IS THERE A REMEDY FOR AUSTRALIA'S AILING HEALTHCARE SYSTEM?

PATHWAYS FOR THE FUTURE

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The Australian government faces significant challenges in funding and providing timely access to high-quality healthcare for all Australians in an equitable fashion. Although Australia's health system ranks highly in many key health indicators such as life expectancy and infant mortality[1,2] among OECD nations, a number of warning signals suggest that there is no room for complacency or inertia with regard to our healthcare. With the burden of chronic disease in an ageing population and a growing demand for new treatments and technologies weighing heavily, health costs continue to increase faster than general inflation and cracks are emerging in the edifice of our health system. As governments hold on to the vestiges of an outmoded system focusing on episodic acute care and shift federal expenses onto the public in the guise of user charges, the alarming health-related inequalities in accessibility and quality of care will only continue to escalate. Equally worrying are the widespread wastages throughout our hospitals and other medical services – needless expenses that are shouldered by the public each year. Looking to the future, it is imperative that governments focus on prevention and better management of chronic illness, forging improved linkages between primary, acute and rehabilitative services and ensuring that socioeconomic and cultural barriers do not infringe on access to quality healthcare for any Australian.[3]

In addressing the deficiencies plaguing the Australian health system, it is vital to understand the inherent challenges in developing sound health policy. The health system is often difficult to optimise due to the differing and conflicting interests of its key stakeholders. This conflict in objectives, in turn, has intensified due to the "ideological cleavage"[4] between successive Liberal and Labor governments, a factor responsible for an incessant oscillation between private and public healthcare systems, resulting in policy instability and discontinuity. Indeed, the beginning of this circuitous "policy web" was when the Chifley Labor government's national hospital service was scrapped by the Menzies Liberal government for a publicly subsidised private health insurance system[5].

Subsequently, Gough Whitlam's Labor government launched Medibank, a universal health insurance system, in 1975. Despite Medibank's success in improving accessibility and equity to quality healthcare, the scheme was dismantled by the Fraser Coalition government to

[1] "Health 2040: A discussion paper on the future of healthcare in Victoria." *Victoria State Government*, September 2015, p.6.
[2] Van der Weyden, M. "Australian healthcare: in need of political courage and champions." *Medical Journal of Australia 179*(6), 2003, pp.280-281
[3] Armstrong, B.K. et al. "Challenges in health and health care for Australia." *Medical Journal of Australia 187*(9), 2007, pp.485-489
[4] Ibid
[5] Marasovich, S, *Evolution of Government Involvement in Healthcare*, 2016, Accessed 21 May 2016, https://federation.dpmc.gov.au/evolution-government-involvement-health-care

counter the untenable rise of Commonwealth expenditure[6]. The Hawke government's introduction of Medicare[7] was a watershed moment in the history of Australian health policy. Medicare provides prepaid public hospital care for all citizens and rebates up to a threshold fee for consultations with general practitioners (GPs), out-of-hospital services and private hospital treatment. Medicare proved to be a success, increasing the accessibility and affordability of health services for the Australian public, taking positive steps in the development of a sound, stable and equitable national health policy[8].

With the arrival of John Howard's Liberal government in 1996, however, the Commonwealth encouraged the uptake of private insurance to relieve the burden on the public system. Howard's government established several incentives for taking up private insurance, including a 30% rebate on private insurance premiums, as well as creating the Lifetime Health Cover policy, which imposed penalties on individuals not covered privately for health expenses[9]. Complexities in hospital funding emerged over the tenures of Howard and his successor Kevin Rudd due to disagreements between the Commonwealth and the states and territories, ultimately making "no-one in charge of health policy"[10]. Although significant positive progress was made in terms of the provision of primary care, mental health support systems, and targeted Indigenous healthcare under the leadership of Rudd and Gillard, the problem not fixed was the "blame game"[11] - the insidious web of policy plaguing Australian politics at the time.

With Tony Abbott's Liberal party's arrival into power, however, a renewed focus on private healthcare and the suggestion of reducing Medicare rebates and introducing a mandatory $7 co-payment for GP services came into play. Yet these policies appeared ill-grounded from the perspective of assuring universal access to healthcare and were condemned as a sacrifice of the needs of the Australian public in the goal of saving federal funding and soon scrapped and declared "dead, buried and cremated"[12] by Abbott himself. Equally ineffective was the so-called "indexation freeze," a stagnation of Medicare rebates until 2020. This policy is a way of circumventing the problem of inflating health costs: the approximate 'savings' of $2.8 billion[13] to the federal government will invariably be shifted onto the Australian public, as bulk-billing medical practitioners will be forced to increase out-of-pocket expenses for their patients due to insufficient Medicare rebates to sustain their practices. Despite some of the positive changes in the current Turnbull government's policies, including a restoration of funding to mental health protection and Indigenous welfare initiatives, the danger remains

