Steering without Navigation Equipment
The Lamentable State of Australian Health Policy Reform

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March 2009
Centre for Health Economics
ISSN 1833-1173
ISBN 1 921187 34 8
This paper comments on some of the areas which have been the subject of concern to Australian health policy makers and areas where the evidence indicates the need for very significant change. The two sets of issues do not overlap. It is suggested that there are two fundamental reasons for this. The first is the failure to develop governance structures which promote experimentation and innovation – the driving forces of progress in every successful industry in the 20th Century. The second and related failure is the failure to equip the health services industry with satisfactory navigation equipment – independent research capacity, independent reporting and evaluation – on a scale commensurate with the needs of the country’s largest industry.

Concluding comment is made on the National Health and Hospitals Reform Commission which, to date, appears to be following the tradition of ad hoc ‘dab’ reform aimed, apparently, at one-off improvement rather than the creation of an adaptive, self correcting system, proactively seeking ongoing system improvement. While the final report is pending, the endorsement of a monopolised system, driven by benevolent managers will be to miss the major lesson of history which is illustrated by Australia’s own failures.
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1 Introduction

Concerns which have dominated national debate and gained most government attention have commonly reflected vested interests and ideologies rather than the evidence-based magnitude of problems. The different interest groups include, as they have always done, the medical profession, private health insurance (PHI), private hospitals, increasingly, the pharmaceutical industry, the public health lobby and ‘government economic rationalists’.

One ideology concerns the unsubstantiated superiority of varying levels of private ownership, control and financing in the health sector. Another ideological belief is that health spending should be dedicated only to health maximisation (ignoring notions of freedom and fairness). Then there is the ideology of many government departments – especially those heavily influenced by economists – that small government is an end in itself and that minimum resource cost per unit of measured output is always desirable. In the health sector this latter ideology does not reflect population values.

In contrast with these views, there is a strong argument for public spending to be based upon evidence, including evidence relating to public values. This, of course, requires information, but currently much of the information needed to achieve this apparently obvious goal does not exist, that is, the health system is being steered without satisfactory navigation equipment.

In the present paper I comment initially upon three of the issues which have dominated the health debate, namely, private health insurance (PHI), ageing and hospital queues. The theme of the brief discussion is that the quality of the analysis has been poor to the extent that it borders, at times, upon disinformation. This raises the question of how this could occur. In the following sections I outline evidence of more significant system failure – the regulation and diffusion of technology, the fairness of the system and the quality of care. Relative to their importance these issues have been largely ignored in the health debate and attracted, at best, a lethargic policy response. This again raises the question of how this could occur.

In the remainder of the article it is argued that the answer to these questions is, in large part, that the health system has poor governance and has failed to invest adequately in research and experimentation. This is symptomatic of a more fundamental problem, namely the near monopolisation of each part of the system by conservative and defensive government agencies and the belief that deficiencies may be corrected by (occasional) one-off tinkering with the system rather than by the creation of a system based upon the production and diffusion of evidence, health services research commensurate with size and importance of the health sector and upon error learning rather than error suppression. Some principles for achieving this are discussed in the final section.
2 Issues of Exaggerated Importance

Private Health Insurance (PHI)

To put PHI in perspective there are two dominating facts. First, the imperfect evidence available suggests that many Australians wish to have PHI. National statistics on the redistributive mechanisms in Australia and the resultant levels of poverty suggest that Australia is one of the least egalitarian and the least generous nations in the developed world. Results from the Monash Health and Ethics Survey reveal overwhelming support for the proposition that people should be allowed to spend additional monies on their own health. Many Australians like to jump queues and support multi-tier access to health services.

The second dominating fact is that, in terms of its importance for the sustainability of the health sector, PHI is quantitatively trivial. In 2005/06 it raised $6.2 billion of the total national health expenditure of $86.9 billion or about 7.1 percent. Even in the hospital sector where its funds are concentrated, it raised only 11 percent of revenues. These sums must be further discounted by the 30 percent subsidy from Government. The highly publicised statistic that PHI underpins private hospitals which, in turn, carry out over 50 percent of elective surgery is one of the many examples of disinformation, or perhaps more accurately, ‘spin’, on the statistics. Health funds and private hospitals are the landlords providing beds and equipment. The Government, not PHI, provides the overwhelming proportion of the insurance against the medical costs in these hospitals.

It would be feasible (as distinct from necessarily desirable), for private hospitals to be nationalised overnight with about one quarter of their operating expenses being met from the existing subsidy to PHI and the remaining revenues raised by PHI met by an approximate 1.2 percent increase in taxation. This would not be an economic cost to the nation but a redistribution from non-contributors to PHI to those who are currently members. This course of action is neither advocated nor criticised here. The key point is that, financially, PHI is an inessential part of the health sector. The Australian health scheme cannot be held to ransom by the self evidently false claim that it depends upon PHI.

