National Healthcare Alliance

2004 Federal Budget strategy submission

TOWARDS A HEALTHY AND PRODUCTIVE OLDER WORKFORCE

An effective health system is fundamental to having a healthy and productive older workforce, which is the key to maintaining national prosperity.

An effective health system cannot be had without investing to ensure a skilled and motivated workforce of professionals and carers, with the health technologies at hand to do the job.

Neither can we have a healthy and productive older workforce without investing in assisting them to help themselves remain healthy and productive.

These are the fundamental facts on which we base our proposals for investment in a healthy and productive future workforce.

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EXECUTIVE SUMMARY

The National Healthcare Alliance is made up of leading organisations operating at the interface between the patient, the carer, and the health professional. The underpinning purpose of the Alliance is to improve health policy decision-making, through positive engagement with government, and the promotion of evidence-based and inclusive processes.

The Federal government's approach to health has been insufficiently informed by an appreciation of the importance of a strong healthcare system as the basis of economic productivity, and oriented towards a narrow focus on cost without counting value. This negative framework is akin to running a major enterprise without considering the returns that may be made by entrepreneurial investment. A naïve cost-obsessed investment approach will lead to only buying what is cheap, and more often than not result in poor returns on that investment.

This submission highlights the relationship between economic wealth and the health of the ageing population, and between population health and the need for high quality health professionals and carers. Niggardly investment will result in a failure to attract and hold highly skilled health service providers, declining productivity of the national health investment, and a loss of the capacity of the Australian workforce to deliver sufficient growth to pay its way as we age. The central propositions made in this submission are:

First. With an ageing population, economic health will only be delivered through a healthy and productive older workforce. We demonstrate that the difference in Gross Domestic Product outcomes from different health strategy choices could exceed $100 billion per annum by 2043.

Second. Having a population of healthy, older workers depends on having a highly effective health system. We demonstrate that such a system contributes to workforce participation, and workforce productivity, and that the economic benefits attributable to these contributions are no less important than other government priorities such as taxation or micro-economic reform.

Third. We show that at the front line of health services, virtually all workforces are showing a pattern of insufficient recruitment and retention. We demonstrate that this is substantially attributable to system-wide failings, and that these should be addressed as a whole rather than 'muddling through' in a piecemeal fashion. Creating more training places, importing more professionals and addressing 'crises' as they arise, are all necessary but far from sufficient to meet the challenge.

Fourth. Fully cost-effective health services cannot be provided unless there is a strategy that deals with the total system, and which directly addresses the decline in the health workforce that arises with failures in that system. We demonstrate that the health workforce is under increasing stress because of fragmented management,

Endorsed by the member organisations of the National Healthcare Alliance

National Healthcare Alliance Principles

The National Healthcare Alliance was established by organisations representing those at the front line of health care, to promote well-informed healthcare reform. The following principles underpin the approach of the Alliance.

1. The aims of Australia's health strategy should be health and social justice outcomes; acknowledging the economic contribution of a healthy population and a viable health industry.
2. Our national health strategy should provide clear principles on which resource allocation is based, and against which allocations can be judged.
3. A financially viable national health strategy will require significant innovation. This includes new policies, financing mechanisms, taxation arrangements, health service networking, government administrative processes, and more effective collaboration.
4. Developing this strategy requires proper evaluation of the full spectrum of health service delivery models and options, and the full spectrum of health financing approaches.
    a. This evaluation needs to consider fully the contribution which healthcare makes to economic performance and other societal values.
    b. The heart of healthcare is the health workforce. There must be sufficient economic incentives and support so that skilled people are attracted to deliver services for all sectors of society.
    c. Strategy needs to be based on a sophisticated understanding of how health needs will evolve with a changing population and changing policy contexts, and the health, social and economic impacts of different types of healthcare strategy.
5. Prevention needs to be valued, understanding that it is more likely to shift costs through time than reduce them outright.
6. A key aim of a national health strategy should be social inclusiveness, not minimal safety nets.
7. Social justice is central to national health strategy, in particular with regard to Aboriginal and Torres Strait Islander peoples.
8. The needs of regional and disadvantaged communities should be carefully considered as part of such a strategy.
9. Any such strategy has to tackle the problem of institutional complexity and the transaction costs of administration. This includes better specification of federal/state and public/private roles, and the removal of silos that inhibit efficiency.
10. A sustainable healthcare system has to be fair and efficient, and deliver health outcomes that the community wants, and will value.

Creating that strategy requires a process that is open, which takes fully into account the knowledge and needs of the people who deliver healthcare

services, and the people who use them. Achieving a process that ensures this is an initial objective of the Alliance.

This budget submission carries a message to government and the community.

To overcome the economic challenge of ageing we need a healthy and productive, inevitably older, workforce. If Australia wants this workforce, we must have an effective healthcare system. This requires a skilled and well-coordinated network of health professionals at the 'coalface', armed with the specialised resources and supports needed to deliver effective services. Australia also needs the commitment of unpaid family and other carers, without whom the costs of care would escalate, and the quality of care decline. We also need a community that is actively responsible for its own health and wellbeing, and in maintaining their personal capacity.

The operation of the healthcare system is driven by choices by individuals to invest their energies and their resources. Policy decisions merely establish the balance of incentives, disincentives and messages that will either discourage or promote the behaviours that are needed to make the system work.

If 'doing the right thing' comes at too high a personal cost, or is too difficult, then people will make choices to do more rewarding things with their lives. We will not get the health professionals, carers or individuals to do what we need them to. Australia is experiencing the early stages of what will become a flood of problems if we do not invest to get individuals to commit themselves to creating a healthy and productive future workforce. Doctors, nurses, pharmacists, physiotherapists, other allied health professionals and volunteers are all signalling with their feet that the personal costs are too high and the incentives and supports are too weak to invest their lives in delivering healthcare.

At a time when the challenges of an ageing population suggest the need for confidence to innovate in healthcare, members of the Alliance are seeing:

- expensively trained young people leaving professions, discouraged by what they experience;
- older professionals leaving, forced out by the personal costs and risks of their involvement; and
- decisions being made to narrow the services offered, to reduce the risks and the costs of participation.

The costs of these deficiencies is falling upon those in need of care, other professionals in the health system, and family carers who in turn are forced to undertake burdens which penalise them in their economic and personal lives.

The Intergenerational Report (IGR) rightly pointed to the economic challenge of an ageing population. It wrongly focused on answering the question 'how can we constrain federal government expenditures in the face of an anticipated decline in economic productivity due to ageing?' It did not tackle the more important question 'how can we prevent a decline in economic productivity due to ageing?'[1] It did not pursue the possibility of longer and

[1] Such 'type 2' errors, asking the wrong question leading to a counter-productive answer, are well documented in science.

more productive working lives, nor consider the fact that to achieve this requires sustained investment in the health sector.

The IGR's counsel of despair is not supported by Australia's historical performance, nor is it consistent with our national aspirations. Neither is it supported by international experience of ageing workforces where there are effective health and social policies in place. Australia demonstrably has a world leading healthcare system that can (provided that it is not degraded) ensure ageing Australians will pay their own way for much longer than narrow economic pessimism would suggest. The IGR's mis-diagnosis leads to a prescription for shrinking our future economy, not to a program for strengthening it.

That is not to say that reform is unnecessary. There is waste and inefficiency in the healthcare system that need to be eliminated. High transaction costs of administration, insufficiently close coordination between specialised roles, mistakes, and resource consuming political and health cost shifting and bargaining are just some of the problems that do need to be tackled. We do need to reduce the costs of health services, but not at the price of reducing essential services. Achieving this will not occur through a naïve approach that is largely uninformed by those who operate on the front line of healthcare. Neither will it be achieved by tackling issues in silos, instead of addressing the total system. Open systems are characterised by complexity and interdependencies. Action in one part gives rise to unplanned consequences elsewhere. Strategies that are not directed to the effectiveness of the whole system typically do not work. Strategies that are informed by only a limited range of perspectives are high risk under such circumstances. To achieve system reform requires full engagement of those who understand that system.

Economic modelling conducted for the National Healthcare Alliance shows that investment in health will more effectively lead us out of the older workforce dilemma, than would reducing investment and lowering the quality of the health services that are available. This is consistent with other economic modelling of future Gross Domestic Product (GDP) given different levels of workforce participation and productivity. Astute health investment, coupled with system reform and innovation in services delivery will be the most effective way of building the social and economic capital of Australia as we age.

Reports from the front line

The human capabilities to provide healthcare are falling short of what will be required to deliver the productivity that will be needed by Australia. There are many illustrations and studies which demonstrate that the balance of incentives and costs for health professionals, carers and self-care is increasingly adverse. This is being reflected in declining availability of the required human capital throughout the health system, with consequent increases in pressures and reduction in service capacity. With this section, we provide a 'snapshot' of what is occurring throughout the healthcare system, and what is indicated for the future unless we reinvest wisely to ensure the future productive lives of Australians as we age[2].

The vicious cycle

Under-rewarding and under-resourcing healthcare workers, in the face of increasing demand, leads to increased pressure and reduced incentive for that extra effort. In turn, this adverse shift in the balance of incentives makes the profession less attractive. Over time it is harder to attract and retain the required expertise. In turn this increases the pressures, and a vicious downward spiral is initiated. The effects are systemic, for failures in one part of the system spill over into pressures in other parts, over time infecting the whole system with a pattern of pressure, disincentive and declining employment attractiveness. The National Healthcare Alliance is of the view that we are in this dangerous spiral for a large part of the Australian health system. The costs of failing to pull out of this decline will be erosion of both the productivity and the participation of our ageing workforce. This will result both in reduced GDP, a reduced ability to save for retirement, earlier entry into dependence on retirement savings and pensions, and in higher costs of healthcare through:

- increased dependency of the unwell, causing a second-order effect of people leaving or reducing their inputs to the workforce so as to support their dependents;
- adverse psychological and social effects through withdrawal from the workforce, reflected in otherwise avoidable health problems;
- increases in direct health costs.

