century epidemic of obesity and diabetes. In the early phases of the epidemic, diabetes and heart disease were labelled “diseases of affluence”, where only the relatively well-off in society could afford to be overnourished and under-exercised. Now at the beginning of the 21st century, it is the lower socio-economic groups who have most obesity, heart disease, hypertension, poor micronutrient intake and an excess of risk behaviours like smoking and physical inactivity. Obesity, the “metabolic syndrome” (central obesity, hypertension, insulin resistance and dyslipidemia) and type 2 diabetes (T2DM) are increasingly seen in children and adolescents, fuelled by sedentary leisure industries, fast food and a steep decline in outdoor activity. It is likely that the reduction in cardiovascular mortality seen in the last 40 years in Australia may soon be reversed by this mushrooming of obesity and diabetes in the population (McCarty et al, 1996). In the meantime, morbidity from diabetes (macrovascular disease, renal failure, limb amputations, blindness) escalates demand for expensive treatments without the hope of cure, and severely reduces the quality of life of patients and their families.

If the health system is to improve, or even maintain, the health of the population in these new circumstances, investments need to be made to reduce the incidence of obesity and consequent chronic diseases, while the demand for costly downstream services will continue to grow. There should be a balanced investment in prevention, early detection and management. Currently, most resources for

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diabetes care and CVD are consumed by end-stage treatments, often in tertiary centres, where the return on investment is smallest. The 30 year decline in cardiovascular disease mortality is now offset by steeper rises in hospitalisations for ischaemic heart disease and a burgeoning of expensive (and often repeated) coronary artery surgery and associated procedures.

Australia has achieved some successes in effective prevention from other threats to the public health. The response to the HIV emergency was relatively quick (in global terms) and at many levels—community partnerships, public education, needle exchange programs, safety of the blood supply etc.—with apparently good effect. The growing problem of road deaths and injury in the 1970's was tackled by a combination of legislation (seat belts, helmets, random breath testing) and public awareness, much of this led by health professionals. What seems to characterise these successes is the acute drama of the preventable health problem (the spectre of the AIDS victim, road carnage images, spinal injuries) involving mainly young previously healthy people, including a sprinkling of celebrities. There was also a direct link between known risks and outcomes, so that prevention strategies could have a clear impact in a relatively short time. Public and political support for prevention was high, at least partly because the interventions did not require the majority of people to change daily routines in a major way.

Most of these criteria do not hold for obesity, depression, CVD and T2DM. Older people are mainly affected (although this is changing), onset is insidious, people may have no specific symptoms for years and complications are often viewed as part of the normal process of ageing. In short, no public fear or outrage is stirred. There is no loud public clamour for prevention. Specific causes cannot be directly pinpointed and made targets for prevention as they lie in practically every aspect of contemporary life (sedentary jobs, television, remote controls for everything, the ubiquity of cars, fast food and the inconvenience of deliberate regular activity). It is not surprising then that the evidence base for effective prevention of T2DM at a population level is poorly developed. Most interventions have produced only small effects, if any, and these are difficult to sustain. The response from the medical research community (largely funded by the pharmaceutical industry) has been to invest in genetic and drug research in the quest for marketable magic bullets. However, despite 20 years of searching, the elusive “gene/s for T2DM” have not been found, although many have been prematurely announced. At the same time, weight loss industries and bizarre food marketing (“lite” foods, low fat, no fat, olestra) serve to further degrade the nutritional value of our food and paradoxically accelerate the growth in obesity. Solutions will probably be found at an ecological level, rather than trying to change individual behaviour in an environment which



encourages physical inactivity. For example, the Netherlands has had a long term policy to encourage pedestrians and cyclists in urban areas, and the provision of good quality public transport rather than building more freeways for cars. While most of Europe undergoes the obesity transition, the Dutch remain relatively slim and fit with a lower incidence of heart disease and diabetes. A health promoting physical environment is a public good, requiring deliberate social investment strategies where health considerations feature prominently in long term planning.

In the health services sector, there is increasing evidence that service models organised for patient-initiated acute care are inadequate to deal with chronic diseases. Changes needed to usual practice include, inter alia, (a) re-organisation of practice to establish registers and recall systems to pro-actively organise consultations, (b) expert systems and the use of evidence-based guidelines, so that care can be shared with appropriate others, (c) patient education and negotiated plans for self-care, and (d) information systems support, so that treatment and outcome measures can be reported, and poor progress can be flagged (Wagner, 1996). This model for managing “classical” chronic diseases is probably also most appropriate for depression, which appears to be increasingly common and can be effectively treated with drugs and cognitive therapy, but is characterised by recurrent acute episodes where, because of the nature of the illness, the patient may not initiate treatment. A proactive management model, where patients are routinely followed up, offers the best hope for improved outcomes (Andrews, 2001).

The current system of Medicare rebates does not support these kinds of changes, although the addition of new items may produce some positive results. The fee-for-service model will not, on the whole, encourage the kind of practice which is known to work best for chronic disease management, including early detection and secondary prevention of complications of diabetes, heart disease and depression. Because chronic disease management is likely to dominate clinical work increasingly, these price signals will need major changes to get to best practice in standard primary care settings.

Clinician behaviour will also have to change if diabetes and other chronic diseases are to be effectively managed. The traditional medical model holds that the physician is ultimately in charge of care decisions, and generations of doctors have been trained to look after hospitalised, acutely ill patients. The patient has made one decision only: to place herself in the hands of the physician for the duration of the (short) illness. It is the physician who makes all subsequent decisions about diagnostic tests and treatment. Having made that one initial decision to seek care, the patient is then viewed as passive, accepting and compliant. Interestingly, it is in

the area of chronic diseases management that the substantial literature around “non-compliance” (patient disobedience) has emerged as a source of serious concern by clinicians. In reality, probably more than 95% of the daily self-care decisions are made by patients. These decisions around how to change eating and physical activity patterns cannot be directed entirely by doctors but must be negotiated to fit reasonably into realistic daily schedules.

Medical schools and continuing medical education programs for clinicians need to include education in a new approach to chronic disease care based on health promotion and disease prevention where the doctor’s role is one of adviser and coach rather than one of exercising complete control. The approach to chronic disease care should be one which focuses on providing expertise and support so that patients can make informed choices about living with their condition.

In summary, greater attention must now be paid to the effectiveness of the system in improving outcomes for the population generally: a population increasingly burdened by chronic disease. There are two parts to this task. The first is to improve the effectiveness of primary care in the early detection and management of chronic diseases. The second is to expand the evidence base for more distal health determinants and to act on what is already known. Health professionals must take on greater advocacy and leadership for healthy upstream social policy.

If we maintain the current narrow view of the role of health services in health, we face a growing burden of incurable chronic disease which could bankrupt the system without noticeable health gain. Prevention of obesity, CVD and diabetes poses probably the biggest challenge so far to the inventiveness and resourcefulness of the community which cares about health. We have a good record to build on, a robust public health community, and now sufficient data to act upon. The public imagination is not so far engaged in the obesity/diabetes epidemic, but the rise in T2DM in children may change these perceptions. Preventing obesity in the population will require joint planning with local and state governments so that physical activity is an easy and pleasant option. Health promotion messages alone are unlikely to impact on behaviour unless the environment changes (NHS Centre for Reviews and Dissemination, 2000). Urban and transport planning should also become health business in the same way as tobacco control, good food and safe sex.

A new approach to chronic disease management is also needed in primary health care, where proactive early detection and follow-up systems are linked to care plans which are negotiated with patients. New funding mechanisms linked to information systems will be required to support these changes.

