# The journey to better health care

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Australians are only too well aware that their health care system is increasingly unreliable, indeed dysfunctional. Public hospitals have major problems because of ever-increasing demand, under-funding and shortages of health professionals. The continuum of care that should link primary, community and hospital services is made all but impossible because of the inefficiencies associated with the great divide between the Commonwealth and the states. Planned surgery is rationed. General practitioners must raise their fees to survive. The fees for specialists make it increasingly difficult for many citizens to benefit from their care. Individual financial capacity is increasingly a major determinant of health outcomes. This is not good enough for a wealthy country like Australia, particularly when the major barrier to progress is political intransigence, rather than any lack of policy options. This chapter outlines proposals that have been generated by the Australian Health Care Reform Alliance, following a national conference and an extensive series of discussions with health professionals and consumer associations.

## Current directions

What sort of a health care system do Australians want? This question has been explored in detail over the past four years by the Australian Health Care Reform Alliance, an organisation composed of 50 of the leading health professional and consumer associations.[1] The Alliance speaks with one voice on health-related issues and hosted a national summit in August 2003. The imperatives identified in the resulting communiqué were re-endorsed at a second conference in November 2005.[2]

A broad consensus within the Alliance has reaffirmed what many others have assumed; namely, Australians want to provide health insurance to each other through payments indexed to taxable income so that *timely* access to *quality* services is available universally on the basis of need, not on the basis of personal financial circumstances. It is true that at no stage has Australia perfected a system based on these principles. But, until

the last ten years, the nation was moving in this direction, and was committed to continuing to do so. Now an obvious ideological divide finds Australia at a crossroads. Through both its words and, more importantly, its actions, the current Liberal-National coalition government led by John Howard is comfortable with the concept of the Commonwealth providing its definition of a 'safety net' to help less economically advantaged Australians, while the rest of the population moves increasingly to supporting their own health care in a user-pays system.

Critics of a universal scheme, which upholds the principle of equitable access and outcomes for all Australians seeking health care, claim the model is utopian. That argument will only be worthy of debate when the obvious efficiencies that could so markedly improve quality and cost-efficiency have been implemented. With nine health departments and some 15,000 health bureaucrats for 20 million people, there is between $2-4 billion to be saved annually in ridding the country of duplication, which could be invested in creating a system that would be far more successful in preventing illness.[3]

*Towards an integrated patient-focus*

There are numerous obvious major health-related problems that urgently need to be addressed. Australia's mental health care programs are grossly inadequate. Mental health problems rob more Australians of wellbeing than any other cause.[4] State and federal programs to address the issue are so disorganised and distanced that many who need help receive no co-ordinated care. There are far too few inpatient beds available for the management of psychiatric emergencies. Many with the worst problems wander our streets or populate our jails. The lack of forensic psychiatric units, where the dangerously disturbed can be detained and treated with dignity, is a shameful reality. While this year's promise by the Council of Australian Governments (COAG) to inject $500 million into the support of mental health programs is to be welcomed, the lack of any detail about the spending has left many concerned that the structural problems will not be addressed.[5] Money alone cannot provide the needed reforms.

Other obvious urgent problem areas concern services for our Indigenous population, dental health and people with disabilities. Our Indigenous citizens continue to

have disgraceful health outcomes, equivalent to those of the poorest countries on earth.[6] In this rich nation, we are constantly confronted with the tragic demonstration that social disadvantage, a sense of hopelessness associated with a lack of opportunity and cultural disintegration, creates lifestyles featuring abuse, with disastrous effects on health. There is an urgent need for a national dental health scheme, which should be funded like our medical benefits scheme. Poor oral health detracts enormously from health and wellbeing and is the cause of much malnutrition, especially among older Australians.[7] Indeed, oral health problems are the lot of a poorer underclass in our so-called classless society. And far more attention should be paid to the health care needs of Australians with disabilities. There can be no more important indicator of the equitable nature of our society than the manner in which we help those burdened with a physical or mental disability. There is a most unfair demand made on families caring for the seriously disabled, with inadequate financial aid and a lack of affordable respite.[8]