> Satisfaction with the work done at the end of a shift, has a positive impact on feelings of self esteem and well being. These feelings of well being and positive self esteem extend beyond the workplace into family and social life. Nurses report that they do not feel satisfied with the care they are currently able to provide in a health care environment that is characterised by a minimalist bottom line and translated into inadequate staffing levels and inappropriate skills mix. This dissatisfaction is negatively affecting the way nurses are interacting with their families and in their social contacts. For a nursing career to be family friendly, the environment in which nursing is provided must contribute to positive feelings of self esteem and wellbeing. Nurses report that inadequate staffing levels resulting in unreasonable workloads are the major factor affecting their job satisfaction.
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> Page 57 Australian Nursing Federation Submission to Senate Community Affairs References Committee Enquiry into Nursing, July 2001.

The state of health workforces

Alliance members report workforce problems across the system. It is well known that the extent of these problems correlates with socio-economic pressures with rural, remote and Aboriginal communities being the least-well served

What is less understood in government is that health workforce issues spill over across specialisations. For example, where there is inadequate medical expertise, the pressures on nursing resources will increase, creating conditions where nurses may see their task as hazardous, over-pressured and unattractive. In a town where there is no local access to specialist services, the GP will find themselves exposed to the demand to provide a broad range of services, or to act without the benefit of full information, involving legally onerous responsibilities. In a community where a doctor or nurse is not available, a local pharmacist or paramedic (if available) may end up being the main treatment service provider, by default. Whenever these workforce issues arise, the absence of specialist human resources results in increased demands on unpaid carers, and on those in need of care. In a growing range of Australian communities we face a vicious cycle of health workforce deficiencies, and this cycle is accelerating.

<u>What is happening in nursing? Increased work, fewer workers.</u>

It is reasonable to talk in terms of a 'nursing crisis'. Older, more experienced nurses are choosing to leave and not return. Aged care nursing is increasingly characterised by under-qualified para-nurses supervised by a small number of qualified staff, and entry into nursing training and training completion rates are less than is needed. Nursing specialisations such as mental health are suffering pronounced problems, and the international market for nurses is increasing the pressures for export of skills.

In 1995/96 there were 45 hospital separations per full time equivalent (FTE) nurse in the public sector. This increased to 49 separations per FTE nurse in 1998/99. There were 205 occupied bed days per FTE nurse in 1995/96. This increased to 208 in 1998/99. Conversely, the number of FTE nurses per 100,000 population decreased from 1171.1 nurses per 100,000 population in 1989 to 1032.7 in 1999[3]. The AIHW report that the number of full time equivalent nurses employed in acute public and psychiatric hospitals fell by 2.8% between 1995-96 and 1998-99 while the number of patient separations increased by 7.4%[4].

The long term effects of these decisions will not only be felt by the health and aged care systems, but will also impact on the individual nurses by, for example, reducing their present standard of living as well as their future retirement benefits.[5]

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[3] AIHW 1999 Nursing Labour force 1998 AIHW Canberra.

[4] ibid.

[5] Page 5, Australian Nursing Federation Submission to Senate Community Affairs References Committee Enquiry into Nursing, July 2001.

What is happening in medicine?

The rural medical crisis is far from the complete extent of the medical workforce issue. The recent problems of indemnity have added to the pressures, and it is reported that a growing number of doctors are considering early retirement or (particularly with specialists) overseas practice options.

In recent years, based mainly on studies by the Australian Medical Workforce Advisory Committee (AMWAC), the orthodox view has been that Australia has an overall surplus of GPs, but a shortage in rural and remote areas. The primary findings of this investigation are that, contrary to this 'conventional wisdom', there is currently an overall shortage of GPs in Australia as well as a maldistribution;

- Shortages of GPs are by no means confined to rural and remote areas but are increasingly apparent in outer urban areas. Inner urban areas generally have an adequate supply, with only very few areas in surplus;
- These findings are supported by the GP Workforce Survey (conducted by Access Economics for the AMA in 2001), by a substantial body of anecdotal evidence and by the Access Economics GP Workforce Model;
- While the Australian community continues to express its support for Medicare, patients' expectations of access to GP services are not being met;
- Unless workforce policy settings are changed, the overall shortage of GPs will get worse. If that is allowed to happen, it will prove even harder to resolve the maldistribution of GPs and

A physiotherapist in rural NSW recently reported that it took five years to recruit a physiotherapist despite widespread advertising. Another in Queensland received no applications for an advertisement and says that every year it has become worse. The story is the same all around the country: typical quotes from physiotherapists include:

- "We received a very low level of applications for a Grade one position" - public sector, Melbourne.
- "I have had to downgrade services because I can't find enough experienced physiotherapists. This has led to reduced opening hours and an inability to send speakers to schools" - private sector, Perth.
- "Finally after nine months we received one application for a senior cardiac position" - public sector, NSW.
- "We have been intermittently advertising a position since July. We will take somebody full-time or part time and still we can't fill the position", - private sector, Melbourne.
- "Mid-year vacancies are common. The consequences are increased workload for remaining staff and compromised patient care" - public sector, Perth.

Pers. comm., Australian Physiotherapy Assoc.

to meet community expectations[6];

Physiotherapy workforce shortfalls

There is a national shortage of physiotherapists, with a shortage of specialists in NSW, Victoria and South Australia.[7] The Department of Employment and Workplace Relations has identified:

- Difficulties recruiting experienced physiotherapists in metropolitan areas and general difficulties in rural areas in South Australia;
- Overall shortages in Western Australia;
- Widespread shortages in Victoria, particularly in the following specialities: paediatrics, cardio-thoracic, gerontology, oncology and palliative care, and generally in rural areas. These shortages are increasing.
- State wide shortages in Tasmania and NSW; and
- A shortage of experienced physiotherapists across Queensland, with supply of locum and part-time workers critically low.[8]

The causes of these problems can be partly traced to the vicious cycle noted above, with adverse staff ratios leading to stress and injury, further exits as a result, exacerbating the original problem and creating unattractive conditions to recruit replacements.

- A staggering 1 in 6 physiotherapists change their profession as a result of a workplace injury[9], many of which result from people trying to do too much because there are not enough staff.
- Rehabilitation sites have physiotherapist : patient ratios at 50% or more above Australian Federation of Rehabilitation Medicine guidelines - due to inability to fill positions, not budget constraints.[10]
- 52% of physiotherapists who resign from physiotherapy positions in our public hospital leave the profession[11].
- 35% of all advertised public hospital physiotherapy positions in 2001 received no applications.

Specialisations are under workforce pressure

One could be led to believe that whilst there may be problems with general practice, the more prestigious areas of the medical workforce are thriving. Whilst some areas of specialisation are providing very attractive, this is not the case across the board.

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6 An Analysis of the Widening Gap between Community Need and the Availability of GP Services: A report to the Australian Medical Association by Access Economics Pty Ltd Canberra ACT February 2002

7 Department of Employment and Workplace Relations 2002. National and State Skill Shortage Lists.

8 Research undertaken by the State Labour Economics Office of the Department of Employment and Workplace Relations, 2002.

9 Cromie JE, Robertson VJ and Best MO (2001): Occupational health and safety in physiotherapy: Guidelines for practice. Australian Journal of Physiotherapy Vol 47: 43-51

10 Unpublished survey data

11 Unpublished survey data

A crisis in pathologist person-power has been identified by the Australian Medical Workforce Advisory Committee. There are approximately 70 full time equivalent pathologist positions vacant nationally with a shortage overseas to compound the problem of replacement. It has also become apparent that the number of new fellows is not keeping up with retirements and increased demand for pathology services. In the public sector a large number of training posts have disappeared or been subsumed by other medical disciplines.

Gastroenterology, geriatric medicine, haematological oncology, medical oncology and thoracic medicine have now been added to the specialities failing to attract sufficient interest from trainees. A report by the Royal Australasian College of Surgeons has also flagged a need for 50% more surgeons by the year 2020.

As noted, with the indemnity crisis has come a morale problem in many areas of medical specialisation. There is a risk that this factor, coupled with high international demand, may place increased pressure on some highly specialised parts of the medical workforce.

The pharmacy workforce is under pressure

Pharmacists provide a low cost point of access for basic health services, as well as providing dispensing capacity. As other sources of services have come under cost and workforce pressure, this role of pharmacy has increased. Australia faces a growing shortage of pharmacists as the demand for pharmacists continues to outstrip the available supply. This is the major finding of a study[12] into the demand and supply of pharmacists.

The patterns within the pharmacy workforce reflect those in other healthcare workforces – ageing, a change in the sex mix, a high rate of exit from practice in the early years, and difficulties in recruitment.

Unpaid care: the release valve?

The strains in the professional system spill over into the unpaid carer community. For many, this role is far from voluntary. It comes with a very high cost to carers and to society. These costs include loss of earnings (and therefore carer's retirement incomes), stress and physical injury, and social isolation. This sector of the workforce continues to grow, reflecting the strains in the rest of the system.

Australia's 2.3 million carers have a dual role in our community and economy. As family and friends of people needing care, they contribute to maintaining and enhancing the social capital of our community which provides for richer relationships and enables people to be cared for in their home environment. In economic terms, this unpaid care for adults alone was estimated to be worth at least $18.3 billion per annum in 1999 (AIHW, 2001), based on the cost of providing alternative paid care. In contrast the Australian Government's budget estimates for 2002-03 for spending on community care and support for carers and welfare payments totalled $2.547 billion. These figures illustrate

[12] Health Care Intelligence "A Study of the Demand and Supply of Pharmacists, 2000-2010", Third Community Pharmacy Agreement, February 2003.

just how reliant governments and taxpayers are on the unpaid care of family and friends in supporting our system of community care that we value in Australia[13].