Box 1 The Ungenerous Country

For those believing that Australians are egalitarian and that the political cliché of a ‘fair go’ and ‘mateship’ describe the Australian character, see Table 1. Casual observation indicates greater ‘downward envy’ in our national press and character than concern with a fair distribution and compassionate treatment of the disadvantaged.

Finally, the strength of the support for PHI is difficult to access. Legislation in the last decade has driven Australians into PHI with policies which deserve to be enshrined in the Guinness Book of Records – as the most bizarre micro economic policy in a developed country in the last half century. The surcharge and lifetime tables defy economic logic. In contrast, a subsidy for those taking PHI (the policy most criticised) is perfectly justifiable in terms of social policy. It is justified, however, not as a device to increase membership per se, but in terms of (one notion of) equity to those who are paying more for their health care. This argument depends upon PHI having no adverse effects upon others by, for example, diverting a disproportionate number of doctors from public hospitals.
In contrast, the levy on the wealthy who fail to purchase PHI has the same economic logic as promoting the Australian automobile industry with a punitive tax surcharge on the income of wealthy Australians who fail to buy an Australian car. Lifetime tables are even more perverse. Insurance, which is usually envisaged as a mechanism for reducing risks has, by legislation, been forced to increase risk. The uncertainty associated with illness over the next 20-30 years is clearly much greater than the uncertainty associated with the next 2 to 3 years. Those making a decision with a respect to the purchase of insurance are now faced with greater anxiety and fear because of the longer decision period, and fear drives people to insurance. An imperfect analogy would be a policy to increase the uptake of fire insurance for houses by randomly burning down houses, increasing people’s fear of being a victim and thereby inducing them to take out fire insurance. It is doubtful if anywhere in the democratic world it would be possible to find a greater loss of perspective on the principles of micro economic reform.

Under these circumstances it is difficult to determine the underlying demand for (legitimately subsidised) PHI, but survey results cited above indicate a rejection of the notion that individuals should not be permitted to spend more of their own income to receive better access to better services.

Table 1 How Australia Compares

The rank order of Australia compared with 18 other OECD* countries: selected statistics

<table>
<thead>
<tr>
<th></th>
<th>Year</th>
<th>Rank</th>
<th>No. of countries</th>
<th>Australia’s ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>% population with income &lt;$US11.00/day (absolute poverty)</td>
<td>1995</td>
<td>1 = lowest</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Social security transfer (% GDP)</td>
<td>1990-1999</td>
<td>1 = highest</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>% elderly in poverty</td>
<td>Late 1990s</td>
<td>1 = lowest</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Income of elderly (above 65) / Income 18-64 (%)</td>
<td>Mid 1990s</td>
<td>1 = highest income</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Income at 90th percentile/income at 10th</td>
<td>Late 1990s</td>
<td>1 = lowest inequality</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>% population with income below 50% of median income</td>
<td>Late 1990s</td>
<td>1 = lowest % below median</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>% children in poverty - single mother</td>
<td>mid 1990s</td>
<td>1 = lowest</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td>- two parents</td>
<td></td>
<td>1 = lowest</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td>Official Aid/GDP</td>
<td>2000</td>
<td>1 = highest</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>Total tax/GDP (%)</td>
<td>2000</td>
<td>1 = highest tax</td>
<td>18</td>
<td>15</td>
</tr>
</tbody>
</table>

Key: * All OECD countries with a population above 3 million
Ageing

The belief that there is a looming crisis because of the ageing of the population and booming demands of those who thoughtlessly chose to be born after 1945 appears to be a function of bad arithmetic. It reflects the well known error of reasoning in percentages and disregarding absolute values. Exaggerating somewhat, the percentage of centurions may well increase by 600 percent in the next 20 years, a frightening prospect until translated into an absolute increase from 100 to 700, a figure too low to have a detectable impact on health expenditures.

Figure 1 Health vs GDP 2007 to 2047

Importantly, and unremarked in reports, a much higher rate of taxation driven by a much higher growth rate of health expenditures is consistent with a rising material standard of living. This may be verified by anyone capable of calculating compound growth rates. Figure 1 illustrates the effect of health expenditures rising at twice the rate per annum as GDP (4 percent and 2 percent respectively). Between 2007 and 2047 GDP would rise by a factor of 2.208. Health expenditures would rise from 10 to 21 percent of this. However, resources left for other expenditures would increase by 88 percent. This is the simple arithmetic result of a larger magnitude (GDP) growing more in absolute terms than a lesser magnitude (health) despite rising less in percentage terms. The result is relatively insensitive to the numbers used in the example. Even allowing for the present recession (which will also dampen health expenditures) it is almost inconceivable that rising health expenditures would significantly contribute to a reduction in the GDP/capita. Even the use of GDP/capita as a benchmark is largely a product of history and intellectual inertia as the available evidence shows no relationship between GDP/capita and individual wellbeing (Easterlin 2001; Frey and Stutzer 2002). Policy, however, appears to be driven by a fear of changes in the percentage composition of the GDP. But there is no economic or social reason why the composition of the GDP should not change, especially if it increases wellbeing. Historically, the economy has been flexible. The agricultural sector, for example has 'imploded' in percentage terms without adverse effects. The service sector, including health, has expanded to our advantage (and possibly to the benefit of the environment).

