# Challenges in health and health care for Australia

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## ABSTRACT

- The next Australian Government will confront major challenges in the funding and delivery of health care.
- These challenges derive from:
  - Changes in demography and disease patterns as the population ages, and the burden of chronic illness grows;
  - Increasing costs of medical advances and the need to ensure that there are comprehensive, efficient and transparent processes for assessing health technologies;
  - Problems with health workforce supply and distribution;
  - Persistent concerns about the quality and safety of health services;
  - Uncertainty about how best to balance public and private sectors in the provision and funding of health services;
  - Recognition that we must invest more in the health of our children;
  - The role of urban planning in creating healthy and sustainable communities; and
  - Understanding that achieving equity in health, especially for Indigenous Australians, requires more than just providing health care services.
- The search for effective and lasting solutions will require a consultative approach to deciding the nation's priority health problems and to designing the health system that will best address them; issues of bureaucratic and fiscal responsibility can then follow.


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*For editorial comment, see page 484. See also pages 490, 493 and 497*

The next Australian Government will confront major challenges in the funding and delivery of health care. Australia's health care system ranks well internationally, as reflected in our continuing high average life expectancy and low rate of infant mortality.[1] These advances are now under threat as our health system is stretched by an ageing population, the growing burden of chronic illness, and the increasingly outmoded organisation of our health services. Inequalities in health between our most and least advantaged citizens persist, and are the sentinels that remind us that there is no room for complacency, or for inertia in reforming our health care system.

There is almost universal agreement that the health care system must focus on prevention and better management of chronic illness.[2,3] This will require targeting populations with the greatest need, especially Indigenous communities, establishing better links between primary, acute and rehabilitative services, and developing innovative ways of delivering health care to rural and remote communities. There is little flexibility to do this in a system hamstrung by a focus on fee-for-service and isolated episodes of acute care, growing out-of-pocket costs for patients, and workforce shortages.

Here, we present a number of pressing challenges that will require national leadership. We do not propose solutions here, but we are committed to being part of the search for effective responses to these challenges after the upcoming federal election.

While our list of health challenges confronting an incoming federal government may not be definitive, we believe these challenges must be addressed if Australians are to maintain or improve on present levels of health and wellbeing, have the health services they need when they need them, and be able to participate fully in the workforce and the community.

## Changing demography and disease patterns

Our ageing population challenges the ability of health services to maintain health and wellbeing, manage serious and continuing illness, and provide support for the frail and disabled.

The average Australian can expect to live 73 years of healthy life. Actual life expectancy is some 10 years longer, but this longevity is often accompanied by increasing disability from chronic illness.[4] Actions taken earlier in life can prevent or mitigate chronic illness, yet preventable chronic illnesses, such as diabetes (Box 1),[5] pose a significant and growing burden of mortality, morbidity and health care costs.

The ageing of the population is not a major contributing factor to rising health costs. The federal Treasury's intergenerational report for the financial year 2002–03 concluded that "ageing of the population will have only a small effect on spending".[6] However, the chronic diseases associated with ageing pose both medical and managerial challenges. Chronic diseases also dominate the long list of health problems experienced by our Indigenous communities.

Preventive initiatives do not reach out effectively to those most at risk, and services for the chronically ill are concentrated in the acute care sector, with suboptimal links to general practice and community care. Coordinating services in the cause of better primary, secondary and tertiary prevention, and better care for patients with serious and continuing illness, some of whom may require support for decades, is hindered by the separate and competing contributions made by the federal and state governments and the private sector to the funding and supply of health services.

