



The politics of health

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Medicare entered the new millennium nearly 16 years old. Throughout its life the core elements have remained untouched; most changes have been incremental and marginal, including those of the present Government. This stability contrasts starkly with the preceding fifteen years – from 1968 to 1983 – during which at least six distinct health-financing systems were tried. In those years Australia was the ideal laboratory for studying health finance, given our constant indulgence in new systems. Yet the sixteen years of relative stability since 1984 have been accompanied by a media babble stressing instability and crisis. Scarcely a year has passed without predictions of either imminent breakdown or slow decay. (With the formal acceptance of Medicare by the Liberal-National coalition in 1996, after thirteen years of unremitting hostility, the fact that such headlines have been less apparent suggests a political dimension to such predictions.) Yet the system itself has simply contradicted the doomsayers. Indeed by virtually any measure Medicare is in a rude state of health. "It has become", in Stephen Duckett's words, 'part of Australia's social infrastructure'.

As far as one measure of the system is concerned, the actual health outcomes, the assessments are excellent. The last annual report of the Australian Institute of Health and Welfare stated : 'Australia is one of the healthiest countries in the world and Australians are becoming even healthier. This is shown by declining death rates, increasing life expectancy, a low rate of life-threatening infectious diseases and, for most people, ready access to health care when needed.' Lest we become complacent Aboriginal health remains a blot on any positive assessment of outcomes in the Australian health system.

Insofar as efficiency is a good measuring rod, the health system has become massively more efficient. Acute care beds in public hospitals have declined under Medicare (11% between 1989 and 1996) yet public hospital separations in the 1990s have increased by 22%. Contrary to much public propaganda private hospitals have flourished under Medicare: the number of private hospital beds has gone up, the proportion of patients being treated in private hospitals has risen

and gains in productivity have at least paralleled the public hospital system. These trends reflect shorter stays, the more appropriate allocation of patients and the dramatic expansion of day surgery – the latter now accounting for nearly half of all hospital admissions.

Medical services per head of population have gone up under Medicare. For example in 1986–7 there was an average of 5.3 consultations per person with GPs and Specialists. Ten years later there were 6.5 consultations per person. The result is that health costs per person have risen faster than inflation, from \$1055 in 1984–5 to \$2345 in 1996–7. Discounting for inflation this is an average cost rise of 2.7% over the Medicare years. There is much debate over whether this is a good or bad thing. Is it evidence of better access to health services or does it signal overservicing by doctors or excessive demands by clients or both? In making a judgment on Medicare this is mostly irrelevant, as the per capita increase under Medicare has not been much greater than under the pre-existing health financing systems. Moreover the trend in Australia is similar to other industrialised societies, as are the causes: aging of populations, developments in medical technology and the increased capacities of health interventions.

The overall result is that under Medicare the proportion of the GDP spent on health has risen from 7.6% to 8.5%, the latter figure remaining stable through the 1990's. This puts us roughly in the middle range of OECD averages. Moreover the capacity of Medicare to restrain costs appears impressive. Prices in the health sector have increased only 0.1% above general inflation in the last twenty years – one of the lowest of any country in the developed world. If our health prices had increased in relation to inflation at the same rate as those of the highly privatised system of the USA over the same period, the present Australian health bill would have been \$20 billion more or half as big again.

Consumer satisfaction with Medicare remains high. The use of the taxation system makes collection of premiums highly efficient. Paying rebates has never been a problem – indeed with GPs bulk billing for 80% of consultations most medical incidents require no collection of rebates by patients. The overall system, apart from the complexities of the private sector, is a simple one and easy to grasp. Although there has been some criticism that 'Australia by adding an overlay of private insurance on top of taxation is limiting the meaning of equal access', there is no significant difference in access to hospital and medical services by income. Despite the storms that have raged about it since its inception Medicare has always commanded majority – usually overwhelming – support in mass surveys.

