# OBSTACLES TO HEALTH REFORM

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The problem with health reform is that even when major redesign is necessary, many 'reformers' continue to think incrementally. Some believe that major redesign is impossible, that political timidity and acquiescence have become a way of life for many health ministers. They see the individual parts of the system working reasonably well, and fail to see that the system as a whole is inefficient and unfair. They ignore the obvious fact that the uncoordinated programs are provider-driven. Journalists are under-resourced to really understand a very complex system, yet patients encounter its failings every day.

Australia's so-called 'health system' lacks clear underpinning values and direction. It lacks leadership – not money. Our health leaders lack the will for health reform because they are strongly influenced by the vested interests that abound in health – doctors (particularly specialists), state health bureaucracies, parochial political interests, private health insurance funds, pharmacies and the pharmaceutical companies.

The health 'debate' is about placating these vested interests rather than listening to the community and patients. Ministers spend their energy in the financing of health programs, when production and delivery of health care is sclerotic. They are concerned with funding individual announcement-driven health programs – pharmaceuticals, aged-care etc, rather than integrating all health care.

Our health care structures have outlived their useful life. They were never designed as a 'system'.

The need for major structural reform takes us well beyond the health portfolio as it is currently conceived. Our failure to invest in preventative health care, and the way we waste health resources have major economic consequences. Any political party that is serious about micro-economic management must be concerned about the structural problems of health. Tony Abbott speaks of health as a 'dog's breakfast', but has made no serious effort to fix the mess.

## System problems that require structural change

1. **No consistent values or principles**

There are no consistent values or principles to guide health programs. The Centre for Policy Development (CPD) illustrated this point in 'A health policy for Australia: reclaiming universal health care'[1]:

> 'Some services are provided for free, while others receive no government support. Some services are covered by tax-funded insurance, but at the same time there are incentives for people to opt out of sharing and into private insurance. Politicians talk of 'universalism' and a 'commitment to Medicare', while encouraging the development of a two-tier hospital system. Politicians talk about 'individual responsibility' while

> encouraging people to hand responsibility over to health insurance corporations. Governments, particularly Coalition governments, speak vaguely about the virtues of a private sector, but in only a few areas of health care is there a degree of market competition; in general, health care has been cosseted from market forces. Labor politicians sing the praises of bulk billing while supporting high co-payments for pharmaceuticals.'

Year by year, our health programs becomes less coherent, with a confusion of values and principles. Do we want a social welfare type health system to serve the poor, or one based on the principle of a universal high quality system available to all?

At the CPD, we assert the importance of social solidarity and a high quality single insurance system as design principles to guide future programs.

2. **People under pressure.**

People working in health are under great pressure. Morale is low and frustration is high. Dedicated people – particularly nurses – are leaving their professions. We expect too much of them. They see no effective solution in sight. We can't have all we want in health – and ministers should say so, and involve the community in real engagement and consultation on the costs and consequences of different funding options. Instead, ministers allow professional and dedicated staff to labour under heavy work pressures in dysfunctional environments.

3. **Health workforce structures and practices are archaic**

Our health workforce structures are a major economic burden. Health is our largest industry, approaching 600,000 employees or 7% of our civilian workforce. About two thirds of health expenditure is labour cost[2]. More efficient workforce practices are essential. The problems arise not because of individual failure but because of failure to address the structural inefficiencies. Archaic work practices deny career opportunities, especially for nurses and allied health workers.

The Productivity Commission in its 'Potential Benefits of the National Reform Agenda, February 2007' estimates that a 5% improvement in the productivity of health services would deliver resource savings of around $3 b each year. I think this estimate is extremely conservative. The system is rife with demarcations and restrictive work practices. For example only 10% of normal births are delivered by midwives in Australia. In the Netherlands it is 70% and in the UK 50%. There are severe shortages in some specialties, e.g. geriatrics and emergency; locums are used widely to fill the gaps. There are large numbers of foreign trained doctors and nurses which present ethical and professional problems.

As the Productivity Commission (Jan 2006) described our 19th Century system:

> 'There are fragmented roles, responsibility and regulatory arrangements … inadequate co-ordination between governments, planning, education and service providers … inflexible regulatory practices … perverse funding and payments incentives … and entrenched custom and practice.'

Auctioning of doctor provider numbers by postcode, for example, would quickly address the geographic misallocation of doctors across Australia, but it is not even considered.