**1 Type 2 diabetes: a preventable chronic disease with high health care costs[5]**

- The major risk factors for type 2 diabetes are being overweight, poor nutrition and lack of exercise.
- Around 90% of type 2 diabetes is preventable.
- About 900 000 Australians have type 2 diabetes; half are undiagnosed.
- Diabetes is the underlying or associated cause of 8% of deaths.
- Each year there are about three million consultations with doctors and 65 000 hospital admissions for diabetes.
- Diabetes is estimated to cost the nation in excess of $3 billion annually.
- The average annual cost for each individual with diabetes is estimated at $7566, of which $5325 is health care costs. The annual health care costs can rise to $9610 if there are complications. ◆

**2 The Productivity Commission's findings on new medical technologies[7]**

- Advances in medical technology have brought large benefits to the Australian community, which outweigh the costs.
- Such advances have driven around a third of the growth in real health spending over the past decade.
- There is a need for more comprehensive, efficient and transparent health technology assessment.
- Health technology assessment can enhance overall effectiveness of health care through better targeting of new technologies, especially compared to existing, often blunt, rationing mechanisms. ◆

**3 Australia's health workforce[11,12]**

- There are around 450 000 paid health professionals in Australia, of whom just over 350 000 are currently employed in health services.
- Over half are nurses, 12% are medical professionals, and 9% are allied health professionals.
- Nearly 34% work part-time, with 38% working less than 35 hours per week, and 12% working more than 49 hours per week.
- 74% of health workers are female.
- 31% of the workforce are aged under 35 years, and 12% are aged 55 years and over.
- The medical specialist workforce is projected to increase by 44 full-time equivalent (FTE) practitioners per 100 000 citizens in 2012, but the general practice workforce, which fell by four FTE per 100 000 people in 2003, will remain at the present level until 2012. ◆

## The costs of new technology

Much of the rise in health care costs can be attributed to advances in medical technology (Box 2).[7] Diagnostic and therapeutic advances, such as new radiological scanners, biological therapeutics, minimally invasive surgical procedures and prostheses, frequently come at a considerable cost. Listing these for subsidy through Medicare or the Pharmaceutical Benefits Scheme (PBS) greatly increases their availability and use, and therefore the cost to the community. Failing to subsidise them inevitably raises questions about why new medical advances are not available to all Australians, and generates political pressure.

Australia has an enviable record in the assessment of new pharmaceutical products, based on the principles of cost-effectiveness.[8] However, the assessment of new surgical interventions, devices and other technology is not comprehensive and lacks the cost-effectiveness rigour applied to pharmaceutical products and vaccines. Different criteria are used in public and private hospitals to determine access to new technology and expensive cancer drugs not yet available on the PBS.[9,10]

## A health workforce for the 21st century

The willingness of doctors and other health professionals to work extended hours has diminished as the health workforce ages, as the proportion of women in the health workforce increases, and as individuals seek to balance work and family life.[11] Work, social and educational aspirations of health professionals and their families influence decisions about where to live and practise, and their criteria may not easily be met outside metropolitan areas.

These and other factors have led to problems in the supply and distribution of the health workforce (Box 3).[11,12] There are serious shortages of general practitioners, dentists, nurses and some key allied health workers. Shortages are more significant in outer metropolitan, rural and remote regions, especially in Indigenous communities, and in particular areas of care, such as mental health, aged care, and disability care. Overseas-trained doctors now make up 25% of the medical workforce compared with 19% a decade ago.[13]

The Australian Health Ministers' Conference developed the National Health Workforce Strategic Framework in 2004 to address these issues, but its implementation has faltered because of lack of national leadership and lack of integration across health and education bureaucracies, governments, and public and private training sectors.[14]

## Quality and safety

Medical errors in Australia cost over $1 billion — possibly $2 billion — annually.[15] The Quality in Australian Health Care Study found that about half of these errors were potentially preventable.[16]

Australia has not come to terms with medical error, neither recording its occurrence nor adapting systems from other high-risk industries, such as nuclear power and aviation, to reduce it. Rigid, fault-seeking, blame-allocating cultures are tolerated, even enshrined, in professional hierarchies. There is a new agency for quality and safety, built on a succession of preceding committees and councils, but its effectiveness has yet to be demonstrated (Box 4).[17]

We do not know whether a decade of quality and safety activity has produced improvements; there are insufficient data at state or national level, in the public or private sector, or for in-hospital or out-of-hospital care.[18]

## The public–private mix in health care funding

Access to health services is becoming less equitable. Patients' out-of-pocket costs have grown 50% in the past decade[19] and now, for some, present a sizeable barrier to needed care.[20]

