

Policy challenges for the Australian health care system

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Abstract

In contrast to the regular media reports decrying the so-called crisis in the health system, a number of academic commentators have identified areas in which the Australian health care system could improve. George Palmer has been one of those, and over the years has published a body of work identifying areas for improvement. This paper reviews the performance of the Australian health care system against the criteria of equity, efficiency and acceptability, and explicates the contemporary problem areas associated with each criterion.

Introduction

The media regularly report various commentators decrying the so-called crisis in the health care system or outlining a particular problem of the health care system which, unless remedied, is alleged will lead to the end of western civilisation as we know it. Normally, the commentator also has a set of nostrums which will prove to be the panacea for the health care system. Of late, the most common crisis is alleged to be the decline of health insurance beneath some magical floor below which Medicare is not sustainable. Those who have identified this problem normally see the solution as being to reduce the price of health insurance through public subsidy. Interestingly, many who advocate public subsidies for health insurance are those who decry any other form of public expenditure, tax expenditure being exempt from their normal criticisms.

In contrast to these populist ramblings, there are a number of academic commentators who have identified areas in which the Australian health care system could improve. George Palmer has been one of those, and over the years has published a body of work which has identified areas for improvement in the Australian health care system (for example, Palmer 1996). Palmer's lists, unlike the scaremongers in the prominent press, reflect a more analytical approach and eschew fashionable ephemera and the self-serving calls for increased subsidies to private insurance. Typically, Palmer's lists focus on Commonwealth–State relations, improving measurement and efficiency, and specific areas for health system change.

In this paper I will evaluate aspects of the Australian health care system to provide an overview of the contemporary problems in the system. The first step in doing so is to propose a framework for describing or evaluating a health care system. One of the early frameworks was that proposed by the American Public Health Association (Myers 1965), which proposed evaluating health care systems in terms of accessibility, quality, continuity and efficiency. Aday et al. (1998), in a more contemporary approach, have suggested three main criteria: equity, efficiency and effectiveness. My preferred framework unfortunately is not alphabetically homogeneous, as at the system level I suggest we should evaluate in terms of equity, efficiency and acceptability. You will note that quality has not been proposed as a criterion at the system level. This is partly because efficiency and quality are inextricably linked in the concept of allocative efficiency. It also helps to confound economic rationalists who like to concentrate on a narrow definition of efficiency, synonymous with technical efficiency. In this paper I will review the performance of the Australian health care system against each of these criteria and explicate the contemporary problem areas associated with each criterion.

Equity

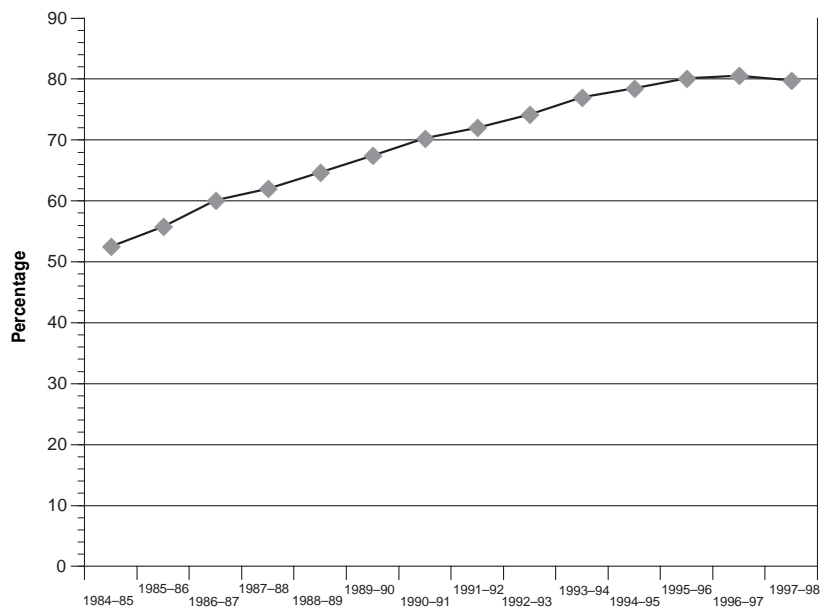
The quest for equity has been a major issue in the Australian health care system over the course of George Palmer's academic career. There are two elements of equity to be addressed: equity of access and equity of outcomes.

