SUPPLEMENT

TALKING POINT

In search of an optimal health care system

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Australians have lived through many changes in their health care system in the past decade. If you took seriously the rhetoric of the politicians and public servants responsible for the changes, you might have believed that they had been searching for the elusive optimal health care system. In reality, they were probably responding to the tensions among the powerful actors in the health arena. This paper describes the development of the system, identifies its problems, and shows how attempts at solving them have generated instability owing to the lack of consensus among those powerful actors.

Background

Australia has a relatively small population—about 15 million—who, contrary to popular myth, lead a predominantly urbanised existence in a continent of almost three million square miles.

Though the six States (New South Wales, Queensland, South Australia, Tasmania, Victoria, and Western Australia) and increasingly the Northern Territory are theoretically autonomous in all areas except defence, external affairs, customs and quarantine, and collection of most taxes, the similarities among the health care systems are striking. Because of its responsibility for collecting taxes and disbursing revenue the Commonwealth government has acquired considerable control over important State and territory activities including health.

At the time of federation in 1901 primary and specialist care in Australia was almost wholly private, and it has remained so. Those who could not afford private medicine sought help in hospitals. This tradition has also held, with many hospitals still offering some primary and specialist care services. Until the early part of this century Australian hospitals relied on charities for their existence. Consequently, they were underfunded and the service they provided was poor. Local governments with hospitals within their boundaries were forced to provide some financial help, but this was insufficient.

The small population, the vast continent, the limited resources, and the federal system made government intervention in the costly hospital system inevitable. One by one, the six State governments introduced legislation to regularise the funding of hospitals. At first, the State governments supplemented the contributions of charities and local governments, though in time they took over the whole responsibility for funding and administering most hospitals, as well as community and public health services. Some short-stay general hospitals, many of which were run by religious orders, and most nursing homes remained outside the government-administered system. There are now 95 000 hospital beds, of which about 20% are in private hospitals, and 65 000 nursing-home beds.

Initially, the medical fraternity continued to be self-employed, with consultants providing an honorary service for public (non-paying) hospital patients. In large general hospitals that service was also used for the training of medical students, interns, and registrars. Increasingly, however, public hospitals have been employing full-time doctors and replacing the honorary system with a sessional payment system.

All told, about 30% of the 28 000 or so Australian doctors are now full-time government employees. The rest are private general practitioners (about 11 000) and specialists (about 9000)—operating singly or in group practices—who charge fees for items of service. They are backed up by comprehensive private pathological and radiological services. Some private allied health services are also available.

These dual health-care services are provided at a cost of over \$A9 billion, representing almost 9% of Australia's gross domestic product. Federal spending on health represents about 10% of all expenditure.

The system up to 1975

The heart of the Australian health care system is third-party benefits in the form of voluntary health insurance and government subsidies. The friendly societies were some of the first associations to offer medical benefits to their members, and New South Wales was the first State to offer subsidies under legislation in 1908. Early attempts by the Commonwealth government in the 'thirties and 'forties to regularise health insurance and introduce pharmaceutical benefits were frustrated by doctors, who even fought the government in a High Court action and won.

1945 marked a turning point in direct Commonwealth government intervention when it offered the States a subsidy for public hospital patients. Since 1950 Commonwealth-funded pharmaceutical benefits have been available; initially, drugs prescribed from a list of essential drugs—that became known as the "free" list—were free, though since 1960 a flat-rate payment per drug has been charged. Since 1951 pensioners have received free primary care, with the doctors refunded by the Commonwealth on a fee-for-service basis. Rationalisation of health insurance came during 1952, when the Commonwealth successfully introduced a subsidy for hospital patients who were insured members of a registered non-profit-making friendly society, association, or health fund. Registration of these organisations was supported by legislation. An additional subsidy was made available to all hospital patients, including those in nursing homes. In 1953 insured members of registered organisations were also offered medical benefits by the Commonwealth.

