

Good health systems, getting better

The health policy of the Liberal Party

Tony Abbott

In view of the impending election, we asked representatives from the two major political parties for their policies on health. The Minister for Health and Ageing replies.

On any fair judgement, Australia has excellent health systems. Our healthy life expectancy ranks just behind that of Japan, Iceland and Sweden. There has been a 10-year increase in Australians' life expectancy since 1960, and a 3-year increase since 1996. These results testify to the effectiveness of the individuals and organisations involved in providing health care. Australia does not need radical experiments in health care delivery. We need refinements and improvements that build on our existing strengths. Our greatest strength, of course, is the dedication and professionalism of Australia's health staff, who can invariably be trusted to act in their patients' best interests.

Australia's health systems face four key challenges: the affordability of increasingly sophisticated health services; the expansion of the health workforce to meet the needs of an older population; the treatment of chronic disease in the community rather than in hospitals; and the integration of complex services to deliver seamless care to patients. All these challenges have been substantially addressed since 1996, but there is still a great deal to do. In particular, the next round of Health Care Agreements should not be about government but about health services. The real test of health policymakers (and would-be policymakers) is not the intensity of their critique, but the practicality of their specific proposals for change. It is easy to say, for instance, that we must take the pressure off emergency departments, or we must put more stress on prevention rather than cure. It is much harder to specify how these worthy objectives might be achieved. It is important to pledge more money for health programs but also to maintain the strong economy needed to sustain them.

Since 1996, the Howard Government has boosted spending on health and ageing from 15% to 22% of the federal budget. In the current financial year, the federal Government alone will spend \$52 billion on health and ageing, including \$13 billion through the Medicare Benefits Schedule, \$9 billion under the Australian Health Care Agreements, \$8 billion on aged care, \$7 billion through the Pharmaceutical Benefits Scheme and \$3 billion on private health insurance rebates. The Government has improved the private sector as an essential complement to a strong Medicare system. Most importantly, the Government has respected the fee-for-service principle because this is the best way to ensure that money is spent on patients rather than bureaucracy. Eleven-year-old governments do not change their spots. People can expect the same values and better services if the Government is returned.

Affordability

The Howard Government has made health care more affordable through record bulk-billing rates, the new Medicare Safety Net and the Private Health Insurance Rebate. Since 2003, largely thanks to the bulk-billing incentive payments that were part of the Strength-

ening Medicare program, general practitioner bulk-billing rates have recovered to over 78%. For children under 16 years, people over 65 and people living in rural areas, bulk-billing rates are now at an all-time high. At 73%, the overall bulk-billing rate for GPs and specialists is also at an all-time high, 2 percentage points above the rate in March 1996.

Bulk-billing is important and should be widely available, especially for people who see their doctors frequently, but not everyone can expect to be bulk-billed for everything all the time. In 2004, the Government introduced a new Medicare Safety Net for people with high out-of-hospital, out-of-pocket medical costs to rebate 80% of the gap between the Schedule fee and the doctor's charge. Last year, more than 1.5 million Australians stood to benefit from this safety net, which paid an additional \$260 million in Medicare rebates. By contrast, the Labor Party promised to abolish this safety net at the last election and is still making up its mind at this one.

The Government has made private health insurance more affordable and more widely available, after private coverage fell from 70% to 35% under the former Labor Government. More than 9 million people (including a million people earning less than \$25 000 a year) now have the choice and security that private cover brings. This is a 30% increase since the late 1990s. Although more than 80% of privately covered services have no gap, about 15% of private hospital episodes still involve gaps (averaging nearly \$700), for which no informed financial consent was previously obtained. The Government is working with the Australian Medical Association and other professional bodies to ensure that patients are warned in advance about all reasonably foreseeable medical costs, because these "nasty surprises" cause people to drop their private cover. This Government is a reluctant regulator and hopes that it will not be necessary to make obtaining informed financial consent mandatory, but will have to act if rates do not continue to improve.