We need role renewal and the creation of new types of health workers. We need upskilling, multi-skilling, broad-banding and team work. We need integration of education and employment.

Blue-collar workers are fair game for workforce reform, but not professionals in health and the law. No health minister in Australia has yet addressed the dysfunctional workforce structure

and workforce practices. The Medical Benefits Scheme (MBS) could be one lever to help influence change.

The productivity improvements and career advancements would be even further enhanced if we could speed up the so-far glacial introduction of IT capability, which would be a great enabler of safer and more efficient health care. The IT revolution, which has driven so much productivity gain in other parts of the Australian economy, has passed the Australian health sector by.

**These options are explored more fully in recent papers by Jill Iliffe ('A New Approach to Australia's Health Workforce'[3]) and by Peter Brooks ('Health Workforce reform: rising to the challenge'[4])**

4. **Medicare is being threatened.**

The government is actively subsidising the growth of private health insurance (PHI). Projecting Australian Institute for Health and Welfare recorded premium rates; the PHI subsidy will cost the taxpayer $4.8 b in 2007-08. In addition, there is a tax loss of the 1% exemption from the Medicare Levy for all with PHI, estimated to cost $890 m in 2005-06. This tax loss escalates each year because the $50,000 individual exemption has not been indexed since 1999.

There are also other government subsidies to private health insurance, including TV advertisements in the run-up to the next election. In total, these subsidies for private health insurance are approaching $6 b per annum. But that would be an under-estimate, because it does not include the effects of higher utilisation and weak cost controls that inevitably flow from private insurance.

Every country that has a large PHI sector has associated high costs. The US is the standout example, which is now desperately trying to unscramble the disaster PHI has wrought. Countries that have pioneered public health insurance such as the UK and the Scandinavian countries have much lower health costs with comparable and sometimes better health outcomes (see 'Paying for Health' by CPD fellow Ian McAuley[5]).

Moral hazard is involved with all insurance ('I don't care what it costs if I have insurance') but Medicare has the advantages of equity, efficiency and buying clout to contain cost increases and ensure better monitoring of the quality of care. PHI is a passive price taker in the market. Fortunately, Australian PHI has not yet followed the example of PHI funds in the Netherlands who contribute to the cost of members' trips to Lourdes! But it might not be far away.

The trend to a two-tier health system in Australia is a serious threat. If only a handful of us want to jump the health care queue it is probably manageable. But when the government subsidises wealthy people in PHI to jump the queue, we are on the way to crippling Medicare. Tony Abbott says that the Howard Government is the best friend Medicare ever had. Words are one thing. Actions tell a very different and alarming story.

Reclaiming a universal public insurance system is critical. To some, such a system has connotations of a free public and 'socialist' system. A universal system however does not have to be free. We are much richer than we were 30 years ago when Medicare was established. At CPD, we recommend a rationalised and simplified system of co-payments to avoid some of the problems of moral hazard. Neither do we suggest that health delivery should be by public facilities alone. Far from it, we believe that a mix of public and private delivery is desirable. Australian private hospitals would be over $1 b better off per annum if the government subsidy was paid directly to them and not via the PHI financial intermediaries. Contrary to outdated ideology, the policy issue is not 'private hospitals versus public hospitals'. The issue is 'who better provides value for money, including the quality of the service.'

In the three years of the next federal government, $18 b will be spent on subsidies to PHI. Just

think of the new priorities that could be addressed with that sort of money – mental health and indigenous health, primary care, prevention and dental care. The capital cost of rolling out 200 primary health care centres across Australia to serve an average catchment of 100,000 persons per centre, would be around $4 b.

$18 b over three years could transform Australian health – what a political opportunity!

5. **The personal, public and social cost of mistakes.**

After examining more than 14,000 hospital admissions in NSW and SA, the national cost of harm from healthcare (adverse events) in our hospitals was estimated at $4.17 b per year in 1995-96[6]. At least 50% of that was avoidable or preventable and would nationally represent nearly 500,000 preventable hospital bed-days, every year. Commenting on the report, Professor Richardson from Monash University said:

> 'Medical errors have been responsible for the death of more Australians per annum, than the average annual death rate of Australian soldiers in WWI (15,800). Permanent disabilities per annum approximate the annual rate of casualties in WWI (62,500). … The conservative estimate of the unnecessary death rate (in hospitals) is about the same as would occur if the Bali bombing occurred every week of the year, year after year.' (ANZ Health Policy January 2005)

Whilst this issue has been clearly identified, there is a lack of commitment to solving this problem, despite numerous committees and tens of millions of dollars. In 2004, the Federal Government provided $580 m to subsidise medical indemnity premiums for doctors. It addressed the symptom and not the problem. Bundaberg Hospital is not a one-off, attributable to foreign doctors. The problem is endemic. Bundaberg Hospital is the tip of a very large iceberg.