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# Advancing from Australia unfair

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## **Introduction**

This chapter looks at how we might advance equity in Australian health. It argues that the key constraint in doing so is lack of political will. The chapter first looks at some broad economic, social and political issues that surround inequalities in health. These include the myth of the fair go; learning from others, especially in Scandinavia; promoting a more educated society with respect to existing inequalities; and attempting to get the community more involved in 'our' health services.

The paper then turns more specifically to health care policy and inequities there. Some recent government policy is highlighted as creating yet greater inequalities. Finally the paper makes some positive suggestions about a way forward to address equity, based on the need to embrace community preferences and to have the community's values heard in setting the principles for health services in Australia.

## **General issues**

To devise an economic policy to address inequality and, thereby, given the link between low income and poor health, inequality in health, is not difficult. Primarily it would require a much more redistributive tax base with genuine progressive taxation, a higher level of public spending and hence higher taxes. It would then be possible to consider how through appropriate social, education, economic and health policy that increased public spending might be targeted. It might also have to consider the current structure of incentives to business and in particular the relative return on capital versus that on labour.

Within health care the increased spending and the increased quality that would follow, together with taking away the artificial stimulants of tax breaks for private health insurance, would result in the withering away of the private sector. The

introduction of a major element of capitation would allow general practice to be more concerned with public health and be equity focussed. A major effort would be needed to raise the status of public health, especially within the medical profession. It is in public health that the heartland of equity lies. We need MPH courses that train future leaders not just technicians. Existing MBA courses tend to assume that private sector management ideas are transferable first to health and second to the public health care arena. We need specialised public health MBA programs to train top public health people to promote both public health and equity of health and health care for the future.

To propose what is needed in an economic policy to address inequality is thus not difficult. The problem is getting to the stage where such considerations become relevant. Most of the above would currently fall on the deaf ears of our politicians.

### **The key points**

Let me raise a few issues at a broad level.

#### *Killing the myth of the fair go*

Many Australians still cling to the myth of the fair go despite all the evidence to the contrary. We do badly in terms of our tax system. Where we are in the league of public sector spending is very low down, along with the U.S. and Turkey. Where does that leave us in a league table of international social decency?

We have recently had the GST introduced. It remains regressive, especially when it is set along side the other tax breaks that accompany it. The Ralph Report recommended decreased tax on capital gains and on business.

In education about a third of our children in the capital cities attend private schools. We have social division and divisiveness from an early age. That would matter less if we had adequate funding of the state schools.

Inequality is rife in Australian political society. Under this government and indeed the Hawke and Keating governments, inequality in income and wealth have grown. We had at the last Federal election the notion of redistribution of income to the poor being described as the 'politics of envy'.

The society of the fair go? Not today; perhaps yesterday but that is doubtful as yesterday was the time of the Stolen Generations.

*Learning from others as a way of overcoming apathy*

Instead of constantly comparing ourselves to the US, there is a need to break out from behind our veil of apathy and learn from other countries. Especially we can look to the Scandinavian countries. Perhaps the greatest single impediment to the promotion of equity and social justice in Australia is believing we already are a fair country.

*Promoting a campaign of education with respect to the facts that underlie key social issues in this country*

The rise of One Nation was largely a phenomenon of ignorance and neglect. Making Australians more aware of some of the key issues in social injustice might go a long way towards getting change in the system. In a questionnaire to a random sample of the South Australian population, with colleagues we found that the strengths of preference for equity in health increased when respondents were informed with some simple basic facts about the state of Aboriginal health (Mooney et al 1999). It is difficult to ask people to be informed responsible citizens, if they are not treated as such.

Also important is the need to examine where we as a nation are with respect to our indigenous peoples and where they are with respect to the rest of us. We cannot do this unless there is first a national apology for the wrongs we have perpetrated on our original peoples.

*'Laying siege' to the bureaucracy*

Jorgen Habermas the German philosopher argues that there is a need in modern society to 'lay siege' to the institutions that lie between our democratically elected rulers and the people (Habermas 1997). Governments have a responsibility to attempt to control their bureaucracies. There is a need for *citizens* to lay siege to the bureaucracy and influence them in the *principles* they bring to bear on the governance of health, education and the other major institutions of our time. This is crucial, especially when the only values that currently appear to be listened to are those of the market place.

**The health care road travelled**

When we assess health care in terms of equity in the last twenty years, then it would seem that we have failed. Let me examine just two facets of this failure.

We have a very large private sector in comparison with most OECD countries. All private health care is inequitable. The ability of the rich to pay is greater than that of the poor. Thus private care is inequitable. Many Australians argue that those who have private health insurance take the burden off the state and leave more for the poor. That may be true but the divisiveness remains and social solidarity is destroyed. There clearly is an argument for the rich to pay more but let us do it in a fair way as in the Scandinavian model by getting the rich to pay more *in taxation* for the public health care system.

We have seen private health insurance being subsidised to the extent of an additional \$2 billion. That same money could have more than tripled the spending on indigenous health care. The situation is worse than that statement implies. Most of the money that went in subsidies to private health insurance did not affect the amount of funds available for public or private health care. It went directly into the pockets of the rich who already had private health insurance. There is no health justification for this; there were many ways in which the money could have been spent that would have resulted in a better return in terms of the Australian people's health. There is no health care justification for this; only a fraction of the money will provide health care; *all* of it could have done. There is certainly no equity justification for this.

In indigenous health the situation remains appalling and as compared with the gaps between indigenous and non-indigenous health in other countries—the US, Canada and New Zealand—our record is abysmal (Kunitz 1994). We spend (Deeble et al 1998) just 8% more per capita on our indigenous people. Here is a situation where detailed analysis of the social determinants of health is needed. The links between Mabo, land rights, self-determination, self-esteem and health are here to be proved. Progress has already been made in the work of Robyn McDermott and others in the Territory in comparing two communities where one had a genuine community focus and the other did not, the former having much better health status than the latter (McDermott et al 1998).

The bigger issue however in indigenous health is knowing what to do. The NHMRC have been shockingly neglectful of the need to research into solutions or ameliorations of the problems of indigenous health. Research into the social determinants of health in indigenous communities needs now to be balanced by research into what to do.

We do not know what works. In fact we do not know what the objectives should be so that we are badly placed to define what we mean by 'it works'. Those objectives

again need to be defined by the informed community, in this case Aboriginal communities.

In general we lack a base for deciding on the importance of equity and getting the right set of incentives in place to ensure that we do move to a more equitable health care policy and more equitable health. This is no easy task. It requires us to stop treating equity as if we had already achieved it. Too often policy documents from Commonwealth and state health departments pay lip service to equity. What is now needed is to switch attention from the problem to the solutions, to action and interventions that will reduce the inequities that society first created and the health care system then neglected.

### **What now?**

What to do? There is a need to think of health services first and foremost as a social institution. The task of the community would then be to decide what broad set of principles they want to be used as a basis for resource allocation within health care. This is not to argue that the community should or would want to determine priorities in health care or decide where a hospital should be located or which drugs to use or whether a woman should have a hysterectomy or for which age groups women should be screened for breast cancer. These are primarily professionally based decisions and judgments to be made jointly with individual patients or groups of patients but they need to be based on a set of guiding principles which currently are lacking.