The effect of Commonwealth subsidies and health insurance on the status of patients in public hospitals was at first confusing, but eventually a three-tiered hierarchy emerged. At the top were the "private" patients, who were admitted to the hospital by their own doctors and accommodated in "private" (single-bed) rooms, for which they were charged an appropriate rate. They received the Commonwealth subsidy available to all hospital patients, and those who were insured received additional payments from their health insurance organisations. Insurance benefits were also subsidised by the Commonwealth. In high-technology teaching hospitals the amount charged for private rooms was generally much less than the real cost, the difference being made up by, and shared equally between, the States and Commonwealth. The doctors (including anaesthetists) charged the patients directly for items of service provided, and the hospitals charged them for tests—for example, pathology and diagnostic radio-

logy—and other services provided—for example, radiotherapy and physiotherapy. Insured patients then claimed what medical benefits they could from health insurance organisations. These benefits were also subsidised by the Commonwealth. Drugs prescribed from the “free” list were also subsidised by the Commonwealth. Other drugs and appliances prescribed were charged to patients, but these would also generally be below actual cost, and the difference would again be made up by equal State and Commonwealth subsidies. State and Commonwealth subsidies were in effect balancing items that equated annual hospital income to expenditure. Finally, insurance premium payments as well as all health costs in excess of insurance benefits were allowable tax deductions for individuals.

“Public” patients

At the bottom of the patient hierarchy were the “public” patients. In 1945, under the Commonwealth subsidy, anyone could be a “public” patient and be treated free of cost without a means test, but free care was abandoned in 1952 in all States except Queensland. Subsequently public patients were defined as the means-tested pensioners and their dependants—they received an additional Commonwealth subsidy—and those who were insured to receive contributions for “standard” hospital accommodation. Later, in 1970, the unemployed and others on low incomes and the newly arrived immigrants (for two months only) were included with pensioners to receive an additional subsidy. They were accommodated in public wards, anything from four-bed rooms to 30-bed Nightingale wards. Despite the additional Commonwealth subsidies which many public patients received, these had to be supplemented by the States and Commonwealth to balance hospital receipts and expenditures. Queensland has carried a heavier burden than the other States since 1952, when it decided to provide free public-ward treatment to anyone who sought admission as a “public” patient. Those receiving free treatment were further differentiated from insured patients in all Australian hospitals by their inability to nominate the doctors they wished to be treated by. There was an exception to this rule for trauma cases, particularly the badly injured and unconscious, who were admitted to hospital initially as general public patients and immediately received public-ward treatment prescribed by the hospital. The question of whether or not they paid for the treatment was decided later and depended on whether they qualified for the additional Commonwealth subsidy. Other insured patients were admitted to public wards by their private doctors either because there was no other accommodation available or because they were only insured to receive benefits for “standard” accommodation. They would otherwise be treated like “private” patients.

The in-between status for public hospital patients was the “intermediate” patients. They were admitted by their own doctors and accommodated in two-bed rooms, sometimes alongside non-paying public patients or, if the hospital had a private wing, they would be admitted there also in two-bed rooms. They would be charged by the hospital, and separately by the doctors who treated them, and receive Commonwealth and State subsidies and health insurance benefits as described above for “private” patients.

Privately owned hospitals differed from public hospitals in that they provided basic facilities—for example, nursing, testing, accommodation, operating, pharmaceutical—exclusively for the insured patients of private doctors. The patients and their insurance organisations also received Commonwealth subsidies.

In primary care there were also three classes of patients. There were those who received free treatment—for example, means-tested pensioners—or free health insurance—for example, the unemployed—those who subscribed to health insurance organisations, and those who were neither insured nor eligible for free treatment. For most Australians the first points of call for persons seeking medical help during normal hours would be private general practices. If specialist care were needed general practitioners would refer their patients to private specialists. Out of hours general practitioners would frequently redirect their patients to deputising services, which were specifically set up to provide back-up home visits for general practices. All patients except those receiving free treatment would pay the doctors directly for items of service received, with insured patients later claiming refunds from the insurance organisations. The Commonwealth would pay the subsidy for insured patients directly to the insurance organisations, and through a system of bulk billing doctors would be paid at a concessional rate for items of service supplied to those who received free treatment.

The system of health care described above remained essentially

unchanged until 1975, though reforms introduced during the early 1970s reduced the burden of direct personal contributions (excluding insurance premium payments) from about one-third of total medical expenditure in 1970 to one-fifth in 1975.

