Managing the Demand and Improving the Supply of Health Services

Submission to the Senate Community Affairs Committee Inquiry into the Fairer Private Health Insurance Incentives Bill 2009 and three related bills: by John Menadue, Centre for Policy Development

Submission from John Menadue, Centre for Policy Development, to the Senate Community Affairs Committee

I would like to draw the Committee's attention to the following points in relation to the current Inquiry into the Fairer Private Health Insurance Incentives Bill 2009 and three related bills.

For further information, please see the Centre for Policy Development website at http://cpd.org.au/category/all-articles/health-o

Main Points

- Healthcare costs must be contained, particularly if we are to live within the cap of 2% real expenditure growth that the Federal Government has determined. There is no way the Government can achieve a 2% cap on the growth of annual real spending in health unless demand is better managed and the system-wide supply problems are addressed.
- The rapid growth in health costs, at about 5% pa in real terms, is being driven by increased usage. We all use health services too much. Ageing is not the problem.
- The health sector is largely unaccountable for its performance in any meaningful way to its funders, the taxpayers.
- We need a community dialogue to highlight that, with limited resources, hard choices have to be made and that as individuals we need to take more financial responsibility for our use of health services. The 'moral hazard' issue must be addressed. Fee for service (FFS) must be modified to minimise perverse incentives in treatment. We could learn a lot from the Canadians about the way they go about their public dialogue, from the Romanov Royal Commission through to the current Health Council of Canada. The Council has the great advantage of being government funded, but being able to operate largely free of health bureaucracies like those which imperil health reform in Australia.
- There are many ways to improve productivity and achieve savings that amount to over $10 billion per annum. Resources are poorly utilised. We don't need to spend more. We need to spend it more wisely. The only proviso I would make is that we probably need to spend more in the short term to address 'bottlenecks' like emergency departments whilst the long-term restructuring is put in place.
- Past incremental and band-aid responses will not achieve the reforms we need. It requires far-reaching structural and systemic changes that will confront powerful vested interests like the AMA, private health insurance funds and state governments and their health bureaucracies. These vested interests will accede to incremental reform but remain vehemently opposed to any structural reform that would threaten their interests. It is no help when the interim report of the National Health and Hospital Reform Commission (NHHRC) blithely skates over the structural problems by accepting the existing 'overall balance of spending through taxation, private health insurance and individual out of pocket contributions'. The health sector is in dire need of structural reform. That 'overall balance' must be changed.
- The Productivity Commission is better-equipped than the NHHRC to bring the economic rigour and 'outside view' (free of conflicts of interest) that we need to address the big issues, particularly curbing over-use and getting better value for money. The Department of Health and Ageing shows far too little concern for efficiency and value for money.
- The Government is sadly lacking in clarity about what it wants to do in health, in contrast to the clarity that characterised Labor's establishment of Medicare in 1974. The Government's health strategy is a well-kept secret. But I remain hopeful.

MANAGING THE DEMAND AND IMPROVING THE SUPPLY OF HEALTH SERVICES

The Problems

We are demanding too much in healthcare. Our healthcare costs are growing fast. We are not getting value for the money we spend. We are spending too much and in the wrong places. There is little accountability for the money we spend. And there is no consistent policy framework, or even a set of overarching values, to help us address these problems.

1. Excessive Demand: Medicare health services per head have increased dramatically from 7.1 services in 1984/85 to 13.1 services in 2007/08. In 13 years, we have almost doubled the number of times we visit a doctor or a hospital. Some providers, for example in obstetrics and pathology, clearly charge too much, but **the real problem we must face up to is that doctors do too much**.

The health sector is under enormous pressure and criticism. We expect too much of our health system with an almost limitless growth in demand for health care. But I am yet to hear a health minister who will publicly say so. As a result, professionals and dedicated people in the health sector are demoralised, the community is dissatisfied and many avoidable mistakes occur.