Of course there is rationing. It is difficult to conceive of a health system, at least an efficient one, that will not have some kind of rationing. In Australia this is reflected in hospital waiting lists. They are often taken as the chief measure of the performance of the hospital system. This is simplistic for they are not a useful measure either of the quality or the efficiency of the hospital system. Indeed the problem of waiting lists, or at least the political salience of waiting lists, seems to differ from state to state. There will always be some waiting lists. It is when people have to wait excessively long periods that the lists become unacceptable. Nor do they arise simply from a shortage of beds or operating facilities that are insufficient for the demands. In the past they were caused in part by a historic allocation of beds to specialist services that did not reflect technological changes. I would hope that by now this problem has been overcome. In other cases it is a shortage of specialists either in general or in the public hospital system. Various specialties can be identified as problem areas: ophthalmology, urology, ear, nose and throat, orthopaedic surgery and plastic surgery.

Again in assessing the waiting list problem we should not be unduly influenced by the notorious case which makes the newspaper headlines. For urgent and semi-urgent cases i.e. patients who should be treated within 30 days, the latest waiting list figures (1995–6) show a median wait of 8 days. For cases not in this category the median waiting period is 36 days. I would not deny that these figures disguise, for some specialties, unacceptably long waiting periods. Again, to illustrate how minor a part of the hospital system waiting lists are, we have a theoretical clearance time measure. Assuming that deletions from the waiting list remain constant, that no new patients are added to the list and that waiting lists are pooled between hospitals – none of which applies in the real world – everyone at present on the urgent and semi-urgent list could be cleared within thirty days and on the remaining lists within 2 1/2 months.

The crisis rhetoric around Medicare may well be a hangover from the bitter political battle waged for over a decade to introduce a system of universal health coverage in Australia. In a review of health care reforms in 17 industrialised countries, an OECD report notes in the typically understated assessments of that organisation: 'The move to improve equity was most contentious in Australia, where the present Medicare scheme was established in 1984 after six major changes.' That it was so contentious is in one sense surprising as the basic model chosen for providing universal coverage in Australia was a system financed mainly by taxation, with a mix of public and private providers. This model was the most favoured compromise in the advanced industrial world between the privatised systems of the USA and Switzerland on the one hand and the more socialised systems of the United Kingdom and some of the Scandinavian countries on the other.

Four factors seem to explain the intensity and the length of the struggle. First the implementation of a publicly funded universal health scheme aroused ideological passions unusual in the rather low-key pragmatic politics of late twentieth century Australia. Moreover these passions were coincident with the major party divide in Australian politics. On the one side the Liberal National coalition believed in personal responsibility for health, with provisos for the less fortunate; feared moral hazard; and opposed compulsion fearing that it threatened the freedom of the providers to provide and the consumers to choose. This led it to sympathise with a market approach to health provision with competition between private funds, hospitals and providers with, of course, safety nets for the less fortunate.

On the other hand the Labor party, egalitarian in ambition, distrusted the workings of the market in health, and favoured universal entitlement, compulsory if necessary, to ensure greater scope for the less well-off to make choices. This led it to an interventionist model with a national insurer and market restrictions. The Labor party had long been committed to a universal health scheme and promised its implementation whenever it should be returned to government. The Liberal National coalition that had presided over the old voluntary approach remained opposed to Medibank and Medicare until 1996. Thus any change of government over a generation promised or threatened the introduction or re-introduction of a fundamentally different health care scheme. It is difficult to find a comparable antagonism between major parties on the issue in any other advanced industrial society.

Secondly the leading doctors' organisation, the AMA, was a peculiarly forceful pressure group in a health system characterised by doctor dominance. It exercised a professional monopoly over health care policy in general. This may partly reflect the higher status of doctors in colonial settler societies than in the traditional European societies themselves. Because of the complex voluntary insurance system that existed prior to Medibank/Medicare, the AMA had immense experience of political negotiation, indeed it could be argued that it was more concerned with the political than

the professional interests of doctors. Although the profession was not monolithic – there were tensions for example between GPs and specialists – the AMA was strongly opposed to anything that smacked of socialised medicine, however innocuous, as a threat to doctors' independence, to the doctor/patient relationship and, of course, to doctors' incomes. Outside the United States it was difficult to find a more solid or more militant medical pressure group.