Equity of access

The most significant development in terms of equity of access was obviously Scotton and Deeble's work on proposals for introducing universal health insurance to address financial barriers to access (Scotton & Macdonald 1993). Their work led to the introduction of Medibank in 1975 and Medicare in 1984. Importantly, there is now bipartisan agreement on the importance of ensuring universal access through addressing financial barriers to access in the health care system. Under Medicare, access to public hospitals is available without financial barriers. Access to general practitioner services is now available without significant financial barriers, as demonstrated by the fairly high level of bulk billing (see Figure 1), although levels of bulk billing are lower in rural areas.

An important aspect of financial barriers is the differential access to timely care. Although Baume (1995) has demonstrated that there are significant waiting times in gaining access to private surgeons, the key issue in this area remains waiting times for elective surgery in public hospitals. This is despite a significant reduction in waiting times for the most urgent surgery in Victoria and other States (Street & Duckett 1996).

The record in terms of other dimensions of equity is not good. In terms of geographic equity, there are significant differences in access to health care (both primary care and hospital care) between urban and rural areas. Identification of the nature of the problem here is complex, as geographic equity is usually described relatively, for example, there are fewer doctors per 1000 population in rural Australia relative to urban areas.



Source: Commonwealth Department of Health and Aged Care 1999.

Figure 1: Percentage of general practitioner attendances bulk billed

Table 1 shows trends in general practitioner to population ratios in urban and rural areas in Australia. There has been a significant increase in general practitioner provision in both metropolitan and rural areas, but there is still a higher ratio in capital cities relative to rural and remote areas. What is remarkable about this is that, although there is a significant focus of policy attention on access in rural areas, the contemporary level of rural access is above the metropolitan level in 1984–85.

Table 1: Full-time equivalent general practitioners per 100 000 population, by region, 1984–85 to 1996–97

	1984–85	1994–95	1996–97	Percentage increase
Capital city	69.8	95.6	96.7	38.6
Large rural centres	65.5	81.7	83.3	27.3
Small rural centres	66.4	77.2	76.6	15.3
Remote centres	41.9	51.6	53.2	26.8
Australian average	65.8	86.6	87.5	33.0

Source: Australian Medical Workforce Advisory Committee and Australian Institute of Health & Welfare 1998.

Geographic barriers to access in metropolitan areas were not generally seen as a problem in 1984–85. However, because of the emphasis on *relativities*, there is now said to be a problem of access in rural areas. This is a complex area and further thought needs to be given to our measure of equity in this area. Whether or not there is a real problem of access, there is a perceived problem of access from the community perspective. Further, general practitioner provision in a number of small rural or remote towns is clearly inadequate (or, in some cases, non-existent), reflected in a contemporary general practitioner to population ratio about half that in capital cities and well below the 1984–85 capital city ratio. However, the solution to the problem of health care access in rural areas is not one of mindlessly increasing medical workforce supply, as this will not attract the requisite number of doctors. Rather, the solution must incorporate alternative methods of supply, such as use of nurse practitioners.

Access to hospital services in rural communities is also perceived to be a problem, partly because of the need to travel significant distances to gain access to specialist services. In a sense, this is almost inevitable as super-specialist services need to be concentrated to achieve economies of scale and expertise and are available in only a limited number in tertiary or quaternary hospitals. Even the infrastructure requirements for more generalist hospital services are increasing, leading to the concentration of hospitals in larger rural centres and the closure of smaller hospitals.

The third element of equity of access is the issue of racial barriers to access. The access issues here are much less clear. Although Deeble et al. (1998) have shown that health expenditure for indigenous populations is not too dissimilar from that for the non-indigenous population, given the differences in outcome discussed below, there may be a case for greater levels of expenditure.

