The Delivery of Health Services

Stephen Duckett*

I would like to start by reminding us that as we travelled here to this venue we walked the paths of Aboriginal people before us. That is particularly important in the context of health services. As you know, there is a 17-year gap in the life expectancy of Aboriginal people compared to non-Aboriginal people. What people forget is that, except for the Northern Territory, most Aboriginal people live in urban Australia. The gap in urban Australia in Aboriginal life expectancy is about 14 years. If we address the gap for urban Aboriginal people, where we do not have the problems of access, we do not have the problems of getting health workers to work in rural and remote communities, then we will have dealt with 14 of the 17-year gap. So we should not ever think about the Aboriginal health problem as being one of people who live in specific Aboriginal communities in rural and remote Australia.

However, that is not what I want to talk about.

I thought I would talk about Commonwealth–State relations as something that is endemic to the health debate. I want to firstly talk a little about who spends what, and try to look at some of those issues, and then look at the choices and options for us. First of all, I remind you of the story about the United Nations High Commission on the Elephant. The United Nations set up the High Commission on the Elephant some years ago. They had a number of countries join it, and these various countries developed papers on the elephant. The first one was put forward by the South Africans. It talked about the impact of colonialism on the elephant and the decline in elephant populations in Africa in particular.

The Swedes put in a paper that was called *The Elephants and Sex*, which was as you would expect from the Swedes. The French put in a paper unfortunately called *Eating the Elephant*. The Australians put in a paper called *The Elephant — A Commonwealth or State Issue*. That is what health is about in Australia. The Commonwealth–State divide causes a number of frictions, one of which is about

* Dr Stephen Duckett , Head of the Queensland Health Reform Team.

Australasian Parliamentary Review, Spring 2009, Vol. 24(2), 50–55.

fiscal squabbles — about cost shifting, debates about whether the States are maintaining their share, irritating interventions by all levels of government, priority distortions, and so on. We also have the waiting time blame game, where the States blame the Commonwealth and the Commonwealth blames the States. Most notably in the area of emergency department category 4 and 5 patients who turn up in emergency departments who could in some circumstances be called primary care patients, the States say that if the Commonwealth had better primary care there would be no category 4 and 5 patients in emergency departments, and so on. And, of course, there are arguments about waste, inefficiency, fragmentation, duplication, and so on.

But more importantly in my view, you do not have a whole system. If we examine spending on health in Australia in 2005–06 the baddies, the people in the black hats, are the Commonwealth. They spend about half the spending on public hospitals. The Commonwealth spends just over one-third of the spending on private hospitals, mainly through the health insurance rebate, about 85 per cent of the spending on medical services, almost nothing on dental, and about half the spending on medications. The States, on the other hand, spend more than half the money on hospitals, with the vast bulk of the money spent on community health, other than provided by doctors and pharmacists. Health insurance funds provide particular spending on private hospitals but not much on anything else.

The Commonwealth when it looks at the health system looks at it through the eyes of what it spends on what it controls — in particular, medical and pharmaceuticals, and to a lesser extent private hospitals. The States look at it in the lens through services they control. So you get State bureaucrats not thinking about medical services and pharmaceutical services and so on; so we get a distortion in the way we think about the health care system. How have things changed over the years? Health expenditure as a proportion of gross domestic product has gone up over the last 20 or so years from about 7.5 per cent to around 9 per cent of gross domestic product at that time. We look to see it growing over the next 30 years to about 12.5 per cent of gross domestic product, with different parts of health expenditure increasing at different rates. For example, we expect to see spending on injury doubling or so over this period but spending on type 2 diabetes going up sixfold because of the obesity epidemic.

But what is interesting over this period is that the Commonwealth's share has more or less remained steady at the start of the decade and the end of the decade, the States' share has gone up from about 23 to 25 per cent, which is a pretty big increase, the out-of-pocket share has gone up, and health insurance has declined, of course, because of the health insurance rebate, from about 11 per cent to 7 per cent. So the Commonwealth's share has been steady but there has been a shift of spending towards the States. There was mention of the share of State Government expenditure. Basically, Commonwealth spending, as a share of the Commonwealth budget, has remained pretty constant over this period 1998–99 to 2006–07. Most States and Territories have had an upward share of their State budget.

