



FACILITATOR: Thank you very much. If you could take a seat at our table. And another round of applause, please.

I'd now like to welcome – and if people who are up the back come in, there's plenty of empty seats down the front. Andrew Podger is our next speaker, National President of the Institute of Public Administration. Andrew is also adjunct professor in public administration at the Australian National University and Griffith University. His CV is extraordinary, but it includes being the former Public Service Commissioner, that's the person with the fundamental responsibility for the whole Commonwealth public service; former Secretary of the Department of Health and Aged Care; he's headed up other federal government agencies; and in 2005 he chaired a taskforce for the Prime Minister on the delivery of health services in Australia.

Please welcome Andrew Podger.

Rural and remote implications of a new structure for Australia's health system

[Andrew Podger](#), National President, Institute of Public Administration

Thanks, Julie. I've spoken at a number of forums about the challenges for Australia's health system and the case for some systemic reform, including a proposal that the Australian government should take full financial responsibility for the system as a precondition for longer term and affordable improvements.

In summary, as set out in this table, and this is a couple of years old, but the data since then is pretty much supportive of it, we do have a pretty good system. We've got universal access to services, generally excellent health outcomes in terms of life expectancy and healthy life expectancy, and while costs are rising, they're only marginally above the OECD average. But our most serious blot concerns Indigenous health, where life expectancy is 17 years less than for other Australians, which is a larger gap than you will see between Indigenous and non-Indigenous peoples in New Zealand, Canada or the US.

We're also facing challenges to deliver services in rural and remote regions, but I'm not aware of direct evidence that the problems we face are significantly greater or that we are managing them more poorly than other nations with long distances and remote communities, such as Canada.

But I want to return to this because I think while we haven't got evidence of that, I suspect some of the structure of our health system does exacerbate the problems of health service delivery in rural and remote areas in Australia that wouldn't exist in a place like Canada.

Apart from Indigenous health, interestingly, the major national challenge we now face is in large part a consequence of our success. I put this table, and I've used this in a few places, it's a fascinating picture. Basically it's just a straight mortality table. If we look at 1907 compared to 1970 and life expectancy, the major improvements are nearly all to do with fewer people dying aged under 50 – many fewer are dying under age 50.

But if you look at what's happened since 1970 to now, the big changes are people who reach age 50 are living longer. We're still getting improvements and mortality rates for young people are dropping, but the big changes relate to mortality rates for those under 80 dropping. So, what's happening? We've got many more old people, frail aged people, we've got many more people with chronic illnesses, but who have survived the onset of heart disease or cancers or whatever.

Why is this important? Because our reliance on separate programs that ensure high quality but distinct services no longer delivers what an increasing number of patients need. They need continuity of care, seamless boundaries, a care management focus on them right across a system rather than a

management focus on the different types of providers—GPs or hospitals, specialists, community care providers, residential aged care providers—all in their own separate programs.

Moreover there is reason to believe that we're not getting the value for money that we could because the allocation of resources through these separate programs is unlikely to deliver the most effective allocation of resources between the programs.

Now, successive governments have been addressing these concerns through sensible—mostly sensible—incremental changes. And further incremental reforms undoubtedly will continue to help this. Some of the ones that have been happening in recent years are for example: quite a lot of work on enhanced primary care over the last decade or so, including in the bush and amongst Indigenous Australians, measures to broaden services for the mentally ill—the initiatives from last year, other initiatives over recent years for chronic disease management, and the steady improvement in community aged care services. These have all blurred some of the boundaries between the programs and provided a more supportive service focused on patients.

But until we address the underlying fragmentation of our system, where the program boundaries are reinforced by separate funding responsibilities, we will all fall short of what we could achieve and spend more money than necessary in the attempt to find a solution.

Some time, whether in the short term or in the longer term, I believe we need the Australian government to take full financial responsibility and to establish a framework where service providers in regions and communities are able to deliver integrated services focused on the patients in their communities.

Now, I don't rule out entirely an option of a pooled arrangement between the Commonwealth and the states, with a shared arrangement for the regional purchasing of services from those pooled funds. But my strong feeling is that a Commonwealth takeover would be simpler and more effective, at least in the longer term, given our history and the underlying forces demanding reform—"our history" meaning there has been a drift towards Commonwealth funding over the last 50 years, and there are underlying forces demanding a more national approach to many of the things we are dealing with, whether it be in the areas of workforce or other health industry type issues and communications or other issues.