It is at this level—the nature of equity, the weight to be attached to it, the concerns for prevention as against treatment, questions of the relativities of patient autonomy, clinical autonomy and community autonomy, who pays and how—all of these issues are ones about which the community of the lay can readily form judgments. Yet they need to be informed and that is crucial. It is not the nitty gritty domain of the professional choosing between drug A and drug B in the treatment of asthma. This is the world of values, about what the nature of the good is that is sought through health services as social institutions. It is essential that this good is defined. Without it we cannot know what health services are about. Once the community has indicated its values, then the bureaucracy must be asked to adhere to them.

It is not that there is no evidence on what the community wants. One survey (Nord et al 1995) found that the public does seem to be rather interested in equity in health care. A study with colleagues in South Australia confirmed that (Mooney et al 1999).



In Perth in March 2000 at a Medical Council meeting both a randomly selected group of Perth citizens and a group of senior health care professionals, including many clinicians, voted overwhelmingly for both greater investment in public health *and for greater equity* in the way that resources are used across this state (Medical Council 2000). That evidence is tentative. For those interested in the pursuit of equity, it is nonetheless heartening.

### **Conclusion**

The political Australia of today is a divided and divisive society. It is not a society of good Samaritans, our politicians seem not to want to foster the altruism and the genuine multi-culturalism of the good Samaritan. Decreasingly does it promote even good Australians.

To make such statements of course requires first that we define the good. No one else has the right to do this than the community. It is one of the disadvantages of our modern liberal democracy that the good is defined in terms of market values—acquisitiveness, avarice and greed—and the optimisation of individual preferences. It is individualistic autonomy that increasingly defines the nature of the good in this country. Given the lack of adequate knowledge for most people to be able to exercise informed rational choice in health care, that leaves a problem.

Public health is about what the public want; it should be driven by the values of an informed community at least as much as the values of science. Foremost it must focus on the autonomy of the public and only thereafter on the health of the public. Health can dominate; it cannot, it should not monopolise—unless that is what the informed public want.

It seems—but the evidence is tentative—that the public want some degree of equity. Two things here: first it is rather shocking that this evidence-base is so tentative. Largely professionals in public health think *we* know and seek to impose our values on others. Can we not learn from the history of indigenous health care in this country? Public health advocacy should be as much about advocating the *public* part, as advocating the *health* part.

Second, if we could firm up on this tentative evidence, what might be the implications? Most fundamentally there would likely be a massive shift of resources from metropolitan Australia to the rest of the country, from hospital to community and a major injection of funds into indigenous health; and the prospect of cardiac surgeons being made unemployed unless they could retrain as public health officers. There would be a big shift in resources from hospital to the

community. If the tentative values of the community were firmed up and the values of equity were to lead, we might genuinely make inroads into health inequalities.

Perhaps however the impact would be minute. Indeed maybe the reason why we have not gone out to find out better what the community wants is because we actually know what they want or at least we worry about what they might want. Just think of the turmoil in high places if the scenario painted above were to be pursued.

There are two conclusions to draw from the above. First given the low status of public health in clinical medical circles, there is little to be lost in trying to determine if the public are prepared to vote more strongly for public health and equity. While one might want to challenge whether the clinical medical fraternity are interested in equity, the evidence from the WA Medical Council Conference (Medical Council 2000) suggests that they may be. Whatever, they—the clinicians—cannot deliver equity; that has to come from public health. It is thus in the best interests of the public's health and the best interests of public health professionals to engage the public. More important still, it is in the best interests of equity.

Second, if we did know which principles the public wanted their health and health care services based upon, if public officials could say 'this is how the public has spake', if community autonomy could lay siege to the social institution that is modern health care, perhaps we could resurrect the good Samaritan, unearth a *genuine* fair go and, who knows, begin to bridge the Australian health divide.

### **Acknowledgements**

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# **Australia and infectious diseases: a challenge to our biosecurity?**

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It is not possible to live in a country free from infectious diseases. It is, however, possible to reduce the risks and to prepare for new problems from such diseases. Further, the advent of emerging and re-emerging infections i.e. diseases that have increased or threatened to increase in the preceding two decades (Institute of Medicine, 1992) has highlighted the need for preparedness. Australia, in comparison to other countries, has rates of occurrence, morbidity and mortality for many infectious diseases that are relatively low. It would be easy to ignore infectious diseases and concentrate on the pressing needs of disease related to, for example, smoking or lack of exercise. This would, however, deny the recent experiences of other countries, as well as our own with respect to the threats arising emerging and re-emerging diseases. It is thus the principle of preparedness that should provide the basis for our thinking about infectious diseases in Australia.

In the last 20 years more than 30 new infectious diseases or organisms have been identified, including the rise of previously sensitive but now antibiotic-resistant organisms. The following examples highlight just three of the challenges that infectious diseases have posed in the last two decades.

- In New York City in the 1990s an epidemic of tuberculosis (TB) occurred, much of it multi-drug resistant (MDRTB). By the time the epidemic was controlled there had been thousands of cases, many deaths and a cost exceeding USD1 billion to instigate and maintain control. The reasons this epidemic occurred are complex and numerous. They include however the failure of public health to identify and solve the problem early; the fact that the interaction of social circumstances including poverty with TB was insufficiently understood; and the fact that detection of MDRTB was delayed due to insufficient support of laboratory functions.

- Creutzfeldt-Jacob Disease (CJD) in humans and Bovine Spongiform Encephalopathy (BSE, or 'mad cow' disease) in cattle occurred in the United Kingdom and other parts of Europe. BSE is believed to have resulted from transmission of the infective agent, called a prion, via production processes which involved feeding bonemeal from cattle to other cattle. Humans are thought to have contracted CJD from consumption of infected beef. Thus far, over 100 people have died from CJD, millions of cattle across Europe have been destroyed in attempts to contain the BSE outbreaks, and the consequent global economic impact on governments, industry and the community is of the order of billions of dollars per annum, and rising.
- All countries throughout the world have reported cases of HIV. The cost of the outbreak in terms of human misery is enormous, and in under-developed countries, particularly in Africa, the impact is felt at all levels of society including the flow-on effects of e.g. the loss of trained schoolteachers. It is now estimated that when 15% of the population is infected (even higher rates exist in some countries) then the GDP falls by about one per cent per year.

In Australia we have seen the arrival of HIV/AIDS, the rise of hepatitis C infections, the impact of drug resistance of various organisms including multi-resistant *Staphylococcal aureus*, and the arrival of newly described organisms such as Hendra virus and Australian bat lyssavirus. Each of these examples highlights the importance of maintaining good public health, including the skills for identifying, diagnosing, treating and preventing infectious diseases. There are many other such examples.

In this paper we make the argument that it is in Australia's national interest to improve control of infectious diseases. In particular, it is timely and essential that we sharpen our focus on our national and regional capacity to respond to current and emergent infectious disease threats. The principle of preparedness should determine our thinking. We frame our argument within the context of 'biosecurity'. Biosecurity embraces the measures taken to protect Australia's public health, primary industry and environment from the entry, establishment and spread of unwanted diseases and pests (Nairn, 2001).

### **Why increase our biosecurity?**

Threats to Australia from emerging infectious diseases are increasing. Australia continues to record exotic pest and disease incursions each year, in spite of having

perhaps the world's most efficient border quarantine inspection systems and strict policies to prevent the easy entry of infectious agents (Nairn, 2001). For example, more "new" animal viral diseases have been identified in Australia since 1994 than in any previous equivalent period. The implications of these incursions for human health are not always apparent but animals have been the most frequent source of newly described diseases in recent years.

