opinion

A COMPREHENSIVE HEALTH POLICY FOR AUSTRALIA – CHALLENGE OR OXYMORON?

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Is a comprehensive health policy a challenge or oxymoron? On the one hand, there is the absolute necessity of having a comprehensive policy about how we will preserve, care for and pay for our health in future. On the other hand, there is the sheer complexity of developing clear policy in such a politicised, bureaucratised, professionalised and increasing consumerised field. The following reflections draw on my experience, working in public health mainly as an academic, but engaged relatively frequently with matters relating to health policy.

First I review prevailing patterns of health in Australia, current health care expenditure and the nature of health policy. I then advance reasons why a concerted effort in health policy development appears warranted in Australia today. Health outcomes and other social consequences are then explored as objects of health policy, and possible approaches to its development are discussed.

The Health of Australians

Australians enjoy very high levels of health by world standards. International measures of health, such as life expectancy, childhood survival and the safety of childbirth all give Australia a 'triple A' health credit rating. As a nation we do not suffer the consequences of starvation or uncontrolled epidemics of tuberculosis and high levels of infant mortality faced by the majority of nations. Nevertheless, Aboriginal life expectancies should worry us, being 15-20 years lower than those of non-Aboriginal Australians (AIHW 1998).

JOURNAL OF AUSTRALIAN POLITICAL ECONOMY.
ISSN 0156-5826. ISSUE No. 45, JUNE 2000, pp. 123-134.

It is worth glancing at the global health statistics. Of the 52 million deaths that occur world-wide each year, roughly 40 million (77 per cent) occur in developing countries. Two-fifths of all deaths in the world this year can be considered premature, in that more than 20 million people a year are dying before the age of 50. Ten million of these deaths are among children under 5 years; 7.4 million others are among adults aged 20-49 (WHO 1998). The World Bank explored the strong connection between economic prosperity and health in their *World Development Report 1993: Investing in Health*. They found that those countries that have the greatest share of the world's wealth have the best health.

This was not a direct relationship. How the wealth was used mattered. Some poorer countries such as Costa Rica which invests in education of women and children rather than military purposes, had better health than some richer countries. Marginal increases in spending on education, environmental control, primary care were predicted to have different benefits according to existing investment profiles. Thus health policy may need to take different directions to achieve health gain, according to the macroeconomic and political directions that were imposed upon or chosen by different countries. Health policy is demonstrated in the World Bank study to be a derivative of the larger social and economic policies adopted by different countries.

Paying for Health Care

Australia's pattern of investment in health can be gauged from the following national expenditures.

Health care in Australia is a mixture of private enterprise and publicly supported services. In 1997-98 we pa id $47.3 billion dollars for it. This represented 8.4 per cent of gross domestic product (GDP). About 68% of the $47.3 billion overall health costs comes from taxes paid by Australians to Commonwealth, State and Local governments. The remaining 32% of health spending from non-government sources is made up of direct charges to patients, health insurance premiums and other non-tax sources (Public Health Association of Australia 1999).

Matching these complementary systems of expenditure are two systems of health insurance. The biggest and most well known is Medicare - a publicly-funded compulsory scheme, run by the Commonwealth government which provides basic medical and hospital cover for all Australian residents. The other system, private health insurance, provides basic medical and hospital cover as well as additional insurance for health care expenses such as dental care and superior accommodation facilities in public and private hospitals.

Medicare has two elements: one concerned with hospitals and the other with medical services. Medicare is administered by the Commonwealth government and is funded by a levy linked to general taxation. The Commonwealth makes financial allocations to the states and territories as part of an agreement which is renegotiated every five years, from which they provide public hospital and related services. In regard to 'medical Medicare', the Commonwealth, through the Health Insurance Commission, makes payments directly to medical practitioners and patients for medical services provided in the community. Not surprisingly, and not inappropriately, this mixture of funding sources and administrative bases is a reflection of what happens more generally in Australia, with its system of federation and its commitment to publicly supported social welfare and 'a fair go'.

