Communist Party of Australia

CAMPAIGN KIT

For a

Nationalised Public Health System

— health care not profits —

— Medicare Card not Credit Card —

— Health care is a right not a privilege—

INTRODUCTION

The Central Committee at its meeting on May 29 and 30, 2010 decided to adopt a Party-wide campaign for National Health System.

The CPA is campaigning for nationalisation of the health system as the most efficient and cost effective way of delivering quality and affordable health services to the public.

This campaign kit includes:

Policy notes
Campaigning notes
a power point presentation
a leaflet
extracts from the 11th Congress Political Resolution
Guardian articles
an *AMR* article

A pamphlet is also being prepared.

July is set aside for campaign preparations: education classes in Branches, research on local health facilities (hospitals, community health centres, etc) and development of relations with other groups and individuals who will take part in or at least support the campaign.

The campaign will be officially launched at the beginning of August with media releases, public meetings and a national speaking tour.

This campaign should be integrated into the Federal election work being undertaken by Party organisations around the country.

POLICIES

These are the Party's basic policy directions in this campaign. More information on these points is provided in this campaign kit.

- Expose the Labor Government's plans to make the private health sector the central provider of health insurance and health services.
- Expose the Federal Government's deception and dishonesty.
- Stop the decay of our excellent public hospitals with increased funding, staffing and resources. The Federal Government must immediately increase its budget to at least 50% of public hospital funding to stabilise the situation.
- Improve primary care. GPs and specialists to be salaried and not working on a piece-rate system – doctors must become salaried employees of the national health system.
- Expand the community health centre model and include publicly paid GPs, community and early childhood nurses, mental health, youth, alcohol and other drugs workers, and other health professionals. Focus on preventative care.
- Medical services, including dental and mental, to be bulk billed.
- Expand the Pharmaceutical Benefits Scheme with free prescriptions for age pensioners, the unemployed and other welfare recipients. The government should develop publicly owned pharmaceutical manufacturing. An immediate lowering of the prescription fee and safety net for those who do not qualify for free medications.
- Increased funding and services for aged care, mental health care, special youth facilities and community care programs provided by the public sector.
- Emphasise the need for a care model for the public health system, not the ALP's business model.

CAMPAIGNING NOTES

Preparation

To prepare members for the campaign, hold an education class or classes to read and discuss the information attached. Discuss what your main political aims are, what problems may arise, what questions you may be asked, etc.

You might like to invite a health worker to your branch – eg a nurse or aged care worker.

Analyse how your Party Branch can most effectively educate and mobilise people around these issues and make your workplace or locality branch a centre of political activity.

Discuss how to develop an effective campaign, how to make it relevant and interesting in your workplace or community, who you are targeting, where it may be possible to integrate it with the other Party campaigns (eg cutting the $30.6 billion military budget), how best to contact and involve other organisations and individuals, etc.

The Party's strategic aim of building left and progressive unity should always be put into practice while developing the campaign.

Plan of action

Then develop your plan of action. This should include a clear timeline and duration, allocation of individual responsibilities, planning for time at future meetings for report backs on work done, discussion and analysis of problems and progress, changes to the plan where necessary, and analysis of the results.

Possible activities

The following points are ideas for possible activities. Party organisations should select from among them the activities which are possible and appropriate for your area of work and combine them with their own ideas for effective actions.

1. Work collectively to develop **local** campaign materials using the national leaflet combined with local conditions. Leaflets and Guardians can be distributed at street and public meetings, in amenities rooms and at stalls, and letterboxed, as appropriate.
2. Local hospitals, aged care and/or community health centres should be contacted through members or supporters working there and/or via a relevant trade union. Be patient – this can take several efforts before contacts are consolidated. Perhaps "adopt" a hospital.
3. Find out the links between your workplace, locality or community and local public health services. Consider an information campaign with a leaflet or bulletin for distribution, possibly dramatic or funny posters, perhaps a street or a factory gate meeting … whatever is appropriate for your area.
4. Consider which local community organisations, trade unions, councilors, or individual activists can contribute to the campaign and which Party members should contact them.
5. Make an appointment to see your local MP; involve Branch members and local community members in the delegation and in preparations for it (agreeing on what you want to achieve; what points you will put forward, the best arguments to present, preparation of a briefing paper for the MP, etc., etc.)
6. Write to local newspapers; develop draft letters in discussion with local community members.
7. Call a public meeting.
    a) Decide on the day and time; book a venue
    b) Contact local councillors and other community activists to invite them along; maybe ask the local Mayor to chair the event