Thirdly the constitutional division of powers over health in Australia creates nine separate health administrations for 18 million people. While the Commonwealth may have the financial power in health matters it is dependent on State governments and State bureaucracies for the implementation of its policies. In the struggle for health care reform over the last twenty years this division complicated rather than necessarily exacerbated conflicts. This is because the States, with responsibility for running the public hospital systems, were more interested in money than in ideology. For example the National party ministers, who ran Queensland health care under Bjelke-Peterson, were desperate for cash to run their free hospital system, a Medicare-type hospital system before Medicare. Whatever their libertarian, competitive rhetoric they were eager to do a deal, even with Canberra socialists. On the other hand Labor State Health ministers, whatever their ideological commitment to a universal health scheme, were hard-headed in their determination to screw the last penny out of the Commonwealth in return for their acquiescence in Medicare. Fraternal appeals were not particularly productive.

The trouble was that although the States are infinitely bribable we did not in the 1980s have the money to satisfy them because of the severe constraints on public spending. Thus Medicare was introduced on the cheap and many of the troubles of the first decade sprang from that. State ministers, Liberal and Labor alike, became adept at cost shifting. For example the transfer out from State public hospitals of diagnostic services, outpatient services, pharmaceutical provision and the Victorian restructuring of community health on a fee for service basis all shifted costs from State hospital or health budgets to Commonwealth medical benefits or other Commonwealth programs. This financial tit-for-tat was often done at the expense of efficiency and overall cost savings and without sufficient consideration for the needs of clients. All this provided ammunition for the critics of Medicare.

But probably the most crucial reason for the turbulence in Australia was how late in the day Australia moved to universal health cover underwritten by government. Most of the advanced societies of Western Europe had moved to national health schemes in the immediate aftermath of World War II. These thus pre-dated and pre-empted the great expansion of the private entrepreneurial provision of health care. This was a phenomenon of the latter half of the twentieth century especially in the countries without national health schemes – particularly the USA, Canada and Australia.

Canada also introduced its national health scheme late but still about ten years ahead of Australia in the latter 1960s. The national government had a considerable struggle and faced a major doctors' strike in Quebec. Unfortunately for the doctors their strike coincided with the kidnapping and murder of a Quebec minister by Quebec separatists. Martial law introduced into Quebec to deal with this crisis was applied to the doctors as well. The strike soon crumbled. Australia, tackling health reform a decade later, faced a more severe and prolonged struggle. By contrast a further decade later in the USA, the Clintons were unable to secure any sweeping change in the American system so entrenched were the entrepreneurial interests. Timing I suspect therefore was a critical variable in explaining the intensity and length of the conflict over national health in different societies.

The most obvious residue from the past is the interlinked network of private health insurance, private hospitals and private doctors. These groups have provided the main opponents of the Medibank/Medicare initiatives. Some overseas critics have seen these elements as a blemish on the Australian system: qualifying the equality of access to hospital services by making holders of private health insurance more equal than the rest because they can escape public hospital queuing. Others have been critical on the grounds that the existence of a significant private sector has undermined effective cost containment.

Not that the links between private health insurance, private hospitals and private doctors are without their tensions. The providers of care (the private specialists) want to maximise their independence and their incomes; the payers for care (the private health funds) want to minimise the costs; and the private hospitals want reasonable bed occupancies (and are therefore dependent on the private specialists to provide patients) and want a reasonable recovery of their costs (and are therefore dependent on the private funds). The dependency of the private hospitals and the wimpishness of the funds have tended to mean that the private medical specialists have called the shots despite the efforts of governments of both political persuasion to strengthen the hands of the private funds and the private hospitals.

