



The importance of universal health care and primary health care for rural and remote Australians

[John Menadue AO](#), Chair, Centre for Policy Development (formerly Policy Portal of New Matilda.com)

People living in rural and remote Australia, and particularly Indigenous Australians, have much poorer health and inferior health services than other Australians.

The House of Representatives Standing Committee on Health and Ageing in their report 'The Blame Game' (November 2006) put it succinctly as follows:

Standardised mortality data show death rates in Australia increasing with rurality; Australians living in regional, rural and remote areas are 10% more likely to die of all causes than those in major cities and 50% more likely to do so if they live in very remote areas.

In respect of Indigenous health, the report was even more blunt:

Life expectancy (of Indigenous people) is around 17 years lower than for other Australians.

The population, particularly farming communities in rural and remote Australia, is ageing. Health demands are rising quickly. Residential care is a particular problem, with people often having to move a long way from where they live. Women who may require frequent pre-natal attention may have to move temporarily to a large city to get care.

Some attribute the incidence of depression to the drought, but I suspect it's more entrenched, because of isolation.

To country people, the notion of free health care is laughable. The clinic may provide free services, but a long drive is costly – not only in terms of vehicle operating costs, but also in terms of foregone income. To farmers and contractors and their families, there is no "sick leave".

Many young GPs will stay in the bush long enough to accumulate the money to allow them to shift back to the leafy suburbs on lower income. Many doctors who would like to stay get disheartened by the quality of education for their children. They might be able to afford boarding school, but they understandably don't want to send their children away.

What can be done?

Our universal system of health care which is so important for country people, is under direct attack through the expansion of private health insurance, heavily subsidised by the Commonwealth Government. These rebates will cost the taxpayer almost \$6 b. in 2007/8. The real threat is that private health insurance is slowly but effectively undermining our universal health care system.

Private health insurance:

- Carries all the moral hazards of public insurance (As long as I have insurance, I don't care what the cost is.) without the Medicare benefits of equity, without the capacity to control and influence providers, prices and consumer usage. (Unlike Medicare, private health insurance companies are price takers and not price setters.)
- Is very inefficient and carries an administrative overhead of about \$1 b. per annum.
- It is costly. Every country that has a strong private health insurance sector, like the United States, has high and escalating costs. The facts are unmistakable.

- Misdirects resources from low cost to high cost services. In Australia's case this is away from public hospitals towards private hospitals. There are very few private hospitals in rural and remote Australia.
- Fragments health care delivery.
- Is skewed heavily against the less well off, and that includes most people in rural and remote Australia where the poorest Australians live. Only 25% of the poorest 20% of Australians have private health insurance, but 80% of the richest 20% of Australians have such insurance. (See Governments Working Together, Victorian Department of Premier and Cabinet, 2004, p80.)
- It has not taken pressure off the public system. It has mainly opened up new areas of demand from the wealthier members of our community in the cities.

The growth of private health insurance endangers our high quality universal system. But let me be clear on two things. I am not suggesting that Medicare should be free. We are much wealthier today than when Medicare was introduced 30 years ago. Most of us could afford to pay more through a sensible rationalisation of co-payments, whilst providing free or close to free services to those in most need. Neither am I suggesting that services should be substantially delivered by the public sector. For example, in 2003-04 – if the \$2.3 b subsidy had been paid directly to private hospitals rather than passing through private health insurance companies, private hospitals could have received an extra \$1.2 b on top of their \$1.1 b. Payment of such amounts directly to private hospitals on a Diagnostic Related Group basis would support the private sector, encourage self-reliance and choice.

Rural and remote Australians stand to lose more than anyone else if the trend to a two-tiered system is not reversed. It is already hard to get resources to the bush, and a two-tier system, with high pay for attending to ailments of the relatively wealthy, will only worsen the problem in rural and remote Australia.

Primary health care

The international evidence is clear that a health system oriented towards primary care achieves greater equity, better health outcomes, lower rates of all causes of mortality (including heart disease and cancer) for a lower overall cost than a health system focused on tertiary or hospital care. The Centre for Policy Development of which I am Chair will shortly be releasing a paper on primary health care.

We have a hospital centric health system. The media distorts public discussion by inferring that 'hospitals' equals 'health'. They don't. Hospitals should be the last resort in health. Primary health care by its nature will be of particular benefit to rural and remote Australians.

In the Centre for Policy Development, we are proposing that Australia should establish about 200 primary health care centres across Australia with an average catchment population of about 100 000. In non-metropolitan Australia a lower population threshold would be necessary. Where possible, they have to be large enough to employ a range of professionals. These are average figures and it would of course be different in rural and remote areas with smaller satellite centres established and linked to a larger centre in an urban area, supported in some instances by remote diagnosis. In many cases these primary health care centres would be based around what is now the local country hospital.