Unlike other parts of the health workforce, carers are often unable to reflect their dissatisfaction and disadvantage by leaving the health workforce, but too often these burdens result in them having to downgrade their own careers, and incur health and other costs themselves. They highlight, through the Carers' Association and other groups, the fact that their basic needs are not being met, and that the rewards and resources available to them are far from sufficient to meet their needs.

The rural and remote community challenge

The vicious cycle is apparent across most workforces and most parts of the health system but it is pronounced in rural and disadvantaged communities.

Despite the special programs in existence for rural and remote health, the situation of the workforce is currently very serious. When there are generalized shortages of health professionals, rural and remote areas will always be most seriously affected. There is currently low morale among many in the rural and remote health workforce. Incomes in nursing (particularly in the aged care sector) are low. Access to information technology is poor. There are the long-standing effects of staff shortages: little time off, poor access to locums and mentors, insufficient access to CPD [Continuing Professional Development]*. In remote areas there are particular issues with staff safety. On top of all of this, doctors, midwives and a number of health facilities, including private hospitals, are now affected by difficulties with indemnity[14].*

> *Stress, anger, sick days, decreased patient care, low morale because there isn't time in the day to give basic care. Feeling of 'we're drowning'. I just can't believe the government won't allocate more nurses to our hospital. I go home wanting to cry, out of frustration, not feeling that I've done a good days work. Working in a small remote hospital you constantly shoulder so much responsibility, loads of overtime and on call, can't get leave when you want it and get tired and burnt out*[1].
>
> Australian Nursing Federation Submission to Senate Community Affairs References Committee Enquiry into Nursing, July 2001, Page 44

A failure of incentives to deliver health

The Federal government engages in financial negotiations with the healthcare professions over medicare, PBS and other issues. Each profession is addressed in a separate agreement at a separate time. The focus of the negotiation is primarily the direct payment for service, and the form of service for which payment will be received. Some ancillary issues like research may also be addressed.

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13 Carers Australia Pre Budget Submission 2004-05 October 2003 Page 1

14 National Rural Health Alliance pers. comm.

This silos-based approach pervades the institutional structures and budget approach of government. It ignores the interdependence of issues, and the broader needs of the people who make up the workforce. It discounts the extent to which perceptions of health system robustness impact on morale and career attractiveness, and the disincentive effects of inefficient administration, role confusion, or resource conflict. The approach limits the opportunity to restructure some of the fundamental 'drags' on the system (such as the transaction costs of the federal/state health relationship, or the costly burdens of inefficient administration). It reduces the opportunities to consider broader systemic reform (such as greater experimentation with service models tailored to different situations) and 'cross-agency' efficiencies (such as increasing investment in one area of health to realise values in other budgetary areas like age or disability pensions), or productivity improvement for non-health workforces. Ultimately these institutional failings are reflected at the coalface.

Doctors, nurses, physiotherapists, other allied health service providers, pharmacists and unpaid carers, all respond to a mix of incentives and disincentives. If the healthcare system is under excessive pressure, it will generate many disincentives. These include:

- Poor morale and emotional stress, particularly associated with concerns about the future of the system, one's career and the patients that one cares for;
- Conflicts, as service providers struggle to access basic resources;
- Adverse outcomes, reflected back upon the service provider as liability risk, criticism, and self-blaming;
- Skills decline, as service providers lack the incentive and the opportunity to enhance their capacity.

The relative attractiveness of a health career is impacted by much more than the short-term salary. Lifestyle and work environment are important.

… the economic incentives of medical practice operate in a complex broader environment with strong influences on the decisions of individual doctors about where to practise. These include the personal influences of family, social and professional ties, commitments and ambitions; geographic location of upbringing; and lifestyle preferences. In the health system, regional and local health service management often includes administrative and structural impediments to improvements in the distribution of the medical workforce[15]*.*

Intelligent, well-educated professionals make career choices based on economic values, but also on the basis of less tangible considerations such as professional status. Consistent downgrading of status will result in declining participation in that workforce.

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15 Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare (1998), Medical Workforce Supply and Demand in Australia: A Discussion Paper, AMWAC Report 1998.8, AIHW Cat. No. HWL 12, Sydney

The only way to ensure that the escalating exodus of nurses from the profession stops is an improvement in the conditions under which they are forced to work. Decrease the patient/nurse ratio, increase time for handover periods and provide mentors for newly registered or re-registered staff. Until my fellow nurses and I are treated with respect by the (employers) and not just as the main drain on the hospital's budget, nurses like me will continue to leave the profession at great cost to the economy[16] (Mary Elgar)[17].

These problems are most pronounced in rural areas. A professional workforce may once have been attracted to the country lifestyle and the opportunity for a close relationship with a community, but with declining work conditions and declining social conditions, this appeal is diminishing. It will not be repaired without major investment.

Incidence and ranking of problems identified by dissatisfied GPs*

	Rank as % of total				
Problem	1	2	3	4	Total
Relatively low remuneration	43.1	16.1	11.4	8.3	19.7
Conflict with family responsibilities/desires	10.7	15.3	18.7	18.8	14.6
Long or inconvenient working hours	11.0	23.4	14.4	12.4	14.0
Inability to take leave, find staff or locums	8.9	15.7	15.7	12.7	12.4
Administrative or management problems	7.5	10.5	12.5	14.9	11.6
Difficulty selling, retiring or changing job	3.3	4.2	7.1	10.2	7.1
Being on call too frequently	4.3	5.2	7.1	8.7	6.9
Social/professional isolation or lack of amenities	2.7	4.0	6.8	8.0	6.0
Under employment	1.4	1.4	1.9	1.8	2.5
Other	7.2	4.2	4.2	4.1	5.3
TOTAL	**100**	**100**	**100**	**100**	**100**

* GPs who ranged their satisfaction as 1 to 7 in the 2001 AMA GP survey Question 8

Work intensity—The AMA Survey revealed that GPs frequently perceive huge disadvantages in country practice, many from the point of view of hindsight. They view the long hours, especially after hours, on-call hours and lack of holidays, with lack of locums or relief—'never off duty'—as a fundamental difficulty, causing stress and burnout. Greater work intensity is also due to the greater diversity and skills challenges of rural work, with emergency and hospital work particularly stressful. There is limited hospital, specialist, technological and allied health back up, generating problems of professional and personal isolation, which increase with remoteness. Many GPs view rural or remote work as underpaid relative to the responsibility, with a 120% loading on top of the current rural remuneration rate required to attract the average urban GP to the bush[18].

Family conflicts and costs—Partner's career, children's schooling and lack of family support are big issues, markedly so for single mothers. As children grow older, there is a substantial problem with education, in terms of the cost of boarding school (around $15,000 p.a.) and university accommodation ('running two houses'), as well as family separation. At this stage, many GPs move back to the city. Discontentment of partners is also often seen as

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16 Australian Nursing Federation Submission to Senate Community Affairs References Committee Enquiry into Nursing, July 2001 page 2

17 Elgar M 2001 Letter to the editor The Australian 9 July 2001.

18 An Analysis of the Widening Gap between Community Need and the Availability of GP Services, A report to the Australian Medical Association by Access Economics Pty Ltd Canberra ACT February 2002, Page 12

'unsustainable', necessitating a move back to the city. Separation from extended family and friends can be a problem for young or single people. These issues were mentioned in two thirds of responses to the survey and were non-negotiable—'wouldn't go for any money'.

Business difficulties—Small business administration (often without IT or other support), difficulty getting partners or selling a business, higher practice costs in many cases, lack of capital appreciation and red tape (eg Trade Practices Act) are also barriers to rural GP supply. Medical indemnity insurance premiums (and associated anxieties) are increasingly prohibitive, especially for obstetric and rural procedural work. Maintaining the required variety of skills is difficult given the cost of travelling (and lack of access) to continuing medical education (CME) and other training.

Lifestyle and other factors—Many GPs perceive the rural lifestyle to be lacking in social choices, amenities, and peer interaction—isolated, parochial (the 'small town' mentality), yet lacking anonymity (the 'goldfish bowl' syndrome). This is particularly true for minorities[19]*.*

Improving the health workforce requires systemic strategies

When such conditions persist, it should not be surprising to see both early exit and failures to enter the health service professions. We are seeing a repeated pattern of:

- Professionals electing to leave the profession, or limiting the scope of their services to areas that are less frustrating or less vulnerable;
- Students completing (wholly or partially) expensive qualifications, but after a taste of the realities of practice, 'voting with their feet' and leaving the profession; and
- Difficulties in filling available training positions, or attracting students of the calibre required.
- The load falling increasingly on those who are unable to avoid it – unpaid carers, and the less advantaged.

> It is of great concern to the ANF that nothing is being done to prepare for future nursing shortages following the retirement of older nurses over the next 10-15 years. Experienced nurses, many of whom will have specialist qualifications, will be exiting in large numbers but there is inadequate succession planning and no national planning to ensure that enough nurses are entering and staying in the health and aged care systems to replace either the numbers, the experience or the specialist qualifications. In the ten years 1986 to 1996, the number of nurses aged 25 and less decreased from 20.9% in 1986 to 5.9% in 1996. On the other hand, during the same period, the number of nurses aged greater than 45 increased from 18.9% in 1986 to 31.0% in 1996[1].
>
> Jill Iliffe Federal Secretary Australian Nursing Federation Australian Nursing Federation Submission to Senate Community Affairs References Committee Inquiry into Nursing
> July 2001, Page 6

[19] Page 14 ibid

A national health workforce strategy is needed, not a series of profession or problem specific band-aid interventions. It will not be possible to create such a strategy until we have far greater clarity about the health services model that will be required in the future. In turn this will not be possible whilst the planners and politicians fail to recognise two basic things – that healthcare is an investment, the returns from which depend largely on system effectiveness, and that the key to this effectiveness is the quality, motivation and empowerment of the workforce. Healthcare is a person-driven enterprise, where human motivations and human needs are what generate economic effectiveness. Taxation and government expenditure issues are important, but are a deficient starting point or end point for developing this strategy.