The key public issue has been the decline in the numbers of those with private health cover. Prior to Medicare private health insurance numbers were running at about 60% of the population. Fifteen years later it had fallen to about 30% and the decline seemed inexorable. The simplistic argument from this is that the decline has imposed unsustainable burdens on the public hospital system – hence long waiting lists and a sense of crisis all stemming from the fall in the numbers with private health insurance.

There is little to sustain this analysis. As has already been noted beds in private hospitals have increased under Medicare, private hospitals have a bigger share of hospital work than prior to Medicare and activity in the private hospital sector has increased at least as fast as within the public hospital system. Despite the fall in the privately insured, private hospitals are doing more work than ever before. There is no suggestion here that any fall off in private health insurance has led to any fall-off in private hospital usage. Thus the plausible hypothesis: fall in private insurance levels leads to fall in the usage of private hospitals and thus to extra pressure on the public hospitals seems unsustainable.

Where the falling-off in private health insurance has had an impact is within the public hospitals themselves not so much in increasing the load of the hospitals but in changing the mix of patients within the public hospitals. Most people giving up private insurance seem to be those who in the past used public hospital facilities but as private patients. Prior to Medicare approximately 50% of public hospital patients were public patients and 50% were private patients. Today the proportion is 90% public to 10% private. This change does not impose an additional workload on the public hospital merely a change in the status mix of its patients.

But this change does, however, have a cost. Private patients in public hospitals were an additional source of revenue for the public hospital system, a source of revenue that fell with the decline in the numbers of privately insured. While there were efforts to compensate the States for this fall in hospital revenues in the early Medicare agreements between the Commonwealth and the States, the Commonwealth almost certainly underestimated the impact of this change and in the cost-constrained 1980s was niggardly in compensation. This led to State tit-for-tat exercises in cost shifting, thereby transferring costs from stretched public hospital budgets to Commonwealth Medicare.

One other feature of the decline of private health insurance is that it is the young and healthy who are dropping out. A Medicare generation is coming to adulthood that has no tradition of private health insurance, attaches to it little in snobbish or protective values and is content to rely on the public system. It is difficult to see this trend being reversed. Only the ending of the universal provision of Medicare is likely to stem this erosion and I suspect that the demise of Medicare would be followed rapidly by the demise of the government that ended it.

The results of this generational shift are twofold. First it further helps to explain why the fall in the numbers of the privately insured has not had the catastrophic impact on the private and public hospital systems predicted in the simplistic scenario. The young do not make much use of hospitals anyway. Secondly it partly explains the accelerating cost of private health insurance, for the risk profile of the people remaining in the private funds has become poorer, the insured population sicker. However, this alone does not explain the doubling in real terms of private insurance rates under Medicare. Just as important is the fact that the insured have chosen to make much greater use of the higher cost private hospitals than to be private patients in public hospitals – a cheaper option. If one has paid for full private care why not use it and there are a lot of interests to encourage such a choice. Finally the gross fees of doctors have risen much faster in the insured sector than in Medicare as a whole.

In the 1990s both major political parties have devoted an inordinate amount of time trying to prop up the private sector. Labor has tried to attack the supply side to constrain the rise of costs in the private sector; Liberals have concentrated on making private insurance itself more attractive.

The last Labor government focused on out-of-pocket private hospital charges not covered by a patient's health insurance and out-of-pocket medical expenses occasioned by specialists charging above the scheduled fee. These out-of-pocket expenses were regarded as a major deterrent to people keeping on or taking up health insurance. The aim was to strengthen the hands of the health funds vis-a-vis the private hospitals and the specialists in an effort to eliminate extra-hospital charges and excessive fees. Some slow progress on the private hospital side has been made but efforts to restrain excessive fees impose increased costs on insurers and anyhow meet specialist doctor resistance. In June 1999 doctors' groups slammed an agreement on fees in two Sydney private hospitals as 'the first step towards American-style managed care and that it compromised medical care for patients'. The president of the AMA, Dr. Brand, a moderate, condemned the agreement on the grounds that "insurers have used contracts to screw down private hospitals and they will do the same with doctors". This would seem an excellent reason to support the activities of the funds. But such attitudes suggest that the courageous effort of the present Commonwealth health minister to continue such policies would face continuing resistance. The resurrection of Dr. Bruce Shepherd threatened a re-run of the politics of the late 1980s and early 1990s, but this time the target was a Liberal rather than a Labor minister for Health.

