



AUSTRALIAN
HEALTH POLICY
COLLABORATION

"Are There Lessons From the Past? Australian National Health Policy Making in the 1970s"

AHPC Policy Roundtable Discussion Paper

Issues paper No. 2015-05

Rosemary Calder

November 2015

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Professor Richard F. Southby, Ph.D. (Med), FFPH, FRSPH

Professor Southby is Executive Dean and Distinguished Professor of Global Health Emeritus, The George Washington University. Dr. Southby joined The George Washington University faculty in 1979. He also served as Chairman, Department of Health Services Management and Policy and Dean and Ross Professor of Global Health, School of Public Health and Health Services.

In addition to his appointment at The George Washington University, Dr. Southby is Adjunct Professor of Preventive Medicine and Biometrics at the Uniformed Services University of the Health Sciences, Bethesda, Maryland.

Since 1984 he has been the Director of the Interagency Institute for Federal Health Care Executives, the major continuing education program for senior health care executives from the US Army, US Navy, US Air Force, US Public Health Service, and the Department of Veterans Affairs.

He was a member of the faculty of the Department of Social and Preventive Medicine at Monash University, Australia, from its founding in 1968 until 1978. He is presently an Adjunct Professor in the School of Public Health and Preventive Medicine at Monash University.

In 1975 Dr. Southby served as a full time Commissioner on the Australian Hospitals and Health Services Commission.

The Australian Hospitals and Health Services Commission 1973 – 1978

In December 1972 Bill Hayden, the then Minister for Social Security, approached Dr Sidney Sax to set up and head the Hospitals and Health Services Commission, where he remained until the Commission was disbanded in 1978. Under Dr Sax's leadership, the Commission pioneered Commonwealth involvement in health services delivery.

The Commission developed policies concerning the supply and distribution of health services and established a national health services planning model. The model envisaged a network of services comprised of primary care, private specialist care, hospitals, nursing homes, hostels and rehabilitation and domiciliary care. Primary healthcare was of central importance.

"Are There Lessons From the Past? Australian National Health Policy Making in the 1970s"

The Australian Health Policy Collaboration is hosting a private roundtable on 16 November in Melbourne with a select group of health experts and opinion leaders to consider how the work of a national health commission, in the reform focussed decade of the 1970s, might inform current concerns and debate about health policy options for Australia.

Much of this debate is focussed on how best to position Australia's health services to manage the pressures of the

- increasing health expenditure and public funding of health care;
- hospital and health workforce;
- ageing population;
- escalating impact of chronic disease; and
- rising costs of health treatments and technologies that manage those chronic diseases and prolong life.

The roundtable will consider a presentation by Dr. Richard Southby, a commissioner in the Australian Health and Hospitals Commission in 1975, considering "Are There Lessons From the Past? Australian National Health Policy Making in the 1970s". What lessons are there to still be learnt from the experience of the first Australian Health and Hospitals Commission?

Rosemary Calder AM, Director of the Australian Health Policy Collaboration (AHPC), and Rebecca Bartel, Executive Director of the Australian Centre for Health Research, will facilitate the roundtable discussion.

Participants in the roundtable are invited to consider the attached technical paper: *"The case for change towards universal and sustainable national health insurance and financing for Australia: enabling the transition to a chronic conditions focussed health care system"* commissioned by the AHPC to inform current policy discussions.

Written by Associate Professor Francesco Paolucci, of Murdoch University and Associate Professor Manuel García-Goñi, of the Universidad Complutense de Madrid, this paper has been developed in discussion with a national expert advisory group and summarises the evidence of the contributions and capacity for health insurance and financing arrangements to enable greater capacity for health service provision to engage in prevention, early intervention and to provide integrated chronic health care treatment and management.

The report considers three different health insurance arrangements relevant to the challenge facing Australia:

- a purely public insurance model;
- a mandatory private health insurance model with mostly private financing; and,
- a mandatory private health insurance market with regulated competition.

The report proposes that the model that most effectively addresses Australia's needs is a mandatory integrated (public and private funded) health insurance market with regulated competition, offering essential foundation components of a universal and sustainable health insurance model designed to provide for chronic health conditions.

