HEALTH: AN ‘AWFUL’ DEBATE (2011)

In February 2011, I was invited to deliver the Malcolm Schonell Memorial Lecture at St George Hospital in Sydney. I chose to speak about the poor nature of what passed for a debate on health issues in Australia. It repeated my concerns that people were being disadvantaged because the debate was so poor. I felt, as a philosophical liberal, that this was preventing informed discussion and entrenching inequality.

Malcolm Schonell is the special person after whom this presentation is named. Many of you would remember him well. But, strange to say, so do I from a previous life. He is remembered because he was such a fine clinician and teacher.

Malcolm Schonell was born in 1934 in London, England. He died suddenly, far too young, at Somerset on Cape York on 15 July 1999. During World War II, he was evacuated to Wales when his home was bombed in the Blitz. His father was a professor of education who became vice-chancellor of the University of Queensland. His mother was a distinguished educational psychologist.

In 1950, the Schonells migrated to Australia and Malcolm finished his secondary schooling at Geelong Grammar School before going to study medicine at the University of Queensland, from where he graduated in 1958. He gained a membership of the Royal College of Physicians of Edinburgh and a Doctorate in Medicine from the University of New South Wales. When my cohort went to England, just a year later, we all eschewed the London and Edinburgh memberships—a generational change. He was ahead of that change and the Edinburgh Membership was rightly valued, and demonstrated to the world that he was a trained physician.
Malcolm was senior lecturer and then associate professor in medicine at the University of New South Wales, working at this hospital establishing an absolutely first-class clinical school. He published a successful textbook of respiratory medicine in 1974. He met his beloved wife, Margaret, on a zoology expedition on Stradbroke Island near Brisbane. His sister regarded Margaret fondly as the sister she did not have until Margaret arrived.

One of my friends reported that the world was made up of healers and warriors. Malcolm Schonell was a healer, and an enabler. A college document records that he had a good ‘listening ear’ and he was revered here as a clinician, as a colleague, and as a teacher. He was called the ‘ultimate encourager’ by one student and his skill was legendary. It is a great privilege to be here, with his colleagues, to remember him and his fabled skill. To be allowed to give this address is an honour indeed.

It was made clear that the remarks today in this named lecture could be on any topic. Other grand rounds, of course, are different, and more like the grand rounds we all know, but this one is special and different. So, your permission was all that was needed for me to proceed. Let us consider the health debate first and then the so-called health reforms second.

The health debate in Australia is awful. For that matter, most public policy debates in Australia are awful.

The wrong language is used. Wrong choices are made. The real main problems are ignored. No courage is shown. There is too much spin and pandering to the popular press and to the shock jocks. Kerry O’Brien was the person from the media who asked really penetrating questions and caused all politicians to be very careful and very fearful. Should not that be standard practice?

It is not that we do not have dedicated practitioners. We do. They work against the odds to look after their patients. But there is no morality in advocating tax cuts when there are hunger, homelessness and unmet need in so many areas. Did you know that dementia is emerging as the top illness in Australia and services are already inadequate to deal with it? In such a situation we do not need, or want, tax cuts. We want decent services and we are willing to pay for them.

To hell with focus groups as a substitute for leadership. Their use is to give us a snapshot of ‘what is’, ‘what people are thinking’, and not to act as a replacement for leadership. Let us have leaders who tell us something new and who lead us, who show us possible futures—who inspire us just as Anna Bligh inspired us in the Queensland flood crisis. It is as if political leaders do not understand, or do not care, about the very real problems you face every day in your work in this fine hospital. You all know the phrase, ‘Of course I must follow them, I am their
leader’. Our political leaders do not lead; they follow. Not only are the debates awful, but also the Federal Government is awful and the Federal Opposition is worse as regards vision and purpose.

But let us look at the health debate and at health specifically. People sometimes wait too long for admission to hospital, people are sometimes discharged from hospital prematurely, common conditions are often despised in teaching hospitals, there is not enough money, morale is low in the sector, there are not enough trained people, and the public system is not always the employer of choice. That is just for starters.