[6] Khadra, M. *Terminal Decline*, Sydney, William Heinemann, 2010
[7] Medicare is Australia's national health insurance scheme
[8] Gray, G. "Health Policy in Australia."
[9] "Public versus private? An overview of the debate on private health insurance and pressure on public hospitals." *Parliamentary Library*, 2005. http://www.aph.gov.au/binaries/library/pubs/rn/2004-05/05rn54.pdf
[10] Duckett, S. "Did the health reforms fail? Now we'll never know." *The Conversation,* 12 June 2014. Accessed 25 May 2015, https://grattan.edu.au/news/did-the-health-reforms-fail-now-well-never-know/
[11] Ibid
[12] "Timeline: The Rise and Fall of the GP Co-Payment." *ABC News*, 3 March 2015. Accessed June 1 2015, http://www.abc.net.au/news/2015-03-03/timeline-dumped-medicare-co-payment-key-events/6275260
[13] "Your Health Will Cost You More." *Australian Medical Association*, 2016. Accessed June 3 2016. https://ama.com.au/nomedicarefreeze

that current and subsequent Australian governments will focus on "piecemeal"[14] initiatives and neglect the more serious problems caused by the indexation freeze.

Perhaps what is plaguing the Australian health system most is the continued inequity in access to quality care options[15]. One of the contributing factors to this inequity is the rapid rise of health-related expenditure. The extent of health inflation can be seen through the fact that health-associated costs have tripled (adjusted for general inflation) in the last 25 years and that the percentage of the GDP allocated to health services has increased by nearly 50 percent in the same period[16]. The financial strain of this inflation is periodically shifted onto consumers in the guise of co-payments, thereby establishing a vicious cycle that amplifies existing inequities. Part of this amplification in costs appears to be unavoidable, especially considering Australia's ageing population and our increased reliance on new technologies and treatments[17].

Yet there are aspects of healthcare-related spending that are inextricably linked to the implementation of health policy and thus, are in our control to moderate and regulate. Critics have argued that a reorientation of policy towards primary care measures instead of curative interventions will be a positive step[18] to reducing wastage in treatment resources and funds at later stages, a policy restructure that has been highly successful in countries such as New Zealand, the UK and Canada.[19] The key issue in Australia is that people of low socio-economic backgrounds are hesitant to seek necessary consultation and treatment due to high supplementary charges, leading to the worsening of their medical conditions and a resultant unsustainable level of health expenditure. Thus, policy makers must make the investment to incentivise entry-level providers to bulk-bill or subsidise their services and facilitate a greater level of "collaboration between sectors"[20] in healthcare delivery. Moreover, many Indigenous Australians also avoid using necessary medical services[21] due to lack of affordability and cultural incompatibility in the delivery of these services. One pathway to rectify this serious flaw would be to emulate systems existing in New Zealand, where special Maori clinics[22] have been opened to deliver subsidised, culturally-sensitive treatment and consultation programs.

In addition, some critics see the current two-tiered hybrid system between public and private healthcare as needlessly convoluted and instead advocate for the adoption of a single-payer

[14] "Budget 2016 all about savings: piecemeal health program support; cuts disguised as strategy." *The Health Advocate*, June 2016, p.6
[15] Armstrong, B et al. "Challenges in health and health care for Australia." *Medical Journal of Australia 187*(9), 2007, pp.485-489
[16] "25 Years of Health Expenditure in Australia." *Australian Institute of Health and Welfare*, Health and Expenditure Series No.56, 2016, p.3
[17] Ibid, pp. 15-18
[18] "Primary Health Care Reform in Australia." *Department of Health and Ageing,* 2009, pp. 8-14
[19] "Primary Health Care the New Zealand Way." *Bulletin of the World Health Organisation 86(7),* July 2008, p.505
[20] "Primary Health Care Reform in Australia," p.22
[21] *Close the gap: Campaign for Aboriginal and Torres Strait Islander health equality by 2030*, 2013, p.2. http://iaha.com.au/wp-content/uploads/2013/03/000205_closethegap_communityguide.pdf, Accessed June 8 2016
[22] "Primary Health Care the New Zealand Way," p.506

system regulated by the Australian government[23]. The benefits of eliminating private insurance can be seen through economists' analysis of the proposed United States National Health Care Act, the adoption of which would yield savings of over USD 350 billion from the removal of insurance company overhead and hospital billing costs[24]. Unfortunately, the private-public healthcare debate cannot be resolved quite so easily. A complete elimination of private health insurance could not only have economic repercussions from the removal of a profitable industry, but also place a possibly catastrophic burden on a public health system struggling with long waitlists, an inadequate supply of medical practitioners and insufficient resources to cater to a growing demand for quality healthcare.

While co-payments are generally deemed necessary to prevent moral hazard and regulate demand, policy makers must devise appropriate ways to prevent these out-of-pocket costs from becoming unregulated and arbitrary.[25] Means-testing of co-payment requirements and modification of the existing safety net system providing a threshold on out-of-pocket expenses are necessary to allow equity in access to appropriate preventive and primary care. However, questions remain on how best to balance the therapeutic needs of Australians with regulatory mechanisms for preventing excessive usage and financial strain on our health system.