Recently a $2B per annum shift in expenditure of public money has occurred from the publicly supported health service to private health insurance subscribers. A further shift in policy, enshrined now in legislation, has followed whereby such subscribers will in future be risk-rated according to age unless they commence subscription to a health insurance plan in their youth. The latter was one of several recommendations made in a review of private health insurance in 1997 by the Productivity Commission. The former has been justified as a mechanism to increase the private contribution to health care and thus reduce pressure on the public system or as a means of increasing choice. The influence of private sector providers in this change of direction is not explicit. There was no critical public debate of the decision prior to its being implemented. At present the determination of national health policy is essentially restricted to discussion in government where voices are heard by political choice. There is no equivalent to the 1998

Constitutional Convention where the proposed referendum on the republic and other constitutional changes were discussed, despite the greater impact significant changes in health service provision may have, arguably, on the lives of Australians.

All governments in Australia are committed to limiting public expenditure on services, including health. Whether the community wishes to lower expenditure to the same extent as government is unclear. But given the various treasuries' inclination to reduce public spending on health care, it is natural (as is happening) for government to seek further to share the risk with private individuals and the private sector. This is done, however, with nothing being made explicit about the advantages and disadvantages of increasing spending in the private system relative to increasing expenditure in the public system in terms of achieving fairness (equity) of access to care, cost control, administrative efficiency, and the ability of government to locate services according to population need rather than the domiciliary preference of doctors, and the power of government to mandate quality.

Indeed, comparative data from the US, UK and Canada all suggest that enhancing the private system will diminish equity, cost control, efficiency and the capacity to determine location of services and quality. Is that what the public wants in voting for politicians who seek to shift risk to the private health care system and the private individual (as both parties promised at the last federal election)? Informed consent, so lauded in the clinical setting, is spectacularly missing when setting major new directions in macro health policy in Australia.

The Development of a Health Policy for Australia

The most important question with respect to health and health care now is, 'Where to from here?'. Given the huge resources that Australia contributes to these activities, it is surely reasonable to expect that when choices are made about how to use those resources, the interests of those paying, those providing, those receiving, and those missing out should be considered. What are we trying to achieve? How do these aspirations mesh with our broader, national values? The multiple players, the size

of the stakes, and the social importance of the issues mean also that health care should be considered when more general public policies for the future of this nation are being developed.

US physician and ethicist, Edmund Pellegrino, suggests that health policy clearly reveals the values that drive a society. This revelation is especially clear when we consider how we treat those in what he terms the shadow of life - the very young, the poor, the sick, the aged or the retarded (Pellegrino 1979). Health policy, he says, is a nation's or a community's strategy for controlling and optimising the social uses of its medical and health promoting knowledge and resources.

Constitutional reform is not as remote from the development of an effective national health policy as it may first seem. A policy deriving from such a process might begin with a negotiated preamble that states the values on which it is built. It would then go on to say what the Australian health care system plans to achieve, what health gain Australians could expect. It would set limits as well as create a positive vision of health for the future. It would tell us how the needs of the chronically ill and of older people will be met. It would contain a strong statement about goals and targets to be achieved. It would commit the health care system to efficient preventive strategies for problems we cannot cure and can only prevent, severe brain damage from trauma being one and HIV infection being another.

Outcome-orientated health policy development was part of the idea behind the development of the Better Health Commission (BHC) in 1985 by health minister Neal Blewett. The late Derek Llewellyn-Jones was chair and twelve of us served as part-time Commissioners. In 1986 the BHC published *Looking Forward to Better Health.* This report contained proposals for achieving greater equity in health in Australia, together with strategies to address several major preventable contributors to death and disease. Task forces established goals and targets for three priority health topics: cardiovascular disease; nutrition; and injury.

In making these choices the Commission was concerned not only to identify big problems, but also problems potentially amenable to prevention. Heart disease, the principal cause of death, was chosen also because of its multiple modifiable causes (i.e. diet, smoking, and

sedentary living); nutrition was chosen because of its multiple consequences (i.e. diabetes, heart disease and cancer); and injury because it cannot be dealt with preventively by efforts confined to health care but must involve industry, transport, law enforcement and industrial relations. All three major health problems in contemporary Australian society are also priorities for health promotion by virtually any criterion.

The report of the BHC was received by the Australian Health Ministers' Advisory Council (AHMAC). AHMAC is a meeting place for all the Australian state and territory health ministers and the federal health minister, and is concerned with policy of mutual importance to all of them. In response, AHMAC established the Health Targets and Implementation Committee (TIC). It was charged with the responsibility of determining the way in which the recommendations of the BHC could be implemented. In addition, it cast its net more widely, establishing goals and targets in five key areas - nutrition, hypertension, injury, preventable cancer and the health of older people - as well as reviewing goals and targets which had been set by other groups including in diabetes, asthma and sexually transmitted diseases.