The Intergenerational Reports and Productivity Commission have carried out analyses in which the loss of perspective results in serious disinformation. Figure 2 encapsulates one of the widely cited headline 'messages' from the 2007 Intergenerational Report. This is that the budget deficit as a percent of GDP will rise alarmingly to the year 2046-47 and in a way that is directly attributable to increased health expenditures. The Productivity Commission reaches similar
headline conclusions *albeit* with qualifications deep in the body of the report. The National Health and Hospitals Reform Commission has clearly accepted this message and warns that health expenditures could so dominate State budgets that there would be no money left for roads or education.

Figure 2 Disinformation: Intergenerational Report 2007, Budget Deficit as % of GDP

Comparison of IGR1 and IGR 2 projected

![Graph showing budget deficit as % of GDP](image)

Source: Australian Government Intergenerational Report 2007 p xiii

In fact these results are entirely attributable to a set of assumptions which are tenuous at best and wrong at worst. In the light of recent macroeconomic experience extrapolation to the year 2046-47 should be undertaken only with irony or humour. Four key points are of importance:

1. Ageing per se in the absence of technological change would have minimal effects on expenditure. With zero GDP growth and no other changes age driven expenditure would have risen between 1997 and 2051 from 7.5-11 percent of GDP (Richardson and Robertson 1999).

2. Belief in a quantitatively significant effect of ageing has been obtained by adding technology driven trend health expenditures to the ageing effect, not by analysing an ageing effect per se. However, the impact of technology over a longer period of time is far more difficult to predict than relatively inexorable changes in the medium term population structure. Technologies may be cost enhancing (as at present) or cost reducing (as with the introduction of antibiotics and possibly products arising from the present biotech revolution). Unlike population, technology can, in principle, be regulated in such a way that increased expenditures should be welcomed if the benefits exceed the costs.

3. The burden of ageing plus technology depends upon the rate of growth of GDP.

4. To date the varying rates of population growth across Europe have been uncorrelated with expenditure growth (see Figure 3). Ageing effects have been absorbed into general
expenditure growth. Historically, the inextricable link between ageing and health expenditures as a percent of GDP implied by government reports and the press is simply disinformation.

Figure 3 Change in health expenditure compared with the change in age/sex predicted expenditures, 21 OECD countries, 1960-95

Source: Richardson and Robertson 1995.

The final assumption underlying these defective analyses is that taxation will remain fixed as a percentage of GDP. Tax rates in Australia are amongst the lowest in the Western world (Table 1) and could rise by 50-60 percent before reaching the levels of countries whose rates of economic growth and standards of living have been unaffected by their higher tax rates.

Policy analysis may have been driven by bad arithmetic. A less benign interpretation is that those steeped in economic theory are presenting data to achieve a covert objective suggested by bad neo classical economic theory. There is an arcane belief in this discipline that additional taxation carries an ‘excess burden’ for human wellbeing. I have described it as arcane because there is no empirical evidence for this belief and the logic behind it is wrong. It assumes that with lesser tax people work harder and are thereby better off (or else why would they have worked harder?). The underlying assumption is that the undistorted balance between work, leisure and all other elements relevant for human wellbeing are in an optimal state before the distortion of taxation. The assumptions behind this evidence-free belief are so absurd they will not be repeated here.

It is worth noting, however, that while the excess burden ‘doctrine’ teaches that each dollar of tax has a disproportionate cost, economic theory has not suggested a way of demonstrating the excess or deficit value of most of the Government activity funded from these taxes. It is implicitly assumed in theory and explicitly in the GDP accounts that health, education, law and defence contribute to wellbeing an amount equal to their dollar cost (and therefore less than the ‘cost’ of taxation). Transfer payments to the disadvantaged also do not generate net benefits but only redistribute them as, according to orthodox theory, we cannot compare the utility benefits of one person with another. Transfers may, however, distort work incentives and, for the same arcane
reason as above this is harmful. Consequently, and without evidence, tax based transfers become a net cost. The benefits must be treated on a dollar for dollar basis; the taxes inflict a more than a dollar for dollar cost when taken and given. This may help explain the clearly prejudicial attitude of many economists towards taxation. It does not justify their insinuating policy by stealth.

Hospital Queues

Queues or surpluses are difficult to avoid in the context of a free service. This is, but should not in the long term be an important issue. Various solutions exist: improved financial incentives to increase the productivity of doctors and hospitals; expanded medical and hospital supply; greater management efficiency or more money. Three comments only are relevant here.

1. It is illustrative of one of the themes of this paper that the policy options known in principle, cannot be put into action with any confidence because of the inadequate research into hospital and medical incentives and behaviour and the inadequacy of the information systems in most hospitals.