But the major effort by the present government has concentrated on increasing private health insurance coverage by a mixture of carrots and sticks. Financially the most significant move was the 30% tax rebate for health insurance, at a cost to the general taxpayer of over two billion dollars. There is little in this massive expenditure that will bring any real benefits to the Australian health care system. The great bulk of the two billion dollars will go to those who already have private cover, as a kind of reward for sticking with private health insurance. But that does little to improve the health system. Of course it may inhibit some from dropping health insurance; without it private health insurance coverage would have fallen below 30%. We will

hear more of that argument since, apart from possibly a small one-off impact, it is doubtful whether the rebate will do much to encourage the numbers back into health insurance. Latest health insurance figures (December 1999) show that health insurance coverage has climbed to 31.2% from a nadir of 30.1% a year before. I would anticipate a further small recovery. The chief advantage of the rebate is that it provides a wonderful nest egg for a reforming government to do something really creative within the health system.

The second and more intellectually interesting proposal to improve private cover has been the abolition of community rating. Community rating provided that all fund members must be offered the same rate of insurance, within membership categories, irrespective of age, sex, and health status. In future, rates will tend to be age-related, being cheaper the younger one is when joining a health fund. This is a sensible long-term strategy and has the great advantage of making no call on public moneys. Indeed while opposed to subsidies in general for the private sector, I think it would have been worthwhile to use some of the money wasted on the tax rebate to structure into this proposal subsidies for the present elderly so that even cheaper rates could be offered to younger people. Moreover this would not be an open-ended subsidy for it would fade out with time.

Governments in most of the industrialised world tend to let their private health sectors get on with the job with minimal intervention and little in the way of governmental resources. We in Australia should do the same. Governments should, where possible, assist the private health sector to be more efficient and cost effective, but not provide taxpayer subsidies, particularly as the few conditions attached to such subsidies have nearly all been resisted by the vested interests involved. Private hospitals and private specialists have not on the whole been willing to accept the constraints that should come with public subsidies. Specialist fees in the private sector are a classic example. Despite generous proposals to provide gap insurance well in excess of the schedule fees, private specialists in general have refused to accept any cap on fees. There is a fundamental contradiction between seeking to provide a better public system and seeking to prop up the private system. The more successful a government is in improving the public system the more people will desert the private system and thus the more pressure there will be on government to devote further public resources to private health. We in Australia should escape this spiral as soon as possible.

This is not to argue that the private sector will disappear. There will always be a residuum who will continue with private health insurance. Moreover there are imaginative ways in which spare capacity in the private hospitals might be productively utilised by contracts with the public sector. But it is about time that Australia, like other advanced societies, began to treat private insurance as a minor issue.

There are some real challenges that we do need to address, and there is a common thread running through them all. The common thread is that our health care system is too much a set of discrete boxes, with insufficient linkages between the different parts of the system, and that the very structures of Medicare itself reinforce this compartmentalisation.

First and foremost there is the fact that Medicare pays for some health care services and not for others. There are various dimensions to this. Medicare pays for public hospitals and diagnostic services and medical treatment outside public hospitals. But because the Medicare funding for public hospitals goes through State budgets, States can reduce their hospital budgets by transferring diagnostic services to outside private providers and outpatient type care to private

medical practitioners. Both of these groups are then paid directly through the Commonwealth medical benefits budget. Then there are the separate Commonwealth programs for pharmaceuticals, nursing home care and home and community care that can again be used to shift costs away from State funds for health provision onto the Commonwealth. Decisions of this cost shifting type are often made without regards to efficiency or the best interests of clients.