Health for All Australians, the 1988 report of the TIC, re-emphasised equity as the key goal for future health promotion activity. *Health for All Australians* was a comprehensive set of goals for health promotion in Australia, to be achieved by the year 2000. The report set out a framework for the development and implementation of strategies focusing on population groups, major causes of illness and death, and risk factors. This report led to a federal and state/territory commitment of $43 million over three years to develop further recommendations into strategic plans and to implement them. The National Better Health Program (NBHP), as it was called, was developed to pursue these initiatives.

The derivative of these efforts still resides in the federal government in the form of its commitment to six National Health Priority Areas, the most recent addition to cardiovascular health, cancer control, injury prevention and control, mental health and diabetes mellitus being asthma. A series of reports on the National Health Priority Areas have been produced, providing an overview of the impact of the priority area on the health of Australians, identifying appropriate and inappropriate activity,

barriers and gaps and suggesting opportunities for improvement. A national report on each priority area is to be prepared every two years, allowing time for major changes in health indicator status to become apparent. The reports will include a statistical analysis of surveillance data and trends for a set of agreed national indicators (Australian Department of Health and Aged Care 1999).

Allied to these efforts has been a local variation of the WHO approach, pioneered by Murray, Lopez and others, and adopted in modified form by the World Bank, to determine the burden specified diseases place on society as a result of their contribution to premature mortality and suffering. The Global Burden of Disease Study first published findings in 1993 in the World Bank's *World Development Report.* The Global Burden of Disease is a measure of population health that combines information on mortality and non-fatal health outcome to represent the health of a particular population as a single number, usually the Disability Adjusted Life Year (DALY). This approach has been criticised by many, including Mooney *et al* (1997), on the grounds that determining what burden an illness inflicts is no guide to the best point for further marginal investment in health care. For a problem which is huge, but insoluble, further investment may provide no return. This applies to some forms of cancer treatment. Investment instead in a smaller, more tractable problem (e.g. the global elimination of poliomyelitis), may bring much higher returns. Thus in the work of the BHC we were concerned that feasibility and likely return for investment should be criteria included in the determination of health priorities if these were intended to guide future investment. Feasibility is much more than simply biological feasibility. It has to do with what is possible politically and socially, including what professionals and consumers are willing to tolerate.

As with the successful Carr government NSW Drug Summit 1999[1], a national health policy with overarching significance would need to include the various players whose influence is essential to its successful implementation. At present there is a dominance at clinical level of

1 For details on the Summit see: http://forums.socialchange.net.au/

provider influence, some of which, under conditions of budget constraint, can be self-defeating. Thus, as part of my work with the NSW Health Council in recent months, I have seen at first hand the extent of disillusionment, frustration and even broken-heartedness among health service professionals, both clinicians and managers, because of their inability to provide services they wish to provide with current resources. There is a massive mismatch. But ironically, while current patterns of service provision prevail, the necessary financial resources are hard to procure from understandably sceptical treasuries who see health care as avaricious, insatiable and unchanging. Tactical approaches are needed to re-enfranchise these players if we are to have a summit on health policy, similar to the 1998 Constitutional Convention or 1999 NSW Drug Summit, that brings all players to the same table.

The current system suffers from excessive concentration on 'saving money' and lack of emphasis on matters cultural and social. However, much analysis of health policy, here and overseas, suggests that it is the material and social interests of providers and consumers, and the broader institutional interests, that structure policy outcomes.

A national policy for health would also say how the Government, as the principal custodian of health care, proposes to educate us, the public, about our responsibility for health and how responsibilities for health gain would be shared among individuals, governments and the private sector.

Objections to a Comprehensive Policy.

There is a contrary view that it is idle dreaming or even dangerous to specify the goals and objectives, or targets, of health policy in terms of health gain and lives saved. Critics assert that the force of circumstances always overtakes our best intentions, that the future belongs to the agile opportunist who carries no encumbering freight of precise expectation in their pack. Why not simply specify the *processes* we will use in running the system? This approach is favoured by those in government with general financial responsibilities, their treasurers in particular. It places emphasis on the acquittal of resources. What you achieve in terms of

health outcomes or health gain is not in the equation. This approach has the advantage that, as nothing concrete has been specified as a goal, no-one can be held accountable for producing anything (or indeed producing nothing). Under this scheme, priority *activities* (rehabilitation, community care, hospital throughput) may be identified for support, but their purpose, and whether this is achieved, is not measured.