Equity of outcomes

The picture in terms of equity of outcomes of care is much more mixed, partly because outcomes are affected not only by the quality of care that is provided but also by environmental factors. What we do know about equity of outcomes is one clear and stark fact: that the health status of our Aboriginal and Torres Strait Islander population is appalling and should be a major focus of policy attention. Clearly, the factors affecting the health status of the Aboriginal and Torres Strait Islander population are not going to be remedied only by actions in the health sector, as broader issues of dignity, identity and justice need to be taken into account as part of any strategy to improve the health status of indigenous Australians. One element of this is obviously the need for further progress on reconciliation (Jackson & Ward 1999).

In summary then, the key problem with respect to equity concerns the health status of indigenous Australians. A secondary equity issue relates to access in terms of waiting times for elective surgery in the public sector. There is also a problem of access to primary care in remote centres.

Efficiency

Efficiency, broadly defined, is the second of the key criteria for evaluating health care systems. From an economic perspective, a focus on efficiency requires attention to two main elements: allocative efficiency and dynamic efficiency.

Allocative efficiency

Allocative efficiency is concerned with ensuring the best allocation of resources in the health care system, so that the inputs allocated to the health care system yield the best possible outcomes. Achieving allocative efficiency pre-supposes that health care services are efficient in the everyday meaning of that term: that we have achieved the best possible ratio of inputs to outputs. Economists distinguish this element of allocative efficiency as technical or production efficiency. A second element of allocative efficiency is about optimising the ratio of outputs to outcomes, commonly referred to as effectiveness. The third element of allocative efficiency involves a focus on priority-setting in terms of the overall ratio of inputs to outcomes.

Technical efficiency

There has been significant improvement in technical efficiency in the health care sector over the last 20 years. A major focus of George Palmer's work, especially in recent years, has been on improving the measurement of the activity of the health care sector, for without the ability to measure activity it is almost impossible to demonstrate whether improvements in efficiency are either necessary or achievable. Palmer has made a unique contribution, both nationally and internationally, to the development of casemix measures for hospital services (Palmer et al. 1986; Palmer 1991). This analytical work on casemix measures, and ensuring that their design and construction were relevant in Australia, provided the underpinning for casemix funding, now used in most Australian States (Duckett 1998). Remarkable efficiency improvements have been achieved through the introduction of casemix funding, which commenced in Victoria in 1993 (Duckett 1995).

The complex interplay involved in Commonwealth–State relations in health are said to lead to technical inefficiency because of multiple reporting requirements. However, I doubt whether multiple reporting results in serious efficiency losses. A more important aspect of Commonwealth–State relations relates to cost-shifting: existing Commonwealth–State divisions of responsibility and other aspects of program design almost inevitably lead to cost-shifting as managers seek to address budget problems by transferring programs to readily accessible Commonwealth entitlement programs such as the Medicare Benefits Scheme (MBS) or Pharmaceutical Benefits Scheme. This allows managers' attention to be diverted from directly improving efficiency, with a possible overall loss of system efficiency.

There are also real problems of Commonwealth–State relations in terms of the political process and accountability. This dissipation of responsibility in the health sector means

that whenever State or Commonwealth politicians are under pressure, they almost inevitably attempt to shift blame to politicians at the other level (the so-called ‘blame game’). The dissipation of responsibility undermines the functioning of political accountability for government actions.

Effectiveness

The second key element of allocative efficiency relates to effectiveness. It is about ensuring that the ratio of outputs to outcomes is optimised. There are a number of elements to this, one of which is efficacy, the extent to which the outputs of the health care service lead to the ideal outcome under the best possible conditions (using a definition from Cochrane 1971). One of the key objects of policy is to ensure that *actual* effectiveness (in terms of the ratio of outputs to actual outcomes) moves closer to this ideal. It is also an object of policy to move the outcome frontier, that is, to improve the best possible (ideal) outcome. This latter task is a focus of medical and health services research.

Many factors affect the actual outcome (effectiveness) for an intervention or system, including the design of the care system, the environment into which a patient is discharged, the safety of the manufacturing devices and pharmaceuticals used, and the quality of care provided. Unfortunately, methods for measuring quality have not been subject to the same methodological advances as have occurred in measurement of efficiency. Important evidence was provided by the Quality in Australian Health Care Study, which reported significant levels of preventable adverse events occurring in hospitals, leading to significant adverse outcomes (Wilson et al. 1995). Detailed analysis of care following trauma suggests that a significant proportion of trauma deaths are preventable or potentially preventable (McDermott et al. 1996). Together, these studies suggest that there are important efficiency issues in the Australian health care system related to quality of care, although at this stage they might best be described in terms of our inability to demonstrate that high-quality care is being provided.