This is at a time when there have been quite significant increases in the size of State budgets. For example in the Northern Territory health has gone from about 16 per cent of its Territory budget to about 23 per cent; in Tasmania, from about 20 per cent to 25 per cent. This is a significant shift in State Government priorities. Unfortunately, New South Wales has not increased particularly greatly, from about 24 per cent to about 25 per cent. This might explain why the New South Wales health system is in such a parlous state. But most of the States are increasing significantly in their share of State spending, probably in an unsustainable way.

The second thing I want to talk about is what the Constitution says. Everyone says, 'Hospitals are a State responsibility.' In fact, that is not true. The Constitution gives the Commonwealth very clear power over hospital benefits, in section 51 (23) (a) plus the other powers that the Commonwealth has. The Commonwealth does not have a general power over health services though, of course. As you know, the Commonwealth power has increased significantly through interpretations by the High Court. One of the issues at stake in health policy, and in fact federalism generally, is: What are the principles you use for allocating roles and responsibilities? These principles are in conflict. An Australian nationhood principle might argue that the Commonwealth Government should take responsibility in areas where there is a national identity issue. But the subsidiarity principle argues that States and lower levels of government should have responsibility for things that can be devolved. So these principles do not help very much in allocating roles and responsibilities.

The good news is that there is substantial effort going in through COAG at the moment looking at roles and responsibilities. Why do I say it is good news? When I heard COAG was going to work on this, I invested in Qantas shares. One of the main outputs of the COAG process has been increased flights by public servants, and the other benefit has been increased paper production. I also invested in paper mill shares. So I am a major beneficiary of the COAG process — probably the only beneficiary in Australia of the COAG process to date.

What is the output of the COAG process? Don Watson has written a book about language use. Here is an example of the language used in defining roles in the health sector. What we have here is that the Commonwealth is responsible for fully funded, subsidised, primary and community-based specialist care. They want to clarify that a little when they say, 'that is, subsidisation of care provided by medical practitioners'. So they are actually not responsible for medical practice in Australia, they are not responsible for the provision of medical services; they are responsible for subsidising. So when they use the term 'fully funded, subsidised', they do not mean fully funded at all; they mean partially funded, because there are out-of-pocket costs in medical services. They only relate to subsidised services, because they then refer to 'some allied health practitioners', not all, and 'other health programs beginning with A'. So what might be thought to be clarity is in fact not clarity at all.

They also say they are responsible for 'jointly funding public hospital in-patient, emergency department, outpatient', and so on. When they say 'jointly funding', that also has a particular meaning in this case. Someone rang me the other day and said, 'If we treat an additional patient through our elective surgery program in Queensland, how much additional money do we get from the Commonwealth?' The answer is zero — we do not get a single additional dollar for treating a single additional patient in Queensland. So when they say 'jointly funding', it has a particular meaning — that is, they give a contribution and then go away and hope for the best.

Then we have the joint accountability. Here we have a joint accountability that is for implementing health and aged care system reform. But if you go to any of the hospitals in your electorate and say to them, 'If you want to introduce some reform — say, change the way outpatient services are provided, or change the flow through the emergency department — who do you ring up?' Many of them would ring no-one; they would just do it themselves. Certainly they do not bother to ring Canberra, because the cost of the phone call would be in excess of the benefit they would get in return. What is also interesting is that the reforms they are interested in are not about efficiency. So do we assume that there are no efficiency gains to be made in the Australian health care system at all? The answer is, clearly not.

Then you say to yourself, 'The answer is better coordination.' Coordination is one of those words that has a very funny meaning. It could mean exercise of power. If you think about it, does coordination mean that some grand coordinator up in the sky controls everything by the coordinatees, or is it about working together? One of the hazards of this is that coordination is complex in the health care system because, as Walter Lutz points out, you can integrate some services for all the people or all services for some of the people, but you cannot integrate all services for all the people.

There are numerous idiocies in the health care system, one of which is outpatient services. If you go along to an outpatient clinic at one of the local hospitals, there are a number of ways that a patient can be treated, or counted in a way. The same patient, seen by the same clinician, for the same condition and, in the same building, can be characterised in four quite different ways: as a truly private service, where there is a contract between the specialist and the patient; as a Medicare privatised clinic, a bulk billing clinic; as a hospital outpatient clinic established post-1998, where they are allowed to convert them to a bulk billing clinic; or as a pre-1998 clinic, where they are not allowed to convert them to a bulk billing clinic. One of the interesting things about the 1998 rule is that it is totally uninterpretable, as the Commonwealth Auditor-General said. So here we have an example of a totally fraught and confused system.