Unfortunately, many of the hospitals in small towns are just not viable. Many should be closed. They are not safe. Country people may see more value in having a secure primary health care centre rather than a small hospital which they constantly have to battle with state governments to keep open. We envisage that these centres would be managed by a range of different not-for-profit private operators, including existing organisations operating in the health sector, such as divisions of general practice, community health centres, Indigenous health and groups of primary care practitioners. If in some areas, private ownership is not viable, these centres would be owned by the government. Where possible the governance of these centres would include Commonwealth, state, local and community representatives.



The primary health care centres, where appropriate, would cover a range of disciplines – GPs, visiting specialists, minor procedural services, treatment of minor injuries, community nursing and nurse practitioners, diagnostic services, allied health, family planning, mental health, health promotion and education. 95% of health dollars are spent on medical services for the treatment of illness. This is at the expense of prevention and the promotion of wellness.

We envisage that the capital costs of a primary health care centre to service say 100 000 people would be up to \$20 m. The cost would be \$4 b. over 10 years to roll these centres out across the country. Importantly these centres could help us move to a prevention and health model of care rather than a sickness model of care which is a feature of our hospital-centric system today.

Such centres would contribute to the better management of chronic disease, more continuity of care, greater population focus, greater accessibility and more focus on Indigenous health and the needs of the community.

The major health problems which rural and remote Australians face – mental health, Indigenous health, public health (obesity and tobacco-related diseases) will be much better and more cheaply addressed in a health system more oriented to primary care.

An invigorated primary health care system can be the vehicle for other essential reforms, particularly in workforce, the lack of community engagement and addressing the never-ending Commonwealth–state blame shifting and avoidance of responsibility.

Workforce

We have an archaic 19th Century workforce structure where demarcations and restrictive work practices are rife. One obvious example is in childbirth where in Australia 10% of normal births are managed by midwives. In the Netherlands it is over 70% and in the United Kingdom, over 50%. Professional people are trained in different boxes and work in different boxes.

If only we had applied the same energy and courage in addressing bad professional work practices in health that we have applied over the last 15 years to the work practices in the blue collar area. If we did address this major problem in health, we would have significantly greater productivity in the health workforce. It would also open up vastly expanded career opportunities for people in nursing and allied health. The Productivity Commission estimates that a 10% efficiency improvement in the health sector would deliver a \$8 b. at the present time and \$16 b by 2050. I think the estimates are too low. My guesstimate is that a 40% productivity improvement in health could be delivered over 10 years if there was the will to do it.

The Productivity Commission and COAG are addressing this issue, but I am not holding my breath. My concern is the debate to date about workforce is about producing more people to do the same jobs the same way. The vested interests resisting change are so powerful.

The House of Representatives Committee report I referred to earlier commented that whilst international comparisons are difficult,

Compared to all OECD countries, Australia is in the top third of general practitioners per 100 000 of population... In 2003, Australia had higher numbers of general practitioners and nurses per 100 000 of population than several selected countries (New Zealand, Canada and the United Kingdom,) with economies and health systems similar to Australia. (p. 83)

I am not saying that we don't have particular workforce shortages. But what I do believe is that we have a large health workforce that should be much better distributed and more efficiently employed than the one we have.

The MBS schedule should be used as a lever and incentive to break down the demarcations and open up new career opportunities. Stephen Duckett has suggested possible changes – nurses undertaking greater responsibility for prescribing, enrolled nurses taking on some of the tasks currently done by

registered nurses, midwives substituting for obstetricians, new allied health assistance supporting allied health workers to treat more patients, practice nurses undertaking some of the work currently performed by GPs, including some prescribing, screening and triage.

In a society increasingly impressed, indeed overwhelmed, by the market, why shouldn't the federal government auction doctor provider numbers by postcode, as a means of addressing the oversupply of doctors in some areas and undersupply in others, particularly in outer suburban, rural and remote Australia. In some postcodes, the auction would produce a premium. For other postcodes, GPs might put in a negative bid (they get a subsidy). The government provides an 80% subsidy for doctors' incomes. It has an obligation to ensure that doctors are available right across Australia.

Importantly, the multi-disciplinary primary health care centres that I have mentioned provide the vehicle for major workforce changes. It would be absurd to introduce old work practices into new primary health care centres. It is a great opportunity to achieve real and lasting workforce change.

Community engagement

An important feature of primary health care centres must be the genuine engagement of their populations in the setting of health priorities. Community engagement is often easier in the country because communities co-relate more closely. The methodology to do this is tested and proven, eg citizens' juries and deliberative polling. Western Australian rural communities in the south-west have shown how this can be done to produce better outcomes for communities. I am not talking about opinion polling and focus groups that give us a snapshot of views at a particular point of time which has been influenced in part by what the tabloids and talk-back radio project. The object must be to inform and educate the community about new ways of doing things in health. Importantly, it is about being truthful with the community about what we can afford.