Questions for consideration may include:

- What lessons are to be learnt from the experience of the first Australian Health and Hospitals Commission?
- Rather than a focus on reform – that is, an ongoing process of adjustments to current arrangements without major change – could and should Australia accept the urgent need for re-engineering of our current policy priorities and particularly health insurance and financing arrangements, through a collaborative engagement and responsibility of all stakeholders?
- What can be gained by considering the work of the second Australian Health Commission: the National Health and Hospitals Reform Commission (NHHRC) of 2009 and the Reform of Federation Issues Paper on Roles and Responsibilities in Health?
- Could an integrated (public and private) health insurance funding framework for Australia transcend, or transform, the barriers and discontinuities within current national, state and territory, public and private, health funding, insurance and service provision?
- Should a national commission with responsibility for health services policies and funding, together with a national health insurance and financing framework, be considered?
- What options are there for health leaders and influencers to promote – and perhaps provoke – the political parties and governments of Australia to work towards a multi-partisan view of health policy, in Australia's best interests?

The AHPC technical paper on a universal and sustainable health insurance and financing system for Australia, together with this policy roundtable, is intended to contribute to a national engagement in a necessary and thoughtful deliberation on how Australia can most effectively and durably respond to these issues in the best interests of Australia's health and economy.

The policy issues

Australian governments have maintained a strong focus on health policy over many years. Much of that focus has been cast as a reform agenda, addressing pressures facing health expenditure and public funding of health care; pressures on hospitals and the health workforce; pressures arising from an ageing population; increasing chronic diseases affecting more and more of the population; and, the rising costs of health treatments and technologies that manage those chronic diseases and prolong life.

These are all pressing issues. However, equalling pressing is the evidence that Australia's health policies, funding and service models are failing about one quarter of the population. Preventable diseases and chronic conditions – like diabetes, heart disease and stroke – affect a substantial and growing proportion of people living in Australia and this lies at the heart of the current discussions about health costs and budgets.

A large part of the problem is that Australia's funding and service models are not geared towards preventative healthcare. Our funding and service models are principally geared towards treatment, rather than the prevention; to be chronically ill seems to be an acceptable state for some people in our health care system, and it would seem access to preventative health care is an optional extra for some Australians.

If we had maintained this same attitude towards the most prevalent health conditions of the past (infectious diseases), we would not have the economy or nation we now have today. It is hard to imagine what life would be like if Australia, along with other countries, had not established the highly successful polio prevention program that commenced in the 1950s. Even more recently, with a resurgence of infectious diseases such as measles and whooping cough, we have effective population protection strategies and high risk response systems in place that work effectively before, not after, the disease becomes an epidemic.

Without an aggressive focus on reducing the risks of preventable illness and improving the management of chronic diseases, government fears of the increasing health costs of the growing and ageing population will become a certainty.

Reducing the risks of preventable illness for everyone would deliver huge benefits on a population scale, it would address the very real fear of escalating health costs and a growing, ageing and increasingly sick population.

The idea that health policy now should have a strong focus on the contemporary health challenge of chronic disease prevention and management is not new, and it has been a focus of both current and previous Australian governments who have acknowledged it as a major challenge. But the complexity of our federated health arrangements – in policy, funding and service delivery – along with rising health costs, the ageing of the population and the growing

impact of preventable chronic diseases, altogether mean that unless we make significant changes, the costs of preventable illness and resulting healthcare demand will continue to be a blinding headache for governments and individuals alike.

Recent government initiated discussions about options for reform of the federation arrangements in health have highlighted the unnecessary complexity, duplication and lack of coordination that arises because of the silos of commonwealth, state and territory policies and responsibilities in health policy, funding and services, and these are exacerbated by the silos of public and private funding and public and private health services and providers.

What policy objectives are useful?

Little if any of the discussions that have been held in the policy, election and budget contexts to date have attempted to articulate the measures that are needed to enable our healthcare arrangements to move towards a high-functioning system.

With the quality of Australia's health services – and the health professionals who deliver them – increasingly under stress, reform of the federation could re-focus funding from a reform focus on health services and adjustments payments strategies to a broader attention to health; to prevention and early intervention services to reduce the risk of avoidable diseases; and, to optimal coordination of primary, community and acute care services for people with chronic diseases who require long term and complex management and for those needing high cost healthcare.

An overarching aim should be to bring Australian health care services together to provide contemporary, connected health care to Australians and overcome the artificial and unhelpful separation between primary and relevant community care and aged care traditionally funded by the Australian government and hospital services that have been traditionally funded by the States and territories.

Engagement of both political leadership and public opinion would be enhanced by articulation and agreement on major aims for Australia's investment in health services.

These aims could be:

- To provide contemporary, high quality, health care to the Australian population and better provide for chronic disease management, to work effectively together to improve prevention of non-communicable diseases, and to improve national standards for health care quality and health security
- To increase the capacity of primary care services - general practitioners and community based nursing, allied health and medical specialists - to work directly with acute care,

aged and disability services in providing best practice health services particularly for prevention and management of chronic health conditions

- To reduce complexity in policy and funding between the commonwealth, state and territory governments and between public and private insurance and financing for access to appropriate and effective health care
- To reduce unnecessary health bureaucracy and associated wasteful expenditure.