c) Ring or email the local newspaper(s) to get an ad put in (most have a free community notices section)

d) Write to or ring local ethnic, church and other appropriate local organisations

e) Unions should be contacted – using local workplaces can be useful for this too

f) Put posters in libraries, community centres, etc

g) Invite any Party contacts in the area

h) Have a draft resolution available for the meeting to discuss and adopt

i) Present some ideas for activities – a stall in the local shopping centre, a public meeting at the Town Hall, etc.

j) Make available some materials – draft letters, leaflets about upcoming events

8. Send reports and pictures of what you do to *The Guardian* and then use any published material to further develop the campaign, to sell the paper and to promote the Party.

[Please try to photograph the fronts of people, get in close and larger sized files are better – 300dpi and around 600k to 1m preferred. Email articles and images to editor@cpa.org.au and guardian@cpa.org.au. Please include your phone number. For any enquiries contact the editor Tom Pearson on 02 9699 8844]

Extracts from the 11th Congress Political Resolution

Public better than private

The development and production of a large public sector, where enterprises and services are run on the basis of public need, not private greed, is a fundamental pillar of CPA policy. Philosophically, successive Labor and Coalition governments have been committed to an intensive program of privatisations.

Privatisation results in a fundamental change in the objective of service provision from one of providing government or the public with a service based on needs to one where the service becomes a vehicle for making private profits.

Apart from providing new sources of profit-making, privatisation involves a transfer of power from sovereign, elected governments to corporate boardrooms whose whole raison d'être is the making and accumulating of private profits.

A massive ideological war has been and is still being waged to gain public acceptance for the privatisation of public services and areas of governance itself and for the withdrawal of the state from taking responsibility for the wellbeing of the people and society.

Health

The CPA supports a national health system in which the public sector offers all Australians high quality, free and accessible medical and dental treatment, hospital and community care and other health services. The CPA places high importance on the use of preventative and early intervention strategies and the principles of universality and equity.

The public health system has become unmanageable as a result of privatisation with public money being siphoned off with the ever increasing cost of private services. Over a long period of time governments have lost control of the cost of many services – diagnostics, pathology, catering, cleaning and linen services.

The increasing cost of pharmaceuticals and over priced medical equipment also weighs down the public system. Private specialists, many who utilise public facilities, are a big drain on the health system. The private profits of corporations providing services to the public health system soak up the increasing amounts of money spent by taxpayers on the health budget.

With the release of the National Health and Hospital Commission's review, the government's "health reform" agenda has become clear. Following in the footsteps of its predecessor, the Labor government has embarked on a program to firmly embed the private health sector as a central provider of health insurance and health services in Australia.

It marks a major shift in the policy and philosophy that underpinned the original Medibank (Whitlam Labor government) and its successor Medicare (Hawke Labor government). It would take Australia down the same path as the far more expensive US-style health system and eventually leave millions of Australians without adequate care. The "reforms" would effectively hand over the Medical Benefits Scheme (Medicare), the Pharmaceutical Benefits Scheme (PBS), a new dental scheme, and public and private hospital cover to the private health insurance industry.

Public hospitals

The states and our public hospitals are under tremendous pressure because of fixed budgets that fall far short of what is required to fund them. They are finding it extremely difficult to maintain the high quality of services that they have provided in the past due to lack of staffing, resources and bed shortages. This is a deliberate result of state and federal government policies that use fear and desperation to drive more people into the private hospital system.