2. Excessive Cost: Australian health expenditure is rising rapidly. Ten years ago, it represented 8.1% of GDP. It is now 10%.

The states have dramatically increased their health expenditures to over 30% of their budgets.

Commonwealth government spending on health is the second largest expenditure item - $51 billion in the last budget. That spending has been increasing at about 5% in real terms per annum, compared with a population growth of 1%. Commonwealth governments have been able to fund increased health expenditure in part through the revenue gains from the China boom – but no longer. The government says it will place a 2% pa growth cap on real government spending to restore the budget to surplus. **Health must be a prime candidate for major expenditure downgrades.** We need to spend more wisely.

3. Little accountability: Despite the rapid increases in costs and the escalating demand, **health care is not accountable in any meaningful way for what it produces**. It is quite unlike almost any other industry. The cost/benefit of pharmaceuticals is rigorously tested, but this does not really happen anywhere else in health care – despite taxpayers paying over 79% of doctors' incomes. This is quite extraordinary and taxpayers have a legitimate question when they ask 'Are we getting value for money?'

In a survey[i] published by a Canadian senior citizens group, 97% of over 1800 respondents over 45 years of age said that health care providers should be required by law to meet certain service benchmarks in such areas as waiting times in both the public and private sectors, patient outcomes and the use of preventive strategies like screening. 78% said that providers should be fined, terminated or suffer a cut in pay if they didn't meet the benchmarks. That sounds like a lot of consumers who are fed up.

The survey also asked the group 'Do you believe health care in Canada will improve if the government spends more money on it?' – 58% said 'no'. That sounds like good sense.

4. No policy or values framework: The Commonwealth Minister for Health and Ageing has appointed numerous health reviews with mixed results so far. In some instances, the reviews have provided a platform for the private health insurance industry, as the National Health and Hospital Reform Commission (NHHRC) did with its draft proposal for the delivery of dental care by churning taxpayers' money through private insurance companies.

The Commonwealth Government has no over-arching values to guide its health programs, like universality, social solidarity, equity and personal responsibility. It lacks guiding principles like a single payer, efficiency and choice. If the government is not prepared to spell out its values and

principles in the terms of reference of an inquiry, it cannot be surprised if the results are confused and disappointing.

Our health care arrangements are not embedded as they are in the United Kingdom, Canada, New Zealand and Scandinavian countries. Each program reflects the priorities of the time it was introduced – the overall fiscal environment, the topical needs (e.g. pharmaceuticals in the late 1940s), and the prejudices of the political party in government – particularly the Liberal Party's obsession with private health insurance (PHI) – an obsession which transcends that party's own espoused values. Government health policies are pushed and pulled by the special interests that dominate the health sector – AMA, PHI, drug companies, pharmacies and health bureaucracies. The community and patients are largely excluded from this closed and privileged circle.

The fiction about ageing

The major excuse for escalation of health costs is that our population is ageing. But the facts refute this. There is continual growth across all age groups as the following figures show.

Annual percentage growth in number of Medicare services/head of population 2003/04 – 2007/08[ii]

Age group	Female	Male
0-4	2.2	2.3
5-14	2.4	2.2
15-24	4.1	2.1
25-34	3.0	2.2
35-44	3.6	2.7
45-54	2.5	2.8
55-64	2.5	3.1
65-74	3.1	3.1
75-84	4.9	9.1
Over 85	2.7	1.9

Note that the oldest group, over 85 years, had lower growth in the number of Medicare services than younger age groups. The same broad patterns of growth rates for age groups in the period 1986/87 – 1990/91 show that the growth was concentrated in the ages 25 to 74. If ageing were a strong driver of usage, we would expect that the oldest categories to have the highest growth of all, for unlike other categories the average age of people in these open-ended age-groups would be rising strongly. In other words, health care is rising for all categories. Age is only part of the story.