A process-dominated approach to service provision, for example, would not serve as a basis for marginal reallocation of resources to or from those activities on the basis of additional health gain that might thereby be achieved. Thus, to reduce investment in one part of a cardiac surgery service, because it does not work as well as another part which might use the resources more gainfully, becomes impossible, because no gains and losses are measured for comparison. Instead, efficiency comes to be defined in non-health, organisational terms - could you use a computer to do the job that a ward clerk is doing at present? Whether you need a ward clerk or a computer, both, or neither to achieve a gain in health is not the question: the value of the work of the ward clerk is not under scrutiny, just whether it could be done more cheaply by a machine.

Some of those who hold to such a non-goal-based approach do so for well-formed, not exclusively financially-based, reasons. For example, there has been considerable criticism of a health policy that focuses on a set of health gain goals because of the inherent difficulty in encompassing other important and legitimate areas of health-service activity (Mooney 1995). These include the poorly-specified gains that occur from the health-care system, such as the reduction in stress resulting from informative counsel by general practitioners and others to their patients, the intangible benefits from a sense of support that comes to a terminally-ill patient through the home visit of a palliative care nurse, or the sense of security a carer for a disabled patient gains from a 24 hour help-line.

While reductionist thinking, which heavily influences health-outcome goal-setting as it does much clinical practice and research, is critical to progress in health care, alone it is insufficient for all our health-related purposes. Central to Kant's notion of critique (of reductionist thinking, in this case) is the need to set limits to our reasoning - and the limits of reductionism need to be recognised: public, social and personal

dimensions of health strain against it for due recognition. Australian ethicists including Max Charlesworth, who has contributed generously to health ethics in Australia, resists the primacy of outcomes in policy strongly. Charlesworth (1992) fears the corrosion of values related to caring and the recognition of the autonomy and dignity of individuals as a result of too intense a focus on health goals and outcomes.

While these objections are of considerable force, the health-care system has not concentrated as much attention on what it achieves by way of health gain as might be expected. Activity perpetuates without critical appraisal of what it achieves, and opportunities for doing things differently, more effectively to promote or gain health, are all too often missed because everyone is so busy. Equally importantly, by not recording and celebrating our successes in caring (and I am not referring here to occasional technological miracles which are celebrated regularly, but the undramatic ones that currently occur out of sight, often at home), we do not reinforce the social values of caring which these activities reflect, and Charlesworth's fears about damage to values are realised anyway. We give no feedback to taxpayers on what their contributions achieve in helping us care as a society. They may get some reinforcement when they become users of the system, but during all the years when their taxes disappear into government coffers, the money taken from their pay packets could be paying for anything. In fact, much of it goes to pay for caring and the gains in well-being that caring achieves. We lament the weakening of social values such as caring and compassion: is it any wonder they are leached when we so rarely say, 'thank you - look at what we've achieved with your money'?

Conclusion

In summary, goals and targets, as expressions of aspiration, can identify the principal aims for a national health policy. There is some danger that if these goals are defined too narrowly, the less tangible elements of health care will be marginalised. The greater danger is, however, that in having no clear goals in relation to outcome, goals concerning process (hospital throughput, number of patients treated, reduction in costs per case treated) will move into the vacuum and usurp the health agenda. A

national health policy then becomes a policy for health care financing alone, and in today's climate that will often mean policy directed toward cutting costs with unmeasured consequences.

The development of a comprehensive health policy for Australia should lead to a national statement that encompasses our intentions with regard to both the promotion of health and our response to illness. The promotion of health requires the development of policy similar to that for the preservation of the environment. The elements of the policy that relate to the way we respond to illness need to be imaginative and comprehensive. It is essential to recognise that the international evidence suggests that no form of health insurance, public or private, Commonwealth or State, will control costs so long as there is no limit to medical practitioners alone deciding how much to spend on an individual patient.

While not denying the difficulty of the task, the need for a comprehensive health policy that expresses the central aspirations of Australians with regard to health and health care, *and* defines the limits and priorities, is essential if the best use is to be made of limited resources in face of unlimited demand. The central players in this debate should be our politicians who must learn to present real options in their election platforms to these matters beyond the ritual mouthings of benefits and costs of different ways of paying for health care, important though that matter is. There are many others to invite to the policy table as well. The process of development of such a policy will not be easy, but if we succeed with an area as expensive and value-laden as health, much else will follow with great benefit to the community.

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