2. The problem of queues is largely caused by constricted budgets (and particularly expenditure on nurses) reflecting a concern with inefficiency, defined as more (government) money being spent on patients than strictly necessary. Extremely accurate budgetary data are collected. Virtually no data exist relating to the inefficiency inflicted upon patients in the form of suffering and disruption to their lives. These priorities appear to conflict sharply with public values.

3. Australian Government, like economics, appears to be ‘efficiency focussed’; that is, it is primarily concerned with eliminating monetary inefficiency and only secondarily minimising the adverse effects on equity while this is being done. Recent research at the CHE (Richardson, McKie and Sinha 2009) clearly demonstrates that, in the health sector at least, there is an overwhelming concern with fairness and sharing and relatively little interest in monetary efficiency, even when this is expressed in terms of maximising the number of life years gained from a budget. Indeed, the research indicates that the general community would sacrifice 1/3 of life years which could be allocated to people in order to achieve equitable sharing. This strongly suggests that the policy of minimising expenditure – extracting an annual productivity bonus and ‘letting health departments cope’ – strongly conflicts with the preferences of the population. ‘Inefficiency’ in the form of greater tax financed expenditure would clearly be preferred to the inequity of non treatment. In view of the evidence that there is no change in subjective wellbeing as GDP rises, policies involving increased taxes and spending in areas of demonstrated public concern should be welcomed.

3 Relatively Neglected Issues

Technologies

New technology has been the great driver of human welfare generally and new technologies will dominate both the costs and the benefits of future health services. Despite this, lamentably small attention is given to health technologies at the level of health service diffusion and delivery. While Australia pioneered the economic evaluation of drugs, and the use of products and devices, and technologies must be approved by the TGA, the overall research effort in this area is dispersed, uncoordinated, reactive and appears to have little error learning capacity. There is insufficient national capacity to evaluate old therapies retrospectively or to monitor outcomes. The data for this is collected, but is not used.
Long term, there is an urgent need to install the capacity to proactively seek new technologies and to ensure (or block) their diffusion and use as quickly as possible. To fail to do so is to reduce population health. But the issue has never been on the political radar.

**Equity**

Medibank and Medicare were established to achieve equitable access to hospital and medical services. They achieved this in one respect only, namely the extension of financial insurance to the 15 percent of the population who had not purchased it privately prior to Medibank. Apart from this small (*albeit* important) improvement the achievement of equity has remained very largely at the rhetorical level. Richardson and Deeble, using the first universal database from Medibank found that the use of both GP’s and Specialists in Sydney in 1976 were both (coincidentally) 4.6 times greater than in Darwin after adjusting for age and sex. Discrepancies between statistical divisions were much greater (Richardson and Deeble 1982).

Studies by the author 25 years later found similar discrepancies in the use of procedures across Victoria and huge differences in the use of new technologies in the public and private sectors. (Richardson 1999, Robertson and Richardson 2000).

The response to the obvious inequities between urban and rural areas in Australia may best be described as ‘dab policies’. There has been little serious attempt to equalise access. The issue, however, has not been near the top of the public agenda and possibly because information about inequities is not routinely documented and distributed throughout the community. Indeed, from the author’s experience, it is possible that the non provision of information which has reinforced this complacency may have been promoted by public authorities (see Box 2).

**Box 2 Attempting to document the equity in Medicare**

The Author’s Experience

Following the studies referred to in the text the author successfully obtained NHMRC funding for a project to evaluate the change in the equity of Medicare through time. This required information from the Commonwealth Department of Health and Ageing (DHA) which has been given monopoly control over historical data relating to the use of medical services. Over a five year period – 1991-1996 – and despite repeated promises that data would be shortly forthcoming, the required information was never provided as a result of a series of ad hoc ‘problems’, delays and ‘higher priorities’ at the DHA. Following the non reply to three of the four letters sent by the Deputy Vice Chancellor, Research, at Monash University the author concluded that these data would never be forthcoming as they were likely to demonstrate the failure of the Department and Government to increase the equity of Medicare. At the time of writing (November 2008) the data request is still with the DHA but there has been no response to the Monash communications for 2 years. This episode may or may not be unique. However it demonstrates the danger of granting monopoly power over public data to a body with a strong interest in the way in which it is used.

Another dimension of inequity relates to the adequacy of insurance coverage by a type of medical service. As shown in Table 2, insurance coverage by Medicare coverage is highly erratic. Hospital services, the most expensive form of care, are almost fully insured and consequently,
cheapest to use. Medicines are very poorly insured despite the fact that the longevity of Australians is most plausibly explained by the widespread availability and use of anti-hypertensive drugs which the majority must now purchase uninsured: that is, possibly the most cost effective therapy in the health system is effectively excluded from Medicare for the majority of the population. There is no stated rationale in Medicare for discriminating against the loss of quality of life associated with vision and teeth. Yet the relevant services are also largely uninsured.

