Achieving equity in the Australian healthcare system*

Stephen R Leeder

IN 1988, I ATTENDED A WORKSHOP of healthcare service managers sponsored by the King's Fund of London. Participants included such managers and the odd academic from the United Kingdom, the United States, Canada, Australia and New Zealand. We were discussing resource allocation, and frustration mounted during the first 2 days. Ideologically, participants had divided into two teams — the US and the Rest.

On the third day, the leader of the US team said, "The difference between us is that you guys believe in equity and we don't. In the US, people are less interested in making sure everyone gets care than that those who can get it get great care. They accept not getting care *now* if they can see the opportunity to improve their position and succeed, so that, when they get the money, they will be able to buy great care the minute they want it. It is all about opportunity. People in the US want opportunity, not equity. That's what they think is fair."

It was important that the US delegate said what he did. It cleared the air. It reminded us that not all societies, and not all people within a society, share a common view of what is fair. In the US, fairness means that you will be encouraged to seek personal success without having to worry much about anyone else.

In the UK, Canada, New Zealand and Australia, there is a general interest in the well-being of others. I doubt that Robert Putnam could have written his book *Bowling alone*[1] about Australia. Putnam's book mourns the loss of social capital, a resource that grows from community trust and participation. Putnam especially laments its replacement with a fierce individualism.

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Stephen Leeder *was Director of the Divsion of Public Health and Community Medicine at Westmead Hospital and Professor of Public Health and Community Medicine (1985–1997) at the University of Sydney and Dean of Medicine 1987–2002. He was the foundation chair of the Board of Censors of the Australasian Faculty of Public Health Medicine 1990–1994, and has served two terms as National President of the Public Health Association of Australia. He chaired the Health Advisory Committee of the National Health and Medical Research Council, 1997–1999.*

The Earth Institute at Columbia University, New York, NY, USA.

Stephen R Leeder, PhD, FRACP, Visiting Senior Research Scientist, and Professor of Public Health, and Director, Australian Health Policy Institute, University of Sydney.

Reprints will not be available from the author. Correspondence: Professor Stephen R Leeder, The Earth Institute at Columbia University, 215 West 125th Street, Suite 3F, New York, NY 10027, USA. sl2249@columbia.edu

The meaning of equity

Equity conveys a sense of fairness, but sharpens fairness by adding equality and fellow-feeling. Equity it is not the same as equality, which simply implies similarity of status, capacity, or opportunity. Indigenous Australians, whose life expectancy is shorter than that of non-Indigenous Australians, represent the pre-eminent example of an inequality that is also an inequity.

Equity is an ethical value. US health and human rights academics Braverman and Gruskin defined equity as it applies to health:

> "... An ethical concept grounded in the principle of distributive justice ... Equity in health reflects a concern to reduce unequal opportunities to be healthy [which are] associated with membership in less privileged social groups, such as poor people; disenfranchised racial, ethnic or religious groups; women and rural residents.
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> ... Pursuing equity in health means eliminating health disparities that are associated with underlying social disadvantage or marginalisation. Equity ... focuses [our] attention on socially disadvantaged, marginalised or disenfranchised groups within and [among] countries, but not limited to the poor."[2]

This definition emphasises that individuals' need for healthcare services is based on both their medical condition and their social situation.

Of course, the problem of inequity in health is not due only to the healthcare system. According to Matthews, the poor health of Indigenous Australians is linked inextricably to social, cultural and educational as well as more classically medical causes.[3] She reminds us that, when addressing the health needs of the less socially privileged, we must do much more than just provide equitable access to healthcare.

Australia's health economists have also written and spoken frequently about equity in healthcare, but none has done so more consistently, clearly and passionately than Gavin Mooney. He accepts that there are many definitions of equity, but the one that he endorses is "equal access to equal care for equal need".[4]

That is fine for people on the same income and living in the same suburb. Nevertheless, as do Braverman and Gruskin, Mooney extends this definition by recognising the additional needs of underprivileged people. These people may need *more* access to *more* care for the *same* health problem than those with more money, better social support and better opportunities. Ring and Brown[5] and Deeble[6] observe that current healthcare service funding for Indigenous Australians does not match their severe and special needs. The extent of the positive discrimination we make in favour of such people will reflect how caring our society is.

In New South Wales, the resource allocation formula that guides the distribution of funding among geographical regions includes a loading that recognises the greater needs

of Indigenous people by multiplying the allocation for Indigenous populations by 2.5.[7] This is a good start, but we need to do more.

When equity is at work, sick individuals who seek help have their needs met. There is no compulsion or competition. No one is told, "Your need is too great; we can't afford to treat you — unless you can pay for it yourself." Patients in need of a heart transplant or expensive long-term therapy for HIV have the same degree of access — equitable access — to medication and care as patients with hypertension or mild asthma. Nor are sick people told, "Because you are old or poor or receive a pension, the government will pay for your healthcare, but will pay the doctor only half or three-quarters of what he or she would receive from treating a younger, rich person."