Many factors contribute to emerging and re-emerging infectious disease threats. These and their relevance in the Australian context must be considered when examining our national biosecurity. Key forces having an impact on emerging infectious diseases are growing tourism and trade leading to an increase in people and product movements; the evolution of organisms to more pathogenic strains which increases the risk of pandemics, such as for influenza; changes in the environment, ecology and climate which are contributing to increasing vector borne disease which may in part be reflected in the appearance of dengue and Japanese encephalitis in Australia; the lack of a coordinated surveillance and response capacity across the region, combined with instability associated with large scale movements of people and animals in PNG, East Timor and Indonesia.

Australia's national capacity for responding to emerging infectious disease threats within Australia needs to be strengthened. Our national biosecurity infrastructure is spread across a range of Commonwealth and State government agencies and networks involved in health, primary industry and environment protection. A benchmarking assessment of biosecurity capability for State based jurisdictions ranked capability as poor (Phillips, 2001). There is widespread recognition that Australian institutional capacity across the public sector is relatively low and facing heavy pressures, with limited capacity to extend beyond current levels of activity, and with a real need for more support, expertise, leadership and better coordination at a national level.

The impact of globalisation and the very existence of what is effectively a 'global village' as far as infectious diseases are concerned make it imperative that Australia recognises the risks from infectious diseases. The impact of globalisation means not only that goods and services (and people) move readily between countries, but also that trade agreements result in health risks having to be balanced with global agreements about trade. The global village means that people travel while still, at times, incubating an infectious disease. For Australia, we can no longer rely on our island status and long sea voyages to protect our health.

In our neighbouring countries, the lack of capacity to identify, diagnose and control infectious diseases is of particular concern. It is in Australia's national interest to strengthen that capacity because of the direct impact that will have on Australia's ability to manage EID threats to public health, primary industry and to maintain our biological diversity. Indeed, national agencies including ACIAR (Australian Centre for International Agricultural Research), AFFA (Agriculture Fisheries and Forestry which includes AQIS, the Australian Quarantine and Inspection Service), CSIRO (Commonwealth Scientific and Industrial Research Organisation), NCEPH (National Centre for Epidemiology and Public Health), AUSAid, CDN (Communicable Disease Network of Australia and PHLN (Public Health Laboratory Network) and international agencies and networks including WHO (World Health Organization), OIE (Office International des Epizooties), APEC (Asia Pacific Economic Cooperation), ASEAN (Association of South East Asian Nations), PACNET (an e-mail-based communication tool serving the Pacific Public Health Surveillance Network (PPHSN) and the Western Pacific HealthNet (WPHNet)), are engaged in a range of capacity building initiatives across the SE Asian region.

### **Why have we not increased our biosecurity?**

There is increasing global recognition of the complex and challenging issues surrounding infectious diseases. Yet international, regional and national responses to these issues have not been adequate. One major factor is complacency, a belief that 'it can't happen to us' and therefore our effort and resources are better directed elsewhere. The recognition that even countries such as Britain with an excellent public health system can encounter BSE is but one wake-up call. Another is tuberculosis which is usually seen as a disease of poor people which flourishes in the absence of good clinical care and public health systems. Despite this, countries which are not poor and which have competent health systems such as the USA, the UK, Japan, Denmark, the Netherlands, Sweden, and Switzerland have seen either increases in the rate of tuberculosis or at least a slowing in the previous rate of decline. Australia cannot afford to be complacent.

In Australia, a major constraint for developing integrated systems for controlling infectious disease is that the day-to-day responsibility for control lies with the states and territories.<sup>1</sup> Neither organisms nor their vectors (including humans), recognise state borders. As the responsibility lies with states and territories, whether the

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<sup>1</sup> The only exception is the quarantinable diseases such as yellow fever, cholera and plague, for which the Commonwealth has responsibility.

problem is an outbreak, establishment of surveillance or development of a national approach to control, the primary responsibility of those involved inevitably lies with their employer, viz. state and territory governments. Attempts to coordinate a national approach include the establishment of the Communicable Diseases Network of Australia. This has certainly led to better coordination of communicable disease control.

Central to better control of infectious diseases is a clear nexus between research, policy, and practice. A major challenge for ensuring the delivery of more cost-effective services is to sharpen our focus on research priorities for solving practical problems. A good example of this is the relationship between antibiotic prescribing and the rise of drug resistant organisms. From the scientific perspective it is clear that unregulated use of antibiotics leads to more drug resistance. Policies in this regard however are patchy. The transfer of policy to practice is even sketchier. We need research that seeks the opinions of prescribers and specifically identifies the barriers to implementing policy surrounding appropriate prescribing of antibiotics.

Increasing global threats from emerging infectious diseases place new demands on Australia to address regional issues for better control. National and international linkages not only between government agencies but also with the research and private sector are inadequate to meet these new demands. A good example of the need for better linkages is the detection in 1998 of Nipah, a new virus among pig farmers in Malaysia which resulted in 111 deaths and the slaughter of more than one million pigs. Such new viruses have the potential for wide ranging impacts on Australia's public health, primary industry, environment, tourism and trade.

As a global society we have not always used the knowledge and skills that already exist. For instance, we know well how to treat tuberculosis. Indeed we have sufficient appropriate (and cheap) medications to cure virtually all the tuberculosis in the world. Despite this we have not adequately worked out ways to fund and deliver programs. Although in Australia tuberculosis is well controlled, this key issue of ensuring that we apply the knowledge and skills we already have is present for many diseases. We know immunisation prevents disease with excellent cost-benefit ratios. Yet that knowledge is insufficient if we do not know how to translate it into action. Central to this issue is the need for better community education and awareness, and for new fora for public dialogue and debate to inform national priority setting.



### **Sharpening our national focus on biosecurity**

Recent global events, and high level government and industry reports and communiques, contribute a mass of evidence that points to two urgent priorities for Australian biosecurity – first enhanced national and second enhanced regional capacity for systematic and coordinated approaches for disease detection, surveillance and response.

We propose that a ‘whole of government’ approach, with community and industry support, is required to sharpen national focus on the following key elements:

- *New and better linkages across the government, research, industry and community sectors.* Biosecurity issues are complex and wide ranging, impacting on health, primary industry, environment, science and technology, trade, tourism, regional and international relations. Accordingly, the national response to these issues must be coordinated across a range of government agencies, and with the support of the community, and research and private sectors where appropriate.
- *Better clinical and epidemiological information for assessment of biosecurity risks.* This needs to be contemporary, accurate and informed by high quality laboratory systems. Australia has improved surveillance of many diseases (and/or vectors) but there are still considerable knowledge gaps and an even greater gap in our capacity to interpret the information we already have.
- *Better use of technology.* Rapidly changing technology provides immense opportunities for facilitating better surveillance and intelligence for disease control. The use of remote sensing, geographic information systems, remote data entry all provide promise as tools for predictive modelling and decision making. At the moment, however, their use is limited. It is in Australia’s national interest to develop world-class capability for exploiting these technologies through better management, training and application of research. This will not only protect our public health, domestic animals and wildlife, but increasingly will protect access to export markets. Evidence of freedom of disease and disease hazards, are essential requirements for trade agreements regulated by the World Trade Organisation.
- *Enhanced and more flexible laboratory capacity.* In recent years laboratory capacity to investigate outbreaks has diminished due to changes in funding mechanisms. This in itself is not a problem provided identified funding is available to deal with new tests and new diseases, however in

general, laboratories are finding it increasingly difficult to initiate new or improved activities.