There is also much that obviously can be done to improve quality and safety in our hospitals and community care settings. The last national survey of avoidable misadventure in hospitals, for example, documented as many as 18,000 avoidable deaths a year in the over-stretched system.[9] An excellent first step to improve this situation would be the long overdue introduction of modern information technology. Electronic prescription writing would eliminate 90 per cent of medication errors. The introduction of electronic health records, which could be shared by all professionals, would add information at the point of patient contact and provide for advances in safety and quality that are already available in many other countries. We need approximately $2 billion to bring Australian health related information technology into the 21st century, an amount which expert analysis indicates would be returned within a very few years.[10]

Against this general background, what follows is a discussion of the four main reforms required to facilitate improvement. The discussion principally addresses the federal-state divide, workforce issues, primary care and hospitals.

**Bridging the federal-state divide**

The jurisdictional inefficiencies associated with having the national and state governments responsible for different segments of health care has produced a major problem for which solutions have been sought over at least the last 20 years. The current arrangements are now recognised by everyone who has looked into the issue as a serious impediment to the delivery of quality, equitable, cost-effective care. The arrangements represent a major historical mistake. Even the prime minister pointed out last year that, were we to design a health care system from scratch, we would not make the same mistake again. The federal health minister, Tony Abbott, has described the current arrangements as a 'dog's breakfast of a system'.

Under the current arrangements, the Commonwealth government is a 'purchaser' of health care for citizens and is caught up in funding a number of open-ended programs (for example, the medical and pharmaceutical benefits schemes), which provide little capacity to tie health expenditure to health outcomes. Under the Australian Constitution, the Commonwealth can purchase health care for its citizens, but not provide it directly. State governments are 'providers' of services that are partially supported by grants from the Commonwealth. Over the last 20 years it has become ever clearer that the lack of integration of the programs organised by the state and Commonwealth governments is resulting in costly duplication and inflation, plus a lack of capacity to focus on the needs of patients. This is particularly problematic where services required by individuals and communities need horizontal integration.

Within the current system, the needs of consumers are often neglected in the constant efforts of the governments to cost-shift sections of their health care portfolios between each other. If the Commonwealth supplies too few nursing home beds in a particular area, for example, a local public hospital may find itself unable to discharge patients who no longer need an acute care bed. This increases the hospital's costs and decreases its efficiency. On the other hand, many public hospitals are loath to continue to offer specialist out-patient clinics, preferring patients to seek help outside the hospital, where the Commonwealth government is required to pick up the costs involved under Medicare. Australians are only too well aware of the constant bickering between governments over responsibility for the problems and, if the polls on the issue are

accurate, they are tired of the 'blame game'. Polling repeatedly tells us that improving the nation's health care system is the number one domestic concern.

The inefficiencies are responsible for poorer health outcomes than necessary, the many problems related to the provision of health care across state borders, and the difficulty in promoting a partnership between public and private providers. The latter problem was highlighted before the 2004 general election, when the Labor Party advocated Medicare Gold, a policy that would have seen the private sector funded to care for the hospital needs of older citizens. With few exceptions, private hospitals have avoided the less profitable care of older patients, who need co-located acute care and rehabilitation services. The current arrangements have fuelled a disturbing culture of antagonism between state and federal authorities, rather than the collaboration, partnership and mutual trust that are needed to continuously improve citizens' health. Over the last two decades, promises from politicians to fix the problem have not been delivered, as the challenge always seems to fall into the 'too-hard basket'.

It is now obvious that the solutions present a leadership rather than a technical challenge. Clinicians, consumers and even the Productivity Commission have been very active in recent months urging governments to try again to find a way to abolish the inefficiencies.[11] This urging has resulted in the heads of government establishing a COAG working party to provide advice on ways of resolving the dilemma, while also providing a reform agenda to tackle a number of other significant problems. The initiative has been backed by the commitment of Australia's health ministers to promote health care reform and it provides, perhaps, our 'last best hope' of finding a way forward. In a very real sense, therefore, the months leading into the 2007 general election will answer the big question that many want answered. Are our political leaders really committed to significant health care reform, to improving the health of the citizens and to extracting more care from the available dollars?