The Productivity Commission confirms that '… to date, population ageing does not appear to have been a major driver of increased demand for health services'.[iii]

Professor Jeff Richardson of Monash University's Centre for Health Economics, in his paper on the 'Lamentable State of Australian Health Reform' in March 2009 put it 'Ageing per se in the absence of technological change would have minimal effects on expenditure. … The … link between ageing and health expenditures as a percentage of GDP is simply disinformation.'

The Health Council of Canada has come to the same conclusion. 'The largest controlling factor in this rise (in health costs) is neither ageing nor population growth … it is increased use.'[iv]

Let us first consider how we can better manage the **demand** for health services and second, how we could get better value for money for our health dollar – improving the **supply**.

Managing the Demand for Health Services

How can we manage and reduce the demand for health services in a rational and equitable way? There are three particular issues that must be addressed.

1. Establish priorities: As a community we all expect more from our health services than they can possibly provide. Health services are not free goods. We can't have all we want; yet the pressure for more of almost everything is insatiable. We have to choose in a sensible and inclusive way the priorities in health spending.

In informing the community and establishing priorities in health spending, we need a process of community debate and dialogue. This dialogue, led by the government, needs (a) to inform the community that choices have to be made and (b) to obtain from the community a clear expression of its priorities in health spending, e.g. more or less spent on end of life treatment, or IVF, or super specialties, or indigenous health or mental health.

The Canadians are more successful than any other country I know in their public consultations and dialogue, which gives the community better knowledge and a sense of control over where their health dollars go. Through deliberative polling and citizens' juries we can gain informed community views about priorities at all health delivery levels. Health services are rationed informally every day, but it is done in a haphazard and inequitable way. Through intensive and continuing community dialogue, governments can be better informed about the broad priorities that should guide the rationing process.

2. Overhaul co-payments: The second 'demand' problem is that with a 'social system' rather than a 'market system' of care, we face the hard issue of 'moral hazard'. With both public and private health insurance, we are encouraged to believe that it really doesn't matter how much the doctor charges or how often I see him or her. That is an invitation to over-use because we don't have to face up to the financial consequences of our decisions. Neither the patient nor the doctor has to face up to them. Patient incentives should encourage individuals to make more sensible decisions about usage of health services.

We need to review our co-payments, particularly for medical services and pharmaceuticals. Our co-payments arrangements, including the safety net, are a dog's breakfast. They are hard to understand and achieve few of the disciplines that are necessary:

- Some services are free, the safety net for medical expenses operates on an individual and on a calendar year basis.
- The safety net scheme for pharmaceuticals is on a family and financial year basis.

Australians as a community are vastly richer than we were 35 years ago when Medicare was established. The mean household net worth of Australians was $563,000 in 2005/06[v]. Many older Australians are very comfortably off. We could pay much more, particularly as a financial encouragement for us to make better decisions about the way we use health services. A revised co-payment scheme would need to be constructed to ensure that people on low incomes are not disadvantaged. It is ironic that a major driver of increased health usage is higher incomes, yet at the same time we maintain the fiction that we shouldn't have to pay more.

3. Reduce fee for service: The third factor contributing to the burgeoning demand is perverse incentives that cause excessive servicing. Our health dollars are skewed towards the treatment of sickness (over 90%) rather than keeping people well (less than 10%). With the skewing of medical effort, fee for service (FFS), together with subsidised PHI provides an obvious incentive for some clinicians to over-service. Doctors are paid by the quantity or number of their services rather than their quality. The worried well are easy prey. If a clinician can see more patients and can perform more procedures, that clinician will be paid more. The temptation is real. It partly explains why Medicare services have almost doubled in 13 years, why caesarean section rates have increased from 18% of births in 1991 to 30% in 2005[vi] and why joint replacements have almost doubled in 10 years.[vii] In some instances, for example in acute care, FFS may be appropriate, but it is much less appropriate in charging for the long-term treatment of chronically ill patients. It also encourages revolving door behaviour. The remuneration mix needs major overhaul. Minister Roxon is badly advised when she says 'the doctors' FFS system would remain central to Medicare'[viii]. It should not remain central if

over-servicing is to be curbed.

