What is the future of universal health coverage in Australia?

Universal health coverage (UHC) is the notion that "all people have access to the full range of quality health services they need, when and where they need them, without financial hardship".[1] Although Australia generally compares favourably to other high income countries in terms of service coverage,[2] our health system nonetheless faces important challenges to delivering the promises of UHC. Our population is ageing alongside the emergence of ever more costly new health technologies, the increasing prevalence of non-communicable diseases, and the ongoing effects of the COVID-19 pandemic. On many measures, health inequalities according to socio-economic status are widening.[3] The burden of disease for Indigenous people remains at 2.3 times that of non-Indigenous Australians.[4] People who live in rural and remote areas continue to experience poorer access to health care and poorer health outcomes than their metropolitan counterparts.[5] And general practice — the bedrock of UHC in Australia — is in the midst of a funding and workforce crisis.[6]

Today in the *MJA* we publish a themed issue on reforming Australia's health system. Almost 40 years since the establishment of Medicare — the funding instrument that supports efforts towards UHC — what is the path to creating a more sustainable and equitable health system?

In their review of 76 articles published since 2000, Angeles and colleagues[7] provide a high level analysis of the fragmentation that characterises the way Australia delivers health care, and the resulting systemic problems such as increasing out-of-pocket costs, poorer health outcomes for Indigenous Australians, high drug prices, and policy confusion over the role of private health care in relation to the public system. The authors conclude that "reforms of the universal health care system over the past twenty years have been piecemeal and uncoordinated", and that "[e]ffective, systemic, and comprehensive reforms of the Australian health system" are long overdue.

Taking a deep dive into primary care, Douglas and colleagues[8] likewise highlight how policy solutions to pressing problems are too often characterised by reactive and superficial thinking at the expense of more considered, strategic and thoughtful approaches. A case in point is the recent announcement of new urgent care centres and primary care pilots, which the authors contend "is intuitively appealing and might, in the short term, take some pressure off hospital emergency departments", but alone "is a simplistic approach that does not account for complexities in shifting demographics, changing burden of disease, or structural inequities in the broader health system [and] does not adequately accommodate the key principles of high functioning primary care and how they underpin effective UHC".

How can systems thinking be harnessed to produce more effective health system reform? The respective roles of GPs and specialists in improving access to mental health care is addressed in a research article by Vacher and colleagues[9] and an accompanying editorial from Gunn and Flehr.[10] Using dynamic systems modelling, the researchers evaluated the likely effects of removing the need for patients to obtain a GP referral to access Medicare-funded specialist mental health services. They found that, in isolation, this direct access approach would lead to poorer mental health outcomes owing to longer wait times to access care. The benefits of direct access would only be realised by concurrently increasing specialist mental health service capacity, highlighting what Vacher and colleagues argue are "the risks of implementing individual reforms without knowledge of their overall system effect", and what Gunn and Flehr contend shows the need for "models of care that build bridges between general practice and specialist mental health care and draw upon the strengths of each discipline to meet the needs of the whole person".

Research by Liu and colleagues[11] identifies how out-of-pocket costs for radiation oncology services in New South Wales vary considerably according to geography, with some patients incurring very high costs that might act as a barrier to access. In a perspective, Callander[12] points out that across Australia, 15% of all expenditure on health care comes directly from individuals in the form of out-of-pocket fees, a situation that undermines equity and leads patients to avoid care. Proposed options for reducing affordability barriers to health care access include increasing subsidies paid through Medicare, expanding Medicare to cover additional areas such as dental care, and increasing the volume of outpatient specialist care through public hospitals.

Finally, to mark 10 years since the establishment of the National Disability Insurance Scheme (NDIS), Smith-Merry and colleagues[13] reflect on progress to date and present priorities for designing a more equitable scheme. While there are many successes to recognise, in their view, a "failure to address inequity within the operation and design of disability support means that the NDIS will continue to perpetuate the disabling and ableist structures that marginalise people with disability in Australian society". ■

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