*Achieving pooling*

Any solution must eventually involve the pooling of all federal and state health funds for redistribution by one planning authority, which will act in a patient-focused manner to

ensure that health care is targeted, integrated, fair and cost-effective. Pooling mechanisms could be introduced in one of the three following scenarios.

Firstly, the states could relinquish all responsibility for running hospitals, with the Commonwealth taking full responsibility for the nation's health care. This would certainly remove the inefficiencies, but Constitutional issues make it difficult, as it would probably require a referendum to seek approval for the change. While a 2007 general election win for Labor may see major opportunities for reform, in the current climate it is unlikely that the states would willingly hand over all their hospital funding to the Commonwealth, even though the Howard government and several premiers have played politics with the idea. Minister Abbott floated the possibility of the Commonwealth taking over in 2004; only to have some states express interest; only to have the minister declare that he would not be interested until the states had solved their hospital problems; only to have the prime minister completely reject the idea.[12] While this is the most difficult option in terms of political acceptability, many experts on the health system consider it the *best* option. You only have to look across the Tasman to New Zealand to see advantages that flow from having a national government responsible for a country's entire health system.

A second scenario would see the reverse, with Canberra providing the states with all the health dollars it currently spends, and the states offering a full range of health care services. This is close to the model that Labor proposed at the 2004 general election, with talk of a 'Medicare partnership' between the states and federal governments. The big weakness in this approach would be the retention of much of the duplication, which is extremely cost-ineffective, and service delivery continuing to be confined within state borders, which is nonsensical.

The third model would see pooled funds from the Commonwealth and the states being made available to a third party – for example, an Australian Health Care Corporation that would not be 'owned' by either the Commonwealth or state levels of government. The body would be managed by a board with consumer, professional and public service members and be accountable to a governing body of state and federal political leaders. Initially, the corporation would in all likelihood report to COAG, as the premiers and the prime minister have agreed that health reform will be driven by them,

not their health ministers and departments. Similar arrangements exist for the management of Australia's water resources, and they appear to be working well.[13] This model has many attractions, including abolishing the current inefficiencies associated with providing health care across state borders.

In reality, political tensions mean that Australia would need to embark on a journey toward a single source of funding, starting with individual states and the Commonwealth agreeing to pool funds in bi-lateral or tri-lateral arrangements that focus on the overlapping areas (for example, aged care). These beginnings could be regarded as 'experiments' or 'pilots', with the lessons that will be learned supplying a feedback loop for continuously improving the model, and perhaps attracting additional states. Programs that should be administered centrally (immunisation policies, quality and safety standards, nationwide health professional accreditation, etc) could continue to emanate from Canberra, but wellness and integrated health care programs would be delivered by regional health services, funded on the basis of local needs and the population base. This scenario would allow Australia to adopt recent improvements in the provision of health services in both the United Kingdom and New Zealand, which were made possible because these countries have all their health care dollars in a single 'pot'. This third scenario is favoured by the Australian Health Care Reform Alliance. What would be required to take us on a journey to this outcome?

*The journey to health reform*

Improving the integration of health programs must accommodate a number of political realities. There is a palpable mistrust between the levels of government that make it certain that no state would presently relinquish all its health responsibilities to the Howard government. It is therefore important to acknowledge that there is no 'quick fix'. It is, in the opinion of the Alliance, essential for all parties to accept the concept of a reform 'journey'.

Even if the COAG working groups were to produce an excellent and politically acceptable raft of reform proposals that were supported by Australia's health ministers, history tells us that it is highly likely that the proposals may remain just that. Many

excellent reports have already been presented to governments, only to gather dust on the shelves in the corridors of power. For this reason, a crucial suggestion by the Alliance involves the establishment of a task force to implement reform strategies. This task force could be constituted as, say, a National Health Reform Council (NHRC) that reports directly to COAG. Keeping the nation's political leaders involved in the journey is crucial, as many of the reforms involve issues not handled exclusively by the health ministers and their bureaucracies. There are, for example, socio-economic factors driving health outcomes that require a whole-of-government and community approach for resolution.[14] While the NHRC's strategies would require endorsement by COAG, their implementation would often require the co-operative efforts of the health ministers through the Australian health ministerial council.