The situation is compounded by the fact that public hospitals have become the "default" solution or place of last resort for many patients in the system. A shortage of GPs, lack of access to bulk billing, lack of community care for those with mental illness, and the privatisation of aged care mean more

patients end up in emergency departments and expensive public hospital beds when they should not be there. Yet the federal government persists with its caps on the number of GPs and aged care packages as a means to cap health budgets.

In the long term, funding issues can also be resolved by measures to improve primary care and frontline services, community health, aged care, etc so people receive care outside of hospitals – where it is much cheaper – and so the sick elderly do not languish in expensive hospital beds due to failure to find an aged care bed when it is needed.

Primary care

Under the current walk-in, walk-out method of fee-for-service payment for doctors outside of hospitals, there is reluctance for doctors to work as a team or to tackle complicated or difficult patient health problems. The perverse incentive under the current model of payment is for doctors to “churn” patients through -- and that means the elderly, the chronically ill, the mentally ill and many others miss out on adequate care and can end up in expensive and often inappropriate hospital care.

We support a reformed and strengthened primary care/frontline health service, including General Practice and the public Community Health system. Under the community health system introduced by the Whitlam Government, community health centres were built in local communities with ready access for the public. They were staffed by publicly paid community nurses, early childhood nurses, mental health workers, alcohol and other drugs workers, youth counsellors, family counsellors, allied health professionals and medical officers. In recent times this model of public of primary care has been undermined with Medicare and other Government money/funding diverted to private, fee- for- services providers. This process needs to be reversed.

In the long term, funding issues can also be resolved by measures to improve primary care and frontline services, community health, aged care, etc so people receive care outside of hospitals – where it is much cheaper – and so the sick elderly do not languish in expensive hospital beds due to failure to find an aged care bed when it is needed.

The Guardian. 26 May 2010 Issue #1456

Budget 2010-11 Health reform: prescription for further privatisation

Anna Pha

The neo-liberal model being imposed on education is being replicated in the Rudd Labor government's health reform agenda with the establishment of new agencies to set standards, measure hospital performance, and publish results. As with the Naplan testing in schools, the performance of hospitals will be assessed by narrow, easily measurable criteria that fail to reflect the human element of health care and complexities involved. Public and private hospitals will compete in markets, health care will be a commodity, and patients expected to shop around. In both areas, the government is starving the public sector of much needed funds and increasing its subsidies to the private sector.

Health and Hospital Reform

The government's Health and Hospital Reform program was flagged in the lead-up to the budget, which is now before Parliament for enactment, so there were no big surprises.

The health budget contains a number of desirable, albeit very modest, increases in funding such as for additional aged care and rural nurses; employment of more nurses in GP clinics; coordinated treatment of diabetes; greater access to after hours care; and extension of Medicare to cover medicine in three new areas of sports and exercise, sexual health and addiction.

There are also nasty little nips at existing items, making relatively small savings. For example, funding to support the return of nurses back into workforce is reduced as is the Medicare rebate for new mental health patients accessing social workers and occupational therapists. Funding is redirected from high-level residential aged care to high-level community aged care instead of providing additional money for the new community care places.

As previously reported in *The Guardian* (See *Guardian* May 5, 2010 – Rudd's health revolution – Designed to fail), the Rudd government's changes to the public health system are piecemeal, failing to put in place an overall, integrated strategy covering preventative, primary, specialist, allied services, Indigenous, aged care, dental, mental and other health areas of health care.

Indigenous, dental, primary, preventative and mental health are neglected. Without addressing these areas, hospital beds will continue to be clogged with patients whose hospitalisation could have been avoided or shortened.

The limited Howard government reform giving people with chronic conditions access to dental treatment under Medicare is to be wound back, and replaced by a totally inadequate dental scheme. The Rudd government refuses to extend Medicare to cover oral health. It would make no more sense to exclude the eyes or heart from Medicare coverage than it does to ignore the teeth and gums.

It is a false economy. More importantly it denies many people access to an important area of basic care. According to the Australian Council of Social Service (ACOSS) around 2.3 million Australians go without dental care because they cannot afford it. Every year thousands of people end up in hospital or with other medical complications arising from lack of dental treatment.

