

Beating the hospital obsession—the key to rural health reform is in primary care

John Menadue AO¹

¹Centre for Policy Development



John Laurence Menadue AO has had a distinguished career both in the private sector and in public service. He was made an Officer of the Order of Australia (AO) in 1985 for public service. In 2003 he was awarded the Centenary Medal ‘for service to Australian society through public service leadership’. In 1997, he received the Japanese Imperial Award, The Grand Cordon of the Order of the Sacred Treasure (Kun-itto Zuiho-sho), the highest honour awarded to foreigners who are not head of state or head of government.

John Menadue was born in South Australia in 1935. He graduated from the University of Adelaide in 1956 as a Bachelor of Economics.

From 1960 to 1967 he was Private Secretary to Gough Whitlam, Leader of the Opposition. He then moved into the private sector for seven years as General Manager, News Limited, Sydney, publisher of *The Australian*.

John Menadue was head of the Department of Prime Minister and Cabinet from 1974 to 1976. He was closely involved in the events of November 11, 1975, and worked for Prime Ministers Gough Whitlam and Malcolm Fraser.

He was Australian Ambassador to Japan from 1976 to 1980.

He returned to Australia in 1980 to take up the position of Head, Department of Immigration and Ethnic Affairs. In March 1983, he became Head of the Department of the Special Minister of State. He was appointed Head of the Department of Trade in December 1983.

He was Chief Executive Officer of Qantas from June 1986 to July 1989.

He was a Director of Telstra from December 1994 to October 1996, a Director of NSW State Rail Authority from 1996 to 1999, and Chairman of the Australia Japan Foundation from 1991 to 1998.

He is an adviser to several companies. He chaired the NSW Health Council, which reported to the NSW Minister for Health in March 2000 on changes to health services in NSW. He also chaired the SA Generational Health Review which reported to the SA Minister for Human Services in May 2003.

He was the founding Chair of NewMatilda.com, an independent weekly online newsletter that was launched in August 2004. He is now a Director of the Centre for Policy Development, which continues the work of the Policy Portal in New Matilda.

In 2009, he received the Distinguished Alumni Award from the University of Adelaide in recognition of his significant and lifelong contribution to Australian society as a public servant, diplomat, critical thinker, board director, advisor and public commentator.

John Menadue is married with four children and ten grandchildren.

In October 1999, John Menadue published his autobiography *Things you Learn Along the Way*.

Summary

There are systemic problems in our health sector—a lack of guiding values and principles, governance confusion, exclusion of the community from health decisions, rapidly rising costs and the obsession with hospitals. We are bedevilled by powerful special interests.

But what are the particular issues which advocates of rural health reform should promote.

First, the driver of rural health reform must be primary healthcare with particular attention to the Medicare Locals and the roll out of the GP superclinics. The MBS schedule should be amended and contracts written with corporate and non-corporate general practices to promote integrated care.

Second, there are many health determinants and services outside the health portfolio that are vital—NBN, prevention and transport. Paper records are problematic enough in the cities. They slow down information transfers even more severely in the bush.

Third, unless there is an informed and open discussion about how the health dollar is spent, the media-savvy and the special interests in the city will squeeze out the major health priority needs in this country—rural health, indigenous health and mental health.

Fourth, we need an upgrading and re-skilling of tens of thousands of people in the health sector who could help fill the gaps in the delivery of health services for country people. Particular attention must be given to expanding the roles of nurse practitioners, other allied health, pharmacists and ambulance officers. We don't so much need more doctors; we need an up-skilling of tens of thousands of other clinicians. We need also to make sure we make best use of the skills they already have.

Introduction

I was sceptical about the claims of Kevin Rudd last June that the health reforms were 'the greatest since Medicare'. I have seen little since then, including the Commonwealth Government announcement in association with the premiers last month that would change my mind. It is more muddling through. That said, however, the commitment of the Commonwealth to take full responsibility for primary care is a great opportunity that must not be missed. This could transform healthcare in Australia. The solution will not be through hospitals, particularly for country people.

What a disappointment it has been since the federal government came to power in 2007 with what I hoped were well considered strategies for healthcare reform and the means to implement them.