Health funding – how we built the Australian health maze

The history of governments' involvement in health policy, funding and service provision was outline in Issues Paper 3 of the reform of Federation work, on Roles and Responsibilities in Health. (<https://federation.dpmc.gov.au/>). While health was not a focus of the constitutional conventions in the lead up to Federation, the establishment of Medicare in 1984 brought the Commonwealth firmly into the health policy, funding and service provision through the agreement with States and Territories to provide free health care for all Australians in public hospitals with free or subsidized access to primary health care through general practice. Subsequently, Commonwealth government's focus has been on its responsibilities in aged care, in specific areas such as population health and mental health and more recently in health workforce.

As the paper observed, these interventions have at times been in areas of traditional State and Territory responsibility and have not always improved the overall effectiveness of the health care arrangements. As well, States and Territories have also addressed areas of health care that are not working well, including the delivery of primary care and aged care in rural and remote areas. They have also led the development of many reforms, including activity based funding for public hospitals and deinstitutionalisation of patients with mental illness.

The Issues Paper proposed that clarification of the roles and responsibilities of governments, whilst not sufficient to address all of the pressures facing health care, would provide a stronger, more reliable platform for governments to act on those issues. The Paper set out the following questions for consideration:

- What is the appropriate role of government, as well as non-government and private providers, in health care?
- What should we change in the allocation of roles and responsibilities between the Commonwealth and the States and Territories to improve the health of Australians? Why?
- Should any roles be shared? If so, which ones, and how can they be clarified and coordinated to minimise overlap, duplication and blame-shifting and improve service delivery?

- What aspects of our health care arrangements involving the Commonwealth and the States and Territories are working well and should be maintained or extended?

Public funding of health services is the most visible element of Australia's health funding complexity and discontinuities. AIHW has suggested that Australia's health arrangements be described as a 'web': a web of services, providers, recipients and organisational structures. (<http://www.aihw.gov.au/australias-health/2014/health-system/>) However, a web is commonly visible in its entirety – whereas a maze, where one starts at the beginning, and has to find one's way to the destination – in health access, the most appropriate or available health service and associated funding - encountering 'dead ends' and diversions along the way, seems a better description from both the consumer and clinicians perspective.

Medicare, the Australian government universal health insurance scheme, is one of three critical funding sources for health care in Australia – the others include private health and public hospitals funding. As recent debates have highlighted, pulling one lever, to deliver efficiencies in one area of the system, without considering the other two, has unintended consequences for the other two – and for people and their health care, including the health care costs incurred by consumers – currently 16% to 17% of all health expenditure.

These three levers are operated by three players – the Commonwealth Government, State and Territory Governments, and private health insurers – but none of them act alone – two of each are coupled in the delivery of most of the funds and of the services that are funded.

Policy Options – re-engineering health insurance and financing

In response to these issues, and to the evident need for a careful, methodical, public and independent debate about the health policies, funding and services, the AHPC commissioned the paper, *“The case for change towards universal and sustainable national health insurance and financing for Australia: enabling the transition to a chronic conditions focussed health care system”* to provide for debate the proposition that re-engineering of health insurance and financing for Australia would transcend the barriers and disincentives of current arrangements and would significantly improve the prevention and coordination management of the most pressing health burden of chronic diseases – a burden for individuals, for communities, for business, for health expenditure and for the economy.

The paper proposes a national health insurance scheme with health financing arrangements for Australia that would improve universal health care access to significantly improve the prevention and coordinated management of preventable and established chronic diseases by enabling:

- health service providers to recognise and respond to risk factors contributing to the development of preventable chronic disease using both a population health approach and individual patient management; and
- coordination of care between health service providers for individuals with established chronic disease; within a universal health care access funding and service system.

The paper reviews health current arrangements in Australia and particularly focuses on the considerable duplication of health insurance arrangements and direct health expenditure that produce significant inefficiencies in Australian health financing and health service provision. As a direct consequence, because both public and private insurance pays for single episodes of care in the main, through a principal service provider, service capacity to provide for chronic health care is highly fragmented. A further and startling fragmentation in the Australian health care arrangements is the exclusion of private health insurance from the capacity to purchase or pay for primary health care. These are all crucial barriers to effective responses to the challenge of the rising impact of chronic health conditions - chronicity - in population health needs.