Now some doctors are better and some doctors are not so good, and some nurses are better than others and so, part of what happens to people might reflect personal factors, but the system is also no good. Doctors see problems naturally enough in terms of the needs of the patients they interact with every day. That is how doctors are trained. So there is nothing surprising about the viewpoint they bring to the table. But they are rather Ptolemaic, seeing their needs and those of their patients as the centre of the universe, with other things rotating around.

Medical practitioners often seem to have blinkers on. They show too little understanding of the resource implications of what they propose. Additionally, they often display what has been called ‘the technological imperative’, which can be stated as, ‘if something can be done, it should be done’; or, ‘if it is done elsewhere, it ought to be done here and done now’. One suspects that some medicos would want all of GDP spent on their area. And, if not all, one wonders what percentage of GDP would satisfy them. They generally will not say.

And what medicos propose usually ignores other realities, for example:

1. other legitimate needs such as housing, education, refugee policy, foreign affairs, road and bridge building, pension levels, social services, river health, flood relief and so many other things in different worthy, needy areas
2. levels of taxation
3. current politics.

And, because the representative medical associations sometimes behave like militant trade unions and nothing more—painters and dockers in white coats, waving shrouds—no-one acts entirely on what comes out of the profession (although no political leader wants every surgery across the country to be a centre of adverse comment).

The bureaucrats, on the other hand, are often obsessed with process and not with outcomes. They look at how things are done, at the details and the language used, instead of looking at the outcomes achieved. They do what political leaders
tell them to do—and that is sometimes wrong from the politicians; that is not the fault of bureaucrats, of course. They are very aware of the power games that go on in Canberra and Macquarie Street and they play in those games. Sir Humphrey Appleby is alive and well in the public services here. For bureaucrats, one has to achieve a budget balance whatever the social effects of doing that. They would actually be comfortable with appalling social outcomes if their bureaucratic needs were met. So they do not have it right either.

But let me say something in their defence. If we want numbers (for example, the length of waiting times in emergency departments or the size of surgical waiting lists), we might need a bureaucrat to do some of that measurement and collation for us.

Neither do health funds get it right. Neither do other professional organisations. Neither do political leaders. Political leaders have not served us well for decades, making silly promises—particularly in the health area—mostly close to elections, and expecting people like us to deliver on those promises. But they were always silly promises. We were not party to them being made. In fact, one prime minister made a silly announcement in the health area when worse for liquor, just a few miles from here. We, who had no part in the announcements, were just expected to deliver what other people promised.

The promises often had nasty implications for our capacity to deliver something else we valued or wanted. For there are opportunity costs involved in any promise and the Minister for Health might be instructed by Cabinet colleagues to incorporate the silly promises into the existing departmental budget, with no increase to meet those promises. Luckily, most often the promises are considered as ‘extras’ to the budget. So if that happens something else has to go.

Some initiatives just skew the system in awful ways. An example is the spending on pharmaceuticals that was taking an increasing percentage of the cash and limiting what was possible in other areas. We only became really knowledgeable about the exact amounts in the months following any accounting period, but Treasury knew the approximate amounts and did not let us forget them.

Some of our outcomes—length of life, maternal mortality, child mortality, infant mortality—are very good by international standards and are achieved with only average expenditure. There are many good features—very good features—about what we do have, particularly our universal insurance arrangements, which were introduced only after a joint sitting of the Parliament, and over the angry protests of the AMA [Australian Medical Association], the then Federal Opposition and the medical profession.
But we in Australia do not have as perfect a system as we sometimes think. In a recent study conducted by the Commonwealth Fund and involving 11 nations, Australia did poorly. We were the fourth-worst ranked nation on the numbers of people who do not see a medico when they are sick. We were the third-worst ranked nation in the numbers who do not fill prescriptions or who skip doses; we ranked second worst in the numbers who skip tests or follow-up; we ranked third worst in the numbers who pay more than US$1,000 for their care in one year and a larger percentage (55 per cent) of Australian respondents reported difficulties in accessing after hours care—we were the fifth worst there. The most devastating statistic was that 75 per cent—the highest percentage of the nations surveyed—said that Australia's system needed fundamental changes.