A decade ago the $4.17 b the estimated cost of harm in hospitals (adverse events) represented 23% of recurrent costs in all hospitals. Assuming the same percentage of avoidable mistakes in 2004-05, the cost to Australian hospitals (i.e. taxpayers) would have been $6.5 b. This would be a conservative estimate, because ageing and the complexity of cases would have increased significantly in the last 10 years. There is a paucity of data, but on the basis of available information, it would not be unreasonable to estimate, very conservatively, that the cost, both within and outside the health system, of mistakes would be about $9 b per annum or about 10% of total health expenditure in Australia. At least half of that is preventable – $4 to $5 b each year.

Healthcare delivery can be described as "good people working in a faulty system". We are not dealing with performance issues by individual doctors and nurses, but rather, the 'system' in which they provide their care. The responsibility lies with tho who have custodial responsibility from a leadership, governance, funding and management perspective. There is a conspiracy of silence. This is a public health, ethical and financial problem of large proportions. It is a scandal. The risks from terrorism are miniscule by comparison.

The clear evidence in aviation safety is that the worst thing is to cover up safety problems and scapegoat those involved. There must be a culture of openness and transparency so that there is continuous improvement, with problems identified and responsibility widely shared. In aviation, investigations of accidents and near misses are very thorough but not judgemental. Reporting is encouraged and the remedies address both the proximate problems, and more importantly, the systemic problems.

Health is very different. There is a major cultural problem, whereby health practitioners – highly professional in their own specific areas – have little knowledge or experience of other industries and different ways of thinking and doing. As at the Bundaberg Hospital, junior staff, who often notice mistakes, are excluded and victimised. Complex systems need a healthy culture to

minimise risks. Health doesn't have a healthy culture.

In addition to these cultural issues, there are a whole range of organisational issues that health must address – rigorous peer review, accreditation, particularly of small hospitals, reliable and efficient recording, better hospital systems, consolidation of clinical services, clinical accreditation, but above all else, responsiveness, openness and transparency in addressing the problems.

Importantly, hospitals must bridge the gap between corporate governance and clinical governance. They often operate in parallel, but not together. Who really runs hospitals? If our patients were protected by many of the elements of our workers compensation statutes then they would be safer in hospital. If our health corporations (public or private) were subject to the public reporting and accountabilities of listed companies, then many current attitudes and practices would rapidly change.

The personal and public costs of avoidable mistakes are the large elephant in the room that we ignore.

6. **Erratic and inexplicable practice variations.**

There are large variations in the pattern of service delivery that are clinically inexplicable. Robertson and Richardson[7] (MJA, 2000,173, pp 291-295) found 'startling variation' in the use of well-known procedures in Victorian hospitals. Standardising the data, they found, for example that the observed variance to state-wide data was 13.4 times greater than expected for coronary angiography. For cataract extraction it was 15.4 times greater and colonoscopies, 45.3 times greater.

They also found 'in the 14 days following a heart attack, men and women admitted to a private hospital were 2.2 and 2.27 times more likely to receive angiography than their counterparts in public hospitals'. They were 3.43 and 3.86 times more likely, respectively, 'to undergo revascularisation (coronary by-pass surgery, angioplasty, and stent)'.

In the reviews that I chaired in NSW and SA, the same very large practice variations were obvious, and across a wide field with no discernible difference in health outcomes. Birth by Caesarean sections is probably the best known example with some areas quite notorious for interventions well above statewide averages.

These variations highlight two very obvious problems, or perhaps a combination of both – under-servicing and over-servicing through perverse financial incentives. Whether it is over- or under- servicing, it represents a misallocation of resources, or in plain English, waste.

These variations identified over 25 years ago have still not been addressed. There has been some discussion that publication of the data would help correct some of the more obvious variations. But doctors have invariably won the argument that the public wouldn't understand or might draw wrong conclusions from publication. As with quality and safety, there is little information or concern about the inequity and inefficiencies involved. Another elephant in the room.