To reduce over-servicing, governments needs more rigorous guidelines on payments for FFS treatment. If and when governments embrace large-scale multi-disciplinary community health clinics, this will provide a good opportunity to employ salaried staff, particularly doctors who want salaried and part-time work. Voluntary enrolment in these clinics should be encouraged, as it is in New Zealand. The government should also look at providing professional or financial incentives for clinicians to cash out FFS payments in favour of salaried employment. There is a precedent for this in funding arrangements in some indigenous communities.

FFS is particularly inappropriate for services with high fixed costs and low variable costs, such as imaging, for, if fees are set on an average basis (including fixed costs), then the contribution ('contribution to overheads and profits') per service is high, giving an incentive for high use. This results in a transfer from funders to providers – i.e. overpayment. This has typically happened with pharmaceuticals; because the per-prescription cost of producing pharmaceuticals is very low (the big costs are in R&D and trials), the drug companies have every incentive to expand their market once a price is set. The government should set budgets for general practitioners when they prescribe drugs, order pathology tests or imaging services. Germany is doing some of this already to curb escalating costs.

Improving the Supply of Health Services

What then are the structural and system-wide problems that we must address in Australia to improve the supply/delivery of health services to get better value for money? For a fuller outline of some of these issues, see my 2007 CPD paper 'Obstacles to Health Reform' at http://cpd.org.au/article/obstacles-to-health-reform, in which I estimate that there are at least $10 billion a year in possible savings or productivity improvements – that is 10% of our total health spending.

1. The $5 billion corporate subsidy to Private Health Insurance (PHI). This is one of the worst pieces of public policy it is possible to imagine. It is a cancerous growth. The PHI industry relies on political pressure rather than logic to defend its position. This is not a health program. It is corporate welfare. Why should the government subsidise the insurance industry? If people want to buy a Mercedes Benz or private insurance, that is their right, but why should the community pay them to opt out of the public system which is available for all? The auto industry only receives a $6 billion subsidy over 4 years. The health insurance intermediaries get $5 billion per annum. That $5 billion figure includes the cost of the taxation rebate and takes into account the persistent undervaluation of the cost of the subsidy.

Despite the government spin, changes to private health insurance in the budget increase the attractiveness of private insurance for the wealthy, and entrench a two-tier system.[ix]

The subsidy:

- Favours the wealthy, who can jump to the front of the hospital queue. Yet it is apparently regarded as good Labor policy – a government which has a Minister for Social Inclusion!
- Increases usage of health services. As the Productivity Commission put it 'Increased levels of PHI have been associated with a marked increase in the number of services performed and reimbursements for their services'[x]
- Favours financial intermediaries whose administrative costs are double that of Medicare. No wonder these intermediaries have to keep pushing up their premiums every year at 2% or 3% ahead of the inflation rate.
- Has not taken pressure off public hospitals, and in fact has allowed private hospitals to attract highly professional staff away from public hospitals.
- Weakens Medicare's capacity to control costs and quality. In 2003, the OECD published a case study[xi] on PHI in Australia. They reported '(private) funds do not exercise control over the quantity, quality and appropriateness of care provided… private funds have not effectively engaged in costs control. PHI appears to have led to an overall increase in health utilisation'.
- Takes us down the dangerous path of subsidised private insurance, which is proving so expensive and inequitable in many countries. Just look at the calamity that widespread subsidies for private insurance have wrought in the United States. It has contributed to General Motors' bankruptcy.

Unless President Obama bites the bullet of a single payer model to manage costs and quality, his healthcare reforms will fail.