But before I become too pessimistic, let me acknowledge some incremental improvements that have been announced in recent months. They will be valuable—activity-based hospital funding, some local governance of hospital networks, primary healthcare organizations to aid primary healthcare integration and broader health service planning, including I expect, full Commonwealth responsibility for aged care. At last there is some progress on e-health, although only this week the Victorian Government and the Liberal Opposition in NSW expressed reservations about the new systems being introduced in those states. There is clearly more money, but I believe that we are not getting value for the money we already spend. A survey of Canadians over 45, who were experienced healthcare users, showed that 58% did not believe that healthcare would improve if the government spent more money in health. I believe the same is true in Australia. We should be spending existing money much more effectively. We waste about \$10 b pa or 10% of our total health expenditure.

Major problems and omissions remain.

- It is not at all clear that the government has any clear values and principles which guide its health policies, e.g. universality, equity, efficiency—both technical and allocative—subsidiarity and single-funder. Without such guiding principles health policy will continue to be subject to managerial fads, responses to hot-button issues and the placating of noisy and selfish special interests.
- Governance problems between the Commonwealth and the States remain. A 60/40, 40/60 or a 50/50 split doesn't make any difference to divided responsibility. It seems that the Australian public are better prepared for reform than the Government with a strong majority in most states favouring a Commonwealth takeover of state hospitals. In addition to the unresolved Commonwealth/state issue, I have also come to the view that the traditional minister/departmental model in health is no longer viable given the size of the health sector, its complexity, its inertia and the power of vested interests. (Professor Garnaut refers to these interests in carbon pollution and mining as 'diabolical'. They are more subtle, but just as diabolical in health.) For these reasons I have proposed a statutory Commonwealth Health Commission composed of professional and independent people, but subject to government guidelines to administer health programs in Australia. This would be similar to the way the Australian Reserve Bank acts in the monetary policy field. The health sector has broadly agreed for a decade about the general shape of necessary reform, but it has not happened because of the political power of health lobbyists to preserve corporate welfare, high prices and work practices, particularly by specialists who exploit their market power.
- The community is still largely excluded from health discussions and decisions. The Prime Minister and the Minister deal overwhelmingly with special interests and ignore the community except for some token photo opportunities, mainly in hospitals.

- Costs are continuing to rise at 5% real per annum. It is not, as often suggested, that it is ageing that is driving up healthcare costs. We all see our doctor or specialist far too much, across all age groups. In 1984/85, Medicare services per person per annum were 7.1 services. By 2007/08 it had increased to 13.1 services and this increase was across all age groups. This is a doubling over 13 years of the number of times we see our doctor. The cosy deal between the government and the Australian Pharmacy Guild, results in Australian taxpayers and consumers paying \$300 m more each year for statins compared with England and Canada. This is only for statin drugs which represent only about 16% of the costs of the PBS. We can't afford these exploitive high prices.
- Fee for service is quite inappropriate for chronic care. It has perverse incentives. It encourages doctor shops and 'turnstile' medicine. It discourages integrated care. Present payment methods are underwriting the rapid growth of corporatisation of general practice in Australia, up to 30% in some metropolitan areas.
- The health workforce is still mired in 19th Century work practices.
- 70% of health expenditure in Australia is for treating chronic disease—heart, cancer, neurological, mental and diabetes. But the public campaign, particularly in the media, focuses on waiting lists and emergency departments in hospitals.
- Dental health is still a Cinderella as is mental health, although we may hear more about the latter in the near future.
- But probably the most serious problem is the continuing obsession with hospitals, an obsession shared, I must say, by the media, many health professionals and the community. According to OECD data, we have for example more acute beds per 1000 of population than in the UK, Canada or Sweden. But the continual drum-beat in Australia is for more hospital beds to accommodate particular medical fashions. In the last decade caesarean sections have increased by about 50% and joint replacement by almost 70%. We all know that about 10% of people in hospitals would not be there if there were proper alternatives available, and that it costs about ten times as much to treat a patient in hospital compared with treatment in the community. The Productivity Commission in 2008 said that 450,000 admissions to public hospitals could have been avoided if there was better community care in the three week period before hospital admission.

Private health insurance and country people

A particular issue which should concern country people is the inequity and inefficiency of the \$5 b p.a. government subsidy to high cost private health insurance companies. Put simply, this corporate welfare enables relatively wealthy people in the cities to jump the queue for elective surgery in private hospitals and it deprives public hospitals of resources. Recent data from the Australian Institute of Health and Welfare (Australian Health Expenditures by Remoteness, January 2011, page 41) shows how this subsidy short-changes country people because of the few private hospitals in country areas.