Every large country faces additional challenges in delivering health or other services to rural and remote communities. Let me turn to that for a second. Distance itself restricts access, the costs of delivery are higher, and attracting and retaining skilled service providers is difficult. While technology is helping in some ways through improved communications and transport to large population centres with specialist services, those same influences are contributing to the population drift to capital cities and regional centres and to workforce problems in most remote areas.

Solutions require not only adequate remuneration for service providers, but career employment opportunities for spouses and non-wage benefits that compensate for such problems as limited schools and other social and business services. Moreover, advances in medical technology and the demand for high-quality and safe treatment present a dilemma. What trade-off would remote communities themselves accept between local access and safety and quality?

What is evident in remote and rural communities is their greater reliance on a flexible and integrated approach that essentially ignores program boundaries and centrally determined administrative rules to get the most from the resources they have. More limited access to specialist services also demands an even wider role for primary care than in the cities, whether through breaking into traditional specialist areas or through drawing on non-medical professionals to deliver care.

As with the broader health system, there have been many useful incremental reforms that have improved services in many communities. The Commonwealth has introduced a range of incentives to attract and retain general practitioners in rural and regional Australia both through direct monetary rewards and through the conditions placed on many of the increased places for GP training.



States and local governments have frequently complemented these by tailored packages involving, for example, housing and education support. The Commonwealth has also introduced more generous and flexible arrangements for funding primary care services in rural areas, and in co-operation with the states has established many multi-purpose health services – that’s an old term – giving a new lease of life to some rural hospitals no longer able to provide specialist care. These services include both primary care and aged and community care. The More Allied Health Services Program is another example of a recent initiative aimed at offering more flexibility to fund a wider range of services in rural areas.

But despite the improvements such initiatives have certainly delivered, or at least ameliorating some of the problems associated with the population drift, the boundary problems evident in the wider health system can be particularly counter-productive in smaller communities if they’re not able to bust across those boundaries.

The typical country hospital relies heavily on local GPs as well as its own staff, and artificial constraints to avoid spending beyond program boundaries are not only more obvious but are also more directly frustrating. Similarly, of course, artificial boundaries limiting the role of nurse practitioners and other allied health professionals are also more obvious and frustrating in country areas.

While some of the Commonwealth initiatives involve considerable flexibility at the local level for local service providers to manage, others involve centrally determined rules and entitlements, and those centrally determined rules and entitlements inevitably lead either to over-generous or to inadequate support or to inappropriate support.

And there is a question of the total resources available. At present no-one produces comprehensive or reliable data on health and aged care spending on the services delivered to a population from wherever that service is located. Nevertheless it’s probably safe to say that lower MBS and PBS spending on rural and remote Australians reflects lower total health and aged care spending relative to their health needs, in large part because of fewer health care providers – fewer doctors or nurses, pharmacists, allied health professionals are in those areas.

Certainly there is evidence that Indigenous communities receive primary health care funding below the national average and well below the average for people with similar health needs, particularly taking into account the additional costs of delivery. Again some action has been taken to address this concern, but far more is needed. The fact that spending by the states on Indigenous people mostly via hospital services is over twice the per capita rate for other Australians partly reflects our under-investment in primary care services.

So let me turn to my suggested change proposals and how they might affect rural and remote Australia. As I said, while incremental reforms are delivering benefits and most are heading in the right direction, I believe it is time to consider systemic reform. If this does no more than clarify the direction for more incremental reform, it may avoid the adhocery that incremental reform can represent, and make future systemic reform easier.

This diagram – it’s a bit messy – summarises the model. Let me go through it just very quickly. Some of you have seen it before but a lot of you probably haven’t. The three columns here represent the funder responsibilities, the purchaser responsibilities and the provider responsibilities. The three rows represent national responsibilities, regional responsibilities and local and community-level responsibilities.

So the funder is up here. Having the funder responsibilities at the national level is what I am suggesting, but then relying very heavily on purchaser responsibilities. Some of these would be national but most of them would be at the regional level. And the provider responsibility would be primarily at the local level, but there would be some regional and some national providers.