Problems of the system

The Australian health system had and still has high standards, but it suffered from many acknowledged deficiencies, the most important of which were:

- The system was inequitable in that the tax deductibility of health expenses favoured those on higher incomes, and there was a sharp cut-off point between the relatively few who received free treatment and the rest who were treated equally (the second point did not apply to Queensland since public-ward treatment was free to all those who wanted it).
- Those who were eligible to receive free or subsidised treatment had to face a means test and the consequent stigma of two somewhat degrading labels (that of being poor and a “public” patient)—a problem once again not applying to Queensland.
- Between 10% and 15% of the population was neither insured nor eligible for free treatment, and most of that group was on low income. The frequent rises in insurance premium payments further discouraged that group from taking up insurance.
- The variety of benefit scales offered by health insurance organisations, the various sources of subsidy, the three classes of patients, the dual system of public and private health, and the variety of hospitals and ownerships made the system incomprehensible to most people.
- The evidence pointed to an overuse of the health system by the insured and underuse by the uninsured and those eligible for free and subsidised treatment. More disturbing was evidence that excessive care—including unnecessary surgery—was provided by doctors in the private sector.
- The administrative expenses of the health insurance organisations were high (estimated at between 10% and 15% of premiums) and these organisations had a propensity for accumulating large reserves (about 25% of premiums).
- The benefits received by the insured were generally much less than the cost of treatment. Though there was a Commonwealth-approved schedule of common fees, doctors did not adhere to it. Furthermore, many services were not covered by insurance—for example, dentistry, optometry, physiotherapy, social work, home nursing.
- The relations between the self-employed providers of primary and specialist care and the employees of the public hospital service were generally tense. The latter complained that the straightforward cases from the private segment were syphoned to private hospitals, and public hospitals were predominantly left with patients whose complications and problems the private hospitals could not or did not wish to deal with. Critics also said that when the demand for public beds was high consultants would tend to allocate them preferentially to their private patients. The honorary service provided by consultants for public patients was not, they alleged, always responsibly carried out. The general practitioners and consultants, on the other hand, resented the growth of the public health sector, fearing the nationalisation of their services—to which they were opposed—believing in the classical economic notion that the quality and value of service were related to the amount paid for that service.
- The cost of health care was rising at a higher rate than inflation. The national expenditure on health had risen from about 5% of Australia’s gross domestic product in 1950 to about 8% in 1975 and was rising. While some of that inflation was justified by, for example, new technology, aging of population,

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increased demand for services, better facilities, and pay equality, some was not—for example, overspending, mismanagement, overservicing, overcharging, and fraud.

A new shortlived direction, 1975-82

In an attempt to solve some of these problems, the Commonwealth government took the major decision to quasinatealise the health services by introducing the Medibank Scheme from 1 July 1975. For public hospitals Medibank emulated the Queensland approach of providing free public-ward and outpatient treatment to all people everywhere in Australia. Primary and specialist care was funded by the Commonwealth through Medibank to the extent of 85% of the scheduled fee, and patients paid the remaining 15% up to a maximum of \$A5 per item. Pensioners continued to receive free treatment, and on the recommendation of doctors those who could not afford to pay the 15% component of their medical fees also received free treatment. Public and private hospitals received from the Commonwealth a subsidy per patient equal to the estimated cost of accommodating a patient in a public ward. The subsidy balancing public hospitals' income to expenditure was shared equally between States and Commonwealth.

The cost of private health insurance tumbled, since its purpose became to provide for medical and hospital benefits in excess of the generous Medibank payments. Despite this, there was an exodus from voluntary health insurance. While Medibank reduced the number of problems discussed above, it could not solve them all; above all, it did not contain the escalation of health costs. The importance of the cost lid for the containment of public expenditure was not then well understood. In any case, Medibank was not given much of a chance to prove itself. In December 1975 a new Commonwealth government took office, and it went about dismantling Medibank through a series of yearly changes. With each disruptive change new problems emerged and now the Australian health system is only marginally different from the one Medibank replaced early in 1975; only in Queensland is there still free inpatient and outpatient treatment on demand. In the rest of Australia the poor, the pensioners, the unemployed, and those receiving a low income may receive free treatment but now they must first identify themselves with a card; the rest are either insured or risk paying

the "full" (subsidised) cost. The latest change—introduced in November 1981—has already added 2% inflation to the consumer price index. Though the problems remain, the pressure on Government health expenditure has eased, from the all-high figure of over 70% of current expenditure in 1975-6 to an estimated 60% now, but the consumers of health care have had to take up that difference on their shoulders.

