

# Breaking through medical myths

## Lifting the veil of health 'stakeholders'

Scott Ryan

Earlier this year, the new Minister for Health referred to the need to 'rebuild health services after the last decade of neglect' as only 73.4 per cent of all Medicare services were being bulk-billed. Apparently, it is a disaster that only three quarters of Medicare services were provided at no out-of-pocket costs to patients.

Claims such as this over the last few years have driven an increasing clamour for health reform, greater public spending on health and claims of a 'crisis' in our health system. It is therefore no surprise that when the government makes such a significant misdiagnosis in defining the real challenges facing our health system, then the proposed cure also has major flaws.

Kevin Rudd's National Health & Hospitals Reform Commission contains two former politicians, three health bureaucrats, three academics, two consultants and a doctor. But who speaks for the consumer—the patients?

Apparently the new government has determined that the best way to deal with these claims is to gather a panel of government-chosen experts who will determine exactly what needs to be done and by whom.

But this approach perpetuates two key problems—the dominance of provider and 'expert' voices to the exclusion of the consumer or patient, and a seeming reluctance to thoroughly examine and test the various claims made by the groups such people represent.

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Health policy affects everyone at virtually every stage of their lives. It often does so at times of high stress, when a health crisis affects themselves or a loved one.

More so than many other policy areas with significant levels of government activity, such as education, policing, even economic management, health policy is often covered by a veil of complexity and inaccessibility that limits debates to experts and excludes the broader community and the patient or consumer. Dominated by these experts with years of training and who are often quoted with a virtual alphabet of qualifications, all claiming to have 'the answer' and to be working in the community's interest, healthcare is continually one of the dominant policy and political issues. It is simply not appropriate that it is an area in which the community at large is excluded from many of the critical debates.

Health policy is also a major driver of voter attitudes, driving the media to report it in the traditional 'he-said, she-said' terms familiar to political debate, with various stakeholders quoted as supportive or otherwise of one of the political players. While the claims and pronouncements of political actors are usually tested, insufficient scrutiny is often applied to the claims of these stakeholders.

The reality is that health is just like every other area of government policy. Actors in the health policy arena have their own agendas. Just as the Australian Medical Association (AMA) will express concern about access to doctors, the Australian Nursing Federation (ANF) will outline the need for more and better paid nurses and government

will often talk of the need to constrain increasing costs.

Most of these claims are well-intentioned, but are at the same time driven by the perspectives their training, needs and personal interests bring. They must be examined and tested to ensure they are not simply claims representing their own interests, intentional or otherwise, to the exclusion of the needs of the consumer.

Testing the claims and assumptions that underpin a great deal of discussion about health policy and, where necessary, puncturing myths that have developed over time, often simply through not being challenged, is critical to increasing public participation in health debates, and ensuring that the interests of consumers are the driving force behind policy and reform proposals.

### Community vs private interest—MYTH

Key actors in the health debate often claim to be acting in the broad interests of the community, virtually to the exclusion of their own. Just as the ANF claims 'Australia's nurses are the backbone of our health care system,' the AMA claims that general practitioners are 'the gateway to health care for most Australians'. The health policy debate often seems to be dominated by doctors, nurses and other health professionals motivated purely by altruism.

These arguments (and they are far from the only ones) are used to underpin claims for greater resources to support their activities within the health system—the most common examples being claims for increased resources or wages, more beneficial employment conditions or greater numbers of employees within the health system.

Similarly, there are pharmacists, private health insurers, pharmaceutical and medical device and technology companies, and various other service providers that also make claims of their critical contribution to the health system.

All of these have a direct interest in the manner and amount of government funding within the health system, as well as all contributing to achieving the aims of the system.

Health comprises just over 10 per cent of our economy, indeed a strong and growing health sector is part of a modern economy. Thousands of doctors, nurses and other health professionals make their living from healthcare and local and international corporations also make significant profits from providing goods, services and technology.

This should not be something that such groups hide (intentionally or otherwise) when pressing their claims. As health is funded by taxpayers to such a substantial degree, the community should examine whether such claims are a result of both most efficiently servicing their health needs as well as in the economic self-interest of the providers concerned

### **We need a single, national health system—MYTH**

It is an oft-heard claim that the division of health between the Commonwealth and states results in inefficiency, cost-shifting, wastage and duplication.

Indeed, with the Mersey Hospital ‘takeover’ in the last months of the Howard government and the comments from Tony Abbott calling for the Commonwealth to take over responsibility for hospitals, along with Kevin Rudd’s commitment to a referendum if his reform process fails, it could be said that this is a sentiment with supporters across the political spectrum. But does a federal takeover automatically mean we will have a better health system?