A 2008 Commonwealth Fund study found that over a third (36 per cent) of Australians with chronic conditions reported problems with accessing health care, a higher percentage than any other of seven countries except the United States. So we should not be complacent about our system now.

Added to that we have in Australia a continuing scandal that has black Australians living 20 years less than white Australians and with worse levels of almost everything that can be measured. By the way, if we advocate equality of resources according to need then extra resources should go to black Australia today.

If we want a better system, we need to get this awful debate back on track. To do this, we need urgently, among other things, an honest debate about rationing in the health system. Such an honest debate is not sufficient to fix the whole problem, but it is a necessary element in any repair. Rationing exists and coherent rationing is essential if the system is to survive and if the system is to have the capacity to introduce anything new.

We do not have an honest debate about rationing now. No-one talks openly of what we can and cannot do, what we will and will not pay for, and essential rationing decisions are made ‘off stage’ by people the general public (the payers) might not select and away from the people who bear the effects of the decisions. For example, a decision that only so many hip joints will be made available to orthopods in any month rations the number of hip replacements any hospital can do, or the Victorian decision a few years ago that uncomplicated cataract removals could not be paid for in public hospitals was a rationing decision. Queues are a form of rationing. The non-availability of beds is a form of rationing. Waiting times in emergency departments or for tests are forms of rationing. Limitations on operating time are a form of rationing. And so on.
They tried to address rationing in Oregon but we can do better than they did. In Oregon they just got the vested interest groups pushing their own barrows. There are other approaches. In some other jurisdictions they empanelled citizen juries who then listened to learned counsel arguing for or against certain interventions, after which they voted like juries do between alternative initiatives. A much better idea.

One problem is that there are necessary, unpopular interventions—things like treatment of drug addicts, or the care of people afflicted with HIV/AIDS, or measures to prevent unnecessary hepatitis C infection, or much mental health expenditure, that people do not want to vote for, but which a compassionate society should provide. But until we address rationing people will expect a Rolls Royce system and will not be happy to receive a Holden instead.

At the end of the day, some publicly funded procedures will have to go or be limited in number, so that other procedures can be accommodated or introduced—rational rationing. And as our clientele becomes older we might have to consider withdrawing public funding for some procedures at certain ages. For example, we might decide to withdraw public funding for certain cardiac procedures at (say) the age of 75. There are many more examples. A friend was told that if he had been two years older, his cardiac valve replacement would not have been done. So age-related procedure withdrawal already exists. This approach might outrage some people, but it frees resources to treat others—to do hernias and cataracts and prostates and varicose veins and provide good quality palliative care for more people, for example. We cannot do everything possible for everyone. The sooner that unpleasant reality becomes part of the public discourse, the sooner we decide what we will do, and for whom we will do it, and what we will not do, and for whom we will not do it, the better off we will be. People might still want more than we will pay for—if so they can pay themselves or they can take an airplane to America.

We provide a public subsidy. We do not provide everything. There is no ‘right’ involved. There is another fallacy that might be discussed here. Some initiatives, for example, ‘hospital in the home’, or community-based palliative care, or more money for prevention, have benefits for the whole society but at an additional cost. They would keep some people from needing to go into expensive hospital beds at all. Then other people could occupy those beds. But while beds remain the same number and remain full, there are no cost savings from any new initiatives. People, sometimes medically trained people, say there are cost savings. They are wrong. Society would be better off but at extra total cost to the budget. It takes Treasury officers about 15 seconds to demolish that argument.
The way to save money is to close beds. Many sector workers do not understand this. They do not understand Treasury thinking. It is like a bridge with people on one side speaking French and people on the other side speaking Hungarian. Communication is poor. Almost non-existent. And our future survival depends on finding people who can understand both languages so that there can be some real communication across the bridge.

Now let us look at the so-called health reforms that are upon us. Let us look at famous hospitals like this one. They are staffed with good clinicians, doctors, nurses, allied health professionals (especially those who attend grand rounds), who are just trying to help sick and suffering people and who are staying up-to-date so that they can do it better.