Though the Commonwealth government has a homogenising effect on the major activities of the States and territories, some important differences between States sometimes emerge. In health one of those differences has already been mentioned—namely, that Queensland offers free public-ward hospital treatment. The reason Queensland can afford to do this is perhaps because its hospitals (particularly the general teaching hospitals) are less costly to run than those of the rest of Australia. Since hospitals account for a large percentage of all health care costs, Queensland's cost per caput are substantially less than those of other States, except Victoria. Victoria's costs are low because it has fewer public hospital beds per caput (about 20% less than other States). It is not clear what effect this has on hospital services in Victoria. It is tempting to assume that it exacerbates the inequities that are known to exist everywhere in Australia between the services provided to the better and to the less well-off members of the Australian society. On the other hand, it is also tempting to say that Queensland's approach provides for a more equitable distribution of health care resources.

The Australian experience highlights the political side of decisions about health care. The actors—the governments, the doctors, the patients, the health institutions and their staff, the powerful lobbies, and the public at large—variously support different views of what an optimal health care system should be. Who these actors are is less important than that their actions manifest themselves as powerful forces that pull the system in all sorts of directions. The governments in power have their own axes to grind, but they also have to consider those of the other powerful actors concerned and the mood of the electorate.

Governments that respond to the forces in their health systems without open reflection and debate are likely to find, as the Australian Commonwealth government has in recent times, that problems are compounded not alleviated. Hasty actions pull the system in unpredictable directions, and make it unstable. Health is too precious to be placed in the custody of a system in that condition.

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Associate Members Group

Any medical student who is enrolled for a course of study in the United Kingdom for a primary qualification is eligible to apply for associate membership of the BMA. There are now nearly 5000 such members.

The Associate Members Group, which is open to all associate members, will meet for the first time on Saturday, 23 October at 11 am in BMA House. The Association will reimburse the travelling expenses of some of those attending and further details may be obtained from Mrs Jane Nicholls, BMA, BMA House, Tavistock Square, London WC1H 9JP.

The terms of reference of the group are:

"(1) To provide a means whereby associate members can meet and discuss matters of common interest.

"(2) To represent associate members and to present their views.

"(3) To facilitate co-operation between associate members and the medical profession.

"(4) To discuss with the DHSS pay and conditions of service for associate members when working in the NHS."

In brief . . .**GPs' remuneration**

The majority of the revised rates of fees and allowances payable to general practitioners with effect from 1 April 1982 were set out in the DHSS Health Notice HN(FP) (82)13. An August Health Notice HN(FP) (82)21 sets out the revised rates of payment in respect of dispensing, the Doctors' Retainer Scheme, the trainee practitioner scheme (except the training grant), additional payments during sickness and confinement, prolonged study leave, and related ancillary staff.

Health and safety at work

The chairman of the Health and Safety Executive has written to the chairmen of the new district health authorities reminding them of their responsibilities under the Health and Safety at Work Acts. The letter is set out in the DHSS Health Notice HN(82)28. The legal

requirements of the 1974 Health and Safety at Work Act are binding on health authorities or boards, notwithstanding their Crown status that protects them from prosecution. Each authority or board must be prepared to satisfy inspectors of the HSE that it has made the necessary arrangements to secure, so far as is reasonably practicable, the health and safety of people at work.

Sight-testing fee

The sight-testing fee paid to ophthalmic medical practitioners has been increased from £4.50 to £4.66 with effect from 1 April 1982. The net remuneration element (superannuable) of the fee has been increased from £3.51 to £3.67. The practice expenses element (non-superannuable) of the fee is still the subject of discussions between the BMA and the DHSS, and details of increases on this part of the fee will be announced later.