Healthcare is an area where unpaid work by carers is a significant contributor to outcomes. Both equity and economic efficiency require that we look to the needs of carers when considering how to maximise the benefits from health investment. They too need to be supported, and to be at the table when healthcare strategies and policies are designed. It should be borne in mind that there is a productivity cost (as well as a high personal cost) when carers foregoing their own careers. Reducing this cost is a relevant consideration in ensuring the future wealth of Australia when we can expect that there will be more care needs with an aging population.

We finish this discussion with comments arising from two of the workforces that will be important to an effective health system that provides a high return on that investment.

- Doctors
  Furthermore the economic incentives of medical practice operate in a complex broader environment with strong influences on the decisions of individual doctors about where to practise. These include the personal influences of family, social and professional ties, commitments and ambitions; geographic location of upbringing; and lifestyle preferences. In the health system, regional and local health service management often includes administrative and structural impediments to improvements in the distribution of the medical workforce[20].
- Carers
  The point that Carers Australia stresses is that people of all ages who need care and support to stay in their own homes must rely on the informal care of their family and friends and community care services. The availability of this unpaid care should not be assumed. For family and friends to fulfil a caring role there is a public and personal cost for what can be a constant, unrelenting and stressful job, depending on the individual situation. Therefore if the caring situation is to be sustainable, carers too must have adequate economic and social support, education for their care responsibilities and access to carer focussed services that are sufficiently resourced[21].

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[20] Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare (1998), Medical Workforce Supply and Demand in Australia: A Discussion Paper, AMWAC Report 1998.8, AIHW Cat. No. HWL 12, Sydney

[21] Carers Australia Pre Budget Submission 2004-05 October 2003, Page 9

The future

With an older workforce, we will have to spend more on health.

There are two issues to note with the future demand for GP services of an ageing population. First, elderly people consume more services per head of population, so the number of services required grows faster than [the] *population. Second, elderly people present with more complex health problems and with more chronic conditions that require management. Hence, consultation times are longer than for younger people. Combined with the larger number of services for elderly people, this means that average consultation times of all GP services are increased. Therefore, the total supply of GP services, expressed in terms of hours of service, grows faster than the nominal growth in the number of services*[22]*.*

That is unavoidable, unless we are to condemn our society to decline. What is more a matter for choice is whether we invest in productivity, or manage health as if it were an unproductive cost.

We are faced with two scenarios for our ageing population. The first will arise if we under-invest in healthcare, or if we waste the investment through ineffective management and high transaction cost administration. This scenario speaks of an ageing population accompanied by declining workforce productivity. Within this scenario there are many inequities and potential conflicts, and serious erosion of our social capital. This is the path that is most likely if we continue our present trajectory of inadequate and fragmented investment in healthcare, if we continue to fail to harness the goodwill and knowledge of those who work within the health system, and if we continue to try to manage health in a piecemeal fashion.

> The vast majority of older people are healthy, active and independent. Only approximately 7% live in residential care, and this percentage is not expected to increase over time. The ageing population is accompanied by improving health and well-being amongst older people as a result of the sound public health policies which have been pursued over many years in Australia, access to a universal health care system, and improving medical technology. Further developments in geriatric medicine are likely to have positive impacts.
>
> Healthy ageing is likely to lead to more people remaining in the workforce for longer. Early retirement is likely to diminish, and as the demand for staff increases due to falling numbers of younger workforce participants, older people will remain in, or re-enter the workforce, making a contribution to the economy through their productivity and payment of taxes.
>
> Page 9, Council on the Ageing (Australia)
> Long Term Strategies to Address the Ageing of the Australian Population over the Next Forty Years
> Submission to the House of Representatives
> Standing Committee on Ageing
> November 2002

[22] An Analysis of the Widening Gap between Community Need and the Availability of GP Services: op. cit. Page 17

The second scenario is that our healthcare system is upgraded to make it more effective. Under this scenario reform is focused upon maximising the value created, whilst minimising the costs of creating that value. Reform is based on harnessing the knowledge of all of the system participants, and on creating system-wide improvement. There is a focus on reducing unproductive elements such as jurisdictional re-bargaining and financial game-playing. Innovation is a central focus of reform. This is the path that the National Healthcare Alliance believes must be followed if Australia is to remain strong and productive even as we age.

HEALTH – AN INVESTMENT IN PRODUCTIVE AGEING

There is a strange myopia in the way in which Australia's government has addressed health, wealth and ageing in recent times. It is exemplified in the Intergenerational Report, but is also evident in other policy papers about workforce participation and GDP.

The argument that is developed goes something like this:

a. we have an ageing population, which will typically mean a decline in economic productivity per person (on average) due to lower workforce participation, (and perhaps some decline in productivity per person).

b. At the same time, we will have higher healthcare costs.

c. Therefore we need to:

   i) Increase workforce participation through such measures as altering industrial law, or retirement pension arrangements; and

   ii) Control the costs of healthcare.

The myopia is this. The argument identifies the pivotal importance of workforce productivity to future wealth, but it treats healthcare only as a cost. This of course flies in the face of logic and experience. At its heart, health spending is an investment: in the ability to keep working (and playing, socialising and loving); in the maintenance of your productive capacity such as eyesight, hearing and movement; and in continuance of an independent and fulfilling life.

The other side of the story is also a well-known part of the human condition. The inability to secure healthcare services results in wealth-diminishing effects: the loss of skills and capacity (reducing productivity as well as satisfaction); the inability to participate fully in work; the redirection of effort into self care or care for dependent others, and the redirection of resources into non-productive expenditure. The Department of Health and Ageing's commissioned study

> The longer a person is unemployed, and the earlier they retire, the greater can be the adverse financial effect of unemployment. People unemployed later in life are less able to increase savings to make up the shortfall in expected retirement income and this loss is greater the earlier a person retires. Unemployed people also have a greater usage of health services, such as higher hospital admissions, doctor and outpatient visits and higher use of pharmaceuticals, than employed people.…
> Access Economics has found that ensuring that mature age workers are not encouraged out of the workforce simply as a result of their age – as opposed to their competence – has the potential to raise the income of all Australians. Experts agree that average per capita income of Australians will be lifted if as few as 10% of people between the age of 55 and 70 years remain in the workforce instead of leaving.
>
> The Hon.Bronwyn Bishop MP
> Minister for Aged Care
> Population Ageing and the Economy
> January 2001
> Commonwealth Department of Health and Aged Care

from Access Economics highlights the economic importance of mature worker participation.

The evidence suggests that tax reform may add somewhere in the region of 2.5 per cent to the annual national income of Australians, and that promoting national competition policy may add 5.5 per cent to the national income. The desire to ensure mature workers are not encouraged out of the workforce simply as a result of their age – as opposed to their competence – has the potential to raise the income of all Australians by a similar amount. Average per capita incomes of Australians could be lifted by 4 per cent if workforce participation by 55 –70 year olds rose by just 10 percentage points.

The relativities are revealing. They suggest that, on published estimates, the benefits to national income of later retirement rank somewhere above those of tax reform and below those of promoting competition policy. Such estimates are imprecise at best, but they are a timely reminder of the importance of an issue that will grow with the passing of time[23]*.*

A more complete understanding of health and wealth[24] *suggests a positive attitude to healthcare investment strategy is well justified.*

Health care investments not only lead to longer and more productive working lives on an individual basis; properly targeted public health care investments can also provide countries with a competitive advantage. According to the Canadian Council of Chief Executives' submission to the Commission (2002, 2), "Canada's business leaders have been strong supporters of Canada's universally accessible public health care system" because it provides a "significant advantage in attracting the people and investment that companies need to stay competitive." Indeed, the "big three" automakers (Ford, General Motors and Daimler-Chrysler) recently signed joint letters with their largest union, the Canadian Autoworkers, expressing support for Canada's publicly funded health care system and noting that it provides an important competitive advantage to the Canadian auto and auto-parts industries relative to their American counterparts. In short, it is more economical for the employers to pay taxes in support of medicare than to be forced to buy private health insurance for their workers.

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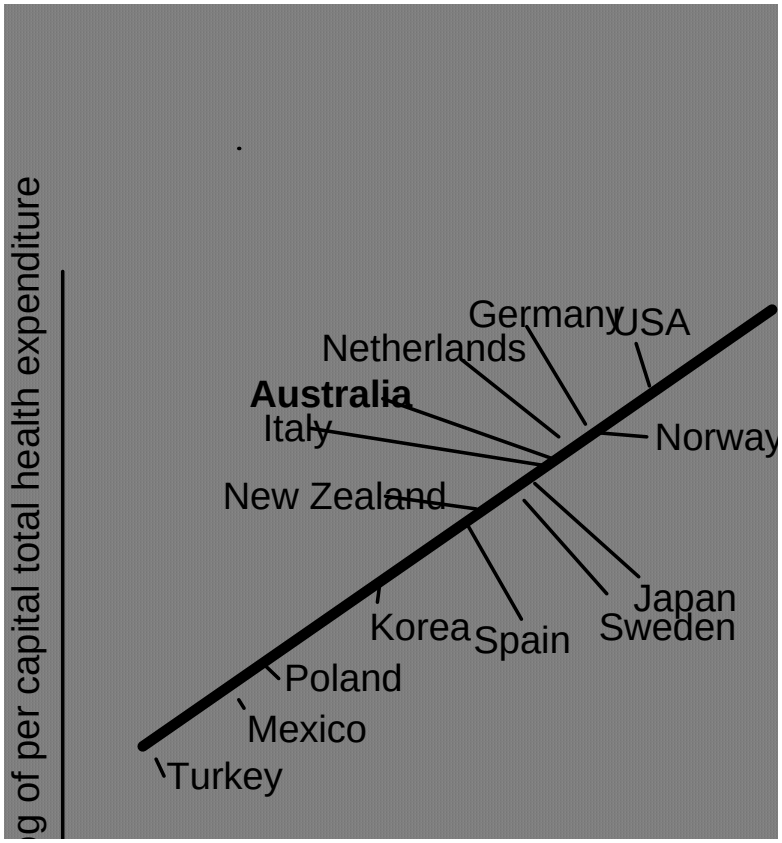
[23] P 19. Access Economics, Population Ageing and the Economy January 2001 Commonwealth Department of Health and Aged Care

[24] Extracts from: Commission on the Future of Health Care in Canada: Building on Values: The Future of Health Care in Canada – Final Report Commissioner: Roy J. Romanow. November 2002 pp 41-43

It is also true that health care is what economists call a superior good in that, as individuals, we tend to spend progressively more on health care than other goods and services as our incomes go up. Based on a series of international studies summarized by Gerdtham and Jönsson (2000), higher income is the single most important factor determining higher levels of health spending in all countries (see Figure 1.34). Indeed, the more economically developed the country, the more pronounced the effect (Scheiber and Maeda 1997). According to Reinhardt et al. (2002, 171), per capita GDP is without doubt "the most powerful explanatory variable for international differences in health spending."