Table 2 Patient Out-of-Pocket payments 1005/06

<table>
<thead>
<tr>
<th></th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>2.2</td>
</tr>
<tr>
<td>Medical</td>
<td>11.3</td>
</tr>
<tr>
<td>Dental</td>
<td>67.9</td>
</tr>
<tr>
<td>Medicines</td>
<td>45.9</td>
</tr>
<tr>
<td>Aids/Appliances</td>
<td>74.1</td>
</tr>
<tr>
<td>Total</td>
<td>17.7</td>
</tr>
</tbody>
</table>

Source: AIHW Health Expenditure Bulletin 2005/06

The apparent (default) explanation is historical inertia, the failure to review the system or by an overriding year by year concern with the government budget. There are no data to properly document the suffering this causes.

There is no reason why regular reports should not be made available regarding access to and use of services by groups differing geographically, socially, racially and by disease category. The data exist, but are not published. Data should also exist documenting the needless suffering which results from the exclusion of services. Explicit comparisons of groups would sensitise the community and possibly force policies that promote equity. It is possible to surmise that it is precisely for this reason that such information is not produced.

Quality and Safety

The issue of adverse events in the Australian health system should dominate all others. However it will be closer to the truth to describe it as Australia’s best kept secret. The ‘Quality in Australian Health Care’ (QAHCS) study uncovered an appalling iceberg of avoidable adverse events including large scale unnecessary death. Following publication, virtually nothing effective occurred on a scale commensurate with the problem. Ten years later an editorial in the MJA reflected upon this as follows:

‘Based on QAHCS outcomes 25 patients die each day in our hospitals from preventable adverse events...... we have had report after report...... we still have no nationally accepted framework for clinical governance to assure the safety and quality of Australian health services... This ongoing vacuum is an indictment of our Health Ministers and organised medicine’.

MJA, September (2005) p 284
It appears that following publication the Health Minister of the day accepted the report as being methodologically sound and of great importance. However the representatives of organised medicine pronounced it, without evidence, to be incorrect. Following a change in Government shortly thereafter, the new Health Minister accepted this evidence free conclusion. The study was not repeated to determine validity nor was there an urgent review of safety but simply a series of reports. The cumulative effect of these was summed up, somewhat despairingly, by the persons initially placed in charge of the reform process in the following way:

‘One might assume that systematic improvements within the health system are either happening or, at least, well advanced. Regrettable, improvements are still patchy. The greatest challenge for all remains how to achieve universal and systematic changes to the health system within a federated system’.

Baraclough and Birch (2006)

The size of the problem which has been ignored is simply astonishing. If the death rates estimated by the QAHCS are correct then the number of Australians unnecessarily dying is approximately equivalent to a jumbo jet full of Australians crashing every 2 weeks each resulting in the deaths of 350 Australians. Alternatively, it is equivalent to a repetition of the Bali bombing every 4 days. The cumulative unnecessary deaths since the publication of the QAHCS report would exceed the number of Australians killed in World War 1.

We can only speculate on the reasons why Australian authorities have failed in their most fundamental duty of protecting the lives of their citizens. One possibility is that the magnitudes involved are simply too large for people to believe. (Indeed, it may even seem a little shrill to mention such melodramatic facts!) Human beings form clear expectations concerning the way in which the world they experience operates. As John Maynard Keynes famously commented in the last paragraph of his ‘General Theory’, after the age of 25(!) most find it very difficult to change these patterns. Australians, their politicians and the medical profession have so long regarded the health system as being safe and amongst the best in the world that results from the QAHCS may simply have been dismissed as absurd, ie conflicting too radically with established patterns of belief. The authorities who endorse or bury such research are well beyond the age of 25. The author’s personal experience in attempting to publicise this report is consistent with this hypothesis (see Box 3). Nevertheless a prudent government would have repeated the study to disconfirm it.

An alternative explanation is that policy makers, like others, are more responsive to sensational media reports than correctly collected evidence. More cynically, they may only be concerned with the lives of Australians that have been identified and politicised by the press. More probably, however, individuals in governments and bureaucracies are likely to have focussed only upon their defined area of responsibility and our governance structures have not assigned responsibility for this situation to anyone and lacks the flexibility to error learn and act decisively, at least in the health sector.
Because of the puzzling lack of policy following the QAHCS, Richardson and McKie (2008) conducted a small scale study which involved contacting individuals with a track record in adverse events or experts in hospital and medical safety. This group was asked to nominate policies which might be immediately implemented and to estimate the time before these policies would become effective. Results from the first round of this ‘Delphi’ research was classified and circulated for comment and for respondents to estimate time lags on policies. The result was a set of 41 policies spanning the health system. Some of the recommendations were common sense. For example, it was suggested that, following a major operation, a hospital should be required to have competent medical staff \textit{in situ} during the recovery period in case of complications. This requirement did not (does not?) exist. In sum, we carried out the obvious first step of a policy reform agenda, namely the collation of ideas.