Workforce

Thanks to the Howard Government, record numbers of doctors and nurses are in training. Even before the Australian Medical Workforce Advisory Council formally told the Government in November 2002 that there was an across-the-board deficiency in future doctor numbers, the Government had been moving to expand doctor training places. In 2004, there were nearly 1300 medical graduates from Australian universities. In 2012, there will be about 2800 domestic graduates. There have also been large expansions in places for other health professionals (including, most recently, 500 extra places a year for enrolled nurses trained wholly within hospitals). The Government has already committed \$60 million for registrar positions outside public hospitals, and will continue to expand private-sector procedural training, as almost 60% of all operations are now done in that sector.

The Government has funded nine new medical schools and established 14 rural clinical schools and 11 university departments

For editorial comment, see page 484. See also pages 485, 493 and 497

of rural health. The Government is paying country doctors up to \$25 000 a year in special rural retention payments and has boosted the pay and training support offered to rural proceduralists. This has already boosted country doctor numbers by 30% since 1996 (in full-time workload equivalent terms based on Medicare data), but more needs to be done as small country centres are always only a retirement away from a workforce crisis.

The Government is working with the states to establish a national system for the registration and accreditation of health professionals. Once registered, doctors (and other health professionals) should be able to work anywhere, and there should be a high, uniform professional standard for everyone practising in Australia. Under the Government's model, each profession will have its own national registration and accreditation board to set standards and procedures. Each national professional board will be assisted by a national registration and accreditation secretariat. Existing state registration boards will become committees of the national board and will administer the registration process in their state. Each board will be sovereign over its own profession, subject only to the national Health Ministers Council, which will operate by consensus. There will be a national health registration advisory council, but it will have no authority over the individual professions' boards. The Government will continue to oppose any state's move to use national registration to push "task substitution". For instance, the Government supports the use of nurses in general practice as part of a team rather than as independent nurse practitioners.

Chronic disease

Within a generation, chronic disease (such as heart disease, the complications of diabetes, and cancer) will account for 80% of Australia's total disease burden. The Government has anticipated this by expanding Medicare to prevent the onset of chronic disease and to treat it in the community before it triggers life-threatening crises requiring admission to hospital. Since 1999, under the Enhanced Primary Care Program, the Government has encouraged GPs to focus on promoting wellness as much as on treating sickness. After a series of refinements, this Program is now working well for patients with chronic disease. In the past financial year, there were nearly 700 000 Medicare-funded GP care plans, nearly 400 000 team care plans, and nearly a million Medicare-funded allied health professional consultations on GP referral. In the first 8 months of operation, there were nearly 300 000 GP mental health care plans and nearly 600 000 Medicare-funded psychologist consultations. As well, in the past financial year, there were more than 250 000 Medicare-funded comprehensive health checks for people aged over 75.

The Budget changes to the Medicare dental scheme are likely to be one of the most important recent innovations in health. From 1 November 2007, GPs can refer patients who have team care plans to private dentists for up to \$4250 worth of Medicare-funded dental work. This is directed to people with chronic disease and contributing poor oral health, rather than to the 650 000 people estimated to be on state public dental waiting lists. Still, many of the latter are pensioners who are likely to be covered by the new measure, which, like all Medicare programs, will be demand-driven rather than budget-limited. From 1 November, Medicare will fund longer consultant physician items for patients with multiple morbidities. From mid 2008, there will be subsidised lifestyle modification classes available on GP referral for patients at serious risk of developing type 2 diabetes.

It is too early to be definitive about the reductions in hospital admissions arising from the use of care plans. Still, general practices involved in the collaborative quality improvement program report significant improvements in patients' management of blood sugar and other chronic-disease variables. Certainly, more practices are starting to focus on their patients' long-term health outcomes. As well, GPs are becoming health managers for their patients, coordinating the delivery of a network of Medicare-funded services, rather than simply treating as much as they can themselves. There are still many GPs in solo or small practices delivering excellent care. There are also increasing numbers of primary health care centres involving collocated GPs, practice nurses, visiting specialists, part-time allied health professionals, on-site diagnostic services and a pharmacy. These are largely funded through Medicare on a fee-for-service basis. They represent private health professionals' intelligent responses to the changing imperatives of health care under the Medicare system. This sensible evolution of services is potentially threatened by government-funded "super clinics" in competition with the private profession.

