Retrospective

IT HAS TAKEN MORE THAN 30 YEARS for *Australian Health Review* to evolve into the prestigious professional journal that it is today.

In the early years, the Australian Healthcare Association, the Australian College of Healthcare Executives and the Australian Public Health Association each recognised the need for a publication to facilitate dissemination of ideas, publish research results, report on innovations and encourage active debate on health care issues. Each struggled in their own way, at times separately, at times collectively, and various attempts were made at commercialisation.

The journal as it is known today was first published in September 1978.

In recognition of the collective effort that has been made by many to establish and manage this professional journal, past editors of AHR and its predecessor publications were invited to contribute an article for this collection. Not all were able to be located and not all were able to accept the invitation. However, it is a pleasure to present this collection of interesting and diverse reflections from my colleagues.

Allan D Hughes

Australian Health Review Editor, 1974–1980

Ideology, change and conflict

Colin Grant

Background — or product disclaimer

It is a long time since my very brief tenure as editor of Australian Health Review came to an end. Not, though, as long ago as I had thought! Swift recourse to an old c.v. shows it was in 1993 that I left the University of New South Wales to become a Visiting Fellow in Hong Kong and teach more or less the same sorts of health and management subjects which I had taught in Sydney, and compile, with Peter Yuen, a ground-breaking source book on the Hong Kong health care system that looks uncannily like the sort of data book that I was prone to write with the inestimable Helen Lapsley about our Australian system.

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Perhaps in making a charm-laden invitation to contribute something to *AHR*, Allan Hughes might have thought I would produce some dazzling synthesis of contrasts and comparisons between the two systems. But I doubt that he would have been even momentarily so unrealistic. My move to Hong Kong gave me the chance to extricate myself from following the tortuous development of our system. In turn my departure from that maddening, bustling and exciting city a couple of weeks after the Hand-over (Glorious Re-unification or Great Take-Away) left me rapidly out of touch with their health care system too.

Ideology in practice

Philosophically, the health care system of Hong Kong in 1997 and later was little changed from

that of 1947. It had two tiers: a small private hospital system and specialist medical care for the better-off locals and expatriates; and massive public health and hospital systems, tax-funded, for most residents, with private competitive general medical practice.

If the dominant social philosophy in the United Kingdom in the immediate post-war years was a Keynesian welfare state, it did not extend to the colonies. In Hong Kong the role of government was defined as 'positive non-intervention'. But this quasi free-market ideology was confounded by the need and desire to treat humanely the enormous flood of refugees from the disturbances in mainland China that followed the defeat of the Japanese in World War II.

Health, like housing and education, came to look very like a form of centrally-funded socialist system, regardless of Whitehall's wishes. But it is interesting to observe that the system, serving over six million people in an area less than half the size of the ACT, is on a par with world leaders in health indicators and outcomes.

Philosophically, the health care system of Australia seems to such a casual observer as myself to have changed little over the last decade or two. There have been peripheral changes as relatively small-scale adjustments are made to funding arrangements, mostly in the direction of attempting to reduce or limit the growth of social welfare by substituting market-derived models. Perhaps negative incrementalism has succeeded disjunctive incrementalism.

Be that as it may, it appears to me that the major problem obstructing the smooth provision of the public health services in Australia is the continued dichotomy in provision and funding in our federal system between the Commonwealth and the States and Territories. Whether the next federal election provides a government of either Thatcherian or Whitlamesque leanings and ideology seems less important in some senses that in sorting out anew the responsibilities for health care provision and for health care financing of the three levels of government.

Divergent rationalities

Regardless of the difficult issues of values-conflict in translating ideology to programs of activity, for decades we have suffered from the debilitating effects of divergent rationalities. If we ignore local government for the moment (while of course not forgetting its particularly vital contribution to environmental health services), we are still left with at least the following list of players who all have in common their needs to protect their perceived interests:

- Commonwealth politicians
- State and Territory politicians
- Commonwealth bureaucrats and their competing departments and agencies
- State and Territory bureaucrats, competing departments and agencies
- Private for-profit organisations
- Private not-for-profit organisations (including professional associations)
- Consumers who mostly pay taxes, duties, fees and/or insurance.

It is hardly surprising that cost-shifting and blaming have become quite finely honed skills. Nor is it surprising that consumers are increasingly suspicious of spin intended to gloss over deficiencies, seeing it as institutionalised lies.

As Solomon is absent from our shores (and might fail to meet the current entry requirements) we are faced, if we want worthwhile change, with finding a new resolution or balance in the divergent rationalities of those players I have listed. Perhaps this may be slightly easier to achieve than changing the Constitution (which we might wish to do for other reasons and objectives). It seems to me that at the root of the problem is the formula by which the Commonwealth with its major revenue-raising capabilities doles out financial resources to the States and Territories to actually provide for consumers' needs. Old Mother Hubbard was a beginner!

A formula to change

Opening an empty cupboard is transparent. Oh that the Commonwealth health funding formula

were too! But inevitably it is presently concerned with more endeavours than health itself.

One wonders how many electors know anything about it. How many State/Territory health Ministers can quote it and quantify its main components? How accurately have the effects been calculated of a growing and an ageing population on the demand for the various levels of care? How accurately are the effects measured of the introduction and diffusion of new health technology and treatment modalities on demand, and then on costs? Are its provisions for capital replacement (hospitals particularly) in line with community expectations of the facilities they use? In which publications, fairly readily available to an interested readership, is the formula and its justification quantified and offered for comment? Perhaps it crept into the Commonwealth Budget Papers in my absence.

An informed and continuing debate on the issues raised by these questions might be one feasible approach to generating change and probably continuing change.

Leadership lacking

Leadership by the Commonwealth in approaching the problem of divergent rationalities has not been noticeable. Nor has the State level been impressive. Indeed, in at least two south-eastern States where, for whatever reason, there have been substantial health funding problems, government and its agencies have not sought to tackle the Federal/State impasse.

Instead there has been a quite pagan sacrificial ritual, regularly practised, of removing the usually embattled head of the local hospital or health service. Although rising, currently casualties are thought to be lower than in the battle of the Somme. Continuing the military analogy, how good are the serried ranks of replacement troops — and their replacements too? Are they more skilled than the earlier management casualties — or is it that their faces fit the changing political imperatives more readily?

We can, and do, and ought to agitate for continued improvement, both incremental and occasionally disjunctive, in Australian health services. For example, we may be concerned that prisons have become a very significant source of government-provided psychiatric care because of inadequacies in government community provision. Or we may be concerned to ensure that young persons requiring nursing home care should be provided with age-related accommodation, facilities and co-residents, rather than abandoned to the usual paranormal collection of institutionalised senior citizens.

But the many, varied and worthwhile themes for agitation are, in my view, less important than the need for change (with its corollary of conflict), at the macro level, of the methods we use to allocate financial resources to Australian health services. In any new determination (probably iterative) of that process, ideology and values-critical analysis will inevitably raise their heads — but, perhaps as in the Hong Kong example above, will not necessarily be dominant or prevent unintended consequences.

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