Ratio of Total Health Expenditures to Economic Growth Among some OECD Countries, measured in purchasing power parity, 2000



The correlation between a nation's preparedness to spend on health, and its GDP, is strong. This suggests that health investment is wealth producing, the rich nations know that this is the case, and they invest accordingly. It certainly does support the view that the appropriate perspective on health expenditures is to consider them within a paradigm of investment return, not merely cost control.

One aim of health policy should be to optimise wealth production, through wise investment, reduction of systemic failings and transaction costs, and through resource building to ensure the returns are achieved. Any investment strategy which counts only the cost will fail, for it will always suggest disinvestment regardless of potential return. Our fear is that this is the error which has arisen from the policy myopia about of the nature of health in an ageing society.

One economic picture of the future Australia is dismal- unemployed ageing Australians struggling to make ends meet, with their health needs barely met through a depleted health system, and a reduced taxation base. To focus excessively on the costs of health will make this self-fulfilling. This is not the forecast that is justified by the facts, nor is it a sensible basis for health or

social policy. A focus on the investment value of health as the key to workforce participation and productivity leads to a different future.

The slowdown in workforce growth is not matched by an equivalent slowdown in demand for goods and services. Baby boomers will retire with large financial assets. If the shortage of labour is not addressed through higher participation rates among mature Australians, the current account may widen, wages may take off and returns to the owners of capital may fall.

On current trends the workforce will grow slowly over the next twenty years. However, demand growth for goods and services will not fall off to the same extent. The baby boomers will retire with savings and superannuation providing disposable income far greater than previous generations of retirees. There will be plenty of demand for goods and services from a fast growing retired population. It will need to be provided by a slow growing workforce, as the population of consumers will grow much faster than the population of producers[25]*.*

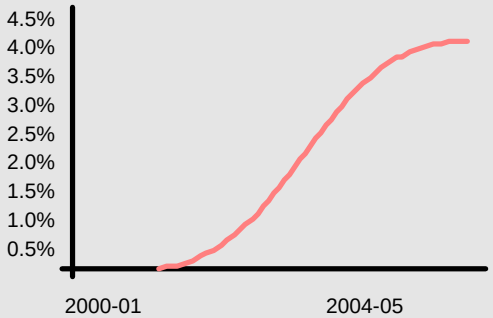
The key to this benign future is to control the dependency ratio: the number of people in work who are supporting the needs of those who are no longer able to work, or who wish to live off their accumulated wealth. The key to this, in turn, is to ensure the highest possible quality of healthcare throughout the community.

Data available to date would suggest that, in addition to economic factors, poor occupational and population health outcomes have played a significant part in the declining workforce participation rate of older workers. Further investment in, and coordination of, disease prevention and health promotion strategies across jurisdictions will be important to arrest this trend and to sustain older workers' productivity and participation leading into the 2020s and beyond.[26]

This basic understanding of the role of health in economic productivity has been identified by the European Foundation for the Improvement of Living and Working Conditions, (though they too are mainly focused upon industrial laws and superannuation issues, making the assumption that the basic health needs will be met through other largely unspecified means than health investment).

The economic success of any policy to raise the retirement

Increase in per capita real GDP from increased participation by older Australians



based on Access Economics
Population Ageing and the Economy
Commonwealth Department of Health and Aged Care
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[25] Population Ageing and the Economy January 2001 Commonwealth Department of Health and Aged Care, P 32.

[26] Commonwealth Dept of Health and Ageing Submission to the House of Representatives Standing Committee on Ageing January 2003 Page 18

age or to reintegrate older workers depends on their being healthy and productive enough to contribute meaningfully[27].

There are many illustrations of the centrality of health issues in economic activity. Often the enormous value of health investment is not seen in the 'big picture' of workforce participation, but in the accumulation of relatively scattered benefits that together become a major contribution. Such is often the case with eyecare.

The social cost of loss of freedom and amenity that comes with reduction or loss of vision, including aged care costs that arise from loss of capacity for independent living. According to the Department of Health and Family Services in its Annual Report 1997-98, each place in an aged care facility has a direct cost to the Commonwealth of approximately $30,000 per annum. Commonwealth expenditure on blindness pensions and related social security costs in 2001-02 amounted to $2079 million.

There is a growing trend worldwide to evaluate disease and disability prevention on the basis of costs incurred and benefits accrued. Public health interventions to prevent blindness are particularly revealing in this respect, as cost savings and return on investment accrue, because of the avoided rehabilitative costs, on the one hand, and the gains in productivity on the other.

In 1990, the aggregated cost of blindness to the federal budget in the United States was estimated to be approximately US $4.1 billion. A minimal federal budgetary cost of a person-year of blindness (vision less than 6/60 in the better eye) for a working-age adult was estimated to be US $11,896.

More importantly, it has been estimated that in the USA, if all the avoidable blindness in persons under 20 and working-age adults were prevented, a potential saving of US $1.0 billion per year would accrue to the federal budget.

In a study in the USA, the annual cost of welfare benefits per patient with severe visual loss caused by diabetes was estimated to be nearly seven times the cost per patient per year of vision saved. The same study concluded that prevention programs aimed at improving eye care for diabetic patients result in substantial federal budgetary savings and are a highly cost-effective health investment for society.

By preserving vision, good eye care can help to keep people in the workforce thereby mitigating to some extent the effects of loss of revenue to the Commonwealth and reducing welfare expenditure predicted in the Intergenerational Report.

The economic costs, including health care costs that come from accidents such as falls or automotive or industrial accidents arising from defective vision. In 1995-96 the cost of falls in the elderly in Australia was estimated to

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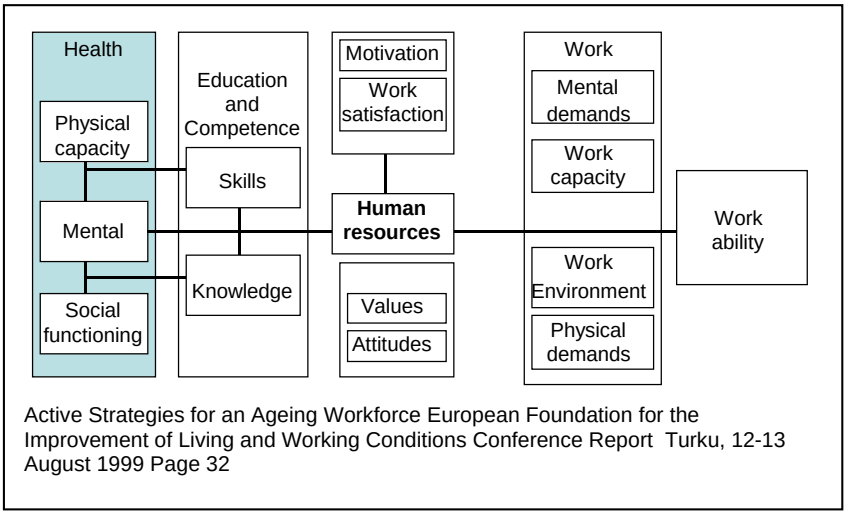
[27] Page 14 New Approaches to Improve the Health of a Changing Workforce Dr. Richard Wynne & Dr. Robert Grundemann, European Foundation for the Improvement of Living and Working Conditions Luxembourg: Office for Official Publications of the European Communities, 1999

be $2.5 billion. Current costs would be considerably higher due to the ageing of the population and escalation of treatment costs. Research has shown that elderly poor vision is an important factor leading to falls requiring hospitalisation. If one per cent of falls could be prevented by improvements to vision the savings to the community would be in excess of $25 million.

The cost of injury from motor vehicle accidents in Australia was estimated in 1995-96 to be $2.2 billion. Again if only a tiny proportion of these accidents could be eliminated by improved vision, the economic gains would far outweigh the investment in eye and vision care.