A threshold challenge is for our political leaders to champion the creation of the concept of the NHRC. Before the last general election, Labor's shadow health minister promised that her party would establish a reform commission within a month of winning office. That pledge now needs to be updated. It is encouraging that Labor has recently committed itself to working with the states to rid the country of the current divided responsibilities. If the premiers, chief ministers and prime minister are to be taken seriously on health care reform, they will need to embrace the commitment to a health reform task force through COAG.

*The NHRC (National Health Reform Council)*

The concept of the NHRC entails a body that would have an extended role on the Australian health care landscape, remaining active for at least the next few years. The demands on health care systems around the world, with ever improving technology, the rapid aging of the population, constant challenges from new disease entities and the re-emergence of more serious infectious diseases, means that a body that could facilitate rapid adaptation to changing requirements makes perfect sense. The sustainability of the desired health care programs will require an ongoing, major overseeing effort to ensure that cost-effectiveness is achieved, with the dollars spent actually producing better

outcomes. For this reason, the NHRC must be established as a living, breathing, full-time, innovative, well-resourced, transparent, inclusive semi-independent, dynamic entity.

Of course the initiative would involve the establishment of a new agency, but it would not necessarily require an increase in the bureaucratic workforce. All jurisdictions have knowledgeable and talented professionals in their health departments who work on the interactions of state and federal health care programs, while others are involved in the most important issues a NHRC would tackle on an ongoing basis; namely, manipulating our health care resources to provide a 'wellness' model and the fusion of state and federal programs. Bringing these talented individuals together in partnership with consumers and clinicians would make it possible to reduce significantly the number of bureaucrats involved in delivering Australian health care, freeing funds for investment in the many obvious urgent health problem areas. Charged with taking Australia on the reform 'journey', the NHRC would be led by a chief executive officer, be staffed by experienced bureaucrats and have full-time clinical and consumer involvement.

**The mission of the NHRC**

There is little controversy about the four major issues that must be addressed to promote health care reform: (1) the provision of an adequate workforce; (2) the development of a health system promoting wellness; that is, the prevention of disease and earlier diagnosis to minimise the development of chronic disease; (3) the integration of health care programs to increase quality and therefore improve health outcomes, while addressing cost-effectiveness; and, (4) the development of a hospital policy featuring the networking of facilities and their integration with primary care services. These four issues cannot be addressed independently.

*1) Workforce shortages*

The nation has a major shortfall in the number of health professionals needed to prevent illness and deliver health care.[15] So often, governments find themselves in the media spotlight, as headlines detail the lack of beds available in public hospitals. Governments

typically react by providing additional funds to correct the situation, only to find that there are no nurses available to open the beds. The average nurse in Australia is 47 years old. It is increasingly difficult to attract young Australians into a profession wherein, at least in hospital-based services, shift-work is inevitable and daily duties are intellectually and physically demanding. Remuneration and working conditions must be made attractive to those drawn to this vocation. The last COAG meeting announced a welcome though inadequate increase in the number of places for nurse education at universities. To increase their attractiveness, the suggestion that these places not attract a HECS fee should be seriously examined.

A number of other issues related to the availability of medical care also need to be addressed urgently. These include the insufficient number of doctors due to the increasing casual nature of the medical workforce, the misdistribution of the available medical workforce and the increasing reports of professional dissatisfaction, which might deter young people from a medical career. Increasingly, medical graduates are female, and many young doctors of both sexes want to work part-time so that they can enjoy more diverse lifestyles. This is easily achieved in the current workforce climate, and hence many hospitals are engaged in a daily struggle to hire casual employees to cover night-time shifts. The impact of this situation on quality and safety is a cause for great concern.