- *Improved, rapid diagnostics.* Central to national biosecurity is the need to detect new and exotic diseases quickly. Rapid global advances in science and technology are revolutionising the way diseases and organisms are diagnosed, providing important new opportunities for harnessing Australia's world class research expertise for addressing real and pressing issues.
- *Enhanced capacity for policy analysis to inform public services.* Australia's capacity to analyse evidence, develop policy options and evaluate policy outcomes remains quite limited across an over-stretched public sector.
- *Enhanced capacity for applied research.* Research across the whole spectrum of issues surrounding biosecurity is needed from biomedical and clinical research, through to population-based, social and behavioural research. Coordinated investment in priority driven research and development programs, appropriately geared to meet strategic government and industry needs, is essential.
- *Systematic responses to legal and ethical issues.* Renewed and ongoing attention needs to be directed to assessing the impact of emerging biosecurity issues on legislative and ethical frameworks, and maximising opportunities for associated public dialogue and debate. Occasionally, the interests of the individual and the state may conflict, requiring considerable and considered debate. This should, preferably, be done in the absence of a crisis.
- *Enhanced public communication and education.* The knowledge of the general public is of paramount importance in both the support of enhanced biosecurity and the management of biosecurity matters. This needs to be managed, and not left entirely to the ad hoc reporting of the news media.
- *Political commitment.* Such commitment is essential to ensure appropriate effort and resources are directed to building national capacity for responding to emerging infectious diseases.

### **The dream: better infectious diseases control for enhanced national biosecurity**

What do we need for better infectious disease control? We need a well-functioning system that includes all the factors listed above, for all the States, Territories and Commonwealth. It needs to be closely linked to our regional neighbours, to be responsive and pro-active. It needs to provide a service that is useful. Considering the current global and national climate it may be time to establish a national

coordinating body, such as an 'Office of Biosecurity' to focus our efforts on building our national biosecurity systems. Whatever actions are decided, it is essential that we build on our existing national infrastructure and systems through new and better linkages and targeting of resources with a focus on outcomes. New and strategic approaches for tackling what is an increasingly important issue must have the endorsement of all of the States, Territories and Commonwealth, and be funded and managed appropriately.

Most fundamentally, however, we need a shift in philosophy in dealing with infectious diseases. The priority is to adopt the principle of preparedness. It is that which provides the key to how we can best address the issues of infectious disease policy formulation.

The potential benefits are better detection and surveillance contributing valuable intelligence about emerging infectious disease threats; more coordinated response mechanisms; a more stable foundation for trade negotiations and tourism, and increased market access through knowledge of existence/freedom from disease within Australia and abroad; increased security across our public health, primary production and environment sectors; and ultimately a more stable and prosperous region. There is benefit for both the Australian population at large and professionals in knowing that we are prepared and able to meet the challenges ahead

### **Conclusion**

It is in Australia's national interest to respond to increasing threats from global emerging infectious diseases. New national policies, strategies and resources are required to support systematic and coordinated biosecurity programs and initiatives across what is a currently over-stretched public sector. Coordinated, strategic investment in priority driven research and development programs, appropriately geared to meet strategic government and industry needs, is essential.

The real challenge is to maintain expertise and vigilance when the risks are relatively small. We can not predict when or what the next challenge will be for infectious disease control, but we can be certain that challenge will come.

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# **A GODS analysis of Medicare: Goals, Obstacles, Deficiencies, Solutions: or, in what form should we adopt managed care?**

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## **Introduction**

The discussion of health sector reform commonly adopts an analytical framework which obscures the overriding importance of health sector objectives. One such approach commences with the observed problems associated with access, cost or outcome and then evaluates the alternative solutions (Richardson 1998). Policy recommendations from this approach necessarily reflect the problems that have been selected or omitted. For example focus upon choice and the omission of equity from an analysis would, most probably, lead to recommendations designed to preserve private health insurance. A focus upon cost control and budgetary pressures might lead to a neglect of the quality of care. A second analytical framework commences with a critical discussion of existing institutions, programs and the methods of financing health care and identifies deficiencies in these processes. For example, the observation of cost shifting associated with the Commonwealth-State division of financial responsibilities might result in the recommendation of measures designed to minimise cost and blame shifting irrespective of the magnitude of the problem as judged by its impact upon health and other social goals.

The objective of this chapter is to discuss the reform of Medicare using a framework which does not draw upon objectives *en passant* or in such general terms ('maximise health and achieve equity') that they have no real impact upon the subsequent discussion of options. The framework, described here as the GODS approach, consists of a sequential consideration of 'Goals, Obstacles, Deficiency and Solutions'. The intention in adopting this framework is to ensure that obstacles and suggested policies are assessed by their impact upon explicit social objectives.

## **Goals**

Health sector goals clearly include equity and efficiency. However even this very general statement can be misleading. For economists, it commonly leads to the analysis of efficiency with only passing reference to equity which, it is assumed, is the domain of government. It is almost universally believed that efficiency and equity are different in kind: that equity relates to social values and that efficiency is a technical matter. Both these views are contestable. First, the separation of equity and efficiency in orthodox economics is based upon the doubtful 'Kaldor-Hicks' criterion, that if an activity increases output to such an extent that losers from the activity can *potentially* be compensated while others remain better off then the activity should be undertaken. Redistribution and compensation, it is argued, are the role of government. The principle is particularly dubious in the health sector. If the reallocation of resources from a less to a more cost effective program results in the death of losers, compensation is impossible. When service provision is financed by taxes the 'losers' from a new program will be healthy tax payers. Compensating this group by redistributing income or some other benefit away from program beneficiaries—people who have been sick—is not a political option and, even in principle, is probably impossible. Consequently in the health sector equity and efficiency cannot be separated. This become even more obvious when it is recognised that the desirability of efficiency is also value laden. Efficiency is only desirable if it leads to an increase in something which is socially valuable—leisure, income, health, etc.

For these reasons efficiency should be regarded as no more than one of several social objectives and possibly not even the most important. This is highlighted by the recent WHO Global Analysis of Health Systems (WHO 2000). In this, five broad objectives are nominated and their importance quantified. The achievement of health per se only received an importance weight of 0.25. The remaining objectives, with a cumulative importance weight of 0.75, all concerned explicit equity objectives.

Unfortunately there has been little investigation of social objectives in the health sector other than the achievement of health. Yet the range of possible objectives is very large. The list includes the distribution of health and health services and the range of services and providers that should be accessible to different population groups. In addition to the effect upon the quality and quantity of life the criteria for selecting services for a national scheme may include the severity per se of the initial health state, the age of recipients, the maintenance of hope and the potential for health gain (Nord 1999; Nord et al 1999; Menzel et al 1999). In particular contexts society may endorse the rule of rescue, the fair innings argument, libertarian or

communitarian values. A consequence of this is that no single health scheme is likely to suit every country. Rather, the 'best' health scheme will depend, in large part, upon country-specific social values and, for this reason, it is not possible to recommend a 'best' path for the evolution of Australia's Medicare without first understanding social objectives.

Despite this, a number of important objectives are known—health, patient orientation/ responsiveness to patient wishes, etc—and, consequently, some of the characteristics of an ideal Medicare scheme can be described. This is done in the following two vignettes, the first illustrating the need for allocative efficiency and the second a hypothetical scenario describing an adaptive and fully integrated system which responds to patient preferences.