Seamless health care delivery

Which level of government delivers care is not important as long as it is the right care at the right time. The fact that public hospitals are the responsibility of the state governments, while most other health programs are the responsibility of the federal government, does not matter as long as people receive the appropriate level of care. The existing divisions of governmental responsibility are a function of history rather than logical design. This does not mean that health institutions cannot be made to work well as things stand, or that the theoretical benefits of major structural change justify the costs of upheaval. For its part, the Howard Government is determined to run federal health programs well, effectively manage the interface between federal and state programs, and fund state health services in ways which maximise service delivery. This Government believes in solving problems, not creating more bureaucracies or inquiries to tell people what they already know.

The states habitually claim that public hospital problems are really the federal government's fault. In fact, the triage system means that emergency patients are seen promptly, and general practice-type patients are seen only when there are no more pressing cases. In any event, the Government has restored bulk-billing rates and funded over 140 after-hours GP services since 2004 through higher Medicare rebates and cash grants. Some of these have been collocated with public hospital emergency departments. As well, the Government has boosted the number of operational aged care places, from 145 000 in 1996 to 210 000 now; funded 2000 "step-down" places under the current Health Care Agreement, and introduced a transition care program for 13 000 patients a year who are too sick to go home but no longer need acute hospital services.

Public hospital problems are caused more by bad management than by poor funding. Doctors and nurses are the "meat in the sandwich" between penny-pinching managers and the patients affected by their decisions. The states' "top-down" management structures typically give local managers little real autonomy. Any local revenue is invariably "clawed back" by head office. Critical new spending decisions are invariably referred to committees, and then passed up the line to a director-general or the minister's office for further procrastination. It is no wonder that many of the best

staff seek refuge in the private sector, while their colleagues soldier on out of a sense of duty to patients rather than faith in their superiors. Putting a different bunch of bureaucrats in charge will not be change for the better. The proposal for a Commonwealth-funded, community-controlled public hospital at the Mersey site in Tasmania is about running hospitals better, not swapping a state bureaucracy with a federal one. It is not a precursor to the federal takeover of all public hospitals, but a test case for a better management system that the states should consider adopting. The Mersey will be run by a chief executive officer accountable to a local hospital board, including representation from local hospital staff. Staff will have an incentive to be creative because the hospital will keep any extra revenue.

The government's immediate postelection task will be the renegotiation of the Health Care Agreements. At present, these are block grants to the states. How the states spend the \$42 billion the Agreements provide is entirely up to them. All that is required in return is to at least match the growth in Commonwealth funding, report on waiting lists, and guarantee to treat public patients at no charge. A re-elected Government will provide at least as much public hospital funding under future Agreements as it does under the current ones. The Government is considering how the next Agreements might drive better hospital performance and, in the long term, fund services rather than bureaucracies. Certainly, the next Agreements should be about better services to patients rather than turf wars between governments.

There are two further matters vital to modern service delivery and fair health systems in Australia. The Government will make Pharmaceutical Benefits Scheme and Medicare data on patients available to these patients online, securely and accessibly, before the end of 2008 as its practical contribution to establishing an integrated electronic health record. The Government will also ensure that there is sustained follow-up treatment for problems identified by Indigenous child health checks in the Northern Territory. Spending on Indigenous health and aged care programs has more than doubled in real terms since 1996, but more needs to be done to give Indigenous patients access to health services comparable to that of the general Australian community.

Australians are entitled to have high expectations of their health care systems and to demand much of the governments responsible for them. The latest opinion poll reveals that people are twice as inclined to blame the state governments as the federal government for problems in health care. This might be a good guide as to which side of politics can really be trusted to keep Medicare safe.

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(Received 20 Sep 2007, accepted 24 Sep 2007)

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