Additional nurses will be trained and the number of beds increased in certain areas of need, but the government still neglects the reasons why nurses continue to leave their profession in droves.

Until nurses' salaries are increased to reflect the pressures they work under and the role they play as highly skilled professionals, there is not much point in providing more beds or giving them more responsibilities. Staffing shortages in hospitals are not addressed, underfunding is set to continue and nurses will continue to burn out and turn to higher paid, less skilled work.

One of the main obstacles to GPs spending more time on preventative health care is the fee for service basis of Medicare. The low Medicare rebates do not reflect the time needed to carry out thorough examinations and discussion with patients. They discourage bulkbilling, and put pressure on doctors to churn patients out as quickly as possible, often with a quick fix prescription, blood tests or xrays.

The situation is exacerbated by a chronic shortage of GPs, particularly in the poorer working class suburbs and regional and rural Australia. The few measures in the budget to train more GPs fall far short of what is required by a system which relies heavily on a brain drain from poorer nations.

Casemix – recipe for disaster

The centrepiece of hospital funding is the one-size-fits-all "efficiency price" that hospitals will be paid for each procedure – known as casemix. Safety and treatment will be compromised to meet cost-cutting targets. Patient need is not paramount when hospitals are assessed on speed of turnover, as if they were part of an assembly line.

Casemix does not make allowances for patients with more complex conditions that might need additional procedures or a longer time in hospital, such as the aged, Indigenous Australians, diabetics and others with chronic conditions. The experience in Victoria and overseas where it has been introduced shows it leads to a much higher rate of patients having to return to hospital following early discharge.

Performance assessment

The budget provides for the establishment of a number of new agencies:

- the so-called Independent Hospital Pricing Authority to set a national "efficient price" for hospitals to be paid for each procedure, regardless of differences in patients;
- the Australian Commission on Safety and Quality in Health Care to set national clinical safety standards; and
- the National Performance Authority to report on hospital performance as measured against these standards, and its reports to be made publicly available – a MyHospital version of MySchool. (Age care providers will also be benchmarked with the public able to compare business efficiency performances.)

The longer term aim is to create a market place in which public and private hospitals compete for patients and government funding. Hospitals which fail to meet specified targets, including waiting times in emergency departments and waiting times for elective surgery, will be punished under a system that rewards high performers with additional funds.

"The introduction of a National Access Guarantee for elective surgery from July 1, 2012 will mean that free treatment in public or private hospitals will be rapidly provided if patients wait longer than the clinically recommended time for elective surgery," the budget papers state.

It is worth noting that the budget provides for the formal merger of Medicare Australia and Centrelink in 2011, bringing together the collection of employment and health records of individuals under one department (see ID article next week).

As Dr Tim Woodruff, president of the Doctors Reform Society notes: "neither e-health nor increased nurses in GP clinics will necessarily do anything to address the barriers to access suffered by our patients in areas of GP shortage in areas where GPs require co-payments which patients cannot afford."

This can only be achieved through cutting the massive multi-billion subsidies paid to the private hospital system through such means as the private health insurance rebate and diverting the funds to the public system. The government has embarked on a program to gradually privatise the public hospital system and taking Australia down the extremely expensive and disastrous path of US managed health care.

The only way forward is through developing and fully funding an integrated public health system, based on a universal access and quality services which are centrally funded through a progressive taxation system.

The Guardian **31 March 2010 Issue #1449**

Editorial The privatisation of health goes up a gear

It is instructive that the Rudd government is going to use the private sector to oversee the implementation of its proposed national hospital network. The government has head hunted Tim Beresford, a former corporate lawyer who specialised in mergers and acquisitions and who spent 15 years as an executive at Westpac and who is currently a director of a management consultancy.

Twelve months ago Kevin Rudd emphasised that the government would "maintain the principles of Medicare and the Pharmaceutical Benefits Scheme and public hospital care". The recruitment of a finance sector hatchet man to such a vitally important role, bypassing the public service, is a pointer to the government's plans for our public health system.