- Is an inefficient way of promoting so-called 'choice'. The Commonwealth Labor Government and the Department of Health and Ageing seem incapable of understanding or accepting that the funding and delivery of health care are quite different issues. We don't need subsidies to private insurance firms to promote private health delivery. PHI companies are not healthcare providers, they are part of the financial world. Private hospitals would be up to $2 billion a year better off if part of the subsidy were paid directly to them and not via financial intermediaries. The money for veterans from a single government payer, for example, follows them whether they choose treatment in a private or a public hospital. Two thirds of veterans choose a private hospital. The key is a single payer and choice by the individual.

The $5 billion subsidy should be progressively reduced and the money saved to directly fund both public and private hospital patients.

2. Commonwealth and State fragmentation. Prime Minister Kevin Rudd says that he wants to pursue cooperative federalism. I wish him well! The States will of course agree with him when he hands out money but not when territory is in dispute. The Minister for Health now seems to be backing away from Kevin Rudd's threat to take over State hospitals. She claims that the States are now proving more cooperative. But why wouldn't they be cooperative with the large dollops of money they have received for State hospitals. Political resolution and courage is necessary. This view was expressed to me recently by a former senior minister in the Howard Government who said that the only way you can get Commonwealth and State health reform is the 'big bang' approach. You won't get it, he said, by negotiation and you won't get it incrementally. Shadow Minister for Families Tony Abbott also recently suggested that the Commonwealth Government should ask the people in a referendum to amend Section 51, so that on matters of importance to the national government, as in health, its position would over-ride that of the States. Brendan Nelson, former Leader of the Opposition and National President of the AMA, has called for Canberra to fully fund State hospitals.[xii] I don't think we are likely to get improvements in Commonwealth/State health relations until the Commonwealth asserts its responsibility. However, at the same time that the Commonwealth asserts its responsibility it is also important to assert the principle of subsidiarity. Wherever possible health delivery should be driven to the most local level possible – for example through newly created regional health authorities. Canberra would be incapable of oversighting or running 750 State Government hospitals.

It is also important in Commonwealth/State reform not to separate hospitals from the other major elements of health, e.g. indigenous health and drug and alcohol. If the Commonwealth takes over only State hospitals, there will continue to be a disconnect with a lot of non-hospital health care presently provided by the States.

The most desirable change is a referendum to establish the Commonwealth's pre-eminent position in health. A less attractive alternative, but perhaps more politically feasible, is to establish a Joint Commonwealth State Health Commission in any state that agrees. In such an arrangement, Commonwealth and State health funds would be pooled, there would be agreed governance of the Commission and a joint plan developed for the delivery of health services in that State. Such an arrangement could commence in one state then hopefully extend to others (see the CPD paper 'Coalition of the Willing at http://cpd.org.au/article/health-coalition-of-the-willing).

The Commonwealth weakens its own case for integrating Commonwealth and State programs when it is incapable of integrating its own programs – e.g. PBS, MBS - which operate entirely separately. Its producer-based program structure is user-unfriendly but very provider-friendly.

Without political will, the Commonwealth/State impasse in health will not be resolved. Unfortunately, along with their Ministers, State health bureaucracies are major opponents of Commonwealth/State health reform. Their jobs would be at stake.

3. Health workforce structures and practices are archaic. They are a major economic burden. The system is rife with demarcations and restrictive work practices. The waterfront 20 years ago was a model of efficiency compared with the work practices today in the health sector. Health is our largest industry, approaching 600,000 employees or 7% of our civilian workforce. About two thirds of health expenditure is labour cost. More efficient workforce practices are essential. The problems arise not because of individual failure, but because of unwillingness to address the structural inefficiencies. Archaic work practices deny career opportunities, particularly for nurses and

allied health workers.