The current reliance on doctors who have been trained overseas is troublesome for a number of reasons. It is clearly preferable for a doctor not only to be skilled in the science of medicine, but also to be culturally attuned to the patients for whom he or she must care. This is obviously easier to achieve with health professionals trained in Australia. Looking at the significant proportion of doctors imported from developing countries, one must stop and query the ethics of trying to solve Australia's workforce problems with professionals who are even more urgently needed in their home countries. Allied health professionals are also in short supply. This is particularly true in the public sector, as remuneration for these professionals is now much more attractive in the private sector. Until pharmacists, radiation technologists, physiotherapists and other allied health professionals are paid what they would earn working outside the public system, Australia

is not going to solve the shortage and the problems of quality, safety and efficiency that this generates.

The NHRC would be charged with implementing acceptable recommendations from the Productivity Commission on workforce issues. A major deficiency in the recommendations to date is the non-integration of workforce planning with the future models of care. The NHRC would be able to solve this problem by simultaneously addressing both issues. The Productivity Commission is currently calling for four new programs to improve recruitment, training and other issues related to the health care workforce.[16] All these programs should be integrated within the NHRC. A plan must accept the need for Australia ultimately to be self-sufficient in supplying the workforce for the health care system, and we need our governments to turn this ambition into a policy decision. Many would also argue that we have a responsibility to train sufficient health care professionals to assist with the improvement of health in the countries surrounding us.

*2) Remodelling primary care*

The recent Senate inquiry into problems with Medicare missed a golden opportunity to ask what contemporary Australia needs from its primary health care professionals that they are not currently providing.[17] Instead, the senators dealt with the less important issue of what remuneration should be awarded to general practitioners to ensure that bulk-billing rates remain high. If the preferred question had been addressed, funding models could have been generated to ensure that primary health professionals could deliver two much-needed reforms. The first demands that much more emphasis be placed on preventing illness and maintaining wellness. The second necessitates the restructuring of primary health care so that many patients currently being sent to hospitals can be cared for in a community setting.

Bulk-billing rates are very important. Yet patients are only too well aware that it is the *quality of the service* they receive from their doctor that is all-important, as this is the major determinant of the outcomes achieved. In the delivery of primary care, the system is becoming increasingly less fair. In many poorer socio-economic areas, doctors

have little choice but to bulk-bill. When pressures force them to ask for a co-payment, we know that a proportion of patients will stay away from the doctor's surgery. In some areas, the situation exists where doctors have to make their income through the *volume of services* they provide. Perversely, this price-volume trade-off inevitably means that, increasingly, those whose lifestyles are putting them at risk of developing major illnesses will often receive the least quality time with their doctors, even though they need the most. This is why epidemiologists report that citizens in poorer socio-economic suburbs in urban areas are five times more likely to die prematurely of a preventable disease that those in wealthier suburbs. The divide is even greater between country (eight times more likely) and city and far greater (20 times more likely) between Indigenous Australians and other Australians.[18]

Australia needs to explore alternative models of remunerating general practitioners that can overcome these difficulties. To do so, we must experiment with programs that move away from the exclusively fee-for-service payments that characterise primary care. As other countries have done or are doing, this involves exploring the appropriateness of offering general practitioners up-front payments; that is, contracts to care for patients with chronic and complex diseases, with the remuneration making it possible for them to look after patients at home rather than sending them to hospital.[19] This is the ultimate solution for addressing the hospital crisis. This model of care, however, requires another major development. Doctors need to work as members of *primary health care teams* where health care professionals, such as specialist nurses and other allied health professionals, are available to provide many of the services currently provided by doctors. This means extending Medicare payments to health professionals other than doctors.