This is consistent with the government's implementation of its agenda right from the beginning. Soon after coming to office it set up a number of health inquiries, including the National Health and Hospital Reform Commission (NHHRC) to deliver health reform. Like all governments planning radical changes, the selection of the committee members is the key to getting the intended outcomes.

There is no need to look beyond the chair of the Commission to determine its ideological direction. Dr Christine Bennett is the Chief Medical Officer of BUPA Australia, better known by the private health insurance brand names it owns in Australia: HBA, MBF and Mutual Community. BUPA is a transnational corporation with global operations in health insurance, aged care and other health related businesses. Other Commission members are also from the private sector. Health unions, the Doctors' Reform Society, the Health Care Reform Alliance and other progressive community organisations had no voice on the Commission.

The thrust of the government's objectives also can be found in Rudd's statement that it would set an "efficient national price" for hospital services to "help ensure the long term sustainability of Australia's finances". This is part of the demands from big business for wide spread cost cutting measures. Said Rudd of his plan: "It is wholly consistent with the government's strict fiscal strategy" to return the budget to surplus.

Along these lines is the intention to scrap the current block funding to the states that covers about 40 percent of their hospital budgets, to be replaced by "activity-based" grants to local hospital networks. Under this set up they will receive pre-determined amounts for each procedure and service, set by "efficiency" formulas, regardless of the patient's recovery or prognosis.

Networks that "over-spend" on caring for a patient will carry the loss, putting health workers under pressure to cut corners and push patients through more quickly.

There is also an agenda to further prop up the private health sector.

The government has plans for people to belong to a private health insurance fund, even if they have no private health cover. It intends to pay the private funds a certain amount per member and the company, instead of Medicare, would hand over refunds for medical expenses and fund hospital visits.

Those needing a higher level of service beyond the most basic of treatment would have to top up with additional medical and hospital cover. Public hospitals would provide basic services for those who do not have any top-up insurance.

The end result would be a private managed health care system. The national health insurance provider Medicare would in effect be privatised as its operations are taken on by competitors in the private sector.

In fact, Health Minister Nicola Roxon at a Health Care Reform Alliance conference last year unequivocally declared her personal support for private health insurance and the private health sector. She said that the almost $4 billion a year private health insurance rebate was a fundamental plank of her government's health reforms.

The Communist Party of Australia stands for major reforms to health and community care services. These should be based around the following principles:

- Increased funding for Medicare;
- Universal access – regardless of income or locality;
- Free services at point of delivery;
- Services to be of the highest quality;
- Services funded through central taxation revenue;
- Services to be provided by the public sector.

The private health insurance rebate should be abolished. This would free close to $4 billion to be put into the provision of public health services.

Mr Prime Minister are you listening?

"G'day and welcome to www.pm.gov.au!" A chatty Kevin Rudd greets visitors to his blog on health reform. "Today I want to speak with you about Australia's hospital and health care system and the challenges it faces in the 21st century….

"Without fundamental change Australia's health system will buckle under the pressure of demographic change, rising costs and modern diseases," the PM says inviting comments on recent reviews of the health and hospital system (see http://www.yourhealth.gov.au).

"We must consult the people with the greatest stake in the future of our health system... our local doctors, our local nurses, health care workers, you and your families. Your views will directly influence the changes we will make to improve the system."

"So get involved, send me your suggestions, participate in the blog and together let's improve the Australian Health System."

Over the five days that the blog remained open the people gave the PM their personal experiences and views – plenty to think and act on:

Andrew S says: "In 1990 (during Mr Bob Hawke's government) I could ring my GP in the middle of the night and get a doctor to attend to my baby daughter within an hour. What has happened to that level of service?"

Mental health

TracyS says: "Just today I came across a case of a middle aged man with a significant psychotic illness and co-occuring drug use. His elderly mother is his sole carer.