So where do we go from here? I think there are basically three solutions for moving forward on Commonwealth–State relations. If you look at the public debate, there are three of them. The first is the California hot tub model, where we basically just

hug each other and hold hands and everything will be okay. This is sometimes called reform of the status quo. There is a paper about the joint commissioning of health services and funds pooling. It is all about all working together. The best example of that was the 1998 to 2003 Australian health care agreement, where they had a specific clause — and this is taken from the Victorian agreement — which says the Commonwealth and Victoria will move together and they will look at what are called measure and share. They have a particular clause here — and this clause is replicated in every Australian health care agreement. There was just one proposal, out of all of Australia, which led to change in this collaborative and coordinated way.

So there are real problems here. What autonomy would the States have in these sorts of arrangements? Would States want to take on the risk of growth of the MBS or PPS? Then there is the real issue of political accountability: If we have joint responsibility, who is accountable for what? If there is a problem with hospital waiting lists, do they go to a State member of Parliament or a Commonwealth member of Parliament? If they want to change the policies, do they have to change both governments, or only one? And so on and so forth. The second solution is the sugar daddy model — that daddy knows best, and what is more, he has got lots and lots of money. It is a pity he lives in Canberra. As everyone knows, Canberra is an Aboriginal word meaning ‘talking place’ or ‘lots of meetings’.

The issue with the sugar daddy model is that we then say, ‘Let’s give all the responsibility to the Commonwealth, and they will fix it all up because they are very, very clever, they have got lots and lots of money’, and so on. If you talk to clinicians, this is the model that they would support. It is widely supported as the prima facie way of fixing everything. It involves a massive transfer of responsibility. About half the GST would be shifted back to the Commonwealth. The Commonwealth’s share of total health expenditure is about 4623. It is minority shareholder of public hospitals. There would be a huge transfer of responsibility. The States would probably be unlikely to continue as providers. Many people might say that is a good idea. It would, of course, remove one of the checks and balances of the Australian health care system. Basically it is more supported by the public in places where people can hop on a plane and fly to Canberra and less supported in States where people are much further away.

The third model is what I call Aristotle meets Caesar and later Adam Smith. That is, you divide the health system into parts. Aristotle was the first person to say that the whole is more than the sum of the parts. He phrased it somewhat more elegantly by saying several parts in which the totality is not, as it were, a mere heap. Some might describe the New South Wales health system as a mere heap, but here we are saying the total is more important than the sum of the parts and we can get it right. Julius Caesar of course divided Gaul into three parts and Augustus divided Gaul into four parts. The National Health and Hospitals Reform Commission is arguing that we should divide the health care system. In its first report it said that primary care should be totally the responsibility of the Commonwealth but the hospital system

should be seen as a State responsibility. What we wanted to do was have single accountability but very clear accountability because, as we argued, joint accountability equals no accountability. We said the Commonwealth should be fully responsible, by which we mean fully responsible, not by and large vaguely accountable for subsidising some parts of it and not others. Importantly, it would give sole accountability in a really important area of the health care system where most of the interactions between the patients occur.

We argued that there should be activity funding for hospitals and that we could improve efficiency if the Commonwealth funded a particular price, and the States would remain accountable and so on. Adam Smith said it is not from the benevolence of the butcher, the baker or the brewer that we expect our dinner but from their regard to their own self-interest. I will give you an example. I am responsible in my day job for outpatient services in Queensland and we have too many people. We are overwhelmed by demand. One of the ways of addressing that is to try to encourage GPs to look after patients for longer and to try to strengthen the role of general practitioners. If you recall, general practice is subsidised by the Commonwealth. That does not alter my interest in it. That is, it is in my interest to get that part of the health care system working better. If I can get general practice land working better then outpatient systems will work better. I have a self-interest, or an interest from my employer's perspective, in improving that. I am arguing that clarity of accountability will actually improve coordination, not hinder it. Thank you very much. ▲