The issue I want to make clear in this model is that it’s not everything run by Canberra. For this to work you’d need to have a balance between the national setting of policy and money and the regional arrangements which would actually have the purchasing responsibilities and ability to cross all the

program boundaries. So it's the regional and community level that balances the national one, or that's the focus of this model.

The system, as I said, would not be managed entirely from Canberra, but would have these regional purchasers with the responsibility and flexibility to purchase a mix of services most appropriate to the region. They'd be required to work closely with local community leaders and providers, such as GP divisions. They would however work within a policy framework established nationally. Geographically large regions would have to have some sub-regional planning structures and associated flexibility to allocate resources within the local area.

The potential benefits of such an arrangement are probably clearer for rural and remote communities than for urban communities.

Firstly, there would be transparency over the allocation of resources across regions and the ability to highlight regions receiving significantly less than their population needs to serve relative to other regions.

Secondly, there would be greater flexibility to find local solutions to regional problems, blurring the current boundaries in particular between hospitals, general practice and other forms of primary health care, and between medical services and aged care services.

Thirdly, there would be room for informed choice by communities about services to be provided locally and those to be accessed from specialist providers outside the area, making the trade-off, for example, between access and quality.

The model I propose would take some time to implement, and there are many details open to debate and refinement. Moreover, there will be costs and risks in the transition. Accordingly, it is sensible to keep pursuing incremental changes in parallel with exploring the systemic change options. But those incremental changes must be in the right direction. So here are a few that I'd be pressing hard at the moment.

Firstly, the AIHW could prepare independent regional health reports identifying population health, service utilisation and total government spending to support regional co-operation and consultation and to inform governments and the public on the regional distribution of resources. If we had a common database for regions, you would get both better co-operation and planning internally, but you'd also get this picture across the regions that we desperately need.

The second one is to increase Australian government funding for primary care and preventative health. Now, the government has been doing that, but I would suggest that if we focus on providing some additional money for those regions with lower than average health spending relative to need, and that additional funding not be provided through MBS but in a very flexible way through some regional framework, you might get some basis for better co-operation and planning at the regional level.

Thirdly, to make a firm long-term commitment to steadily increase funding for primary care in Indigenous communities to finance services at the level available to other Australians with similar needs. We've been slowly moving in this direction, but if we set ourselves a 10 or 15-year objective to commit into the future, we would actually get a substantial improvement.

We should use that and, as I said – the additional primary care funding – to promote closer co-operation between the Commonwealth and the states in regional or primary health care planning in particular.

And to have the Commonwealth take over full financial responsibility for all non-acute aged care services. So we've already moved somewhere in that direction but we could go the rest of the distance on the aged care side very quickly. And to continue investing in integrated information systems that might support continuity of care across service providers.

I've also proposed elsewhere changes to the health care agreements and private health insurance arrangements. I know John Menadue spoke about his thoughts on this. I won't go into that because it's



not as relevant in the rural areas where there isn't as much of a role to play for private health arrangements.

Let me conclude. Obviously many aspects of my systemic change proposals are open to a lot of informed debate, and I'm not wedded to every detail, and many of the details are still to be worked through. I am also acutely aware that systemic reforms do not automatically reap tangible benefits, and they do always represent some risks.

To be successful they have to be complemented by practical measures that deliver early tangible benefits to priority clients and communities and they have to be well managed. Nonetheless I believe we should not be satisfied with incremental reforms alone, particularly if they smack of political adhocism rather than reflect a clear and coherent longer term strategy that might make systemic reform easier in the future.

Systemic reform along the lines I propose and incremental measures in that direction have the potential to be of particular benefit to rural and remote communities so long as the system genuinely allows greater flexibility at the regional and local level in response to regional and local requirements and so long as there is a more equitable share of resources across regions.

Thank you.

FACILITATOR: Ladies and gentlemen, I'm going to be inviting onto the stage in a moment Dr Paul Mara from Gundagai and also Susan Markwell from the Royal Flying Doctor Service. So if you guys could get ready to sprint. But just before Andrew takes his seat on our panel, the systemic reform you're calling for – we have a very large number of students in this room, but also the diagram was complex. What's the guts of it? Are you talking a big bag of money in Canberra and policy framework set in Canberra but with a lot of that money handed out at local and regional level but guided in policy terms from Canberra? Is that the guts of it?