"His erratic and some times violent behaviour is making it more and more difficult to cope. When she requested assistance from the local mental health service, and told them about her concerns about her own wellbeing due to her son's erratic behaviour, she was told to 'either move or get a restraining order out on him'.

"This is not an uncommon example. A comprehensive approach to care is needed; and the buck passing has to stop."

Rural & regional

Alison says: "I am in a rural area and we have a largish hospital nearby. The wait times at this hospital are very poor. I have a young son and one morning at 4.30 I waited three hours before seeing a doctor. I was the only one in the waiting room this whole time. This may seem small compared to the city but it is a big deal. There are many stories of people waiting up to seven hours during the day to be seen."

Barbelle says: "Massive growth in management structures over the past five years must be a drain on the resources of this health service, which runs several large hospitals and numerous small hospitals and other health services in regional areas.

"At the same time, services to the community have been withdrawn and equipment, paid for by community fundraising for their hospital has been taken away. A case in point is a hospital in a town serving a community of some 6,000 people – their maternity ward was incrementally closed down by the health service – when medical and nursing staff and community leaders objected, they were told that only half a dozen babies are born in this locality each year – last year's stats (the rest of the babies, several dozen, had been born in hospitals 100-200 kilometres away – many had been born in the ambulance on the way to these locations)."

Janice says: "I think it might be a good idea if some thought was given to the problem of getting doctors out into rural and remote areas... If the government changed the doctor provider number system to one where the provider numbers were allocated to districts/towns/cities rather than to doctors individually, then doctors would have to go where provider numbers are available."

Nurses

ozkate62 says: "Please take the time to consult with Community Nurses. We are paid less than acute care, yet expected to take on more and more to save acute beds. Why do you continue to say nurses can do more, when we

are already stretched now? Doing more is just not possible most of the time. We are not funded for most of the work we do now… Please talk to us."

Private profits

JoeSmith says: "We have seen, read and heard all the excuses on why the hospital system is falling apart. I will put it concisely why Australia's essential infrastructure is failing; politicians on all sides simply don't give a toss about anything if it can't make a quick short-term profit."

NimbusWeb says: "Mate, now how to move forward: First, dismantle the 30 percent uncapped private insurance rebate…. what other inefficient industry gets such a subsidy these days."

Andrew S says: "Private insurers by definition are not in the business of serving sick patients. Their only responsibility is to their shareholders. Therefore basic medical needs of the community should be funded through the tax system…

"Public Healthcare professionals should be paid competitive rates so that new graduates can be attracted to public service."

Training & income

RachH says: "Fund more uni places. Pay students for clinical prac and put more training back into hospitals. Increase staffing to reduce patient load. Develop and implement models of care that increase continuity of care; this is more satisfying for staff and leads to improved patient outcomes – people heal or birth better when they are comfortable and feel safe! Support staff education – it should be more than just the odd half hour at handover when everyone is busy and distracted. Put more money into primary health – an ounce of prevention is worth a pound of cure. It's not brain surgery!"

deidrejay says: "I'm training in the health field and the HECS debt I am accumulating as a woman in my mid 40's who's needing to build up superannuation horrifies me. Also the practicals are 26 weeks in total and as a self-supporting woman not earning for 26 weeks is impossible so I'm still trying to figure out how to do the practicals and continue to earn an income. A block period of seven to eight weeks is in the country meaning I probably have to pay two sets of living costs on no income."

Craig Rowley says: "It seems reasonable to me that citizens putting their shoulder to the wheel, studying and learning to become competent health professionals and completing a clinical placement to translate learning of theory into practical learning should indeed receive payments at least equivalent to NewStart for the duration of the clinical placement."

The Cannulator says: "As both a Paramedic and a Critical Care RN I have seen the 'system' change over 20 years. To improve the shortage of professionals like nurses and paramedics, salaries need to reflect the responsibility they carry. If I work on a cardiac arrest patient, I receive about 20 percent of the wage of a fully qualified anaesthetist or emergency doctor.

"To allow more useful care outside of hospital and reduce hospital attendances, bulk billing 24-hour medical centres with adequate complete pathology and radiology services for non emergencies; so that EDs [hospital emergency departments] aren't full of those seeking free health care.

