

THE GOVERNMENT'S HEALTH CARE PLAN: IT'S ABOUT HEALTH CARE FINANCING NOT HEALTH CARE REFORM

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Prime Minister Kevin Rudd has launched his second election run with a policy proposal that finally delivers on some significant aspects of his previous election commitments. The release last week of the Government's plans for a National Health and Hospitals Network represents what we must hope is the first installment of a series that will eventually deliver on those commitments in full. Only in that context can this current plan be seen as anything close to health care reform.

As outlined, the plan to have the Commonwealth Government take over a significant part of hospital funding and oversight of how those funds are spent has the very real potential to address current problems with a fragmented system riddled with cost and blame shifting.

The genesis of this new policy was in the Department of the Treasury, and this shows in the focus on health care financing, on who pays for what, and on what basis. The patient and their needs are not at the centre of this proposal. And while the Commonwealth Government will now fund 60 per cent of both recurrent and capital hospital expenditures, this falls far short of a complete takeover of public hospitals, as once mooted.

It's not even a particularly generous offer, given that the original deal for hospital funding was a fifty - fifty split between commonwealth and state and territory governments. Moreover, this Commonwealth Government largesse is funded largely through a claw-back of GST revenue from the states and territories.

The Prime Minister has made it clear to the state and territory governments, which will still have to find 40 per cent of hospital funding, that this is a non-negotiable proposal. What will happen if, as appears likely, at least one of the states does not agree to adopt the Prime Minister's plan? And what will happen in the future if a state is unable or unwilling to make its 40 percent contribution? There are considerable administrative and political difficulties inherent in this plan.

Redirecting the funding of public hospitals directly to Local Hospital Networks, bypassing the state and territory government bureaucracies, should mean that regional health care delivery networks are more responsive to local needs. But it could also mean that they are prey to local politics. Careful oversight will be needed to ensure that areas of disadvantage and health care disparities get the additional resources they need and do not lose out to more powerful voices in better-off suburbs and regions.

A single national funder will certainly be better placed to demand, and receive, uniform national reporting on nationally agreed standards. If this reporting system is transparent and open to public scrutiny, and comes accompanied by requirements that deficiencies are remedied within agreed timeframes, then this will help boost quality and safety.

Realistically, hospital financing is an odd place to start a fundamental health reform, when all the prior consultations and reports make it quite clear that the real problems facing the health care system are those around prevention, better management of chronic illness, giving children the best start in life, and getting more health care professionals to work where they are most needed.

There are a host of questions about what this new approach means for important issues such as equity of access to care, the integration of mental and physical health services, the better coordination of community, hospital, rehabilitation and residential care, and promised improvements in dental care. For real health care reform, these cannot be ignored.

There is a huge gap that should have been addressed in this plan, and that is the integration of private hospitals into the health care system; currently they apparently sit outside of the reforms. This is a serious omission, not least because of the significant federal subsidies which private patients in private facilities currently receive.

A report from the Australian Institute of Health and Welfare (AIHW), released late last year, highlights the inherent unfairness in the current system, where those who can afford to purchase private health cover and use the private system receive substantially more financial assistance from the Commonwealth Government than those using the public system.

For example, the Australian Government pays \$889 for a lens procedure in a public hospital, and \$1548 for the same procedure in a private hospital. In 2005-06 it cost on average \$17,364 to get a cardiac pacemaker replaced in the private sector, of which the Australian Government's contribution was \$7,066, while the same procedure in the public sector cost \$6,650. No wonder health costs are blowing out, public hospital budgets are stretched, and specialists are looking to maximize their incomes in the private sector.

Which is why reforming health care funding is only part of the problem of developing a health care system for the 21st century. The other half of the equation is about reforming the way in which health care services are delivered and the need to move from paying for activity to paying for health outcomes. Our current reimbursement system rewards volume and not value, quantity and not quality.

Real reform should include a move away from fee-for-service and towards bundled payments which would ensure that patients get the complete suite of needed health care services. It would reward doctors and other health care providers for keeping patients as healthy as possible and avoiding preventable hospital admissions and readmissions. And

it would tackle duplication and waste in the health care system, particularly in the areas of pathology testing, diagnostic imaging and prescribing of medications.

As President Barack Obama well knows, and will undoubtedly be able to explain to the Prime Minister in the course of his visit later this month, moving health care reform from fine words to legislative reality is a difficult and tricky task. Of necessity real reforms are big reforms; tinkering at the margins, doing things on a small scale, leads only to problems elsewhere in the system.

President Obama can also advise on the level of opposition, sheer obstinacy, and sometimes outright nastiness that such changes invoke. Opposition to change is everywhere, and it is always easier to do nothing and claim that the status quo is just what everyone wants.

The process has begun. The Prime Minister and his government must now work to bring Australians the health care reforms they were promised and they deserve.