This proposal is supported in the workforce paper provided to COAG by the Productivity Commission, but is yet to be accepted by the Howard government. Primary health care teams would focus on the personal needs of patients and pay attention to individual health plans that help avoid illness. Only part of the work of general practitioners need be remunerated in this way. A number of standard services could continue to be available through a fee-for-service mechanism. A similar system exists in New Zealand where, without any coercion, 80 per cent of general practitioners have

embraced the model. Seventy-five per cent of New Zealanders are now registered patients of primary health care teams. Hospital admissions have fallen, and a genuine partnership between hospitals and primary health care organizations has emerged. In south Auckland, for example, hospital admissions have fallen by 8 per cent, while admissions in Australia have continued to rise by 2 per cent per year.[20] Many of Australia's general practitioners have already indicated their enthusiasm for trying the model. Both the Royal Australian College of General Practitioners and the Divisions of General Practice have publicly supported moving to a new model of care that emphasises the team approach to prevention and earlier diagnosis.

The importance of this approach is underscored by studies which show that half those who have diabetes do not learn of their problem until a major complication occurs. Only the wellness model can help tackle the epidemic of obesity. The major stumbling block in implementing these changes remains, as usual, the need for federal and state governments to pool funds to allow the appropriate business plans to be developed. There is also an important corollary to the modelling. Currently, the majority of Australians do not have one doctor to conduct their health care orchestra. The concept of a family doctor providing continuity of care is fading. At the same time, there is little discussion of the mutual obligation Australians have to each other to pay attention to staying well, given that someone else's tax dollars will support them when they are sick. The concept of 'minimal obligation' may amount in practice to no more than needing to be a registered patient of a primary health care team that would provide specific advice on lifestyle, yet this would be an all-important preventative development in the remodelling of primary care.

What is clear is that, if we are to successfully introduce new models for primary care delivery, we must have a state and federal government partnership. The NHRC would be the appropriate vehicle to pursue this partnership. In taking Australia on the journey towards a wellness model of health care delivery, the NHRC would be charged with helping introduce what is referred to as 'organised primary care' in a partnership with clinicians and the community. The establishment of integrated primary health care organisations would feature a 'team medicine' concept, involving a more mature approach to clinical role delineation among team members. These advances will provide

a better capacity for health promotion and the prevention of avoidable disease, earlier intervention to minimise the onset of chronic disease and the capacity for clinicians to care for more people in a community and home setting.

*3) Hospitals*

Particularly in recent years, there has been insufficient political honesty about the problems within the hospital system. Many consumers feel that, no matter which public hospital they attend, they will find a broad range of services available, including those for the management of emergencies, and that all these services will be of similar quality. Given the workforce situation, this is not true, and is never likely to be true. Nothing is more important for improving quality and safety than explaining to the public the reality that role delineation for individual hospitals will ensure that the services they do offer, although not the full range, are of the highest quality. Hospitals should be networked so they create, in a given region, 'a string of pearls', with each hospital offering programs of excellence where the workforce skill mix is available to do the job properly.

No matter where an Australian enters the hospital system, they should be triaged (sorted into medically related groups) and assisted in moving to a facility that does have the capacity to care adequately for their problem. Increasingly, evidence suggests benefits in this 'centre effect'. If a person requires a major gynaecological cancer operation, for example, that surgery should be performed in a centre where a team of experts can provide the patient with world's best practice. To provide this quality, it is necessary to restrict the service to a very small number of sites. Consumers should understand that, while the services that they access frequently (for example, dialysis three times a week) need to be provided close to home, for those once-in-a-life major events, geography is far less important than quality. Even if Australia had the appropriate number of health professionals, the opening of the additional public hospital beds that are critically needed at the moment is not the ultimate answer. The primary care remodelling described above, will provide the best solution for the pressure on the country's hospitals by reducing the demand for hospital admissions. As it is Australia is forced to operate more hospital beds per capita than most OECD countries**.**

Current data proves beyond doubt that the almost $3 billion used each year to support private health insurance does not achieve the goal of relieving pressure on the public hospital system.[21] Private hospitals provide a range of very different services to those that place pressure on public hospitals. The vast majority of Australian emergency department services are only available in the public sector. Most sophisticated tertiary and quaternary services are also only available from the public hospital system. The federal government has consistently confused increased activity in private hospitals (not in itself necessarily a bad thing) with a reduction in pressure on the public hospital system. What is needed is a partnership between the private and public hospitals, with considerably more of the private health insurance dollars going directly to hospitals rather than to third party payers. With appropriate leadership, policy makers can do far more to promote synergy and collegiality between private and public hospitals.