And the money to run hospitals comes from several sources. It comes, as to the majority of the money, from the Commonwealth, and from the state—the dual government provision of hospital funding has been a problem recognised for at least 40 years. The money also comes, in lesser amounts, from other sources like the health funds and private pockets. What was said about rationing might mean that an extra amount might have to come from private pockets.

And there is not enough money overall. Actually you cannot promise a Rolls Royce and then provide a Holden and then say that you are surprised that expectations cannot be met. Those who have only enough resources to provide a Holden cannot satisfy those who have been promised a Rolls Royce by people who should know better.

The current system is characterised by:

1. Big deficits in most hospitals. Those at area levels responsible for budgets are tearing their hair out at the deficits and their size. You see, community expectations and available money do not match.
2. A ‘blame game’ in which each level of government blames the other for deficiencies and shortfalls.
3. Cost-shifting as each level of government tries to shift costs to the other level. It is sometimes obscene—and funny. Did you know, for example, that one state once tried to put all its ambulance service under hospital control and thus get the Commonwealth to pick up part of the tab for its ambulances?
4. A shortage of trained staff. You know all about this. You know how impossible it is when someone on annual leave or prolonged maternity leave is not replaced and yet you are expected to deliver just the same standards of service. Not only that, when you do get permission to advertise the job, often some months later, there are often too few applicants, particularly suitable applicants. Not only that, but sometimes new staff can be obtained only by poaching staff from someone else—the recruitment of overseas nurses and
other clinicians comes to mind as one form of poaching, as does the story of
the new radiotherapy unit at Wagga Wagga that was staffed only by poaching
staff from a unit in nearby Canberra.

That tells me that opening new facilities is not going to solve the problems. For a
start, we do not have enough doctors or nurses or therapists or physicians to
service new facilities. Cost-shifting games are played with deadly seriousness
and are played hard. A premier once told me that his job was 'to take the socks
off the Commonwealth' at every opportunity. Nothing about desirable social
objectives. All about money.

Prime Minister Rudd talked a lot about health in 2009. Let us summarise what
Kevin Rudd promised us when he was prime minister. You recall that he pushed
for hospital reform, that he spoke of it, that he appointed a special commission
to go into it, that he made an announcement in March 2010, that he called the
states together in a Council of Australian Governments meeting, and that he
bullied everyone until a package emerged in April 2010. And that package was
taken to a subsequent election by Julia Gillard, who won the election.

Now Julia Gillard has changed it again. There will be no GST clawback.
There will be only 50 per cent funding from the Commonwealth—eventually.
A national pool will be established. There is some talk of an extra $16.5 billion—but
details are sketchy. She has abandoned a Rudd promise to fund 100 per
cent of primary care in hospitals. In fact all details are to be worked out mid-
year. We are entitled to be confused and a little sceptical. There is already a
43 per cent Commonwealth contribution, so the new offer is not worth much.

The details are all-important. Only if the detailed promises are any good will
health care be any better. The process started by Kevin Rudd would have had
to involve reform of primary care eventually to include a greater emphasis
on prevention; you know that a prevention focus offers big gains for little
expenditure—just think of obesity and smoking and alcohol.

So now we are seeing:

1. Local health networks replacing the eight baronies that we were used to.
   There used to be 17 areas so it is 'back to the future' in some ways. By the way,
   Kevin Rudd and Julia Gillard spoke of local hospital networks, whereas this
   state has established local health networks—a subtle difference in terms—
   which inter alia keep real control with the state and away from local boards.

2. New funding arrangements where:
   a. all money will go into a proposed national pool
   b. the Commonwealth will be responsible for payment of 50 per cent of
      agreed costs of hospitals instead of 43 per cent at present.
Going back to the speeches that were made when the whole thing was announced and after the Council of Australian Governments meetings that led to the agreements, we learn that the first was touted as a ‘landmark plan to seize control of the ailing hospital system’, that the Commonwealth would become the majority funding agency of hospitals and that the Commonwealth would provide 100 per cent of the agreed costs of GP primary care in outpatient clinics.