Ethix, a Seattle based Managed Care organisation was asked to establish a health plan for a nearby country town. The scheme included, inter alia, detailed utilisation review. Shortly after commencement this detected an unexpectedly high level of spinal injury in youths. Investigation established that the reason for this was a tree stump which had been left in the middle of a popular toboggan run. Young people were crashing into this and injuring their backs. The health plan paid for a bulldozer to remove the tree stump.

(Summary from a public address, Richardson et al 1999)

Medicare does not, currently, pay for tractor services!

'A woman with dizziness is concerned about her health. She rings the State call centre which advises her to visit her local health team. She is able to see the GP quickly who asks her a series of questions from the relevant research based protocol. The GP emails the results to a local specialist ... who orders some further investigations consistent with the state research based care path... Advice of (an) impending admission is automatically conveyed electronically to the GP and the social worker in the referring health team. The social worker contacts the hospital to discuss discharge planning ... The specialist ... suggest a number of sources for information about the patient's condition. The patient contacts the call centre for further information ... The case is randomly selected by the hospital audit committee for quality review. The committee suggests some slight changes to the state-wide protocol committee'.

(Duckett 2000 p241).

Australia does not generally have systems which could result in such a scenario.

## **Obstacles**

The obstacles to the achievement of an ideal health scheme are well known and have been widely discussed (Duckett 2000; Richardson 1998; Bloom 2000; Mooney and Scotton 1998). Only three of these will be highlighted below. The first, and arguably most important, is the all pervasive lack of good information about the effectiveness of health services. The US Office of Technology Assessment and the OECD have both estimated that less than 25 percent of services currently used have been adequately tested for efficacy. This implies that selection of best treatment protocols is very largely a matter of judgement and not simply a matter of knowledge. This in turn disempowers consumers and justifies a very wide range of treatment options for service providers. This would not, in itself, represent an obstacle to change if information was adopted and acted upon as it became available. However health service delivery is fragmented and the demand for 'clinical freedom' may frustrate measures designed to disseminate best practice.

A second and related obstacle is the existence of vested interests. Health expenditures are identically equal to provider incomes and, consequently, policies designed to reduce health expenditures will be resisted by those whose incomes will be reduced. Health sector providers are a particularly articulate and politically effective pressure group. Partly for these reasons it is likely that the effect of modest reforms will not be very significant in the short run as illustrated by recent UK and New Zealand experience (Ashton 2001). Consequently, short run experimentation with health system financing and delivery, such as occurred in Australia with the Coordinated Care Trials, may be unable to determine the long run potential impact.

Thirdly, the multiplicity of independent health programs in Australia makes the achievement of allocative efficiency very difficult. That is, there is no incentive for the flexible delivery of services illustrated in the first vignette involving the health scheme established by Ethix and the treatment for any given problem is likely to depend very largely upon the point of entry into the system. In principle there should be no obstacle to the establishment of a unified source of funding and program coordination. In practice, this is frustrated by State-Federal jealousies and the existence of localised self interest.

Finally, there is a further broad category of 'obstacles'. These arise from the technical inevitability of trade-offs between the achievement of possible objectives. These include, *inter alia*, the trade-off between total expenditures and the scope of the health sector, between cost and quality (at least in the long run) between the equity of a single national scheme and the choice provided by a multi tier system;



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between unlimited choice of provider and the wider range of service types possible when constraints are placed upon the range of providers (as occurs with Health Maintenance Organisations) and, finally, there is a potential trade-off between provider autonomy and the patient's right to evidence based medicine.

### **Defects**

Each of the obstacles mentioned here or elsewhere may lead to manifest problems; that is, a failure to realise achievable objectives. However health policy should reflect the quantitative importance of each problem. While this conclusion may appear self evident, policy has not, commonly, been driven by the empirical evidence concerning the need for reform; nor have governments systematically sought to determine system failures. Thus, significant effort has been devoted to the privatisation of hospitals despite the lack of evidence of the effectiveness of such a policy. The self evident importance of the quality of hospital care has not, until recently, resulted in a significant attempt to monitor and ensure this outcome. The huge discrepancy in the distribution of services has not been properly investigated. More generally, there has been remarkably little attempt to systematically evaluate the relationship between health delivery and social objectives.

Figure 1 and Table 1 indicate two sets of problems which are arguably amongst the most serious challenges for Medicare. Figure 1 depicts the number of services received per 1,000 population in the different statistical local areas of Victoria. The rates are adjusted so that the index number 100 represents expected service delivery given the population, age and sex. The thick lines in the box plot represent the 25th and 75th centiles (i.e. 50% of SLA's are in this range). Dots represent statistical outliers. Even disregarding outliers the figure reveals variation in service use of 200% to over 1,000% over the two year period from which data were obtained. As this pattern cannot be explained by known medical factors, it reflects the erratic allocation of resources that might be expected when there are no clear guidelines for particular interventions.

Table 1 indicates the type of treatment received by patients following a heart attack. The numbers in the table represent the likelihood of receiving a procedure for a private patient in a public hospital or a private patient admitted to a private hospital divided by the likelihood of a public patient in a public hospital receiving the same service. The table indicates a dramatic difference in patient treatment and indicates the existence of a two-tier system, at least in the treatment of AMI.

The significance of these illustrations is two-fold. First, they highlight behaviours which many would consider to be a 'problem'. From Figure 1 it must be concluded that either some populations are over-serviced or some under-serviced. The problem, in part, reflects the discrepancy between service rates in urban and remote areas. From Table 1 there is a question of whether or not we wish to have such a two-tier system as reflected in the data. The second issue illustrated is that governments have not had an interest in the type of data presented in Table 1 and Figure 1. They have neither sought such analyses nor responded when such analyses have been made public. This is a problem of government failure.

### **Solutions**

A wide range of possible solutions have been discussed in Richardson (1998). Three general points will be made here, each concerning the prerequisites for 'efficiency', broadly defined as the achievement of policy objectives. First, as there are various possible objectives, both the nature and precise structure of the ideal health scheme for Australia cannot be determined until these objectives are known.

Secondly, the achievement of allocative efficiency will almost certainly involve a change in current funding arrangements. Within a health scheme designed, basically, to provide the same kind of care to all citizens, there is a need for the flexibility that can be achieved with a single fund. The disappointing results from the recent Coordinated Care Trials should be interpreted with great caution. They demonstrate that a change in funding unaccompanied by a significant change in delivery may have little effect in the short run. However, as noted, change in the health sector performance may be slow. Fund pooling may be necessary but not sufficient for significant reform. It may be necessary to experiment with different modalities of service delivery such as, for example, the primary care groups which have evolved in New Zealand. If the ideal health sector seeks to provide greater choice with private payments in higher cost competitive schemes, then government subsidies must reflect patient needs and funds must follow the patient and not the provider.

Thirdly, it is almost certain that evidence based medicine will be adopted eventually. Protocols are evolving both in Australia and, very rapidly, in the USA. The medical profession, led by the various colleges, may work autonomously or cooperatively with government to further develop protocols. If practitioners then adopted such protocols self regulation—self management—would achieve at least one important social objective—best practice medicine. If this process is thwarted by provider self interest and the demand for 'clinical freedom', governments may attempt to drive the process by regulation and with financial incentives. If

government fails then the residual solution is to employ—using Reinhardt’s phrase—the ‘bounty hunters’ of the private sector—the problem may be privatised. This would imply an Australian version of Managed Care. Scotton has already, on numerous occasions, described a framework which might be employed to achieve this objective (Scotton 1998).