7. **We have a sickness model rather than a wellness model.**

The Australian Institute of Health and Welfare (May 2007) identified 14 preventable health risks. The top five were tobacco smoking, high blood pressure, high body mass, physical inactivity and high blood cholesterol. These 14 preventable health risks accounted for 32% of the total burden of disease and injury in 2003. Yet only 2% of health funds are spent on public health and prevention. The rest is spent on medical services in treating sickness. Our health model is fundamentally flawed. It needs redesign to focus on keeping people well.

8. **The importance of primary care.**

We have a hospital-centric health system in which we regard hospitals as the first resort rather than the last resort. Our public debate is all about hospitals – waiting lists and congestion in emergency departments. Ministers produce health plans but they are really hospital plans. Just follow the money trail and see where the money really goes. The fact is we have too many hospitals and hospital beds when we need health resources out in the community.

All the international evidence is that a health system oriented towards primary care achieves better health outcomes, lower rates of all causes of mortality for overall lower cost and greater equity than a health system centred on hospitals.

In 'A new approach to primary care for Australia', a paper by Jennifer Doggett published by the CPD in June this year[8], we set out a primary health care system in Australia with indicative costings. We envisage that most of the multi-disciplinary primary health care clinics would be privately run. Some would be a mix of public and private, and there would be a mix of remuneration patterns – fee for service and salary.

Such a system would have major benefits in itself. It would provide an ideal platform for tackling key health priority issues, particularly mental health and indigenous health. It would also introduce a new structure in which to develop 21st Century work practices. A major roll-out of primary health care clinics would, over time, greatly relieve the pressure on state hospital budgets.

9. **Fragmentation of Commonwealth and State health programs.**

Another major structural problem is the fragmentation, gaps and lack of integration of commonwealth and state health programs, estimated to cost over $1 b p.a. The public doesn't give a hoot who supplies the services, as long as they are supplied safely, efficiently and on time. At the CPD we have proposed a 'Coalition of the Willing[9]' – establishing a Commonwealth/State Health Commission in any state where that state and the commonwealth could agree. We have set out pooling, coverage and governance arrangements. It is doable; provided there is political will and a willingness to let competent experts get on with the job within their areas of expertise.

But there is not only fragmentation and compartmentalism between commonwealth and state health programs. It often seems that the commonwealth's two major health programs, MBS and PBS operate in separate and unrelated silos. Through the Pharmaceutical Benefits Advisory Committee mechanism, the PBS has an excellent process of cost benefit analysis of prescription pharmaceuticals. Strangely, that process has not been extended to hospital and medical treatments under the MBS. We need cost and benefit checks across the whole of health care, including the inexplicable pattern of practice variation.

Both commonwealth and state programs at present are structured around providers. We need to fundamentally redesign program structures around users. In the 1960s manufacturing fundamentally changed in such a way. Whereas previously a car firm would have an engine division, an assembly division, etc., it changed to a small car division, a commercial vehicle division, etc. It made them focus on customers. Governments have picked up the rhetoric when they talk about program design, but it's not reflected in health programs.

10. **The system is not driven by patient and client needs. It is provider-driven.**

A major structural problem is that patients and clients are ignored. The debate is invariably between ministers and doctors. All the information and advice I have seen show that when informed community members are consulted, they have clear priorities. And it is not more hospital beds or shorter waiting lists or fertility treatments. Their priorities are mental health, indigenous health, prevention and primary care.

There are proven methodologies to tap the informed views of the community, e.g. citizens' juries. But in opposing community engagement, many doctors contend that patients don't really know what they need. Some ministers argue that they represent the community - so why should they consult the community?

The CPD has also published proposals for community engagement[10] to introduce countervailing power in health.

11. **The community is confused.**

Not only is the community excluded, but also it is confused by what is on offer. The aged and the frail find it almost impossible to navigate the system. Others are not much better off.

Consider for example Medicare safety nets. Once your out-of-pocket medical expenses in a calendar year exceed $1000, you are reimbursed by the commonwealth for 80% of any extra out-of-pocket expenses. That is provided you have kept receipts. On the way, you may have accumulated eligibility towards what is known as the 'gap threshold'; when the accumulated difference between the scheduled fee and the medical rebate, which is only 85% of the scheduled fee, reaches $354.50, all future claims are reimbursed at 100% of the scheduled fee. These safety nets relate to medical expenses only, and they operate on an individual basis. The safety net scheme for pharmaceutical benefits by contrast is on a family basis. And if you accumulate $1500 or more in out-of-pocket expenses in a financial year (not the calendar year of the safety nets) you can claim a 20% tax rebate on the excess over $1500. That's just the start, without going into special schemes for pensioners and others, the special but restricted programs for physiotherapy services, or the subsidies for PHI.