*4) Integrating state and federal programs*

The NHRC would be responsible for taking us on that part of the reform journey that would see an ever-increasing integration of state and federal programs. Thus, the NHRC could be involved in assisting with the development of bilateral and trilateral agreements between Australian governments around specific programs. Examples include the integration of primary and community care services, the integration of cross-border programs and the fusion of numerous state and federal programs aimed at improving the care of older Australians. The Commonwealth would always be a partner in these bilateral and trilateral arrangements and the NHRC would promote the pooling of funds to achieve the goals of the fused programs.

Importantly, the NHRC would establish and evaluate the governance mechanisms set up for each of these joint Commonwealth-state ventures. In this way, as we proceed along the journey, we would learn what safeguards produce appropriate comfort zones for state and federal governments, making them more confident that they can, through collegiality and partnership and a determination to focus on the needs of the community, end many of the current jurisdictional inefficiencies. The partnership that we need between federal and state governments must be supported by efforts to promote and

evaluate partnerships between the public and private deliverers of health care. The NHRC would also be charged with driving these initiatives.

**Engaging Australians**

Given that health, wellbeing, happiness and productivity are so deeply intertwined, it is imperative to know whether the ideologies and philosophies being brought to healthcare reform by governments and non-government organisations reflect the current and considered views of the citizenry. The Australian Health Care Reform Alliance believes it knows what Australians want in the way of healthcare, but admits it does not know as a matter of empirically verifiable research. Neither does the Commonwealth government, as there has been no in-depth community dialogue on the issues to guide the policy architects driving the reform agendas. This combination of faith and ignorance is not the situation in other countries tackling the major reform imperatives. Canada, (Romanow enquiry), Sweden, France, New Zealand and, most recently, the United Kingdom are but some of the countries that have appreciated the need for in-depth consultation.[22] In the latter, the conversation the Blair government is having with the British people is resulting in a fundamental policy change towards prevention of disease and early diagnosis – the 'Choosing Health' commitment. As re-structuring is contemplated in our country, it is time to give Australians the opportunity to make their wishes clear.

In a serious public conversation on healthcare, we would need to ask some fundamental questions. Do we want a system where users increasingly pay for care with less and less public support, with a safety net provided for those the government defines as poor and incapable of self-sufficiency? Alternatively, would we prefer to maintain and strengthen a system where access to quality service in a timely fashion is available to all on the basis of personal need, and not individual financial security? Are we prepared to pay for this system through taxation? If we insure each other from the financial burden that can accompany illness in this way, does such collective largesse impose on us, as individuals, obligations to pay attention to our health? If the answer is 'yes', would we be willing, as is the case in other countries with a national health system, to have maximum Medicare benefits available to us only if we were registered patients of a primary

healthcare team that would help us avoid risks to our health? Is the nature of the way we care for each other an important Australian characteristic we would wish others to appreciate? Do we wish our government to use our wealth to supply more services and smaller tax cuts?

The Alliance has written to the prime minister and premiers urging that COAG provide the impetus for a serious community debate on the expectations and priorities Australians have for their health system, and for an exploration of what would be involved in implementing the proposals outlined in this chapter. We have suggested six months of intensive community consultation with the results being presented at a national health care reform conference. In our opinion, the NHRC would engage the Australian community in a significant and detailed dialogue about health care into the future. The NHRC would implement programs that would engage, inform, listen to and empower the community to provide direction for, and facilitate the embrace of, the changes.