The current arrangements are undoubtedly complex—the Commonwealth solely funds parts of the health system such as access to doctors and associated medical services (for example pathology, radiology) through Medicare, jointly funds state-managed public hospitals with the state governments, and jointly funds various community care programs with state and local governments. The Commonwealth funds universities to train the medical workforce, yet their in-hospital training is jointly funded by the Commonwealth and states.

The most public aspect of this overlap relates to hospitals. Often the dominant element of the public debate about healthcare due to its political sensitivity, hospital funding is the prism

through which health policy is seen and debated.

But would hospitals being run from Canberra necessarily lead to improvement in services, waiting times and emergency rooms? No evidence has been offered to suggest this. The most often quoted benefit is that the costs of duplicated health bureaucracies could be saved, but this is nothing more than a perennial centralist furphy.

Firstly, the bureaucracies at a state level cover more than just hospitals—they also cover public health programs, community and home care programs and many activities not covered by Commonwealth bureaucrats. Many such functions would need to be retained.

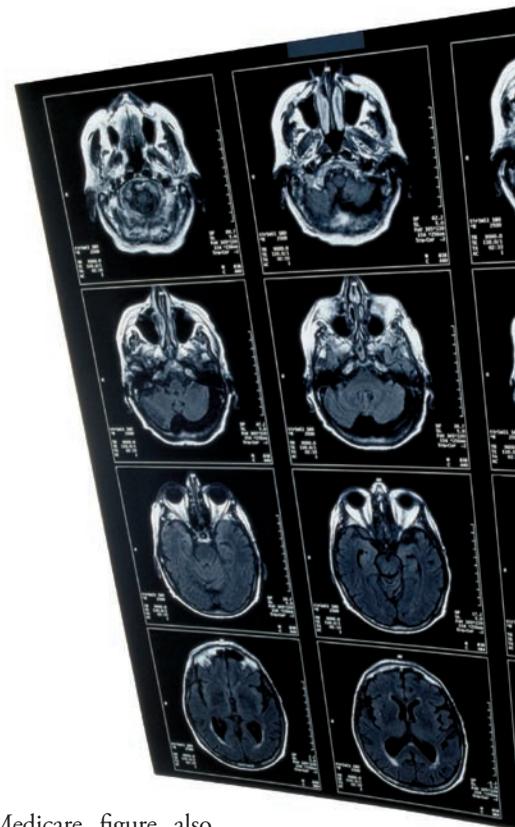
Secondly, this alleged duplication in bureaucracies comprises a relatively small amount of more than fifty billion dollars of taxpayers’ money spent on health care annually—the reality is that this is more about rhetorical support for centralisation than real savings that can be poured back into service delivery.

Finally, there is no evidence to suggest that the centralisation of hospital and health policy would in any way benefit consumers. There is a legitimate fear that removal of the ongoing political pressure on both state and federal governments and its replacement with a single authority would actually reduce the responsiveness of policy makers to the community’s needs and demands.

### **Hospitals are the most important part of the health system—MYTH**

The health debate often attracts public attention through the prism of public hospitals. While they are undoubtedly a critical part of the healthcare system, and recent incidents, particularly in NSW, as well as the ongoing growth of waiting lists across the country are a very significant issue, they do not represent the most significant part of the broader health system.

In simple numeric terms, access to a general practitioner is much more important to more people, most of the time. In 2003-04, there were 208 public hospital ‘separations’ (interactions) for every 1000 people. However, there were 1087 Medicare services for the same number of people. While this latter



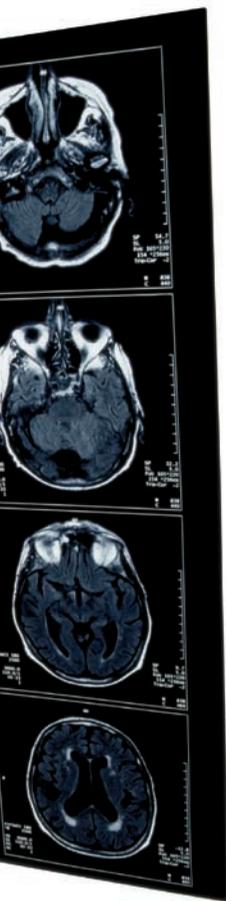
Medicare figure also includes procedures associated with visiting a doctor (such as blood tests or x-rays) and so they cannot be directly compared, it is clear that access to a doctor is the most common interaction people have with the health system.