**Table 1 Ratio of rates of angiography and coronary artery revascularisation procedures in private versus public hospitals\***

	Rate ratio (95% confidence interval (not for Line 1))**			
	Angiography	Angioplasty/ stent	CABG***	Any CARP***
Public patients in public hospitals	1.00	1.00	1.0	1.00
Private patients in public hospitals	1.43	1.09	0.90	1.00
Private hospital patients	2.17	3.05	1.95	2.87

\* Rates are for all Victorian residents aged 15-85 years admitted to Victorian acute care hospitals with acute myocardial infarction, July 1995-December 1997, adjusted for age group, sex and half year of initial admission. Comparative group: male public patients, 55-64 years old, in public hospitals July-December 1995.

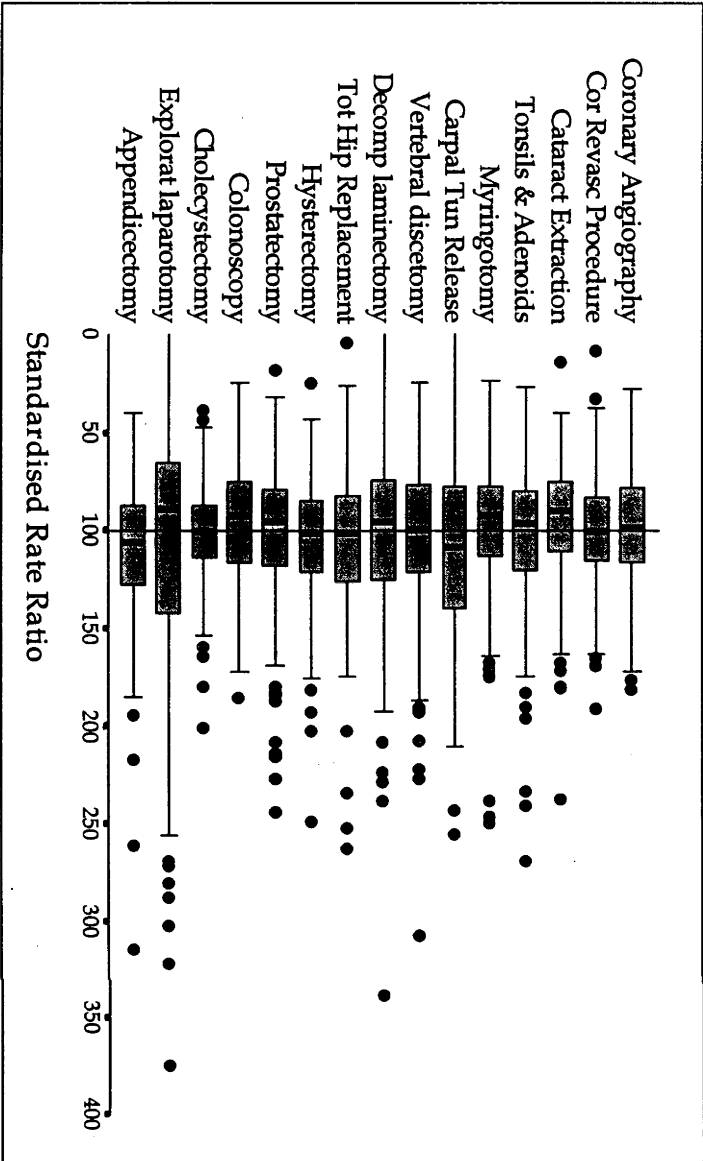
\*\* Rate ratios are calculated using the Cox proportional hazards model.

\*\*\* CABG = Coronary artery bypass grafting

CARP = Coronary artery revascularisation procedure.

- Source: Richardson & Robertson 2000, *MJA*, p 293.

Figure 1 Standardised Rate Ratios for Various Operations in the Statistical Local Areas in Victoria, Compared to the Rate Ratios for All Victoria



Source: Richardson J, 1998, 'The healthcare financing debate' in *Economics and Australian Health Policy*, G Mooney & RB Scotton (eds), Allen & Unwin, Sydney, p198.

**Conclusion**

There have been two major themes in this chapter. The first is that policy analyses should commence with a clear understanding of objectives. It is not sufficient to state these in such general terms that they have no operational meaning or for precise objectives to emerge as the analysis proceeds. Rather, goals should be explicit and detailed. It has been argued here that the usual distinction between the objectives of 'equity' and 'efficiency', defined as the maximisation of health, is not particularly helpful and that the more general objective should be the

efficient—cost minimising—achievement of all objectives irrespective of whether they concern health or social justice. In this task, economists have a significant role to play. The skills of economics are particularly suited to the determination of population values and the quantification of the inevitable trade-offs that will result from the technical constraints upon the health system.

The second main theme has been that Australia's Medicare system does not achieve allocative efficiency nor the desired distribution of services. In part this has arisen because of the paucity of information about best practice and the power and flexibility this has bestowed upon individual practitioners. As this informational deficit diminishes, mechanisms must evolve which ensure information based policy and practice. As there is no known formula for ensuring that this will occur, health systems must be flexible and capable of ongoing experimentation with alternative systems of funding and service delivery.

The final destination of Medicare will depend, not simply upon objectives, trade-offs and the type of care which is most cost effective but also upon the response of the medical profession to the challenge of best practice medicine. The rate of change of medical knowledge is so great and the incentives for self-interested behaviour so strong that this challenge is unlikely to be met by an anarchic system of inviolate 'clinical freedom'. As it is unlikely that a country will indefinitely deny its population best practice medical care, it is concluded that Australia will almost certainly adopt Managed Care in one form or other. As best practice medicine is best for patients, its achievement should be very high on the priority list of desirable policy reforms.

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# The health futures market

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Investment in health care in Australia has some features that are similar to those of the commodities futures market. An examination of the similarities between the two systems may teach us something about the way we fund health care services. The money for investment in the future of health comes from taxation revenue. It is invested for taxpayers by health system bureaucrats on behalf of the elected representatives of the taxpayers (the Minister for Health and other members of cabinet). Taxpayers do not usually have an opportunity to make specific decisions on where to place these investments.

It is usually only at election time that taxpayers can give guidance to the political system for the direction of investment in future health. Politicians respond to lobbying or perceived need with promises of new or expanded services. There are some interesting examples of this process in action in Australia. The offer of a mammography screening program was used by Labor in the 1989 election in an attempt to win votes from women; people with kidney failure have been successful in lobbying politicians to provide dialysis programs instead of kidney transplantation; politicians often offer to build new hospitals in areas where they hope to win votes. Unfortunately, such strategies do not necessarily deliver much health to those who vote for them. This is not to say that these services are not valuable; it is just to emphasise that there may have been more efficient ways to spend the money if the overall aim was to improve the health of the community as much as possible.

The arm's length relationship that taxpayers have to investment decisions in health is similar to that between investors and brokers in large investment houses or trusts. The decisions are made not by the individual investors but by specialists who study the market and use mathematical models to design the overall investment portfolio. The investor judges the performance of the trust on the basis of the overall cash

flow that it generates. In financial markets, there is rarely any attention given to the needs or aspirations of society apart from purely financial returns. However, this may be changing. Environmental issues have been forced on to the agenda by stockholders and in the past investment houses were forced to withdraw from South African investments because of pressure from investors. In recent times there has been pressure on insurance companies and others to withdraw investments from tobacco companies.

There are many different ways to invest in future health. It is important to distinguish which of these investments will actually deliver more health and which are merely investments in perceptions about health which may have little or no impact on the future health of the community.