**What waits at our destination?**

It is conceivable that in the course of a journey that produces a continuous improvement in health care, political leaders and the community alike may decide on the central government assuming responsibilities for all aspects of the system. The Alliance believes that it is more likely that the journey would arrive at the formation of an Australian Health Care Corporation; a third party that would run health care on behalf of both state and federal governments, accountable through COAG to the parliaments and the Australian people. What is clear is that a NHRC, which utilises the best talent and recognises the need for discussion and research to continuously improve our programs, would be best suited to developing the models that will provide the superb health care system Australians deserve and can afford into the future.

It can be anticipated that, in the short-term, the commitment to reform and the establishment of a NHRC to provide leadership would generate public enthusiasm. Australians are tired of the constant blame-shifting that is a feature of every story about problems in our health system, and they would welcome signs that political leadership is at last moving us forward. These initiatives would see an end to cost-shifting and an end

to perverse and inappropriate outcome measures, while increasing the amount of 'health' being extracted from the available dollars. In so doing, these reforms would do much to resolve problems related to the inequitable access to and outcomes from health care that is so troublesome in contemporary Australia. Professionalism rather than politics would be allowed to dominate the health agenda. The restructuring of a health care system that is failing to keep up with contemporary needs could again provide Australians with a system second to none.

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**Notes**

1. Information about the Australian Health Care Reform Alliance (AHCRA) can be found at the organisation's website www.healthreform.org.au

2. The communiqué from the national summit is available on the AHCRA website, as are the details of all the papers presented at the November 2005 workshop (see 'workshop').

3. See, for example, William Birnbauer (2006), "Crazy state system costing us billions", *Age* 5 August.

4. See Burgess, P., Pirkis, J. et al. (2002), *Mental health needs and expenditure in Australia*, Report to the Commonwealth Department of Health and Ageing, Canberra. Gordon R W Davies (2005), "The crisis in mental health: the chariot needs one horseman", *Medical Journal of Australia*, 183 (5): 277

5. Details of COAG initiatives on health are presented on their website www.coag.gov.au

6. See studies documented by Australian Institute of Health and Welfare, "Australia's Health 2002"

7. See Mark Shifter (2004) "An effective dental health scheme needs more than funds for fillings", first published in the S*ydney Morning Herald* and available at Online Opinion, 5 February.

8. See interchange respite care website www.interchange.respite.org.au

9. See Wilson RM, Van Der Weyden MB (2005), "The safety of Australian healthcare: 10 years after QAHCS", *Medical Journal of Australia*, 182: 260-261.

10. See Alden Solovy (2006), "**T**he 100 Most Wired**:** The Quality Connection" ,*Hospital & Health Networks*, 12 September (online at hospitalconnect.com)

11. See Productivity Commission (2005), *Productive reform in a federal system*, Roundtable Proceedings, 27-28 October, Canberra.

12. See Mark Metherell (2004), "PM's grand plan to take over hospitals", *Sydney Morning Herald*, 10 March; ABC Radio (2004), "Howard rules out backbench push for federal hospital takeover", *The World Today* 10 March.

13. The national water initiative is under the control of the national water commission. See website under Australian government

14. See review at public health association website: www.phaa.net.au on socio-economic determinants of health outcomes

15. Productivity Commission (2005), *Australia's Health Workforce*, Research Report, Canberra.

16. Ibid.

17. Senate Select Committee on Medicare (2004), *Second report: Medicare Plus: the future for Medicare?* Commonwealth of Australia, Canberra, 11 February.

18. See Strong K, Trickett P, Titulaer I, & Bhatia K (1998), *Health in Rural and Remote Australia* (Australian Institute of Health and Welfare, Canberra.

19. An extensive examination of global trends is readily available by searching online for 'primary care, prevention and wellness'.

20. For a good review of trends in New Zealand, see online at http://www.moh.govt.nz/primaryhealthcare

21. See David Cromwell (2002), "The lore about private health insurance and pressure on public hospitals", *Australian Health Review*, 25 (6), 72-74.

22. See an excellent discussion in the articles (1) "The future of public health in Canada" published on line by the Canadian Institute of Health Research. Department of Health (2004) and (2) *Choosing Health:*

*Making Healthy Choices Easier (*White Paper, UK Government) on new ways to deliver primary care. Both are available online.