Another element of quality of care relates to system design issues and here possible poor quality arises because of weaknesses in continuity of care. There are two main factors which might impact on enhancing continuity: integration of acute and primary care services, and Commonwealth–State relations.

There is significant anecdotal evidence of poor coordination of acute and primary care services, principally described as poor discharge planning. Although it has been suggested that poor discharge planning has only occurred with the advent of casemix funding, anecdotes about poor discharge planning have circulated for decades. Continuity or coordination of care might be inhibited by our existing Commonwealth–State division of responsibility, which can place barriers in the way of efforts to ensure that care is provided in the most appropriate setting. There are probably many examples where additional expenditure in tightly constrained State programs would lead to improved efficiency for the same, or better, health outcomes from the whole system, compared with additional expenditure on Commonwealth entitlement programs such

as the MBS. Elimination of Commonwealth–State discontinuities, however, will not eradicate coordination problems: there are many anecdotes of poor coordination within institutions (especially large institutions such as teaching hospitals), and even unitary health systems, such as the United Kingdom National Health Service, have coordination problems (see Pritchard & Hughes 1995).

A further example of poor coordination is within the primary health and community services sector, where poor coordination of services inhibits provision of coordinated services to consumers who have multiple service needs. There are a number of factors which contribute to this poor coordination of services, including the multiple Commonwealth and State funding sources for primary health and community support programs. However, these Commonwealth–State issues are only one of the factors leading to poor coordination. Possibly more important are ideological differences in service orientation, for example, in terms of private versus not-for-profit provision, the most notable distinction here being private general practice versus publicly provided community nursing services and other non-medical services. Similarly, professional jealousies also inhibit coordination. The nature of the ideologies in the sector also encourage multiple ‘micro’ providers, especially in primary medical care where the average practice size in Australia is still quite small. These aspects of coordination probably have real, if unexplored, implications for the effectiveness of service delivery.

The Coordinated Care Trials represent one attempt to address service integration issues in the context of Australia’s complex Commonwealth–State health funding arrangements. Although the first results of these trials are not yet available, many promoters are already out and about suggesting that they should be expanded. There are two key elements of the trials: fund pooling and care planning. Fund pooling is extremely controversial and the benefits of this approach need to be weighed carefully against the costs, including the costs in terms of solidarity and the maintenance of Medicare as a universal health care system. Extension of systematic care planning, however, can bring significant benefits, albeit with some costs (Furlong 1997), and so can be supported.

Priority-setting

The third element of allocative efficiency relates to the issue of priority-setting, both in terms of priority-setting between diseases (for example, the appropriate relative emphasis on orthopaedic services versus cardiac services) and also within-disease choices (for example, in terms of preventive versus curative investments). Health economics and health services research (the two disciplines which underpin most of George Palmer’s research) have much to contribute in these areas. Segal and Richardson (1994), for example, have provided a framework for addressing within-disease choices. However, the experience of the most notable attempt to use economic analysis to assist in the area of between-disease choices, Oregon’s priority-setting experiment, does not auger well for those who advocate a simple application of cost-effectiveness analysis (Tengs et al. 1996).

Spending on prevention accounts for a relatively small proportion of health expenditure in Australia. This by itself does not necessarily imply that preventive services should be expanded. Before advocating any increase in expenditure (or increased relative expenditure) on prevention, we need to demonstrate that such expenditure will be cost-effective. The cost-effectiveness of preventive services has been subject to considerable academic debate (see Russell 1986, 1987), and simple-minded advocacy of increased prevention is not appropriate.