The response to this report was telling. Informal feedback challenged our authority to do such work and at least one reviewer wished to know the names of the experts consulted as, presumably, the policies needed to be assessed by the authority of the initiator and not by their own merits.

The author sent the report to the current government twice without reply. When sending it a third time I asked for acknowledgement of its receipt and duly received a terse note thanking me for my interest in adverse events signed, not by a member of the Minister’s staff to whom the letter had been sent, but by an officer in the DHA.

This suggests a culture in which policies are driven by due process and authority and not by urgency.

Richardson and McKie (2008)

The National Health and Hospitals Reform Commission has acknowledged the existence of adverse events in muted terms and has, chillingly, stated that there is a need for ‘culture change’. This same phrase was used over a decade earlier and appears to be code for ‘postpone the problem for a generation/leave it to the medical profession, to put their house in order – as they failed to do in the 20th Century’.

4 Principles for dynamic adaption

A common feature of recommended reforms has been what might be described as ‘static optimality’: A series of one-off recommendations are made for the achievement of the optimal health system. The author has contributed to this literature (for example Richardson 2005). Many of the principles suggested are, of course, sound (particularly in the latter reference!). In the optimal system there would be a single purchaser of all services for defined populations. The present irrational, geographic, service-based and disease-based boundaries would be eliminated. Many or possibly all of the performance indicators listed in the NHHRC’s April Report would be initially adopted.
Below I focus upon a dimension of reform which is seldom considered but, in the light of the previous discussion, would appear to be of greatest importance. The focus is a response to repeated failures; the failure to adequately respond to information when it is available — adverse events and, evolving technologies; failure to investigate or address issues of stated importance — inequity; failure to seek out the nature of health system related social objectives; failure to match policy priorities with the magnitude of the problem and failure to invest in the system navigation equipment necessary for planning the future and responding flexibly to error.

Repeating an earlier theme, the economic (and other) history of the 20th Century has been dominated by technology, innovation and uncertainty — elements for which economics has comprehensively failed to provide either explanation or guidance. This is reflected in the health economics debate over optimal health systems which, apart from innovation of the moment, have largely ignored the implications of these three dominating themes for system reform. While market capitalism self evidently requires regulation and the market model is manifestly unsuitable for the health sector, the history of capitalism in the 20th Century provides one important insight. The market provides a flexible, adaptive and creative mechanism for allocating resources.

The experience of the last 100 years, reviewed comprehensively by Beinhocker (2006), suggests the following principles:

- Monopolies, however creative initially, have generally evolved into conservative organisations which commonly fail;
- Corporations which do not ‘reinvent themselves’ regularly have a limited life time. Most firms fail after a period of initial creativity and success;
- The engine of progress is often small, innovative enterprise with an idea which has not or cannot be implemented by the larger monopoly/corporation. (The most spectacular recent example is Microsoft’s takeover from IBM of the market for desktop computing);
- Growing bureaucracy and overemphasis on due processes are often the reasons why larger ‘non-reinventing’ corporations loose the innovative advantage (a generalisation again illustrated by the history of Microsoft and IBM); and
- Organisations which have survived, innovated and ‘reinvented themselves’, have invested heavily in technology and market research – their industrial ‘navigation equipment’.

The reform of the Australian health system should be informed by this experience. The reform process should be driven to a significant extent, by the need to achieve dynamic adaptability through time and, in particular, by error learning. None of the reform proposals of which the author is aware, including those of the HHRC, have emphasised this need. The ‘buzz words’ are scattered liberally throughout theoretical passages, but proposals do not show how these translate into policy. Uniquely, the advantages of dynamic adaptability are implicit in the Scotton-Enthoven proposals for Managed Competition although, as elsewhere, Scotton emphasises the static properties of the model.

The experience summarised above suggests that the following principles should be considered in the reconstruction of the health system, in addition to the principles for static optimality.

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1 The dangers inherent in monopolised organisations were recognised by the Australian Prime Minister Kevin Rudd when, in the context of homeland security, he endorsed the view that ‘big departments risk becoming less accountable, less agile, less adaptable and more inward looking’ (The Age, 5 December 2006 p10).
1. No part of the Australian health system including the funding of research should be subject to monopoly control. The simplest way of achieving this is to base an integrated health system upon a sub-national unit, either the state health regions or, possibly, fund-holding unit as envisaged in the model of Managed Competition. These units should have a significant degree of autonomy in the way in which they allocate resources. As in the market, diversity maximises the chance of successful innovation and improvement.

The counterargument that differences imply inequity is simply hypocritical. There has been no sustained concern with equity and, as evidenced by their support for PHI, Australians are not particularly interested in the reality of equality. More substantively, when successful elements of a sub-national health system are identified by a national authority they can be mandated for the other health systems. It is doubtful that many would openly defend the structural pretence of equity for the reality of better health especially as both goals can be currently improved.