Not surprisingly, the community is confused, and those who thrive are accountants and those who use them.

12. **Costs are escalating rapidly**.

The problems outlined above contribute significantly to our escalating health care costs. I have indicated where budgetary 'savings' could be made, e.g. abolition of the $6 b plus annual subsidy for PHI; enhanced workforce productivity, $3 b p.a; reduced avoidable adverse events, $4 b plus p.a; and reduced waste of $1 b plus p.a. through lessening Commonwealth/State duplication. That's $14 b of tax wasted every year.

This waste must be seen within the context of a worsening trend of overall cost rises. In the 10 years to 2004-05, health expenditure at current prices grew at 8.3% p.a. – more than double the GDP growth rate. In the same decade, real growth of health expenditure has been 4.8% p.a. compared with population growth of 1% p.a. At the state level, health budgets are taking a higher and higher proportion of total expenditure, often over 30%. Ten years ago health represented 8.1% of GDP; it is now 9.8% ($90 b).

The Productivity Commission (Health Workforce Study, January 2006, p.25) estimates that health care expenditure could account for at least 16% of GDP by 2044-45. The growth of health expenditures is driven by unrealistic community expectations, ageing, high technology costs and these fundamental design problems. We don't need to spend any more real dollars on health. There is a huge volume of fat and waste in the system. We need better value for money through fundamental redesign.

## Why don't we address the problems?

There are several reasons why we fiddle with incremental issues when we need to address fundamental problems.

- Health is a complex and large system and that most of us, unless we have chronic illness, have only intermittent contact or interest with.
- Governments have a fool's paradise view that revenue from a once in 50-year mining boom will continue.
- Health professionals have an introspective view of the system, rather than looking at the system from the outside or as a whole.
- The system is built around provider interests, who are determined to maintain their privileged and protected positions.
- Whilst public employees work hard in the health system, they have inadequate interest in efficiency and system improvement.

But after examining Australian health as an outsider for over 7 years, I have come to one particular conclusion as to why we do not address the big structural issues. It is that there is insufficient political will to manage and contest the vested interests that abound in the delivery of healthcare. The health lobby that delivers health care, doctors, pharmacists, state health bureaucracies, PHI funds and pharmaceutical companies are given a summary veto on reform.

All of our attention is on the financing and demand side. That is what Medicare does. Medicare is the means by which we finance the established health delivery programs.

What we badly need is micro reform in health care to address the great structural problems on the delivery side that I have mentioned above.

There are none of the corrective or stabilising factors in health that have been established elsewhere in the economy over the last 20 years – a floating dollar, an independent reserve bank, and a flexible labour market. It was ministerial and political decisions that made these changes possible. We are not seeing the same in health. Yet if we can take the example of the Reserve Bank, we can see the benefits that could occur in health if ministers would stand back from day to day health management and allow independent and professional people to tackle the hard decisions – hard decisions that ministers so far have been unable to unwilling to take.

Manufacturing reform went down a consistent and patient path. It was steered by John Button with a great deal of consultation. It was more than just a courageous ministerial decision.

Rather than address the big picture issues and the health lobby, ministers retreat into media management and micro-management. Some defend their performance by asserting that the Westminster tradition of ministerial responsibility requires ministerial micro-management! The short-term and urgent supplants the long-term and important. Politics pushes out policy.

## So what can be done?

**Firstly**, in at least some states, ministers need to get themselves out of the media loop and micro-management. They need to instruct their senior executives to manage and explain a very complex and costly health system. Senior executives must be given real responsibility and not just accountability. Letting managers manage would be a great improvement. Hopefully it would also provide ministers with the thinking time to address their major areas of responsibility – values, principles and long-term structural problems. They need to keep out of the day-to-day health panics.

**Secondly**, we need a national, independent and professional authority to explain and drive

health reform, subject to government policies and guidelines. In Ontario, Canada, in 1996 the provincial government set up a Health Services Restructuring Commission, not only to advise on restructure in health but also to implement the restructuring. Ministers recognised that they were too subject to pressure by vested interests in the health sector and that a more arms length and independent commission could achieve outcomes that ministers couldn't. Ministers had shown that they were unwilling or unable to address necessary closure or rationalisation of hospital and clinical services. The Commission made significant progress and after a period, handed back its powers to ministers. A key in the Commission's success was public education so that the public could better understand and accept the necessary changes.