The premise of the paper is that the principal challenge for Australia is how to reorientate existing health funding and service arrangements through better design to be inclusive of, and focussed on, the prevention, treatment, management and long term care requirements of chronic diseases and their sequelae, including social and economic impacts and costs.

Policy Options – a national health commission?

Interestingly, the 2014 Commonwealth Budget included an intention to establish a national health productivity and performance commission. Little was said about this at the time, despite the evident significance of the proposition,

The establishment of the Hospital and Health Services Commission (AHC) in 1973, which was charged with creating a comprehensive approach to healthcare policy and delivery at the local and national level, offers interesting reflections across the years.

In its five years of operation, the AHC led to major changes in the planning and delivery of services across the healthcare spectrum, and firmly established the role of the Commonwealth government in health service provision and in health insurance and financing.

Subsequently, there has been persistent muddling of governments' responsibilities for service provision, and the complex maze of payments between different levels of government and to service providers – a continuous source of contention and confusion for healthcare consumers and policymakers alike.

A contemporary national commission could be the missing keystone – capable of enabling a non-partisan, multilateral platform for shared responsibility and accountability in the development and implementation of coherent and consistent health policy, with a focus on national interest, encompassing, but not limited by, sectional and jurisdictional interests. Such a commission would comprise both Commonwealth and jurisdictional governments as members, with independent experts from the health sector including consumers.

A national health commission could provide policy advice to all governments on the provision of comprehensive and coordinated health services for the nation. Successful achievement of this goal would require the commission to have the authority and capacity to influence the structural and funding arrangements for acute and primary health services that create – or fail to address – barriers to coordinated, clinically effective and efficient healthcare; that is, healthcare delivered in the most cost-effective setting, particularly for chronic disease.

Such a commission would need to have a mandate to work with private health insurers and private health providers to enable it to advise on the implementation of comprehensive, clinically and cost effective healthcare arrangements for people with chronic and complex healthcare needs. The lack of direct engagement between primary care services, particularly GP services, and specialist consultant care, as well as acute care services, has been one of the major barriers to effective and coordinated service provision for chronic health conditions, for both consumers and for clinicians.

A national – federated – strategy could, over time, encompass other essential elements of a national health system as well. For example, national standards and criteria for the provision of individual electronic health records for implementation throughout Australian health services, as well as health workforce planning and development. The latter would logically fit within the purview of a commission focused on performance and productivity. Therefore, this commission should have a mandate to work with education agencies and authorities to develop health workforce education and policies to meet the population healthcare needs for increased primary and community care service capacity.

To function effectively and eliminate duplication of effort, a national commission would need to work closely with the existing national agencies that reflect effective federalism and the goal of the national interest, in particular the AIHW and national health and welfare data and information, and the AHPRA and national registration of qualified health professionals.

What lessons can be gleaned from the establishment of the Australians Hospital and Health Services Commission in 1973, which was charged with creating a comprehensive approach to healthcare policy and delivery at the local and national level? With the quality of Australia's health services – and the health professionals who deliver them – increasingly under stress, reform of the federation could re-focus policies and funding from a myopic attention to healthcare to a broader attention to health; to prevention and early intervention services to

reduce the risk of avoidable diseases; and, to optimal coordination of primary, community and acute care services for people with chronic diseases who require long term and complex management and for those needing high cost healthcare.

The Australian Health Policy Collaboration

The Australian Health Policy Collaboration (AHPC) is a health policy and research think tank established by Victoria University in 2015. AHPC promotes and supports a national policy agenda for the prevention and management of chronic diseases that improves population health and wellbeing in Australia. It aims to inform an efficient whole-of-population approach to policies, funding, structures and services.

The AHPC contributes to the development of public policy and its practice, and works to improve health outcomes through evidence-based research, particularly for socioeconomically disadvantaged Australians. It commissions the collection and analysis of evidence about options and opportunities for significant change in the health system, including:

- funding principles and objectives;
- service models and provision;
- health performance measures and targets; and
- the interaction of national, state and private health funding and services provision.

The Australian Centre for Health Research

The Australian Centre for Health Research (ACHR) is a leading independent, not-for-profit public policy research institute. We work to address challenges in performance, policy and productivity across health and ageing sectors.

ACHR is driven by knowledge exchange. We generate, manage and share research, information and knowledge about healthcare and ageing to accelerate the impact of research and evidence in policy and practice.

Throughout our work, we look for emerging trends and innovative ways to meet our charter. We design novel approaches and investigate promising solutions being employed in other parts of the world that may have exciting ramifications here at home. We collaborate within and beyond the field of health, seeking new relationships and fresh thinking that may accelerate progress.



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