Another aspect of this problem is that while Medicare directly and indirectly covers medical and hospital care services, dentistry, physiotherapy, speech therapy and other paramedical services are not covered. In fifty years we have moved from having amongst the worst children's teeth in the developed world to among the best but these gains are being threatened by neglect in early adulthood due to the costs of dentistry; and such costs also weigh heavily on the old with their great needs for dental care. It has been quipped that it is easier under Medicare for a diabetic to get a toe amputated than secure adequate podiatry care.

Governments of all political persuasions have been unwilling to extend Medicare coverage to these areas, fearful of getting onto the fee-for-service treadmill once more. This was always a concern when introducing universal health insurance for medical services. As I accepted philosophically nearly twenty years ago 'fee-for-service medicine is deeply entrenched in Australian society, strongly defended by the medical profession and favourably evaluated by the population at large'. I suspect little has changed.

The economic problem with fee-for-service, underwritten by insurance, is that doctors can simply increase the intensity and quality of their services to offset any fall in income deriving from greater competition or other sources. For example GPs can see a patient more often and provide for that patient a wider range of services. Pathologists and radiologists can do more tests and more complex and expensive ones on a declining number of patients. Surgeons can do a more financially rewarding mix of operations or, in the private sector, simply raise their fees. A degree of competition, constraint on GP numbers and the reforms of general practice are likely to minimise this problem in the GP area. One result of competition among GPs is that whereas in 1984 only 52% of GP services were bulk billed today the figure is 80%. Again reforms of general practice mean that today 93% of GPs income comes from fee-for-service, 7% from practice payments. The trend to practice payments is likely to increase. Pathologists appear to have brought about their own downfall, their services being acquired by non-medical corporations attracted by the high profits in this sector. Constraint on surgical fees in the private sector will probably occur as a result of actions by the health funds and the private hospitals, particularly if they are spurred on by the knowledge that governments will not rescue the private sector every time it runs into difficulties.

But the health care problem, as distinct from the economic problem of fee-for-service, is that fee-for-service furthers the tendency to deliver particular and separate services, rather than treat the patient as a whole. This of course is very much encouraged by the structure of the medical benefits schedule. I recognise that many good GPs do seek to treat patients holistically but the incentives in the system under fee-for-service are perverse – they fund services not patients.

This brings me to my last critical point – the need to be more efficient in our allocation of resources to competing health needs. Australian health care has achieved much in the way of technical efficiency i.e. reducing the costs per treated patient. The use of casemix funding to pay public hospitals, now used by every state except NSW, is one example of an advance in technical efficiency. In simple terms the casemix system funds a particular hospital in terms of each activity

performed there on the basis of the average cost of that activity throughout the State hospital system. Thus if a hospital performs an activity at below average cost it gains, if at above average cost it loses. This method of funding by outcomes provides real incentives to technical efficiency.

But it does not help us much in deciding which mix of activities in a hospital is most in the community's interests, which activities should be encouraged, which activities should be discouraged. It does not help us decide whether we should invest in a high cost medical technology which will save and extend individual lives rather than some low cost intervention that will improve the quality of life for a larger number of patients. Technical efficiency does not help us with the value-laden questions of allocative efficiency.

Australia's allocative inefficiencies arise from points already noted – the existence of nine separate and often disputatious health administrations and the tendency, partly arising from Federal/State relations, to treat programs as compartmentalised on the basis of their differing financial bases. But the lack of transparency in health financing also makes a contribution to these inefficiencies. It has often been remarked as a form of criticism that the Medicare levy does not cover the whole Commonwealth health bill but merely a fraction of it. It was of course never intended to cover the whole bill but – as I made clear in my speech introducing the Medicare legislation – only to cover the additional cost to the Commonwealth of the Medicare program. Indeed we made a profit on Medicare in the first few years of the program i.e. the levy brought in more money than required to bridge the gap between the costs of continuing the old system and the cost of operating Medicare. A more transparent system is needed today.