There was a statement that it would end the blame game, and that it would eliminate waste, and that it would provide a basis for dealing with rapidly rising health costs. Macho words! Hair on the chest! But it is not so. The claims are wrong.

Rifts did appear—and quickly too. For example, the ACT Government considered that the agreement would be based on state and territory borders. Kevin Rudd, for his part, thought it logical (as would most people looking at a map) that the Canberra hospital, the Queanbeyan hospital and the Yass hospital should be one ‘natural’ administrative unit. So that was one disagreement; the ACT Government showed no inclination to take on the management of the neighbouring New South Wales hospitals, different Commonwealth subventions notwithstanding.

Before we look at the likely effects of the changes, just remember that real reform would come only if one level of government had, and took, total funding responsibility, and just remember that the promise is of 50 per cent Commonwealth funding rather than 100 per cent funding.

And let us relate my prognostications to the world you know and work in. We can predict that the move to local health networks will have mixed effects—few benefits and many problems. Yes—in theory administration will be closer to you, and more responsive to your local needs, but not much, there will still be an inadequacy of resources and real control will still be exercised from the Department of Health in North Sydney.

Then there are some functions that are greater than a small health area can provide for—medical research, for example—and it is likely that all players will want someone else to be responsible for that. Another matter that a local area board cannot handle well is the provision of super-specialised services like some transplant surgery. That could only happen at some hypothetical hospital, for instance, at the expense of something else or if extra money was provided, and then only in a limited number of selected places in the state.

So the so-called reforms will not likely mean any of you will be able to introduce anything new. Anyway the state has appointed three super-administrators—a new level of bureaucracy—so that the Health Department in
North Sydney will still be in charge in actuality. By the way, does it not smack of 1984 and Orwellian double-speak that anyone speaks of a health department when the business is largely related to sickness?

With all that said, let us look at some of the effects of the so-called reforms. First, there will be no end to cost-shifting. The state will still be responsible for up to 50 per cent of agreed costs and the imperatives to cost-shift will be almost as great as ever. Secondly, there will be no end to the blame game. The Commonwealth will say that state and territory systems are not good enough, not robust enough, not efficient enough; the states and territories will deny this and say that the Commonwealth is heartless, is bleeding them dry, and does not understand.

What should happen of course is that all funding and all control should be from one level of government.

You might know about Willie Sutton. The story is that he was on the FBI list of the 10 most wanted men. Anyway he was a noted bank robber who spent half of his adult life in prison. Someone asked him why he robbed banks and he is said (incorrectly) to have responded that he robbed them because they were where the money was.

Now you might also know that the states and territories gave up their taxing powers in 1942 in the darkest days of World War II and have never got them back. Before that we received a separate tax notice from the state—rather like the rate notices we receive from local government today. At the same time as they surrendered their taxing powers, the states and territories kept their constitutional responsibility for the health system—but without much money to run it. So the whole shebang, the constitutional responsibility added to the financial powers that the Commonwealth already has, should go across to the Commonwealth. (That was spoken like a ‘Fed’.) That would end cost-shifting. It would end the ‘blame game’.

But until that happens, ladies and gentlemen, do not expect the so-called health reforms to deliver anything much. Waiting times will be just as long in good emergency departments. Surgical waiting lists will be just as long. The ‘blame game’ will not end. Cost-shifting will not end. The new so-called reforms will not make your busy lives any different or any better. They will not make 2011 a better year for you.

And you do deserve better. The work you do is important and needed and appreciated. Not only do you treat the sick. Not only are you the flagship for an important geographical area that plays good rugby league too, but you prepare the next generation of doctors. The current arrangements are not good enough to support you now. The current debate is bad and ill-focused. And both will
become increasingly inappropriate as time passes, especially if they are not changed substantially and quickly. And most Australians want a better system. You are exemplars on whom future generations of medicos will base their practice. Good luck in your important work. We are in your debt just as we all are in the debt of people like Malcolm Schonell, who we remember today.
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