The central question here is: what is health? While answers to this question range from the existential to the prosaic (not being sick, living longer), it has become popular in recent years to measure 'health' programs by their ability to give people illness free years of life. One unit of measure is the QALY (the quality adjusted life year) derives from the work of Sullivan (1971). If a new operation enables those with hip fractures to live ten years longer but leaves them in considerable pain, the ten years might be discounted to only two or three QALYs, depending on the amount of pain likely to be suffered. A modern derivative of the QALY is the DALY (the disability adjusted life year) which was adopted by the World Bank in 1993 and which forms the basis of the landmark work of Murray and Lopez (1996) who used an adapted form of the DALY to report on the global burden of illness.

The use of relatively objective measures such as the QALY and DALY does not take into account many consumer preferences in relation to health but it does provide a good starting point for examining the investment potential of some popular 'health' strategies.

Examples of possible investment in future health are:

- \* Expansion of the childhood immunisation program to ensure wider coverage and the inclusion of new vaccines.
- \* Promotional campaigns designed to lower the prevalence of tobacco smoking.
- \* The installation of isolation fences around swimming pools.
- \* Research into genetic screening to reduce the incidence of cystic fibrosis and other major genetic disorders.
- \* Building of a large new metropolitan hospital with modern surgical and cardiac care facilities.
- \* The training of more doctors.



Of the above investments, only the first two are certain to produce cost effective outcomes in terms of QALYs. Research into genetic screening might deliver important outcomes in the future, but the investment is speculative. Swimming pool fencing will save the lives of young children, but the cost per QALY is relatively high. Most members of the community probably think that the provision of more teaching hospital services and the training of more doctors will add greatly to health, but this view is mistaken. The marginal contribution to health from new tertiary services in Australian cities is small because the services are very expensive and they often prolong life by only a year or two in older people, therefore not scoring well in QALYs. Fuchs (1974, p56) points out that the provision of more doctors in systems such as that in Australia will usually add to the cost of health care provision!

### **Do 'Investors' benefit from investments in the health futures market?**

Who wins from the investments in health? In particular we should ask who actually gets the health that is produced by this investment. At first sight it may seem that the beneficiaries will be the same taxpayers whose money was invested in the first place. But this is not necessarily so. Depending on the nature of the investment made, the individual may benefit a great deal or very little from the future health produced. The average 40 year old wage earner may have relatively little to gain directly in terms of increased health from the strategies available to us.

For example, the forty year olds do not benefit directly from childhood immunisation campaigns, although such campaigns are an excellent strategy for protecting the health of the next generation. However, the adult taxpayer may be happy that their children (and the children of others) are protected by this investment. In the exciting new field of molecular genetics there are many opportunities to invest taxpayer funds in genetic screening programs. Once again, the adult taxpayer will not benefit directly from genetic screening programs, but their unborn children and grandchildren will. The adult, however, may benefit from the savings that result from lower demands on hospital services if genetic diseases were prevented.

In the area of behavioural risk factors for cancer and cardiovascular disease, the adult taxpayer does stand to benefit directly. For example, if they smoke they can benefit from quit smoking programs. But even in this case, the proportional benefit in terms of QALYs will be much greater for younger people. Perhaps the most significant area of perceived benefit to the adult taxpayer is that they will benefit from investment in major hospitals, because they anticipate that they will need these services as they grow older. This is an important consideration, and one

which is well understood by politicians who know that new hospitals are often vote winners. For the adult taxpayer, however, the actual benefit in terms of QALYs may be disappointing, since the new hospital will not reward the taxpayer with many more years of healthy life.

There is however strong consumer preference for high quality hospital services for serious illnesses like heart attack, and these preferences must be taken seriously by health planners. In summary, the adult taxpayer is happy to pay for the services they may require when they or a family member needs urgent medical attention. Even if there is not much health to be gained from a tertiary hospital, we all would like to know that we can expect the optimum in terms of pain relief and modern care if we have a serious injury or illness.

### **Technical considerations relating to futures market**

There are a number of technical considerations which are normally considered in judging the operation of health futures markets. These include:

- Perfect and imperfect markets in health futures
- Diversification of risk
- Impediments to the flow of funds
- Insider trading

In a perfect market, the investors have full access to all relevant information on the future prospects of the product being considered for investment. In the case of health where the taxpayer is the primary investor, it is unlikely that they know how much health they are buying with the investments made with their tax dollars. The reason for this is that most taxpayers do not have a genuine opportunity to analyse the choices available. This situation is described as an imperfect market because accurate information is not easily available to the investors.

For a perfect market in health futures to evolve, the information from epidemiology would have to be widely available. This approach was used in the USA Centers for Disease Control PATCH (Planned Approach to Community Health) program in much the same way as brokers and other investors use models like CAPM (capital asset pricing model) to calculate the best balance between risk and profit. In the PATCH study, communities were given local risk factor data and a computer model which gave future outcomes of various risk prevalence levels. This enabled communities to assess the relative value of different preventive and treatment strategies. The interesting thing is that they wisely chose to implement those strategies (such as smoking control) which would give maximum value in terms of future health.

There are very few successful examples of attempts by communities to assemble and analyse information on which to base decisions on investment in health. Two notable examples of at least partial success are the community input into health planning in state of Oregon and the introduction Report Card for Child Health in the state of North Carolina. The Oregon process combined widespread community consultation with in the provision of epidemiological data on mortality, illness and disability. The aim was to develop a priority list for investment. A useful summary of the Oregon process and the North Carolina Report Card are found in Kreuter et al (1998, p 52).

In the present imperfect health futures market which exists in most industrialised democracies, dominant interests (elite health professionals and politicians) make most of the decisions and much of the investment is directed into hospitals. This form of investment is not resisted by the community because the community has been led to associate hospitals with the production of health. The community also has been led to believe that their health will be improved if they take large quantities of multivitamin tablets, despite the very weak evidence of real value from such expenditure.

In building an investment portfolio, an important principle is that of diversification of risk. This rule can be very usefully applied to the buying of health futures. Given the very complex nature of health and its protection and our incomplete knowledge of the effectiveness of some strategies, it would be wise to spread investment across prevention programs, treatment services, and research into possible new prevention and treatment strategies to give a balanced portfolio.

An important issue for the operation of futures markets is the analysis of factors which impede the flow of funds. In financial markets, the main impediment is usually lack of investor confidence in the borrower. This certainly seems to be the case in the USA health care system where taxpayers seem reluctant to invest more heavily in publicly funded health programs. Although the total American expenditure on health is easily the highest in the world as a percentage of GDP (AIHW 2000, p 246), American support of taxpayer funded health services lags behind many other OECD countries. This does not reflect a basic unwillingness to spend on meeting perceived health needs, since private health investment is much greater than any other country, but it seems to indicates a low level of confidence in government programs.

The question of insider trading is an interesting one, since doctors and other health professionals sometimes gain information which has great investment significance.

In the year 2000, a great deal of media attention in Australia was devoted to accusations that radiologists had purchased MRI scanners in the knowledge that the subsequent Federal health budget would provide them with a massive financial rebate. It was alleged that Federal Health Minister had inadvertently released information in meetings with senior radiologists before the budget. While the facts of the situation were never conclusively determined, it provided the public with a striking example of the way that insider trading occurs.

The basic question here is whether the taxpayer knows how much health they are buying with the investments made with their health dollars. The answer is that they do not because they are not given an adequate opportunity to analyse the choices available. Worse still, such information as they get may be distorted by insider traders like doctors, politicians, and drug companies. No wonder that rationalisation of the health system is a slow process.

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