We need role-renewal and the creation of new types of health workers. We need up-skilling, multi-skilling, broad-banding and teamwork. Blue-collar workers have been fair game for workforce reform, but not professionals in health and the law. By comparison with countries like New Zealand, Canada, USA and the UK, we don't have so much a shortage of doctors but a refusal of doctors to allow other qualified people to share their territory.[xiii]

Health Minister Nicola Roxon has shown that the MBS schedule can be a lever to promote workforce changes. She has commendably pushed the door open for midwives and nurse practitioners. But the opportunities for much wider reform are enormous, e.g. nurse anaesthetists, enrolled nurses, practice nurses, ambulance officers and pharmacists. There is a whole smorgasbord of reform opportunities available to us – we can do more than just taste one or two dishes.

The Commonwealth Government should also make it a condition for increased grants for state hospitals that State Governments modernise hospital work practices.

4. The personal, public and social costs of mistakes. After examining more than 14,000 hospital admissions in NSW and SA, the national cost of harm from health care (adverse events) in our hospitals was estimated at $4.17 b pa in 1995/96.[xiv] 51% of mistakes were avoidable and would represent nearly 500,000 preventable hospital bed days per year. Richardson and McKie in 2008 commented 'preventable deaths … occur at a rate equivalent to a Bali bombing every three days'. Deaths, losses and costs are staggering. Bundaberg, Hawkesbury and the Royal North Shore are only the tips of the iceberg.

If we take the $4.17 billion cost in 1995/96, project it forward, include non-hospital mistakes as well as the cost to families and individuals denied an income earner, or the effects of disability, the cost is close to $10 billion p.a., of which about one half would be avoidable.

Despite tens of millions of dollars spent on inquiries and committees, no discernible progress has been made in improving quality and enhancing safety. Regular newspaper stories confirm the continuing problem. Some hospitals are not safe and should be closed. Others require role delineation to ensure a sufficient scale of efficient and safe operation. The lack of effective action by the Commonwealth and State Governments is scandalous.

Transparency is essential to highlight where the problems are occurring, e.g. infection rates, so that remedial action can be taken. It is also essential to resolve the disconnect in hospitals between corporate governance and clinical governance. They often run on parallel but unconnected lines. Some hospitals are run more like a cottage industry than a large business enterprise. Mandatory disclosures and compulsory hospital accreditation, as well as transparency, are some of the urgent requirements.

A national electronic health system would not only increase efficiency, but it would also reduce mistakes. Commonwealth funding to the States should be conditional on full and speedy cooperation in e-health. It has not happened to date.

The problem does not only lie with the system itself. The aviation industry has shown that culture is also a very important determinant of safety. In aviation, the question is asked 'what went wrong and how do we find a systemic solution?' Unfortunately in health, the question seems to be 'what went wrong and who can we blame?'

5. We have a hospital-centric health system when we need one which is anchored in primary and community care. Hospitals should be the last resort and not the first resort in health care. All governments in Australia are seduced by the iconic status of high-cost hospitals. Some hospitalisation can be avoided if there are appropriate alternatives. 'Selected potentially preventable hospitalisation represents 9.3% of all (hospital) separations in 2007/08'.[xv]

> 'There is a wealth of international evidence that a health system oriented towards primary care achieves better health outcomes, lower rates of all causes of mortality (including heart disease and cancer) for a lower overall cost than a health system based on tertiary or hospital care. … Primary care reform is the single most important strategy for improving the health of our population and ensuring that our health system remains sustainable into the future.'[xvi]

In comparison with its generous funding of State hospitals, the Commonwealth Government's

funding of super clinics and community health centres is minimal. The funding seems more related to a marginal seat strategy than a bold and confident roll out of multidisciplinary health clinics across the country. Perhaps the pending review of primary care will give the government the opportunity to move away from a hospital-centred service to a community and locally based primary health care service. It would relieve pressure on hospitals.

6. We have a highly medicalised, 'sickness model' of care rather than a 'wellness model'. The Australian Institute of Health and Welfare (May 2007) identified 14 preventable health risks. The top 5 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, mainly supplied by doctors, in treating sickness. Our health model is fundamentally flawed.