In this context Canada’s leading health economist Bob Evans comments that:

‘A particularly interesting feature of the Spanish article (chapter) is the way in which devolution of political authority to sub-national governments served – against conventional wisdom – to open a democratic window, advancing and securing the universal system in the face of ambivalence (at best) at the national level. (Canada provides a similar example’). Evans (2005) p 282.

2. Innovation should be ongoing’ not simply the ‘dab innovation’ which characterises the present management, but should involve significant and sustained experimentation. As in every other industry this costs money. The expectation that the Coordinated Care Trials commenced in 1995 – by Australian standards, more a ‘splash’ than a ‘dab’ – would achieve rapid cost saving without the outlay of significant expenditures was as naive as the expectation by a manufacturer that a new and profitable mode of production might evolve without any venture capital.

3. Innovation should be informed by the careful observation of success overseas, something which has never occurred in Australia. Despite evidence for over 30 years that the Kaiser Permanente Corporation has operated highly successful, cost effective, integrated clinics there has been no attempt to seriously study or experiment with their experience. New Zealand (NZ) experience has likewise been ignored. The inward looking nature of Australian policy is epitomised by the by the failure of the PBAC to look at the international market prices for drugs when negotiating with pharmaceutical companies and this has resulted in examples of extraordinary over payment (Spinks 2009). This is as irrational as a corporation negotiating in a market in terms of the data provided to it by an interested party and ignoring the known prices elsewhere in the market.

4. The above principles cannot be implemented without investment in ‘industry navigation equipment’. It is likely that no other industry in Australia spends as little, proportionately, on the marketing, delivery and adaption of their product to customer (social) needs as occurs in the health sector despite the fact that the industry is almost certainly the most complex and important for future wellbeing. The fact that this appears to be true in other countries does not lessen the consequences of this. There has been a failure to invest in health services research on anything much more than a symbolic level and then without serious strategy or plan. While having one of the best data systems in the world, it is largely unused in terms of its real potential for management and evaluation. Research is largely conducted on an ad hoc, or ‘on demand’ basis, by health departments for specific purposes. There is a dearth of creative ideas flowing through to the level of creative planning.
The last serious proposal for comprehensive, coherent reform – the Scotton plan – died at least in part because of the failure to create a new generation of health economists capable of developing such or similar plans and carrying out the prerequisite technical analysis as has been ongoing in the USA, the Netherlands and elsewhere. Perhaps with the wisdom of hindsight it is likely that the existence of serious navigation equipment in the field of new technology would have suggested such extreme uncertainty with respect to workforce requirements that a much greater emphasis would have been given to the training of a flexible workforce capable of varying its level of performance in accordance with the emergence of new technology driven needs.

5. A uniquely Australian problem with system reform is the extent to which health policy has been politicised in the post war period. If the control and delivery of health is directed almost exclusively to short term Ministerial objectives then Australians will pay both financially and with their health. This suggests the need for the distancing of health care delivery from immediate political pressure with government only responsible for broad policy, monitoring, and funding.

**Governance Principles**

One example of the allocation of responsibilities based upon a modified Scotton model which satisfies many of these requirements is summarised below:

**Purchasing:** Semi-autonomous commissions should be established at either the State or regional levels responsible for the purchase of all hospital and ambulatory including dental and ophthalmological services. The commission should be directed by a board including representatives of the Commonwealth, State and major providers of services and be able to innovate in both the form of purchasing and the physical organisation of delivery.

**Funding:** Pooled government revenues should be based upon a predetermined formula with shares unrelated to any element of delivery. The per capita allocation to the purchasing authority, determined by the Commonwealth, should ultimately be based upon principles of equity but initially, upon the status quo and subsequently modified.

**Service Provision:** Initially, as at present, States should run State hospitals, and the private sector run medical, dental, other ambulatory and pharmaceutical services. The Commonwealth should be responsible for negotiating certain prices such as pharmaceuticals and the rebate for private medical services because of the lack of market power by sub-national units.

**Regulation and Monitoring:** The Commonwealth should mandate a minimum package of services and monitor access to these services with penalties for violation of the principles. However there should be capacity for difference and experimentation.

**Private Health Insurance:** This should initially be unchanged except for the removal of the surcharge and phasing out of life time tables (efficiency measures). The subsidy should initially be maintained. However research is needed to determine the true effect of PHI on the availability of health services to Medicare patients and the size of the subsidiary should be determined in the light of this and further research into population preferences with respect to a multi-tier health system.
5 Navigation Equipment

At least one, and on the principle of non-monopoly, preferably more statutorily independent institutes should be created similar to but independent from the AIHW. They should have the following functions:

Quality monitoring and assurance: The institute should have powers to acquire and require information and to conduct onsite investigation. It should be required to carry out ongoing international collation of techniques for quality assurance and to translate these techniques into a form compatible with the Australian system.

Technology and Innovation: The institute should proactively seek out new technologies (preferably in conjunction with the relevant medical colleges) and refer them to the relevant technology assessment group for possible inclusion in Medicare.