In Australia, the Health Insurance Commission and the Pharmaceutical Benefits Advisory Committee are two independent statutory bodies that work effectively in the public interest. They do not detract from ministerial responsibility. The SA Premier proposed an independent commission to manage the Murray Darling Basin, explicitly conceding that there is value in ministers standing back in order to better manage the vested interests who make good administration of the Murray Darling Basin very difficult. Working with a clear mandate, as the Reserve Bank does, an independent and professional health authority is necessary to explain and drive health reform.

**Thirdly**, I would urge federal and state Treasurers and Finance Ministers and their departments to actively engage themselves in the long-term issues that are contributing to the rapidly escalating health expenditures. They should insist 'no more money without structural reform'. Treasurers, Finance Ministers and their departments are not as beholden as Health Ministers to the health lobby. They are health outsiders - a distinct advantage. Greater involvement by Treasurers, Finance Ministers and their departments in health delivery could be a major factor in promoting fundamental reform. They could start by insisting that funding in the next Commonwealth-State Health Care Agreement be dependent on substantial and measurable improvements in health workforce productivity, and building a health system focused on primary care and not hospitals.

Administration of the $6 b annual subsidy to PHI should be transferred to Treasury, who would quickly recognise it for what it is – corporate welfare and not a health program.

It is significant that it was the Treasurer who commissioned the Productivity Commission to report on health workforce issues. It wasn't health ministers. I am not holding my breath on the outcome of the Productivity Commission's report, because implementation will be left largely to Health Ministers and their bureaucracies. I hope nevertheless it is the beginning of a major interest by Treasurers, Finance Ministers and their departments across Australia in health.

**The fourth** suggestion is that we need a two-stage approach to health reform. The first stage would include such issues as dental health, commonwealth-state fragmentation, prevention and primary care. I think the needs in these areas are clear and most of the solutions incontestable. The second stage of reform could include a public inquiry such as the Romanow Royal Commission in Canada[11] on such issues as reclaiming universal health insurance; the rationalisation and simplification of co-payments, and quality and safety. Such issues are complex and require public understanding and support for reform. Romanow was very important in underlining the social values – the importance of community – in any restructuring of health in Canada.

The Productivity Commission recognised the need in 1997 for an enquiry. It recommended 'a broad public enquiry into Australia's health system'. It was ignored. It is long overdue.

An inquiry would be an opportunity to involve the public in asserting its key role in health. Unless there is public understanding and support the vested interests will continue to make it difficult for the public interest to be asserted through government. An enquiry will open up the sector to detailed public examination, and make reform politically easier for governments. We need countervailing power in health to give ministers the political will to manage the vested

interests and assert the values of a national system of health care. Such a national enquiry should be continued over time through a professional and independent statutory authority that reports publicly to both the Health Minister and the Parliament along the lines proposed above.

The nervous nellies will still say that it can't be done – that ministers in today's political, economic and media climate can't be expected to stare down the vested interests.

But Australia has a good record in fundamental change. Curtin did it in modernising the economy in 1942. Whitlam did it with Medicare in 1975, despite a long and vitriolic campaign by the medical lobby. Fraser buried White Australia in the late 1970s. In the 1980s, Hawke and Keating gave us tariff reform and financial deregulation that laid the basis of our present prosperity. Howard has given us indirect tax reform and an independent Reserve Bank. The historical evidence shows that Australians will accept fundamental reform if it is cogently argued and the community is well-informed.

Further, what we are proposing in health is within a sector that is growing rapidly. Health expenditure is growing faster than total expenditure. The health workforce is growing at almost twice the rate of the total workforce. No-one should really fear for their jobs with structural reform in health. Australian blue-collar workers over the last two decades in textiles and auto manufacturing – when structural reform was introduced in a contracting market – faced much more serious problems. All change presents problems and some pain, but in a growing market and with our history of reform, I believe that we can address the serious system failures in Australian health. Political will is the key.

The political party in Australia that can demonstrate its determination to address these structural problems will also demonstrate its economic management credentials. Health is our largest and fastest-growing sector. It is our least efficient. The problem is not Medicare, which is a financing arrangement. The problem is the uncoordinated and inefficient health delivery programs that Medicare funds.

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## Endnotes

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