Health ministers, Commonwealth and State, are confined to 'health' issues. Issues such as poverty, unemployment, urban design, workplace safety, retirement policy, food labelling etc should all be central concerns of health departments. All these issues, particularly poverty, are major determinants of health. The problem lies in the government 'reforms' of the 1980s, which tended to isolate departments from one another, and destroyed many of the mechanisms of policy integration.

7. Erratic and inexplicable variations in clinical practice without obvious health advantages. Robertson and Richardson[xvii] found 'startling variation in the use of well-known procedures in Victorian hospitals', without any evidence of different health outcomes. Standardising the data, they found, for example, that 'the observed variance to statewide data was over 13 times greater than expected for coronary angiography, for cataracts 15 times and colonoscopies 45 times.' 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 private hospitals.

Birth by caesarean section is probably the best-reported example of variations in clinical practice with some areas and hospitals quite notorious for interventions well above statewide averages. Private hospitals in Australia are more likely to have caesarean births, 40% compared with 27% in public hospitals.[xviii]

There are also variations between the States in the incidence of both hip and knee replacement procedures. In the 10 years to 2004/05, these procedures increased by 77% in SA, 83% in NSW, 99% in WA, 125% in Queensland and 190% in ACT/NT. There is no evidence of an ageing effect in these figures; if there were such an effect we would expect SA to be higher.[xix]

Medicare is reluctant to publish and analyse these major variations in clinical practice. They should be published to provide transparency and highlight opportunities for review and possible remedial action against clinicians whose patterns of service are clearly well outside the norm. Large savings are feasible. It would also identify areas of under-servicing.

Conclusion

What is lacking from the Commonwealth Government is a clear health strategy based on broadly agreed values and principles. This strategy is necessary to manage the demand and improve the supply of health services.

The key to any strategic reform is the political will to assert the public interest over and against privileged and powerful special interests. Developing a good policy is easy – the hard part is implementation because of the resistance of special interests, including the States. Unfortunately, the so-called 'health debate' tends to take place between the Minister and these special interests, to the exclusion of the community.

About the author: John Menadue AO was formerly Secretary of the Department of Prime Minister and Cabinet, Ambassador to Japan and CEO of Qantas. He conducted reviews of the NSW and SA health services. He was the founding chair and is a current board member of the Centre for Policy Development. View more of John Menadue's recent work at http://cpd.org.au/user/johnmenadue

Endnotes

[i] View the results of this 2009 survey at http://www.canadavalueshealth.ca/carppoll
[ii] Derived from HIC Annual Reports
[iii] Productivity Commission Report on Technology, 2005 p.25.
[iv] Value for money – making Canadian health care stronger, April 2009, p.9
[v] ABS Household Wealth and Wealth Distribution Survey 2005/06 p.4
[vi] Improving Maternity Services in Australia – Australian Government, p.5
[vii] 7th Annual Report of the Australian Orthopaedic Association Joint Registry
[viii] Sydney Morning Herald, June 09, p.4
[ix] Ian McAuley, Crikey, 13 May 2009, available from http://www.crikey.com.au/2009/05/13/dont-believe-the-headlines-phi-reforms-entrench-two-tier-system/
[x] Productivity Commission Report on Medical Technology 2005, p.26
[xi] OECD, Colombo and Tapay
[xii] The Australian, June 20, p9
[xiii] Australian Institute of Health and Welfare, 2006, p.330
[xiv] Quality in Australian Healthcare Study 1995, Wilson et al
[xv] Australian Institute of Health and Welfare, Australian Hospital Statistics 2007/08, p.xiii
[xvi] CPD Paper 'A New Approach to Primary Care for Australia', Jennifer Doggett, p6 available from http://cpd.org.au/policy_papers
[xvii] Medical Journal of Australia, 2000, 173, pp291-295
[xviii] Improving Maternity Services, (see above)
[xix] 7th Annual Report of Joint Registry, (see above)