Another aspect of priority-setting relates to the balance of services, with an important issue here relating to funding of allied health care (*vis à vis* medical services) and natural therapies. When Scotton and Deeble were developing their policy on universal health insurance, the main focus of the health care system was doctors and hospitals. The health care system in Australia in the last year of the twentieth century is significantly different to what it was in the 1960s. There has been a notable increase in the role of allied health personnel, partly associated with the increased chronicity of the Australian population associated with ageing. The important role that allied health personnel play in rehabilitation services, and the change in the allied health workforce in terms of supply and skill levels, have also contributed to the increased importance of these disciplines in the health care system. Similarly, the Australian population is embracing natural therapies.

Our financing arrangements have not kept pace with these changes and so it may be that we are over-investing in services for which there is a Medicare rebate and under-investing in other more effective or cost-effective services. Certainly, there is evidence that poorer people have less access to some allied health services relative to those on higher incomes (Schofield 1999). To some extent the Coordinated Care Trials are trying to address this in the case of allied health, but there is no systematic investigation of policy on natural therapies. This issue of investment in non-medical services (allied health and natural therapies) seems to me to be a further problem area for the health care system.

The final aspect of priority-setting I will raise is whether we are over-investing in institutional care. Certainly, there is now abundant evidence that there is considerable variation in utilisation across Australia, and separation rates for many conditions vary considerably between local government areas (Richardson 1998), variations which cannot be explained in terms of demography or other clinical factors. The lack of utilisation review and analysis of the appropriateness of care allows continuation of this variability. The high level of variation of hospital separation rates is one of the underlying factors which provides supporting evidence for those who advocate moving to managed care in Australia. Although managed care is not the only policy response to variation in utilisation rates, variation in utilisation patterns is clearly a contemporary problem in the Australian health care system.

Dynamic efficiency

Dynamic efficiency refers to the extent to which the health care system as a whole, and its constituent elements, adapt to and embrace change.

The Australian health care system exhibits dynamic efficiency at the clinical level, that is, the system is relatively open to adopting new technologies (drugs, surgical and diagnostic) soon after their development. Although there is some criticism of the processes of our regulatory bodies which monitor safety and efficacy, on the one hand (for example, the Therapeutic Goods Administration), and cost-effectiveness (Pharmaceutical Benefits Advisory Committee and the Medical Service Advisory Committee), this is an inherent side-effect of attempting to slow the introduction of ineffective (or cost-ineffective) technologies. Overall, there is relatively speedy introduction of new technologies at the clinical level.

Our track record on system level change is not so good. There are relatively powerful interest groups in the health system (such as health insurers and the medical profession) who combined to delay for many years the introduction of universal health insurance and also some other essential reforms. Australia was one of the last countries in the western developed world to adopt a system of ensuring universal financing for health care, following the long and bitter struggle to introduce Medibank (Scotton & Macdonald 1993). It may be that this struggle over universal health insurance distracted the attention of policy-makers from other needed reforms.

It is still extraordinary, for example, that Australia does not have a comprehensive platform on which to build community-based health services. A brief flirtation with a national policy in this area, through the community health program initiated in the Whitlam years (with which George Palmer was associated in his role as a member of the National Hospitals and Health Services Commission), was soon undone in the Fraser years. This is still a major gap in the Australian health care system. So dynamic efficiency at the system level leaves much to be desired. Unlike the United States, there is relatively little culture in Australia of trials and experimentation in health policy innovation, the Coordinated Care Trials being the most notable counter example.

Acceptability

Along with equity and efficiency, a key criterion for evaluating health care systems is acceptability of the system from the perspective of patients, communities and providers.

Patient acceptability

Acceptability of the service to patients is principally measured by patients' experience of the health care system. There has been a burgeoning interest in this area in recent years in terms of understanding the factors which affect patient satisfaction, how to measure it, and how to improve it (Draper & Hill 1996). However, there are still no

nationally accepted measures of patient satisfaction, and policy use of patient satisfaction questionnaires is still subject to significant political overlays. Governments usually trumpet very high levels of overall patient satisfaction with hospital care, but the overall results mask significant differences between hospitals and very poor performance on some specific questions evaluating patient experience with the system.

Community acceptability

Blendon et al. (1990) have undertaken a number of cross-national surveys of overall community attitudes to health care systems. Their early work showed the United States stood out by having a very high proportion of the population who wanted to see their health care system 'completely rebuilt'. The Australian results in the 1988 survey showed only 17% of Australians in that category.