Results of routine health services research and statutorily determined information should be regularly provided to the public regarding the level of disaggregated service use and the (standardised) quality of different provider groups.

Ideas for Innovation: The institute should monitor ‘good ideas’ which have succeeded in other countries and proactively provide these to appropriate bodies throughout the health system.

Ad hoc research: It is highly desirable that issues of current public or political interest should be satisfactorily researched and not be the subject of disinformation and unsubstantiated spin. The Institute should have a capacity to conduct research on the request of a Minister and on its own initiative. It should have the task of proactively providing relevant information to members of the media who are perceived to be providing factually incorrect information to the public.

Blue Sky Research. There should be a capacity to either conduct or promote additional research of a more long term or exploratory nature.

HSR Workforce: The institute should be responsible for monitoring and recommending measures to ensure a satisfactory health service research workforce. With current ‘dab’ funding of HSR there is no career path for health economics and unsurprisingly an almost complete dearth of research into health systems. Part of an institute’s function should be the training of such a work force via cadetships in its research divisions in conjunction with relevant university and government departments.

Data: The institute should have a statutory right to all relevant administrative and other data collected by the AIHW but also data which is not collected by the AIHW such as that monopolised by the current Commonwealth Department of Health and Ageing.

Timetable

With the exception of the creation of one or more institutes for health services research and evaluation most of the suggested functions, or variants of them, could be achieved relatively quickly as they involve governance and financial flows rather than the creation of new physical infrastructure. Initially the public would feel little effect.

Subsequently, the form of delivery might change substantially as the area based commissions responsible for purchasing services experimented with new methods of delivery (such as Kaiser-like clinics for integrated care). An additional option would be a movement towards Managed Competition as private health funds or other groups negotiated a ‘carve out’ for a voluntary group.
Such a task would involve research into the determination of risk related premiums and likely effects upon cost and equity. (Recent evidence from the Netherland’s experiment with Managed Competition suggests that this option might result in inequalities unacceptable even to the unegalitarian Australian public. Evans (2005) notes that from 1995 to 2002 fund specific extra premiums (above needs-based capital payments) rose from 3 percent to over 50 percent implying significant quality differences between schemes. This again illustrates the need for reform based upon careful research and modelling of the impact of different regulatory structures.

6 Conclusion

There has never been a truly comprehensive review of the Australian health system and virtually no serious debate over its long term structure. The relative self satisfaction with the system largely arises from a widespread ignorance of the issues discussed here. The existence of similar problems in other countries does not represent evidence of success but, more probably, similar histories of defective governance. Bad ideas have also been globalised. The relative good health of Australians also cannot justify system satisfaction as its cause is not well understood (deficient research) and as suggested earlier, is probably more attributable to the widespread use of anti-hypertensive drugs than to the system which generally excludes them from subsidy.

By default, reform has been incremental where the increments have been tiny, timid and sometimes backwards (eg PHI legislation). While it is true that we are, in large part, prisoners of history this perspective can be overstated and the consequences of this rationalisation of inertia extremely deleterious to the wellbeing of the population. There can be little doubt that major problems with the system have simply been ignored and that this is not attributable to history but to a lack of dynamism.

It has been argued here that the approaches to reform implemented and discussed in Australia have largely missed this dimension of the problem. Proposals are ‘static’. Once achieved the health system will be optimal.

This approach has been taken one step further in the April report of the National Health and Hospitals Reform Commission (2008). In this, various performance indicators are listed but they arise from nowhere and at least in this report lead nowhere. Possibly it is assumed that with the slightly clarified governance structure which is recommended we should trust the (monopoly) bureaucracy to achieve these targets. No broader thinking is revealed in the report. But historically the bureaucracy has comprehensively failed to reform important elements of Australia’s health system or even to ensure that the health system is safe. Belief in the flexibility, benevolence and wisdom of monopolies in either the public or private sectors simply misses the major lesson of the 20th Century.

In view of the overwhelming evidence from outside the health system that progress depends upon the ‘reinvention’ of organisations from time to time, the final conclusion here is that the health sector, which represents the most expensive industry in the country – 10 percent of the national use of its resources – and a major potential source of future wellbeing, requires a comprehensive, long term and long overdue review of all aspects of its operation. This should not be based solely upon the collation of opinions, however authoritative, and the balancing of interest groups. It should include a detailed analysis of the system’s strengths, weaknesses and opportunities.
References


Baraclough B, Birch J 2006, 'Health Care Safety and Quality: Where have we been and where are we going?', Medical Journal of Australia, vol 184, no 10, pp S48-S50.


Richardson J 2005, 'Priorities of health policy: cost shifting or population health', Australia and New Zealand Health Policy, vol 2, no 1, http://www.anzhealthpolicy.com/content/2/1/1.


Spinks J, Richardson J (forthcoming) ‘Is Australia paying too much for generic pharmaceuticals?’.