Active Strategies for an Ageing Workforce European Foundation for the Improvement of Living and Working Conditions Conference Report Turku, 12-13 August 1999 Page 32

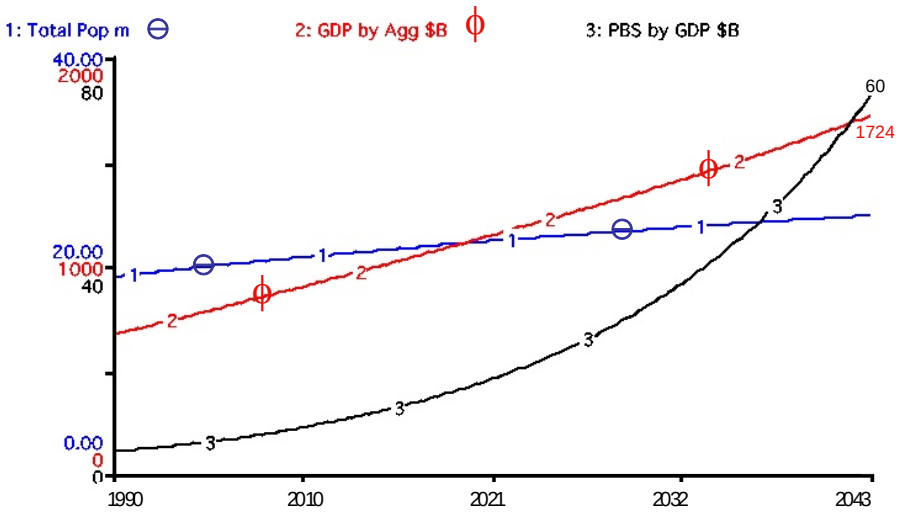
Productivity losses due to uncorrected refractive error or visual impairment reducing the capability to work or the efficiency of work. Several studies have shown that approximately 20 per cent of office workers require a change to the glasses they wear or that the workers were in need of vision correction for the first time. Apart from reduced efficiency inadequate vision correction can cause a variety of symptoms of eyestrain ranging from sore eyes to headaches[28].

The same type of analysis could no doubt be made about dental care, dietary interventions, and many largely uncounted health maintenance activities that are the way in which Australia, through its health workforce, maintains its capacity to be productive. Such positive relationships, between health, productivity, participation and wealth production, are everyday parts of our national healthcare system. However they are poorly counted in the development and explanation of policy, and this is leading to a misguided approach to health investment and cost control.

[28] Optometrists Association of Australia pers.comm.

MODELLING HEALTH INVESTMENT

Chart 1: IGR perspective on medicines



The Intergenerational Report sought to predict future health costs, with a focus on pharmaceuticals. The modellers made macro-level economic assumptions about population growth and migration, participation in the workforce, productivity and the future price of pharmaceuticals. The IGR focused on three elements – population ageing, GDP, and the health cost to government.

In order to discuss the important issues raised by the IGR, the National Healthcare Alliance has taken the basic conceptual structure of the IGR as a starting point for a re-examination. Our modelling[29] replicates the same outcomes as the IGR model, when the same settings are used[30]. It goes further and considers the productivity impacts of health investment, and estimates the potential for future quality improvement and transaction cost reduction in the health system.

We highlight the caveat that this modelling is preliminary, and is subject to further development. It does however point to some of the key issues and relationships that are not being adequately considered in health policy development.

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29 Prepared by Healthcare Dynamics, based on extensive workshops with Alliance members and front-line health workers, coupled with a literature review. Different underlying assumptions will give rise to different outcomes, and any results are indicative only. Further development and calibration of the model is intended.

30 In turn these results approximately mirror the Access Economics modelling results referred to earlier.

Understanding health investment

The IGR modelling did not highlight the extent to which health expenditures are positively related to GDP, through enabling productivity. This is fundamental in the design of a national health policy. The model indicates, even within the narrow confines represented by the IGR, that there is a powerful economic impact of health investment with an ageing population.

Good health can be supported well into Australians' later years with good health policy and the effective management of resources across the preventive, treatment and care spectrum. The challenge for the health and aged care system will be how to respond effectively to the increasing numbers and expectations of older people as they become frail in their later years of life, using an appropriate mix of private and public funding sources.

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Further, the extent of that investment payoff is linked to functional improvements in service delivery and a reduction of the transaction costs and waste associated with sub-optimal system management. These cannot be achieved by the strategies proposed through the IGR but are the focus of the strategies proposed by the National Healthcare Alliance.

The National Healthcare Alliance does not accept the narrow framing of health issues adopted by the IGR modellers. Healthcare is a 'knowledge' industry, where many elements interact to create the outcome. In achieving a healthier population, there is interaction and inter-changeability between (for example) preventative care and community education, early intervention, lifestyle advice, pharmaceuticals, and community care. Frequently the optimal strategies involve networks of professionals, carers and patients addressing the same issue from a range of perspectives. Efficiencies arise from the quality of the operation of the system, not from any one particular form of intervention.

Illustration

To illustrate with respect to medicines, pharmaceuticals are a product representing 'embedded knowledge', that is to various degrees replaceable by other health knowledge such as

- preventative knowledge, whether held by health professionals or the general community who may apply that knowledge to prevent harms which would otherwise require medication; or
- non-pharmaceutical curative knowledge, whether in the form of medical practice or paramedical services, including self treatment.

The utility of medicines is relative to other interventions, both pharmaceutical and non-pharmaceutical, the effectiveness of which largely depends upon other contextual matters, such as the quality of diagnosis, and interaction with

If there is a greater GDP increase from health expenditure than the costs, then there is a case for that investment.

other interventions during the period of recovery. Such interchangeability/interaction characteristics are the norm within the health system. Curative surgical or physical manipulation (for example through optometric work) is often a post-hoc remedy for earlier failures of prevention or less drastic intervention (for example dietary interventions to reduce the impacts of diabetes). Mental health intervention is frequently a cost made necessary by social or educational system failures earlier in life. It is for this reason that the key strategy needed to maximize the economic (and social returns) from health investment is systemic quality improvement to increase the return from that investment.

Modelling suggests that by 2043, on a 'business as usual' approach to healthcare, Australia with a population of 24.85 million will be spending around $60billion/annum on the Pharmaceutical Benefits Scheme alone, with a national GDP of around $1724 billion/annum. We do not yet have the benefit of projections for other aspects of the total health system including:

- health insurance (public and private);
- non-government expenditures;
- hospitals and institutions; and
- related interventions such as prevention focused campaigns

We do however have sufficient modelling results to show that in GDP and health cost terms the likely result from focusing merely on cost to government within the existing management paradigm will be far less beneficial than working on increasing the value of health outcomes through systemic reform and innovation. That is the essence of the case made by this submission.

Health investment with benefits considered

The NHA model considers medicines use taking into account:

a. the systemic effects of healthcare on productivity, and thence on GDP; and

b. the existing inefficiencies within that system (opening up the possibility of counting the economic impacts of reducing these).

There are barriers to the effectiveness of medicines use that are not considered by the IGR, the reduction of which would improve the return on the investment in healthcare . Such limitations are relevant to all forms of health care, but modelled with respect to pharmaceuticals. The three categories are:

a. Overuse. Overuse occurs when treatments are prescribed that are not essential to treatment

It has been calculated that improved health from reduced cardiovascular disease alone benefits the US economy by over one trillion dollars a year.

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outcomes. An example of this is prescription of anti-biotics for the common cold. The impact of overuse is avoidable waste of health resources. This form of waste is a result of poor diagnosis or prescribing, poor dispensing, or poor use of treatments. The key to reducing this cost (which could be as high as 20% of medicines purchased) is in the quality and availability of services surrounding the treatment provision. Reducing investment in the quality or availability of advisory support has the (perhaps counter-intuitive) potential to increase the overuse cost of healthcare.

b. Misuse. This occurs when the wrong treatment is used, or when it is used in the wrong way. There is a number of possible forms of this effect, including the replacement of less expensive treatment with more expensive (a waste of health resources), or adverse health effects from misuse. Since the causes of this problem are found in the patient/professional relationship, and in the circumstances of the patient, then it is to these issues that effort must be directed to improve the outcomes. Once again, quality of intellectual input and support for the user is the pivotal consideration in reducing these inefficiencies.

c. Under-use. This arises when there is a treatment available that could relieve a medical condition, but where that treatment is not used. The result is preventable loss of quality of life and productivity, and frequently additional higher costs once the avoidable problems become critical. Under-use is attributable to causes as diverse as:

   i. Unawareness of the health issue (such as where a low level chronic problem is accepted and not treated until it has matured);

   ii. The inability to obtain diagnosis, perhaps due to access difficultly, affordability, or the absence of suitable diagnostic resources;

   iii. Mis-diagnosis or mis-prescription of the treatment; and

   iv. Inability or unwillingness to apply the treatment. This can be attributable to a host of economic or social causes.

In none of these instances is the management of the cost of purchased inputs (is pharmaceuticals) in isolation from other forms of knowledge input, or in isolation from management of the social context of treatment, the key to improved value for money.

Health effects are systemic

The effects of poor vision and visual impairment are pervasive in both a social and economic context. For example, a somewhat bizarre illustration of how disparate the effects of poor vision are is given by dental research that shows that elderly people with a vision impairment were more likely to have dental problems, presumably because they could not adequately brush their teeth and could not see signs of dental decay or gum disease at early stages. There is little that we do that is not enhanced and made easier by good vision.

Optometrists Association
Pers Comm, 2003

Modelling possible strategies

Modelling of different strategies shows the marked range of possible outcomes from health investment. Again, the modelling is focused on the medicines aspect of healthcare but the conclusions can be extrapolated more widely to the health system as a whole.

	Description	GDP $B.	PBS $B.	Dependent/ employee impact
1	Base case (reflecting IGR assumptions)	2143	60	0.75 dependents per employee
2	Adjusted for positive feedback and moderate system improvement	2221	58	Reduced by about 10%
3	Adjusted for feedback without systems improvement	2110	61	Increased by about 5%

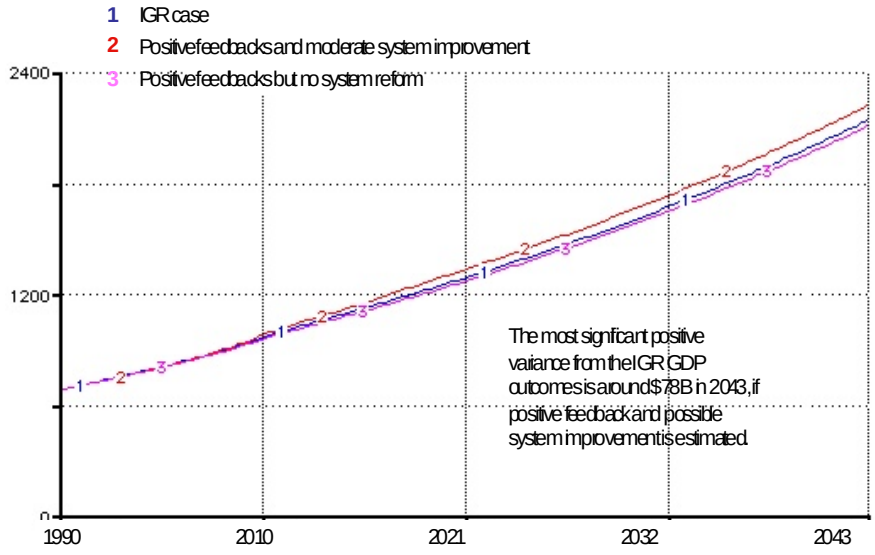
The structural improvements in scenario 2 involve a reduction of overuse to 10%, underuse to 5%, and misuse to 5%. In scenario 3, these levels remain as per current estimates.