"Similarly pathology and radiology services need to be reined in so they aren't charging twice the scheduled fee after the fact. We just can't afford to pay big business for health-care, even if we aren't on pensions."

Kevin, mate, are you listening?

Guardian 12 August 2009 Issue #1423

Medicare Select Rudd's privatisation of health

Anna Pha

The Rudd Labor government has embarked on a massive transformation of the health system in Australia that will turn Medicare on its head and firmly embed the private health insurers as managers of a US-style health system. The "reforms", as the government describes them, will effectively hand over the Medical Benefits Scheme (Medicare), the Pharmaceutical Benefits Scheme (PBS), a new dental scheme, and public and private hospital cover to the private health insurance (PHI) industry.

The aim is to create a health industry in which health care becomes a commodity and public and private providers compete for patients seen as "customers" in a market. Providers will be judged and rewarded according to performance measured by such indicators as rapid through-put of customers, not quality of care. It will be a system of vouchers, league tables, failed hospitals and choice at the expense of equity, where customers select what they can afford and gamble on what health conditions they might develop.

The key elements of the government's program are outlined in the final report of the National Health and Hospitals Reform Commission (NHHRC) which the Prime Minister and his Health Minister Nicola Roxon released on July 31. It is economic rationalism (neo-liberalism) at its worst, where health care is treated as a commodity and the public sector is there to subsidise an unsustainable private system and ensure its profitability. The new Medicare Select means that customers – the people of Australia – will be able to "select" what medical services their health insurance covers them for – their choice only limited by their ability to pay.

The nature of the report is not surprising; its chair, Dr Christine Bennett, has a background in the private health care industry. In June 2008, while the Commission was undertaking its review, Dr Bennett was appointed as Chief Medical Officer of BUPA Australia Ltd. Its brand names include MBF and HBA which are two of the largest private health insurance funds in Australia. The PHI industry should be very pleased by the Commission's work.

The report correctly identifies areas of pressing need such as mental illness, dental health, aged care, Aboriginal and Torres Strait Islander health, hospital emergency services, hospital waiting lists, etc. It stresses the importance of early intervention and preventative measures. It identifies other needs such as training of more health professionals, funding of research, centralisation of knowledge and a multi-disciplinary approach in the treatment of patients with chronic and complex conditions. Its proposes additional spending in these areas which could be of considerable benefit, depending on how the money is spent.

The Commission notes the two-tiered nature of the present system which advantages those who can afford private health insurance and avoid waiting lists. But its system will only perpetrate the two-tier system and widen the gap as the insurance industry extends its grip into new areas.

Choice for some

Every Australian will automatically belong to a government operated **health and hospital plan** under a voucher system. They can then select to move to a not-for-profit or PHI fund of their own choosing. The insurance fund would receive a "risk-adjusted" allocation of funds for each member – the amount would vary depending on the age, medical history, and other possible risk factors of the individual. For example, the allocation for a 60-year-old diabetic would be larger than for a 25-year-old who visits the doctor once a year.

The payment is attached to the individual – hence the term voucher. It is the government's contribution towards payment of medical and hospital services. This voucher covers a very basic level of cover, referred to as "universal service entitlement". This is a minimal safety-net.

When someone visits a GP, has a blood test, etc, the health fund not Medicare pays the rebate to the doctor or patient.

Those who can afford it, may buy additional coverage for services not included in the universal service entitlement or to cover the gap between the rebate from the fund and what the medical practitioner charges.

The health funds will shop around on the health market and purchase services from competing public and private providers for their members. A fund may buy places in public or private hospitals for its members. Dr Tim

Woodruff, president of the Doctors' Reform Society, sums it up: "Choice remains a taxpayer subsidised option for the minority of Australians who can afford PHI and can queue jump public hospital waiting lists, whilst the most needy just wait. They have no choice. Vested interests remain untouched."