Australia has always had a health system that relies on public and private financing and service delivery. This has been presented as a matter of choice. However, the private health insurance

**4 Australia's previous Chief Medical Officer* on the Herculean task of improving health care quality and safety[17]**

- "So a fourth national body has now come into being, the Australian Commission on Safety and Quality in Health Care . . . The Commission is expected to make things happen in a way that its predecessor could not."
- "If the Commission is to know whether things are indeed happening, it will need data of high quality . . . And there's the rub. Epidemiologically sound data which might be used for benchmarking nationally or internationally, or to show trends over time, are not easy to come by."
- "The new Commission has a Herculean task ahead of it . . . The Commission has been given a solid basis for action by the Council, but it will take vision, skill, resources and, above all, persistence to achieve the changes we are all hoping for."

* Richard A Smallwood, Emeritus Professor of Medicine, University of Melbourne. ◆

**5 Private health insurance in regional Australia[21]**

- Regional Australians have substantially lower levels of private health fund membership. In 2001, 50.2% of people living in capital cities were covered by private health insurance compared with 43.5% living outside capital cities. This equates to 350 875 fewer people in regional areas having private health insurance.
- The main reason for the lower level of membership in regional areas is the limited availability of private inpatient facilities. Only 16% of hospitals located outside major cities are private facilities.
- Regional areas appear to be receiving substantially less federal health funding than they would if federal funds were allocated on a per-capita basis. The cost of the private health insurance rebate to regional Australia may exceed $100 million a year. ◆

surcharge can be seen as unfair by those who live in rural areas where access to private health facilities is limited (Box 5).[21]

Some areas of surgery are now performed predominantly in the private sector, and the 57% of Australians without private health insurance must wait, often for months, for elective surgery in the public system. This creates an equity challenge where access to care is based on ability to pay rather than need. Specialist surgical training remains concentrated in the public sector, where the caseload is diminishing.

The private health insurance sector is heavily regulated. Premiums for private health insurance are the same for the active and the indolent, the prudent and the profligate. Should this be so? Health funds respond by shifting their bad risks back to the public sector — for example, they do not pay for home renal dialysis and limit payments to specific dialysis centres.

The reinsurance scheme, which evens out the risk to insurance companies irrespective of performance, obliterates incentives for funds to seek out and develop imaginative solutions to chronic disease management and prevention. Innovations linking health services to health service financing are forced to the margins, and flourish in the health management programs of the Department of Veterans' Affairs. An example is the program to improve hospital discharge planning and prevent hospital readmissions, which is expected to deliver savings of $46.1 million in hospital costs over the next 4 years.

## Addressing modernity's paradox

Since the beginning of the last century, there has been a dramatic decrease in the mortality rates of babies and children. But after decades of progress, children's health is under fresh threat from an array of modern conditions that impair their life expectancy and quality of life.

In what is described as "modernity's paradox",[22] many Australian children are now not as healthy as were children of earlier generations. The responsible afflictions include: low birthweight; rising rates of obesity and diabetes; childhood asthma and other allergies; a range of developmental disorders; autism; and mental health problems including depression, anxiety and behavioural disturbance. There is an increase in learning disabilities, aggressive behaviour and violence. Children living in rural and remote areas and from the lowest socioeconomic groups are particularly at risk.[23]

Such problems are likely to become more prevalent as these children, impaired through no fault of their own, become adults and parents (Box 6).[23]

## The consequences of global growth

Rapid expansion of the urban Australian population is creating challenges in planning for healthy and sustainable communities.

Increasing urbanisation — especially when there has been little attention paid to the preservation of pedestrian amenities, public safety, access to cheap, fresh food, social cohesiveness and the potential for pollution — is associated with higher rates of obesity, asthma and depression (Box 7).[24]

This urban challenge, akin to those that initiated the public health movement in the industrial revolution, extends beyond health to jurisdictions of town planning, architecture, commerce and industry. Threats to the global environment and international concerns about the transmission of infectious diseases are perceived with growing clarity in Australia, but the impact of urban design has yet to be appreciated adequately.