In 2006/2007, the latest year for which these figures are available, the expenditure per person in private hospitals in the country compared with major cities was 16% lower in 'inner regional'; 34% lower in 'outer regional'; 48% lower in 'remote' and 60% lower in 'very remote'. By contrast, public hospitals served the country community much better. Compared with expenditure in public hospitals per person in major cities, public expenditure in public hospitals in 'inner regional' hospitals was 10% higher, 28% higher in 'outer regional'; 68% higher in 'remote' and 250% higher in 'very remote'.

Country people are being duded by the \$5 b p.a. subsidy. Yet National Party MPs allow themselves to be led by the nose by the Liberals. Because there are so few country private hospitals, the \$5 b p.a. subsidy inevitably operates to the disadvantage of country people. The transfer of this \$5 b subsidy to rural health, mental health and indigenous health would have dramatic benefits. That would be \$50 b over ten years. The new hospital package that Julia Gillard announced last month is only \$16 b over ten years.

Winning the case for country health reform

On almost any measure, country people have worse health outcomes than city people. Mainly due to lack of early detection, cancer sufferers outside capital cities are 35% more likely to die within five years. Country

sufferers of heart disease are more likely to die early. The story is similar across the board—stroke, birth defects and mental disorders.

I suggest that there are four major issues on which country health reform should focus.

First, primary care. The inequity in healthcare in Australia, rural, mental and indigenous, will only be effectively addressed through primary care, not hospitals. The dignity, autonomy and good health of all citizens are best served by delivering health services in the home or as locally as possible. It is the principle of subsidiarity.

Second, health improvements are just as likely to be advanced outside the health portfolio, eg broadband.

Third, winning the debate for priority-setting and allocation of health dollars depends on an informed community. Unless this is done, the well-organised and worried-well in the cities will continue to skew resources in their favour. Unless country people can win the debate, they will continue to be unfairly serviced in health.

Fourth, workforce reform.

Primary care

In the hospital sector, it is hard to teach old dogs new tricks. Ministers, officials and professionals with their century-old ways of doing things, are hard to change. They think institutions and providers rather than people, and the almost sacredness of existing work practices. Primary care offers the best prospect of services for country people, integrated care, the curtailment of chronic disease, reduced service fragmentation and increased efficiency, particularly through new work practices. As Jennifer Doggett has set out in 'A new approach to primary care...' (CPD, June 2007), primary care provides

- A greater focus on prevention
- Faster medical action
- Consolidated service delivery
- A seamless one-step approach
- Consolidated history with test results
- Better access for all.

As Jennifer Doggett summarises it 'Primary care reform is the single most important strategy for improving our health and making the health system sustainable. Community level prevention and primary care is essential to restoring universality and efficiency in Australian healthcare'. Health decisions and health services must be made at the most local level possible—the principle of subsidiarity.

In the long and recent statements arising from the government's obsession with hospitals, there has been included, almost as a footnote, that 'the Commonwealth will have full funding and policy responsibility for general practice and primary care ... including community health centres ... and aged care'. Those few lines if properly and fully implemented could really reform and transform healthcare in Australia. That reform won't come through hospitals.

How Medicare locals develop will be an important key. The first thing that government should do is change their name to make it clear that these entities will not be delivering care. This is not just a cosmetic issue. They must be seen to be, and in fact become, regional planners and coordinators with adequate funds based on population and socioeconomic needs and for the purchasing of some services. They must be proactive in prevention. They must develop so that they can influence all hospital and non-hospital services in their region. These newly named entities must have resources and government support to drive regional planning and the delivery of services by others, e.g. early childhood, schools, welfare, housing and transport both for patients and families. Dialysis is a major problem. These new entities must be judged by their health outcomes and not their health inputs. They must get away from the medical model based on sickness that determines so much of what we do in health. If they in fact become a new name for the Divisions of General Practice, they will fail. I

suggest that the rural health alliance should be focusing its activities on the development of these new entities, mistakenly called 'Medicare locals'.

We also need to improve General Practice. I spoke earlier about fee-for-service dramatically putting up costs and discouraging integrated care. The government should consider two possible changes. The first is that the MBS schedule be amended to permit private practices to remunerate a supervising general practitioner in their practices. That supervising GP would be remunerated for over-sighting the treatment and referral of patients and their records. The second is that the government should offer to negotiate contracts with practices, both corporate and non-corporate, that will commit to the delivery of integrated care. I expect that the government would be agreeably surprised at the number of GP practices that would respond because of their concern about the 'turnstile' nature of a lot of general practice in Australia today.