Results of a 1998 survey, however, show that the proportion of Australians who wanted a complete rebuild of the system has increased to 30% (Donelan et al. 1999). It is difficult to discern the reasons for this. Unlike the United States system, the Australian system provides for access to care at relatively low cost to consumers. However, health complaints bodies receive many complaints about the way in which consumers are treated in terms of dignity and communication when they interact with the health care system. Further, as outlined above, there are still significant access issues in terms of waiting times for public hospital care. These factors may be creating the perceived need for system reform.

A key element of the Australian health care system which contributes to the historically high level of acceptability relates to consumer choice. Australians have almost unlimited choice with respect to primary care provider and, in the case of primary medical care provider, this is heavily subsidised. This is unlike the situation in the United Kingdom, where consumers must sign up to a general practitioner's list and there are formalised procedures for transferring to another list. Similarly, in the United States, most managed care plans restrict consumer choice in terms of providers from whom consumers might seek care.

There are contemporary policy flirtations with managed care in Australia. It is easy to understand the attraction of managed care in the United States (where managed care might provide the way around political obstacles to increased access and reduced cost) and in developing countries (where managed care might provide increased access at relatively low cost). However, the Australian situation is quite different, as we are a moderate-cost provider of health care with high levels of access. Thus the driving force for managed care in Australia is not increased access but, principally, reduced cost. The trade-off then is between reduced choice and reduced social cost, and this trade-off may not be acceptable to consumers and voters. (It is sometimes argued that managed care might be seen to increase quality but, given the very poor measurement of quality in Australia, it is difficult to see how this will be demonstrated to consumers.)

Provider acceptability

The Australian health care system is vulnerable to major change if providers can persuade the public and political parties that it is failing. The most notable success in this regard was the campaign by the medical profession (and the health insurance funds) to destabilise Medibank and facilitate its dismantling under the Fraser Government in the late 1970s. Obviously, the interests of providers are not necessarily coincident with the interests of consumers (Duckett 1984), and it is important that policy not be driven solely by provider acceptability. However, provider acceptability obviously affects the system and, to some extent, affects the extent to which it is able to achieve dynamic efficiency.

Antediluvian elements of the medical profession still rail against universal health insurance. However, the mutterings of the medical profession should not be dismissed, as health professionals often have a high level of personal commitment to providing high-quality care and a clear understanding of the effects of various reforms. What is important, however, is that we disentangle the financial self-interest of the providers from the interests of consumers and the system as a whole.

Evaluating the Australian health care system in terms of equity, efficiency and acceptability has led to the identification of a number of outstanding problems to be addressed:

- waiting times for elective surgery in public hospitals
- access to primary care in remote centres
- health status of Australia's Aboriginal and Torres Strait Islander population
- the inability to demonstrate that high-quality care is being provided
- the level of investment in non-medical services such as allied health and natural therapies
- variation in utilisation rates
- dynamic efficiency, including lack of policy experimentation at the system level
- the absence of a universal infrastructure of non-medical primary care services
- aspects of Commonwealth–State relations, including dissipation of responsibility; program boundaries inhibiting allocative efficiency; and system complexity leading to failure to address the problems listed above.

Non-problems

It is important to highlight what is missing here compared with typical lists.

Health cost escalation is not a problem. Table 2 shows data on trends in health share of gross domestic product (GDP) and in MBS expenditure over the last 10 years.

Table 2: Trends in health expenditure (as percentage of GDP) and growth in MBS expenditure, 1985–86 to 1995–96