The process for determining what is included in the universal service entitlement and level of rebates and who might be eligible for bulk-billed services is not clear. The report stops short of saying that the health insurance companies will be able to determine what procedures a fund member may have and where – as in the US – but that is where it is heading.

The Commission's report sums up the new system: "`Medicare Select' would retain a mixed public and private system of financing and service provision, reflecting community preferences. But the private sector would be embedded in the national system, allowing better use of both public and private health resources." (Section 6.6.1)

In effect, the administration of Medicare is being contracted out to the private health insurance industry.

The Commission's relative silence on such important issues as bulk billing, the PHI rebate and means testing is of concern. It appears that the 30-40 percent tax rebate for private health insurance will be extended to those taking out additional medical insurance. The report makes reference to co-payments – the gap between what a doctor, pathologist, radiologist or other practitioner charges and the Medicare refund – but leaves it open as to who might still be eligible for bulk billing (no fee at point of service).

Denticare

"The belated recognition that dental care should be a universal entitlement is a huge step forward for many Australians who until now have had no choice but to live in pain, unable to eat properly, waiting years for treatment", said Dr Woodruff.

Denticare is a separate voucher system which relies heavily on the private sector and will only cover a limited range of services.

Residential aged care is also based on a voucher system to meet "core needs", where the consumer shops around and pays extra for quality care and services.

PBS

The pharmaceutical industry has been waging a long and hard battle to gain control over the Pharmaceutical Benefits Scheme which evaluates medications, extracts lower prices from Big Pharma and subsidises prescriptions. The Commission raises the idea of decentralising and handing over the PBS's functions to PHI funds.

ID card

The new" patient-centred" health system includes the use of unique personal identifiers for centralising and matching up of data by government agencies – prescriptions, visits to doctors, hospital stays, treatments, taxation, social security records, ethnicity, etc.

The individual will have a "person controlled" electronic health record as well as the centralised data. The whole system is voluntary, but government payments are conditional on being part of it!

It is the old ID smart card revisited in the name of "e-health".

"More with less"

PM Kevin Rudd, in releasing the report, spoke of the need "to drive efficiencies across the health system – so that we can do more with less" and warned that the government would be making some "tough decisions, unpopular decisions and some budget cuts" as it set about returning the budget to surplus. He specifically referred to "difficult trade-offs" in health financing.

The Commission looked at the public hospital system and saw cost savings in the region of 20-25 percent! It acknowledged staffing problems but did not recommend increases in staffing, improvements in wages and working conditions of staff or better resourcing of public hospitals. Funding is so inadequate that nurses in some hospitals have been forced to buy swabs and other basics. The Commission and government clearly have no intention of adequately funding public hospitals.

The government, in its 2009 budget, introduced a number of recommendations made by the Commission in an earlier report. These included additional spending on primary health, Aboriginal and Torres Strait Islander, rural and remote health services, additional funds for research and training of health professionals, and the establishment of GP superclinics. The Australian Health Care Agreement adopted by the Council of Australian Governments in late 2008 laid the basis for some of these more immediate changes.

The Commonwealth proposes to eventually take over the funding of all primary, dental, hospital, aged, mental, and Aboriginal health services from state and local governments. It would create the framework for the distribution of public monies to public and private sector operators but not provide services.

Act now

The government has embarked on a program of consultation with the key participants in the health sector to thrash out more detail and the Commonwealth's role. The government hopes to gain agreement for its health agenda from the states and territories at a meeting of health ministers in late 2009. If it fails to gain their cooperation Rudd has vowed to take it to a referendum at the next federal elections.

There is still time to raise public awareness and build a campaign to defeat these changes. The people of Australia time and again have voted for a genuinely universal Medicare with bulk billing and have indicated they would prefer to pay higher taxes to have a high quality, universally accessible public hospital system and affordable medications.

Dr Woodruff again: "Despite the many excellent ideas within it, this report is ultimately about entrenching those [private sector] vested interests, about a long term vision for health care as a commodity to be subject to competition and the market. Swine flu affects us all. We do not need a health industry – we need a health system for all. That will only happen with co-operation, not competition."