What of the GP super clinics that the Commonwealth is rolling out? Including this year the Government will be spending \$650 m over two years on 64 clinics. It is not yet clear that these clinics are on the right track. I hope we don't have another insulation mess.

- I can't see that the roll out of these clinics is part of a universal program. Only six of the planned 64 are operating. Why call them 'super'? I should have thought they should be ordinary and common-place. They do appear to be part of a marginal-seat strategy rather than a health strategy.
- 'GP' suggests that it is doctor-centric, when the emphasis should be on multidisciplinary teams with enrolled patients/families. Often the need is not even for a clinician, particularly for people who face lifestyle and social problems. Often a case-manager is necessary to access other agencies, e.g. education, housing and justice.
- Are the clinics the right size to enable the team to be made up of a wide range of health professionals, or will they be GP clinics with a few and limited professional add-ons?
- Emphasis seems to be on bricks and mortar and co-location, rather than the provision of integrated care. Accommodation under one roof does not necessarily lead to integration.
- How can the MBS be amended to promote more team treatment and payments to all professionals in the clinic?
- Two vitally interested organisations, the Australian Nurses' Federation and the Australian Practice Nurses' Association have heard very little about the program.
- The Australian Pharmacy Guild has refused to allow professional pharmacists to join the clinics unless they do so as shop-keepers. That clearly tells me that the APG is more concerned about shop-keeping than the professionalism of its members.
- There is a 'deafening' silence about the superclinics and how they are performing. The fact that the AMA is saying little, suggests to me that the program is not going well.

Improving health outside the health portfolio

The mis-named Medicare Locals must also drive improved health services outside the health portfolio.

Ministers for Health in Australia are seen very largely as ministers in charge of health services rather than health. The fact is that some major issues causing poor health or which could be the means to improve health are outside the normal health portfolio.

- Medicare has become a payments vehicle, and an efficient one, rather than a health insurance commission as its name suggests was intended. How can we have integrated health funding, even at the Commonwealth level, when the Minister for Human Services, not the Minister for Health, has administrative responsibility for Medicare.
- The major health problems caused by junk food, alcohol and tobacco are best addressed through taxation and restrictions on advertising, particularly for children. (Health improvement is made very difficult when

the major sponsors of sport in Australia are interests associated with alcohol and junk food. They are complicit in promoting bad health habits and undo a lot of the good work on prevention. How can our sporting codes discipline players for excessive alcohol consumption, when the main sponsors of the codes are liquor companies?)

- We know that because of social and economic disadvantage, the death rate for those with the lowest socio-economic status is 13% higher than the Australian average, and for those living outside capital cities it is 8%. Poverty is the principal cause of poor health in Australia.
- Education, childcare, including pre-natal, spacial planning, housing, trade (particularly relating to intellectual property in pharmaceuticals), population, transport, taxation and social security, employment, justice and the environment, all have direct impacts on the health of Australians.
- We are coming to appreciate how electronic health and the national broadband network offer great opportunities for improved health services, particularly for people in remote areas. They offer a new model of care particularly for remote and chronically ill patients. It will hopefully be possible to bill Medicare for online treatments. But the NBN is not within the health portfolio. NBN can transmit data-rich information such as scans and close-up real-time high definition videos, say, of a burn or a cancerous skin mark.

In short, the health Minister and her department must have expertise beyond 'health services' and particularly economic expertise in a joined-up government approach. As Ian McAuley has put it

'One problem ... is a reluctance by policy makers to look on healthcare as an industry and to apply the normal evaluative mechanisms which are applied to other industries. Such a blinkered view allows the development of an idea that health should be exempt from the normal economic considerations of efficiency and equity. It's a notion that pushes economic thinking to one side, in the erroneous belief that economics is intrinsically illiberal and dismissive of human welfare. For a country reviewing its healthcare industry, it is useful to take a broad view and consider the whole industry. Only in such a way is there likely to be policy coherence and resulting economic and equity benefits of integration of programs into one system, underpinned by principles which align with the community's values and priorities.'