Accessing a doctor at an appropriate time can also avert the need to visit a public hospital, either immediately or at a later stage. And in many areas of the country, particularly rural and remote areas, accessing a doctor requires a wait of weeks, due to a severe workforce shortage in such areas. To focus purely on public hospitals is to miss the real challenge—access to medical expertise when and where it is required.

### **Ageing is the major driver of rising health costs—MYTH**

One of the major elements of the health debate in recent years has been the growth in concern about an ageing population. While Australia’s ageing population is a factor in driving healthcare costs, it is far from the most significant one. The federal treasury’s most recent intergenerational report, published in 2007, conceded this when it outlined that ‘factors other than ageing account for the remaining three-quarters of the projected increase in health spending.’

# It is critical that the current health reform debate further involve the most important but under-recognised part of the system—the patient.



The major driver of increasing healthcare costs is the development of new health technologies. All new technology costs money. A generation ago, there were no MRIs or CT scans, and organ transplants were a news item more than a regular procedure.

The second component to rising costs is increased utilisation of health technology. While this is partly driven by an older population, it is overwhelmingly the product of more people generally using

the more widely available technology. Whereas sports people a few generations ago retired when they injured a knee, teen footballers these days have anterior cruciate ligaments repaired and continue their careers. Similarly, we have an array of medicines now available that were unheard of a generation ago.

Medicines, medical devices and increasingly complex testing and diagnosis options mean that we are spending more to better treat conditions in people that would previously have not been treated, or not been treated in the same fashion, usually less effectively treating or managing conditions (particularly chronic, long-term conditions).

The results of such costs driving health spending can be seen through population screening programs. Mass-screening programs have reduced deaths from cervical cancer by half over the last decade. Similarly, vaccines against cervical cancer are now part of the publicly-funded immunisation schedule for young women. Both of these have cost more in simple spending terms, but they have ‘purchased’ an improvement in health outcomes—lower incidence of cervical cancer and

a dramatic reduction in the death rate.

Some increases in spending on new technology in the short term can also lead to lower costs in treating conditions over time. The 2005 Nobel Prize in Medicine was awarded to Barry Marshall and J. Robin Warren of Western Australia for their research into the cause of peptic ulcers. This research led to a dramatic shift in the treatment of ulcers—many people could now be treated with a series of medicines rather than major surgery.

## More government spending will fix our health system—MYTH

Not surprisingly for an area dominated by government, the debate about how to improve our health system is dominated by demands for increased government spending. This is particularly true when it comes to discussion of the public hospital system. However, the truth is that we actually have very little information about exactly what our health spending delivers in improving health outcomes—that is, the improvement in health for the money we spend. We measure inputs through spending and government programs, outputs through hospital and aged care beds, Medicare services delivered and hospital separations—but we are particularly poor at actually measuring what all these do for the actual health status of patients.

The Medicare system is predominantly managed through a ‘fee for service’ structure. Rather than paying for effectively treating a patient or managing a condition, most interactions in our health system are funded by paying for time or procedures. Simply paying more for such interactions is no guarantee of improving the health status of those being treated. Similarly, substantial increases in funding to public hospitals are no guarantee that more patients are being treated or that such funding is being used in the most efficient manner.

Per capita health spending in Australia increased by over 80 per cent in the ten years to 2003, but at the same time concern about the state of our health system remains unabated. Similarly, over the term of the Howard government, health spending nearly doubled (in nominal terms) but these concerns seemed to increase towards the end of that period.

Little research has been undertaken into the ‘efficiency’ of our recent increases in health spending overall. In this particular area, the influence of the labour force issues is critical. The influence of health sector unions in the state-run public hospital system is particularly strong—and this may in itself lead to extra spending being directed to wage and salary increases that do not benefit patients or the efficiency of the system overall.

The health debate is likely to only increase in importance over time. Health spending is rising faster than inflation, health technology continues to develop, bringing further cost increases, and an ageing population and increasingly aware consumers demand access to the best health treatments available. As long as we retain a predominantly publicly-funded health system this has a direct impact on the public through higher taxes.

It is critical that the current health reform debate further involve the most important but under-recognised part of the system—the patient. Sadly the tradition of provider and expert-dominated debates seems set to continue, as even the Prime Minister’s National Health and Hospitals Reform Commission fails to include a consumer voice.

Expert advice has its place. But experts should guide, not determine, the structure and funding of our health system.

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