Despite spending \$80 b. annually on health in Australia, these dollars are limited. It will always be the same. What we need is to decide as a community where our scarce resources should be spent. But unfortunately the debate is between ministers, bureaucrats and providers. The public is excluded.

My experience is that when the community is engaged and well-informed to contest the views of 'experts' they have clear views on priority health spending. Mental health and Indigenous health are invariably at the top of the list. In south-western Western Australia, the community placed mental health, Indigenous health and prevention at the top of their priorities. Well-informed community members are less concerned about waiting lists, fertility treatments, transplants, super specialties or keeping people alive in the last stages of terminal illness. But the debate and resources are skewed by those who have influence or media savvy or both. We need some countervailing power in health. Primary health care centres should be the platform to do that. We have a provider-driven health system and not a community-driven health system. It is important that country people have an opportunity to effectively say how they want their limited health dollars to be spent.

The blame game—Commonwealth and state avoidance of responsibility

The problem is well-known. The difficulty is to find the political will by governments to do something about it.

I don't believe that a Commonwealth takeover of Australian health services across the country or a joint Commonwealth and state health commission involving all the states is possible.

I have long advocated a joint Commonwealth–state health commission in any state where the Commonwealth and the state could agree—a 'coalition of the willing' Commonwealth and state ministers would need to agree on governance, coverage and pooled funding. There would be a joint commission to plan health services on a state-wide basis. Existing providers, Commonwealth, state, local and private, would continue to deliver services in the same way as before, but subject to a state-wide plan.



It is suggested that such proposals as this would detract from ministerial responsibility. I don't believe that that is the case. This problem can be resolved provided there is the will to do so as we have seen in recent weeks over the Murray–Darling basin. I have suggested processes and dispute settlement arrangements to overcome difficulties. Ministers will continue to find excuses in all sorts of areas if they are not prepared to face up to the basic political problem of working co-operatively together.

Summary

I have made several suggestions for structural changes in which the poorer health status and the poorer provision of health services for remote and rural Australians, and particularly Indigenous people, can be improved.

- We need to stop the erosion of our universal health care system.
- Build a primary health care system across the country which is accessible for all Australians.
- Substantial workforce changes within a new primary health care system across the country. I mention particularly the MBS as a lever to produce change and also the auctioning of provider numbers.
- Effectively engaging country people in decisions affecting health priorities in their local area through such means as citizens' juries.
- A coalition of the willing in any state where the Commonwealth and a state government can agree to develop an integrated state-wide health plan.

Presenter

John Laurence Menadue AO has had a distinguished career both in the private sector and in the Public Service.

He was made an Officer of the Order of Australia (AO) in 1985 for public service. In 2003 he was awarded the Centenary Medal "for service to Australian society through public service leadership". In 1997, he received the Japanese Imperial Award, The Grand Cordon of the Order of the Sacred Treasure (Kun-itto Zuiho-sho), the highest honour awarded to foreigners who are not head of state or head of government.



John Menadue was born in South Australia in 1935. He graduated from the University of Adelaide in 1956 as a Bachelor of Economics.

From 1960 to 1967 he was Private Secretary to Gough Whitlam, Leader of the Opposition. He then moved into the private sector for seven years as General Manager, News Limited, Sydney, publisher of *The Australian*.

John Menadue was head of the Department of Prime Minister and Cabinet from 1974 to 1976. He was closely involved in the events of 11 November 1975, and worked for Prime Ministers Gough Whitlam and Malcolm Fraser.

He was Australian Ambassador to Japan from 1976 to 1980. He returned to Australia in 1980 to take up the position of Head, Department of Immigration and Ethnic Affairs. In March 1983, he became Head of the Department of the Special Minister of State. He was appointed Head of the Department of Trade in December 1983.

He was Chief Executive Officer of Qantas from June 1986 to July 1989.

He was a Director of Telstra from December 1994 to October 1996, a Director of NSW State Rail Authority from 1996 to 1999, and Chairman of the Australia Japan Foundation from 1991 to 1998.

He is an adviser to several companies. He chaired the NSW Health Council, which reported to the NSW Minister for Health in March 2000 on changes to health services in NSW. He also chaired the SA Generational Health Review, which reported to the SA Minister for Human Services in May 2003.

He is the Chair of NewMatilda.com, an independent weekly online newsletter, which was launched in August 2004.

John Menadue is married with four children and ten grandchildren.

In October 1999, John Menadue published his autobiography *Things You Learn Along the Way*.