At the same time, poor management and severe organisational inefficiencies continue to plague our hospitals and are manifested in a wide range of systemic stresses, including the growing elective surgery waitlists and the proliferating phenomenon of access block[26] in public hospitals. This is evidenced by the statistic that over 50 percent of patients on elective surgery waitlists are not admitted to Australian public hospitals within 35 days[27], an indication of inefficiency in meeting patient demand. If we are to counter the rise of health inflation and ensure universal timely access to our healthcare system, we must begin by improving the efficiency and work practices of the institutions providing our healthcare.

A promising strategy to achieve this challenging goal appears to lie in the area of *lean healthcare*, a revolutionary approach to innovation focusing on the elimination of systemic wastages and the maximisation of productivity, that is, attaining the best possible "ratio of inputs to patient benefit"[28]. Based on the fabled Toyota Production System, lean thinking seeks to map and quantify the value of various activities and processes within a system and

[23] McAuley, I and Menadue, J, "A Health Policy for Australia." *Centre for Policy Development*, May 2007, pp. 7-10
[24] "Single Payer National Health Insurance." *Physicians for a National Health Program,* 2016. Accessed June 8 2016, http://www.pnhp.org/facts/single-payer-resources
[25] "Co-payments keep Medicare healthy." *The Australian*, 26 May 2014. Accessed June 3 2016, http://www.theaustralian.com.au/opinion/columnists/copayments-keep-medicare-healthy/story-fn7078da-1226931018209
[26] Access block refers to the situation where patients who have been admitted and need a hospital bed are delayed from leaving the Emergency Department because of lack of inpatient bed capacity
[27] "Admitted patient care 2014-15." *Australian Institute of Health and Welfare*, Health Services Series No.68, 2016, pp.190-198
[28] Cheetham, L. "Lean thinking for lean times." *Private Hospital*, June 2013, p.60.

dissect the system to its constituent parts (known as value-stream mapping)[29], thereby being able to remove inadvertent wastages and optimise the allocation of limited resources and funds. Critics often argue that "patients are not cars"[30], and that these optimisations to the health system may lead to a "fundamental tension between the production of healthcare and the protection of the patient"[31]. Yet it is vital to recognise that lean healthcare is not a production mechanism; it is an ideological suite allowing an informed analysis of proliferating wastages in any system from the automobile industry to the health sector. It certainly has the potential to serve as a catalyst for a continuum of self-improvement in our healthcare-providing institutions.

A shining example of the application of lean operations in the health industry is the case of Virginia Mason Medical Centre in Seattle. As efficiency consultant Charles Kinney puts it, through a systematic process of self-appraisal, the team at Virginia Mason succeeded in "sorting, simplifying and standardising" treatment steps, something that allowed them to reduce treatments times by over 50 percent[32]. Furthermore, Virginia Mason has pioneered a range of innovations to reduce waiting times at a range of junctures over the hospital stay by making productive use of these periods of ostensible "value loss," They frequently streamline pre-treatment activities, such as patient education and medical tests, to reduce unnecessary sinks in the hospital's intertwined "web" of activities. With Australian hospitals such as Adelaide's Flinders Medical Centre[33] successfully adopting these lean principles to improve organisational efficiency, the future looks bright for this innovative approach of self-appraisal and continuous improvement in the Australian healthcare system.

Is there a panacea that could treat every deficiency in Australia's health system and provide outcomes fully satisfactory to all stakeholders? Considering the delicate balance required to provide for the conflicting needs of the various players in the web of healthcare, this utopic target will probably never be achievable. However, what is possible is to achieve targeted, policy-related improvements to create an increased focus on primary care measures, regulating and curbing systemic wastages and ensuring that out-of-pocket costs do not infringe on the target of universal access to healthcare for all Australians. To ultimately move towards true universality, it is imperative that policy makers "see the big picture" in constructing health policy and combine the fragmented units of the health industry into a cohesive whole, thereby maximising systemic gain and prioritising the holistic welfare of the Australian public.

[29] Jones, D. and Mitchell, A. "Lean thinking for the NHS." *The NHS Confederation: a leading edge report*, 2006, pp.10-20
[30] Winch, S. and Henderson, A.J. "Making cars and making healthcare: a critical review." *Medical Journal of Australia 191*(1), 2009, pp.28-29
[31] Ibid
[32] Kinney, C, *Transforming Health Care: Virginia Mason Medical Centre's Pursuit of the Perfect Patient Experience*, New York: Productivity Press, 2011
[33] Ben-Tovim, D.I et al. "Redesigning care at the Flinders Medical Centre: clinical process redesign using 'lean thinking' " *Medical Journal of Australia 188*(6), March 2008, pp.27-31

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18. Cheetham, L. "Lean thinking for lean times." *Private Hospital*, June 2013
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