ANDREW PODGER: That is the guts of it, but I'm not talking about turning the whole system upside down. I mean, already two-thirds of the government funding of health comes from Canberra, primarily through the MBS, PBS and the Health Care Agreements with the states. But that is through very strict national arrangements. I wouldn't be changing MBS and PBS, but there would be room for additional money which would be managed more discretely and flexibly at the regional level.

But you're right, that's the main issue. If I look at –

FACILITATOR: Just coming in there. So the big change would be the nature of the distribution of money that is currently done by all those debates between Commonwealth bureaucrats and state health bureaucrats, with all the states and territories. I mean, that's a huge process isn't it, where there's all this argy-bargy about how much money each state and territory health system gets from the Commonwealth, and then they get to put it out in their state. Is that where the change would come under your model?

ANDREW PODGER: Absolutely. I mean, the boundaries we have – every huge health system has boundaries, but our boundaries are made far worse by having different funders. Let me give an example – this was a few years ago. In the 1998 Health Care Agreements we tried to break down those boundaries by, in that agreement we said – the Commonwealth – we, the Commonwealth, said to the states, why don't we have what we call 'measure and share'. If there's an obvious boundary problem between the hospital and the care outside the hospital, let's agree on looking at it and sharing the issue. 'Measure and share', we called it.

And I thought we were going to address a whole range of things. It took us five years to agree with one state on the one issue of handling prescriptions for patients on discharge. I couldn't believe that we took that long because of the boundary problem and the concerns about whether this was going to be cost shifting by the Commonwealth, or further cost shifting by the states. We just couldn't get our act together.

It seems to me that that was a very good example of the continuing problems. We get a bit of co-operation between the Commonwealth and states, and then there's political misgivings and distrust and we go back to square one.

FACILITATOR: And just to explain that, and tell me if I've got this wrong. You were talking about prescriptions for drugs. So, if you're in hospital and you're sick and you're getting pills while you're in the hospital, that's coming out of the state government's budget. But once you go outside and go to the singing pharmacist in Wagga Wagga with a prescription, that's paid for by the Commonwealth?

ANDREW PODGER: That's right. And so it's to the benefit of the state to say, "We're going to limit the prescriptions, the medicines we're going to give you when you're discharged, and tell you, that's your business, you go to the local doctor, who's under the MBS paid by the Commonwealth, and he will write a prescription." Then you got to the pharmacist for a medicine subsidised by the Commonwealth. So the whole system is actually costing more, but it is not focused around the patient's needs. So the system costs a lot more and that's what happens. But it took us five years to negotiate agreement with one state to sort that one minor issue out.

FACILITATOR: So, what dead set is the chance of a structural reform of the size you're talking about, if it took five years to stop elderly people being discharged on a Sunday with not enough pills till Monday?

ANDREW PODGER: Well, I think this is an issue where the politics of it are the key. That is, if the Australian population says, "Look, we're sick of this arrangement", we could actually do it. I've set out not just a model, I've actually set out ways in which you could bring it about. The main issue is not – is a re-thinking of the GST deal where the Commonwealth would get back from the states some of the GST money in exchange for it having the full responsibility, and it would be responsible there for the funding of the hospital system. You would still have state bureaucrats transferred to the Commonwealth to manage a lot of that, and you would do it in the sort of regional frameworks that a lot of the states do it.

So, you're not totally turning the system upside down. The main issue is you're simply transferring the financial responsibility to a higher level. It is much easier to negotiate a high-level finance agreement than thousands upon thousands of little agreements at every regional and community level.

FACILITATOR: Andrew, could you take a seat on my panel. And a round of applause, please.

Presenter

Andrew Podger AO is National President of the Institute of Public Administration Australia and Adjunct Professor in public administration at both the ANU and Griffith University. He is also a consultant on health policy and public sector governance.

Before his retirement from the Australian Public Service in 2005, he chaired a task force for the Prime Minister on the delivery of health services in Australia.

Prior to that, he was the Public Service Commissioner for three years following six years as Secretary to the Department of Health and Aged Care. He has also headed the Departments of Housing and Regional Development and Administrative Services.

Originally a mathematician, Andrew has had a long career in social policy and financial management. Apart from the Public Service Commission and the departments he has headed, he has worked in the departments of Finance, Prime Minister and Cabinet, Social Security and Defence and the Australian Bureau of Statistics.