The positive effects of monopsony purchasing power were also considered, but the results have not been displayed because actual effects vary markedly depending on what strategy is used in implementing a more 'open' scheme. All versions of an open market scheme show significant cost escalation of the PBS. When the price and price escalation characteristics of the open market US pharmaceuticals markets are incorporated, the outcomes show a scheme cost that is over three times the modelled outcomes under the Australian PBS. This modelling indicates that government has a substantial value-adding role in the health system. This supports the case that has been made elsewhere of a substantial downside potential in the free trade negotiations between Australia and the USA, should the PBS be changed substantially in ways that move towards the American model.

Modelling GDP, PBS and dependency outcomes

The GDP difference between the modelled scenarios seems small in a

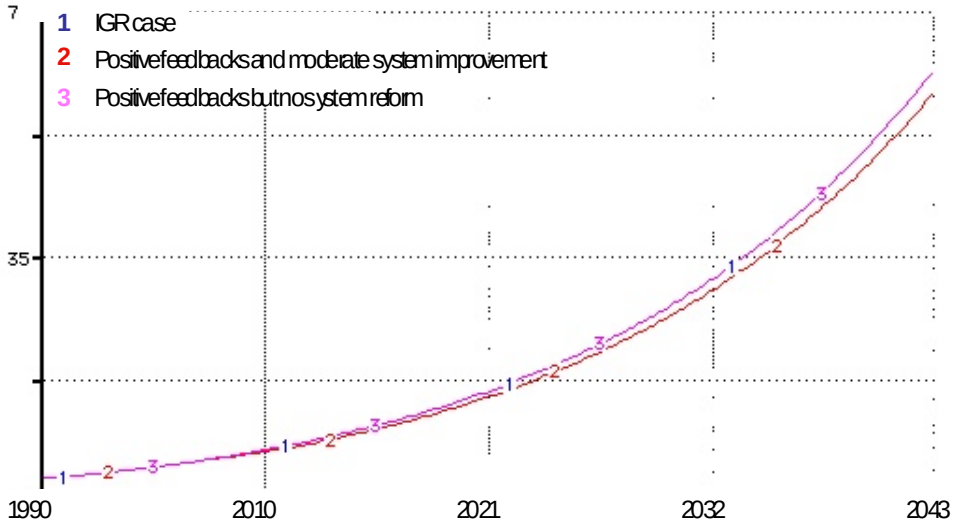
Chart 2: GDP Impacts of possible strategies



graph, but in absolute terms are substantial. Scenario 2 (improving the effectiveness of the health service) delivers some $78 billion per annum in economic benefit.

These outcomes are persuasive of a view that adopting a ‘cost to government’ measure of return on investment in the national health system is a poor management choice. It places one stakeholder interest above all others, and treats funding through government (a form of risk and financial pooling) as inherently undesirable rather than as one management option among a myriad of pooling possibilities. A more persuasive measure is the impact of health investment on the dependency ratio – a measure of how many people are supported by each person in employment. The various scenarios modelled show that there are marked differences in outcome depending on the management focus adopted.

Chart 3: PBS cost under different assumptions

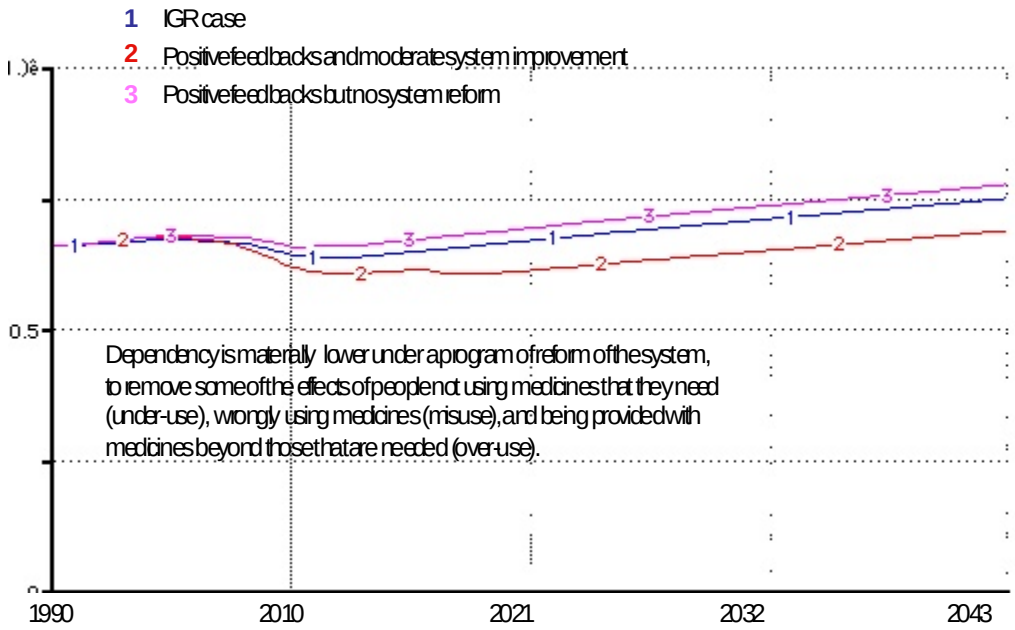


The most significant positive variance from the IGR model PBS cost outcomes is around $2B in 2043, if positive effects of health investment and possible system improvement are considered.

Any scenario that does not reflect full government use of monopsony power results in far higher scheme costs.

Dependency is a fundamental measure of the social and economic potentials generated through health investment. The strategy represented by Scenario 2 provides the clearest benefit in this regard. In all instances dependency increases over the long term, but with a strategy of health system improvement but continued government investment the increase is marginal even over a 40 year time frame. As outlined in earlier discussions, dependency is important but is not necessarily disastrous. Provided that there is a sufficient working population to ensure that the consumption needs of the dependent people are met, and sufficient capacity to pay for these services, dependency does not equate to community impoverishment.

Chart 4: Dependency under different strategies



Implications for policy

Any modelling is indicative. Conclusions need to be treated with caution. The Alliance modelling of the medicines use system takes into account the productivity impacts of healthcare investment, and considers the opportunities available from both increased investment, and refinement of the health system to reduce the existing barriers to its full value contribution.

The National Healthcare Alliance recommendations are for this reason focused upon measures to improve the value generated, and lowering the transaction costs of generating that value, from current levels of health expenditure within the framework of the institutional structure of a publicly owned and publicly coordinated national system.

A secondary issue, not directly part of the Alliance reform agenda, is the need to take a very cautious approach to any strategy that emulates the American healthcare system approach. It is demonstrable on virtually any statistic that this is not an effective approach to cost-effective healthcare or social equity. The results are a reduction in economic productivity along with marked increase in health costs. Placing this alongside an ageing population does have the potential to create major long term problems for

The modelled results suggest that reducing inefficiencies (including under-use) offers potential benefits measured in the tens or hundreds of $billions, with marginal cost increases. It also indicates that the payoff from shifting from the efficient purchasing through government model (as embedded in the PBS) could markedly increase the costs to government and the community of healthcare.

Australia.

High-leverage reform

These proposals are the result of transparent consultative processes involving experts at the front-line of health care. The first stage was the creation of an economic model, the Medicines Use model[31]. This model was developed through intensive consultation with National Healthcare Alliance members and other experts, representing a diverse range of health professional, carer and consumer perspectives. It was verified against the modelling results of the Intergenerational Report[32], and presented to the national symposium of health professional, carer and consumer representatives in June 2003.

The main difference between the Medicines Use model and the logic of the IGR is the recognition of the link between good health, effective healthcare and economic productivity.

The second stage was an independently moderated value management study, involving 40 experts[33]. Federal government health agencies were invited to participate in this study, but chose to limit their participation. Out of that study 8[34] areas were identified as areas for further development that offer a good cost/value ratio[35]. These areas of potential high leverage reform are:

1. Looking after those who deliver healthcare
    a. Human resource planning for the professions as a whole[36], and
    b. A human resources and incentives approach to caring, to ensure the both availability of and fairness to carers[37].
2. Targeting improved value, not merely cost to government[38], in the design of health policies and strategies, including:
    a. setting national value-focused performance indicators for health, that account for the contribution of health services to social and economic goals, and synergies across health ‘silos’.
    b. Encouraging debate about health financing that recognises health as the key to many social and economic outcomes.

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31 A fuller description of that model, and of the processes used to identify reform proposals, can be obtained from the National Healthcare Alliance web site.

32 Further refinement, verification and calibration of the model is intended.

33 Independently facilitated by the Institute of Value Management. Copies of the study report are available from the web site.

34 These are ‘interim’, pending a properly developed national healthcare approach that engages both government and the users and providers of health services. It is towards such a system-wide integrated national healthcare strategy that the work of the National Healthcare Alliance is directed.

35 The detail of these concepts is available in the Value Management Study report.

36 Including a ‘zero-based’ reconsideration of incentives, supports and role allocation to deliver the optimal health outcomes, with full consideration of the preferences and capabilities of those who are expected to serve these roles.