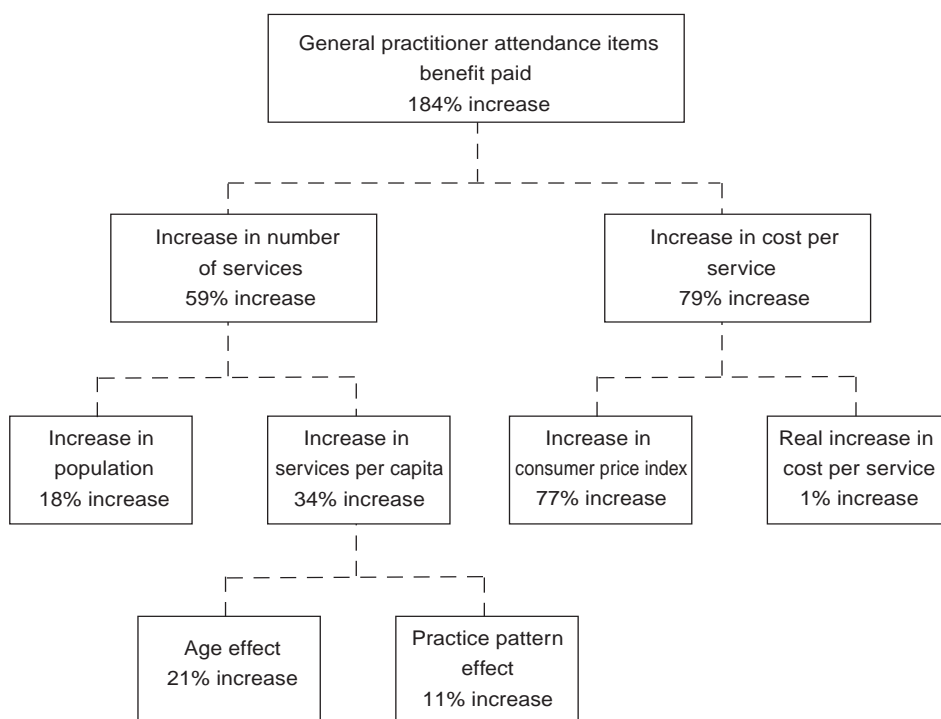
Year	Two-year MBS growth moving average	Percentage of GDP
1985–86	12.78	7.7
1986–87	10.79	8.0
1988–89	6.75	7.7
1989–90	9.22	7.8
1990–91	10.21	8.2
1991–92	8.48	8.5
1992–93	7.63	8.6
1993–94	7.11	8.5
1994–95	5.35	8.5
1995–96	4.68	8.5

It can be seen that health expenditure as a percentage of GDP has been stable for most of this decade at around 8.5%. The increase in the late 1980s to early 1990s was caused by the recession: a stable health expenditure and declining GDP led to an increased health share. Assuming health spending maintains its current patterns, the current booming economy may lead to a decline in health expenditure as a percentage of GDP in the next few years.

Similarly for MBS expenditure. Although growth rates in MBS expenditure in the last 15 years have been high, data for more recent years show that MBS expenditure is relatively stable in real terms, probably caused by a slowdown in the growth of the medical workforce.

Another non-problem is about the future of Medicare. Dire predictions about the ‘unsustainability of Medicare’ are often based (intentionally or unintentionally) on misrepresentation of trends in health care costs and the consequences to the health sector of an ageing population. Doomsayers’ choice of high projections of health care cost growth and low GDP growth combine to yield worrying consequences for the economy. However, as Gibson and Goss (1999) point out, the choice made by the chief doomsayers (Economic Planning Advisory Committee and the National Commission of Audit) is on the pessimistic side of recent experience. Ageing of the population does not cause a crisis which requires dismantling of our social infrastructure. International experience shows there is no direct link between an ageing population and service demand (Gibson & Goss 1999). Further, the older person of the future will be healthier than similarly aged people of today. (That is the reason they are living longer!) In turn, this means that an 80 year old of the future will not use as many health services as an 80 year old today, and we therefore cannot validly project forward demand on the health system based on our current age–sex utilisation patterns.

A fair amount of work has been done on projecting patterns of the health of the population in the future and likely demand for health care. In general, the conclusion is that for Australia, as for other developed countries, gains in life expectancy represent extra years with disability but not extra years of severe disability; that is, we should not expect dramatic increases in demand on the health sector because of this ageing population. Despite significant growth in the elderly population over the last few decades (between 1975–76 and 1995–96, 65+ as a percentage of total population increased from 8.9% to 12%; 80+ as a percentage of 65+ increased from 17.4% to 22%), health and welfare expenditure on the elderly (including pensions) only increased from 4.8% of GDP to 5.1% and represented a constant share of government outlays (Choi 1998). Simplistic projection of age and claiming it will cause a funding crisis has been referred to as ‘voodoo demographics’ (Schulz 1998). Such projections are usually made as part of politically-based destabilising campaigns and should be treated with as much credence as the tobacco industry’s assertion about the positive health benefits (and lack of adverse consequences) of smoking over the last 40 years.