## Health inequality and concerns with equity

Despite the great improvements in average life expectancy achieved in recent decades, health gains have not been equally shared across the Australian population. Women do better than men; well edu-

**6 Fiona Stanley* on the need for healthy child development[23]**

"So if we have a society where most children commence their lives in environments which enable full opportunities for healthy child development, what I call 'the building blocks', then we'll have most children … reaching their educational and social potential. We'll have most young people participating to their full potential. We'll have a competent workforce, and we'll have national economic prosperity, and we won't have Australia's health and welfare budgets draining Australia's capacity, and we'll have the next generation of parents. You understand, don't you, that so many of these adolescents that are in our data will be parents in five to 10 years' time. And so we've got to make sure that we have an intergenerationally competent group, and then we'll have cycles of economic prosperity, and we'll have a national capacity."

* 2003 Australian of the Year, founding Director of the Telethon Institute for Child Health Research, Professor in the School of Paediatrics and Child Health at the University of Western Australia, and Executive Director of the Australian Research Alliance for Children and Youth. ◆

**7 Health and the urban environment[24]**

"There are many known influences on health in the urban environment. These include: physical activity; social cohesion; personal safety; food supply; air and water quality; and open space."

"Health outcomes as diverse as mental health, obesity, injury, violence, asthma and infectious diseases are affected by these and other aspects of the urban environment. The relationships encompass social, physical, behavioural and economic determinants."

"The relationships between contemporary public health epidemics and the urban environment are considerably more complex than the associations between water quality, sanitation and overcrowding and infectious disease epidemics. There are however an overlapping set of risk factors for the most important contemporary public health issues — lack of physical activity, nutrition, obesity and alcohol and other drug use. The nexus between diet, physical inactivity, obesity, heart disease and diabetes in particular is of great relevance to urban and transport planners in our cities." ◆

**8 Health inequality among Australians aged 25–64 years[25]**

Statistically significant differences between the health of the fifth of the Australian population with the lowest socioeconomic status (by socioeconomic status of area of residence) compared with that of the fifth with the highest socioeconomic status include:

- More with fair or poor health;
- More with arthritis;
- More with high blood pressure;
- More men with bronchitis and emphysema;
- More women with asthma;
- More women with diabetes;
- More obesity;
- More smoking;
- More with insufficient physical activity;
- More men at risk from alcohol consumption;
- More general practitioner consultations;
- Fewer dental consultations;
- Fewer women who had a Pap test in the past 2 years; and
- More men had days off from work. ◆

cated city dwellers in leafy neighbourhoods do better than people living in the bush or less affluent suburbs, the less well educated and the unemployed (Box 8).[25] Indigenous Australians live, on average, almost 20 years less than other Australians.[26]

The Australian Institute of Health and Welfare found that if all of Australia experienced the same death rates as do the least socioeconomically disadvantaged in our population, more than 23 000 fewer deaths could have occurred in 1998–2000.[27] Persistent health inequalities can signal deeper rifts in society that warrant broader examination and discussion.

## Conclusion

We have examined eight major health and health service challenges that Australia faces. Doubtless there are many more. Of these, the pre-eminent challenge of achieving health equity for all Australians, regardless of race, income and where they live, must drive the search for effective and lasting solutions to the others.

Recent announcements from both major political parties outlining their policies about the way in which hospitals are funded and managed mean that health issues will be important in this election, and that is a welcome development. The willingness of the next federal government to invest in public hospitals is crucial, but not enough to improve the health of the nation.

The solutions to these challenges must recognise that new approaches to prevention, primary and acute care and rehabilitation will be needed to effectively and efficiently tackle the health problems facing Australia in the 21st century. Public consultation and agreement about what a wealthy democracy such as Australia should provide for the health and health care of its citizens, and how the health system might be structured to achieve that provision, should take priority. The focus should be on the big picture. There is little point tinkering with the carburettor, worrying about the tyre pressure or replacing the battery if we have the wrong vehicle for the drive ahead.

The eight challenges outlined above await Australia's next government. It will need leadership, wisdom and courage to engage with them effectively.

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