Setting health priorities

Unless there is an informed community debate, rural health will continue to be squeezed out by organised city-centric interests. You just do not have the lobbying power of the AMA, private health insurance funds, the Australian Pharmacy Guild and hospital interests. But you do have Independents who hold the balance of power in the House of Representatives. The case must be won that choices have to be made and priorities set. It will be a red-letter day in Australia when we have a prime minister, premier or health minister who will publicly say that we can't have all we want in health. We need to shift the debate away from hot-button issues of more beds, and emergency departments, to the longer-term issues of priorities in spending the health dollar. I happen to think that the major priority areas of need in Australian health are rural health, mental health and indigenous health. But that is not reflected in informed community debate. The squeaky city wheels get the oil.

Healthcare is rationed on a vast scale. But it is done behind closed doors to the benefit of the powerful and the media savvy. Canberra has 34 full-time lobbyists for every Cabinet minister. They are very influential in determining priorities in government health spending.

Unless the debate is continuously conducted about limited resources and choices, we will always be applying bandaids rather than ensuring genuine long-term reform. The urgent will be addressed rather than the important. In speaking about community engagement—I am not speaking about opinion polling, marketing and focus groups. If that is all we do, we will only get a snap shot at a particular time on community attitudes formed by the West Australian, talk-back radio or hospital vested interests. We must move beyond this superficial debate of community attitudes. The object must be to educate and inform the community about new ways of doing things. It is about being truthful with the community about what is possible. There are a whole range of ways of doing this where the methodology has been validated—citizens' juries, town hall meetings and deliberative polling. Country health in Western Australia has had some success. Professor Gavan

Moody will be talking further on this subject. My experience is that when the community is informed and engaged in structured discussions it comes to good decisions about the choices that need to be made and the priorities set. This makes it easier for ministers to make hard decisions when they confront the special interests. This would greatly benefit country people and country patients.

Julia Gillard was derided in the last election campaign for her proposed citizens' assembly on climate change. But it has the germ of an idea for an informed public discussion and informed government decisions on health spending priorities at every level in Australia—national, state and particularly, local.

Workforce

There is certainly more money in the COAG package for workforce training, although it is largely to do the same things, the same way that we have done for decades. A break-through has been made in nurse-practitioner prescribing and accessing MBS (\$59.7 m over four years), and \$18.7 m over four years in the budget for the evaluation of the role of nurse practitioners in aged care. Hopefully, we will see many nurse practitioner led clinics being established. In Canberra, such a clinic, established in mid-2010 had 10,000 patients in the first nine months. Other clinics are operating out of pharmacies. There is also \$390 m in the budget over four years to assist in the employment of practice nurses. But there are vast areas where we need to restructure work practices. We have tens of thousands of health professionals whose skills are under utilised or undeveloped—nurses, allied health, pharmacists and ambulance officers. We need clinical assistance at almost every clinical level, e.g. a physician assistant. We don't have so much a shortage of doctors as a misallocation. In 2007 we had 1.5 GPs per 1,000 of population. In other countries it was much lower, NZ 0.8, Canada 1.0, USA 1.0 and UK 0.7. (AIHW, Australian Health, 2010, p.461) We have problems because doctors refuse to share territory with other clinicians, in the name of 'safety' - a notion that ignores the danger of people finding it difficult to access any services. Auctioning provider numbers by postcode may not be politically do-able, as I suggested at your Albury conference, even though 80% of doctors' incomes come from the Commonwealth Government. Perhaps we could start by capping the number of new provider numbers in areas already in over-supply.

About 10% of normal births in Australia are managed by midwives. In NZ it is over 90%. We have about 400 nurse practitioners when we should have thousands. The medical colleges have disproportionate influence in controlling access to the professions. Medical training is strongly focused on acute care in hospitals, whereas most of the work of future doctors will be with chronically ill patients in the community. Few are trained to work in team practices and certainly not in country areas. Primary care is not seen as an attractive option for young doctors. Only 13% of final year students have any interest in working in primary care, and only 13% would consider working in rural areas. General practice must be made more attractive and better paid, but not via fee-for-service.

Health is the largest part of the Australian workforce (825,000 in 2008). It is the fastest growing—23% growth in five years. We are regularly told that we need to improve the productivity of the Australian workforce. Every cocky in every aviary is cackling on about it, but the largest part of the Australian workforce is not mentioned. We have seen the dramatic benefits in productivity improvements through workforce reform on the waterfront. But those gains are small beer compared with the potential gains with health workforce reform, leveraged by such means as wider access to MBS and making all Commonwealth health funding conditional on substantial workforce reform.