37 Taking into account the compounding effects of ageing and potentially declining workforce capacity on voluntary carers.

38 The Alliance notes that payment through taxation-based mechanisms is conceptually little different to other forms of forced payment and pooling of resources and risk. The Alliance is consciously agnostic about the superiority of either public or private funding mechanisms. The choice of risk pooling and payment mechanism should be based on demonstrated efficiencies.

3. A more constructive policy and strategy dialogue between government, community and practitioners including:
    a. Serious consideration of an Australian consumer health package concept, which captures the best aspects of managed care (mainly the efficient management of networks) but which does not accept the serious deficiencies of the US models (particularly associated with corporatisation, and abuses of economic influence); and
    b. A more open and transparent process for the design of health strategies to meet national objectives.
4. Improved communication/education involving community including:
    a. Finding ways of letting the community have a stronger voice in the shaping of policy goals of the health system;
    b. Developing proper measures of satisfaction with community outcomes, to evaluate the effectiveness of the system; and
    c. Community education about quality use of medicines, and improved empowerment in health matters.

Addressing these four recommendations requires a far higher level of strategic leadership than has been evident in healthcare policy in recent times. The issues are pivotal to Australia's social and economic future and should be seen as such. The next four, which fit within this framework, are more operational but nonetheless vital to the future operation of the health system.

5. Fostering flexibility, innovation and experimentation, leading to new and more flexible models of health services delivery. Directions identified included:
    a. Better prescribing support so that prescribers more actively consider non-PBS alternatives or low cost alternatives[39];
    b. Ways of removing the practice 'silos ' and opening up/rewarding/enabling local innovation[40].
6. Developing better networked healthcare including:
    a. Focusing on the use of teams tailored to circumstances; and
    b. Integration and coordination, and allocation of roles to maximise value of expertise[41].
7. Plugging leakages and wastage, including:
    a. Finding better ways of dealing with fraud and misallocation of health resources;

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[39] for example, ensuring that the 'yellow book' addresses non-PBS medicines, so that non -PBS alternatives are more commonly part of the evoked set of possibilities considered by the practitioner.

[40] for example by far more flexible reimbursement schedules to encourage innovation by networks of practitioners to address particular local circumstances, or clinical issues.

[41] This may include the consideration of different triage models and more rational structures for managing administration so as to free up the general practitioner to do more highly skilled and better rewarded work, at the same time as making better use of para-medical staff and allied health professions.

   b. Pursuit of radical reduction of transaction costs, centrally considering the transaction costs to the patient[42].

8. Marked improvement in medicines information including:
   a. Radically better means for ‘teaching’ and ‘listening’ interactions with the consumer;
   b. Improved evidence base for clinical and policy decisions, including better consideration of non-pharmaceutical and non-treatment options[43];
   c. Standardisation of prescribing and other information provided about drugs, leading to easier (and less risky) substitution.

These priorities are not put forward as a ‘take-it or leave-it’ approach to the problem of how to ensure cost-effective healthcare for an ageing workforce. That challenge is one that can only be met with the full engagement of all stakeholders, of which government is one. These are reform opportunities that offer a significant payoff, and which can be pursued immediately as part of a larger agenda of moving to a more carefully considered national health strategy.

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[42] making the patient the central consideration in system design, and taking into account all transaction costs including personal cost and inconvenience.

[43] like lifestyle improvement.

Where should the re-thinking begin?

The challenge that we have painted is not unique to Australia, though Australia faces it armed with a stronger healthcare system and national retirement program than many other nations. Most developed countries are either at the same point in rethinking age, wealth and health as we are, or have only recently moved on to trying to grapple with these issues at a national strategic level.

Canada has recently completed a comprehensive review of these issues, the Romanow Commission. The Commissioner's perspective is informative[44].

As one report described it, health human resources planning is like a "classic soap opera – tune out for years, and there is a reasonable chance that not much will have changed when one returns" (Barer et al. 1999, 3). It is time to bring this soap opera to a satisfying conclusion.

Throughout its consultations, the Commission repeatedly heard calls for leadership and a more concerted effort across the country to address not only the immediate issues but also to initiate a national discussion about future needs, and the best ways of optimizing Canada's health workforce.

In the work done for the Commission by the Canadian Policy Research Networks, the researchers quickly came to the conclusion that there is "… one key thing that must take place if we are to get anywhere with improving health human resource planning capacity. Over and over again in this project, we were told that there is currently no viable mechanism for health human resource planning in Canada and therefore, human resource issues go round in circles, never really getting to the heart of the matter" (CPRN 2002, 36).

Experience with health human resources (HHR) planning in Canada has been plagued by the following problems:

- *Planning is intermittent at best – There is little evidence that planning adequately considers population demographics and trends, the broader determinants of health, the specific needs of patients, or the unique and shared knowledge and skills of health care providers. Further, planning approaches are frequently based on one-time estimates focusing on a single discipline.*
- *Too often, the emphasis is on quick fixes – According to a roundtable on health human resources sponsored by the Commission, Canada has a relatively poor track record in health human resources planning because its policies have tended to focus on quick-fix solutions. As British Columbia's Minister of Health Planning pointed out, we are currently paying the price for decades of patchwork vision (British Columbia 2002).*
- *The lack of adequate planning has contributed to the declining quality of work life for health professionals – Our over-reliance on part-time, casual*

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[44] Building on Values: The Future of Health Care in Canada – Final Report Commissioner: Roy J. Romanow. NOVEMBER 2002, pp110-111

and overtime work has created a health care workforce that is extremely dissatisfied with its work environment.

The Clair Commission in Quebec observed that "Recent years have been difficult for the people who work in the health and social services network. To this day, overwork, the instability of work teams and shortages in some professional categories, in particular nurses, along with all sorts of inflexibilities, continue to create the general feeling of dissatisfaction, exhaustion and gloominess that too often prevail in the network's institutions" (Clair 2001, 106). The declining quality of the health care workplace, especially in nursing, has also created further pressure on salary rates across the country.

- *Planning has been limited to individual provincial and territorial initiatives – In isolation, provinces, territories and individual communities are developing their own solutions to many of the challenges facing their health workforce, from specific initiatives to recruit and retain professionals in rural and remote communities to targeted education and training programs. The result is considerable duplication in efforts across the country. Barer et al. (1999, 39) suggested that our lack of a national approach to health human resources planning, coupled with limiting and narrow perspectives from individual provinces concerned with their own supply issues, has resulted in "a history of destructive competition rather than cooperation." Some also have suggested that the decisions of some provinces result in effectively "poaching" scarce health professionals from other provinces. As was observed at the Commission's expert roundtable in Halifax,*

  "Across the board, we have a national pool of trainees – yet provinces are working in isolation without a national presence. There is an irony in Nova Scotia increasing enrollment in medical schools when what we are training is more doctors for Alberta."

- *Planning is complicated by the interdependency of issues and the significant number of actors involved – Workforce planning is affected by a number of interrelated issues including education and training, scopes of practice, different regulations in the various provinces and territories, and continuing workforce tensions in the health care system. Combined with that, there is a multiplicity of actors involved from provincial and territorial governments to universities, regulatory bodies, unions, and individual employers (see Table 4.3). As CPRN (2002, 40) notes, "Historically, Canada has had a situation in which governments do one thing, educational institutions do another, and regulatory authorities do a third."*

In America and in other jurisdictions there are moves towards a comprehensive rethink of health and wealth issues, because of similar pressures. Australia needs to grasp the same nettle.

In the meantime, what approach should the Australian government adopt?

First, we should recognise that it is far easier and faster to dismantle a health workforce than to create one. We need to increase our investment in health services, whilst at the same time being brave enough to begin to rethink the model for delivery of that investment. A number of the National Healthcare

Alliance participants have put forward budgetary submissions that are directed towards strengthening various aspects of our capacity, in the interim. These and other similar strategies should be embraced as mechanisms for at least maintaining our strategic capacity.

Second, Australia needs political leadership in health investment. We need someone with the power and the insight to take on the difficult problem of leading the creation of a national healthcare strategy, and driving it through to implementation. This is probably the major challenge for Australia in the next 20 years, and it should not be lost.

Third, we need to bring the detailed expertise alongside the 'big picture' policy formulation expertise in shaping this strategy. This means that the process has to be inclusive, it has to be detailed and it has to be painstaking. Finance issues have to be reconsidered alongside clinical and social issues, and all have to be considered within a context of values that reflect our national aspirations.

The National Healthcare Alliance is committed to an approach to health policy formulation that is open, transparent and which harnesses the knowledge of those at the front line of service delivery. Government is one of these stakeholders. The proposals outlined above are put forward in the belief that there will be a rich dialogue with government to refine these, to ensure that the maximum value to the community. If we (as a community) fail in the development of policy formulation processes that generate this constructive dialogue, we will certainly fail to deliver optimal value from our national healthcare investment.

We invite this dialogue and collaboration, and offer this submission as a framework for reconsidering the public investment in the health system as a source of community wealth and social

Along the same lines, a North Carolina participant observed that, " the reality is that America does not have an agenda for health care, which should be the driver of the health care system…. We have random acts of improvement going on, but there is no overall vision."

Creating a national vision for health care will require the involvement of all health care sectors,community leaders and the public, but it starts with courageous political leadership. "Unless we have someone who is willing to step forward and very publicly say health care is the agenda, I don' t think it's going to take place," said a medical group CEO.

For too long the problems in health care have been pushed aside in favor of other issues. Leaders in every community agree that now is the time for elected officials to put health care at the top of the nation's list of priorities. In the words of one Jackson participant, "If we could declare our health care dilemma as a threat to national security, our country would react as it did in Iraq and act to correct it." The magnitude of the problems that face health care today demands that level of attention and focus.

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equity, not merely as a cost to the taxpayer.