Note: Factors are multiplicative, not additive; decomposition of per capita increase in service based on all MBS items.

Figure 2: Factors affecting growth in expenditure on general practitioners, 1985–98

Finally, analysis of trends in growth of expenditure in the past does not suggest that ageing is a critical factor.

For example, from 1984–85 to 1997–98, Commonwealth expenditure on benefits for general practitioner services (unreferred attendances) increased almost threefold (184%). The main reason for the increase was the increase in cost per Medicare service (increasing by about 80%, most of which is the consumer price index effect). There was a 60% increase in the number of services because of an increase of almost 20% in the population and an increase of one-third in services per head. The age–sex effect accounts for about two-thirds of this per capita increase. Ageing of the population thus accounts for less than one-eighth of the total increase in expenditure over this period.

Overall, then, the figures do not give any support to an argument that Medicare financing is in a parlous state. Medicare has been strongly supported by consumers and electors, both in public opinion surveys and at the ballot box. An analysis of some of the underlying financial issues does not lead one to believe that the public has made a wrong judgement here. Medicare is serving us well and there is no reason why it cannot serve us well into the future.

Another non-problem relates to the viability of the private sector. Australia's private sector is large by international standards, and about 60% of all health expenditure is spent on private providers. As Table 3 shows, private hospitals are booming, with sustained increases in activity since 1990.

Table 3: Private hospital activity, 1991–97

Year	Separations (‘000)	Separations/’000 population	Bed-days (‘000)	Bed-days/’000 population
1991–92	1210	69.1	4845	276.6
1992–93	1238	70.5	4955	282.0
1993–94	1313	74.7	5117	291.2
1994–95	1460	82.2	5407	304.5
1995–96	1577	87.7	5893	327.6
1996–97	1685	92.4	5834	319.9

In the face of these patterns, it is extraordinary that the government recently provided over \$1.3 billion of industry assistance to the private health insurance industry in the form of a new 30% rebate, a level of assistance greater than the 1997–98 budgetary assistance to manufacturing, mining and primary production combined (see Table 4).

Table 4: Government industry assistance, 1997–98

Budgetary outlays	\$ million
Primary production	544
Manufacturing	614
Mining	120
Services	407
<i>Sub-total</i>	<i>1685</i>
Taxation expenditure	
Primary production	227
Manufacturing	837
Mining	170
Services	434
<i>Sub-total</i>	<i>1668</i>
Total	3353

Source: Productivity Commission 1998.

These non-problems are occasionally presented as the main problems of the health care system, despite the absence of evidence to support such claims. A focus on the non-problems of ageing and/or the future of the private sector should be recognised for what it is: part of ideologically driven attempts to create an atmosphere of crisis, usually to destabilise Medicare.

Conclusion

Ideologically driven problem lists are inevitable as part of the policy process in a field such as health policy, where attitudes and values play such an important role. These attributes and values affect perceptions of problems and an important role of policy academics is to attempt to shape public debate to make these perceptions more rational and reality-based. This is a role that George Palmer has played.

Many of the items on my list of problems/issues are similar to those on Palmer's list. In contrast to his 1996 list, although I have included some aspects of Commonwealth–State division as problems, George has it as problem number 1. His list is also longer and includes government–profession conflict (less of a problem now than then); lack of consensus on the roles of public–private sector; lack of consumer involvement; frequent restructuring; and demoralisation of providers. Importantly, a number of the policy problems identified by Palmer in 1996 are now central to the policy agenda and, if not fully addressed, are at least the subject of specific strategies (for example, out-of-pocket costs, evaluation of new technologies).

In his 1996 paper, Palmer proposed a number of solutions to the identified problems, not all of which were adopted. The important lesson, however, is that progress is being made on addressing identified problems. Of course, as one set of problems are fixed, there is then 'policy space' to address new ones and, hopefully, as a result, our health system experiences continuous improvement.

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