The result of this inter-linked set of weaknesses in the Australian health care system means that, while it does a good job for most Australians, it fails many of those who most need it. It has been said with some truth that 'the Australian system performs worst for the people who are sickest and most depend on it'. The result of a system with too many separate boxes and significant allocative weaknesses is that it does not work well for those people with ongoing, complex and/or multiple needs.

This is why the coordinated care trials being conducted at the present time are potentially of enormous value to the whole system because, while focusing on care for those most in need of health services, they impinge on all the issues I have touched upon. For they are not simply a new approach to care delivery; they are also a method of resource allocation. Successful coordinated care will break down the separation between discrete settings – hospital, home, community service – the basis for present funding – to a continuity of care across different settings, moneys attached to the client rather than the setting.

What the coordinated care trials do is to pool funds from the whole range of care services – from hospitals, medical benefits, pharmaceutical benefits, home and community care – and use them for the management of clients with chronic and usually complex conditions, the money being attached to the patient rather than to a care setting. The care coordinator is in most cases a general practitioner, indeed the Commonwealth guidelines for the trials identify a key role for general practitioners in coordinated care.

The considerations underlying coordinated care have a broader application for the whole health care system. There is a powerful case for a body relatively close to the community – perhaps a regional body – channelling all the resources for all types of health care to local providers. I rather like the proposal of the Australian Health Care Association for some fifty

regional Integrated Care Providers around Australia, contracting with local agencies to provide services. Whatever the particular mechanisms, such a system would do a lot to break down the barriers between services underwritten by different funding sources. Again a body close to the community would contribute to the allocative conundrum – ultimately how we spend our health dollars must reflect community values. It would be open to private hospitals to participate in such contractual arrangements. The development of the casemix approach within the private hospitals is a matter of urgency for such a measure would enable the regional body to purchase services from the most efficient provider.

The coordinated care trials also support the central coordinating role of the GP and therefore his involvement in allocating funds for client services. The GP's critical role has, of course, been emphasised for many years due to his gatekeeper role for specialist services. A logical implication of these roles is the development of a GP fundholder system as found in the United Kingdom or New Zealand. The regional body would provide a GP with funds with which to purchase services for his patients. The range of services a GP could purchase is a matter for debate. Should he, for example, purchase services inside hospitals? Given that any savings would accrue to the GP he might be tempted to under refer. However what such a fundholder scheme would do – in the same way as the coordinated care trials do – is allow the GP to purchase ancillary health services – physiotherapy, occupational therapy possibly even dentistry. Thus in a controlled, cautious and incremental way such services could be brought under the Medicare umbrella.

Of course changes would be required at the top. COAG, the Council of Australian Governments, advised by the Council of Health Ministers, is proving a useful body for providing the macro decisions. It was COAG that initiated the coordinated care trials. It will be COAG that will have to make the broad allocative decisions for these are essentially political choices. But the task would be facilitated if the revenue and funding for health were made transparent. The total cost of the health system, broadly defined, should be made explicit, as should the revenue needed to cover it. It would be ideal if this came from a single source, with revenue arrangements between the States and the Commonwealth adjusted accordingly, and even better if it could be dispensed directly from the single source to regional bodies. However this would probably conflict with the imperatives of federalism. Even if we have to accept more cumbersome machinery that should not be an excuse to avoid transparency.

There would be the usual objections to such courses. Treasurers and treasuries have never been keen on transparency or the hypothecation of moneys for specific purposes. State shenanigans would be more obvious and therefore more difficult, so resistance would come from those quarters. But in an age where there is considerable popular resistance to increases in general taxation, there may be less resistance to increases in a Medicare levy, which fully captures the costs of health care. This would be more likely if people were confident that any increase would go to health and not be siphoned off by other Commonwealth departments or State treasuries. Ultimately in a democracy the voters must decide, one way or another, how much of the community resources should go to health and how broadly these should be allocated. The task of politicians should be to provide a framework to facilitate such decisions.