So the care provided under this definition is impartial. Who you are or how much money you have does not determine your care. Equitable care does not depend on your fame, fortune, or your ability to pay.

The principle of universality, on which Medicare has been built, takes seriously the reality that sickness and accidents happen chaotically to any of us, and that a humane and caring society wishes all its citizens to have the same access to the same standard of care, according to need, and unrelated to their financial status. This principle should apply to all public expenditure on healthcare in this country.

At present, many Australians do not have equitable access to good quality healthcare. The reasons for this are as follows:

- Some general practitioners have closed their books, healthcare services are scarce in poorer areas, and, in rural towns, "up-front" payments for consultations are increasing while bulk-billing is in decline.[8] Indeed, there were recent reports of some patients having received more speedy attention because they were willing to pay a surcharge (Professor J Richardson, Director, Health Economics Unit, Monash University, personal communication). All these things tear us away from equitable primary healthcare.
- Public hospital infrastructure is growing old and needs replacement.
- Access to high technology is patchy. Richardson (see personal communication, above) has shown that investigation and treatment of heart disease is three times more common among privately insured patients.
- Access to timely surgery is uneven, with private patients getting it quickly and public patients often waiting for a long time.
- Access to dentistry and ancillary healthcare services is inequitable — better access to high-quality services is offered to those who are privately insured and/or wealthy.[9]

Public funding for healthcare and equity

I want to examine two aspects of the relationship between public funding for healthcare and equity.

- The first follows from the observation that rich countries apply more public funding to healthcare (as a percentage of GDP) than do underdeveloped countries.[10] Investment in healthcare is a sign of a country's economic strength, and a reflection of its democratic values. Government investment in healthcare is both ethically desirable and economically rational.

This has some clear implications. To honour equity, as a nation, we must set aside enough resources to buy appropriate, quality services and safe treatments, and make these accessible to our citizens based on their need.

If the level of remuneration to doctors and other health professionals is lower than is economically or socially appropriate, or if the funds do not allow procurement of the most appropriate treatments, problems follow. Deeble estimated that the consumer-price-index-adjusted Medicare rebate for a standard general practitioner consultation (Item 23) has declined by $6 since 1984.[6] The recent fall in bulk-billing by general practitioners has led to reform proposals from the Commonwealth Government and the Opposition. While these proposals are different, both would cost an extra $300 million per annum, and neither would apply the funds equitably.

General practice is by no means the most expensive item in the healthcare system. As well as supporting general practice, we must ensure that our public hospitals are adequately funded. It is disappointing that the federal budget surplus has been used to fund a tiny personal tax cut when $2.4 billion, or thereabouts, would greatly help in raising our public hospital infrastructure to acceptable standards.

Canadian social commentator John Ralston Saul has suggested that governments which are committed to corporatism, rationalism and cost cutting as means to achieve greater efficiency can make beliefs such as "publicly-funded healthcare services cannot cope" come true. The failure of publicly funded healthcare services is an inevitable consequence of insufficient investment or disinvestment. Indeed, the Romanow Commission, set up to review Canadian Medicare, recommended an increase in its funding.[11]

I am convinced that, as a nation, we need to spend more public money on healthcare services, and that much of the strain on Australian healthcare in recent years is the result of underfunding. Furthermore, there is room to improve the effective, safe and efficient use of the allocated money, thus assuring its support for equitable access.

- The second aspect of the relationship between public funding of healthcare and equity that I want to discuss is the observation that high levels of government funding for healthcare do not guarantee equity. A strong investment by government in healthcare may be necessary, but is not sufficient, to achieve equity. Big private-sector contributions bias the government contribution in favour of the rich. This is the case in India[12] and the US, and is increasingly the case in Australia.

About 14% of GDP goes on healthcare funding in the US, compared with about 9% in Australia. The difference is the result of healthcare spending in the private sector, not the public sector. The public sector accounts for 44% of US healthcare spending,[13] and the proportions of GDP spent on public-sector healthcare are similar in the US and Australia. However, US public-sector healthcare expenditure is distributed preferentially to middle-class Americans

because of the huge additional expenditure from private sources which drags government funding in its train.

In Australia, the private health insurance rebate actually increased overall government spending on healthcare.[14] However, the rebate tends to distribute government expenditure preferentially to those with private health insurance — that is, the wealthier members of the community.

Moving forward

To place equity on the agenda in the public funding of healthcare for Australia, we need two things:

- Greater clarity as to what Medicare and other public money for healthcare actually fund (clearly, where the nature or means of funding is inadequate or inefficient, we should develop new funding mechanisms); and
- A way to determine funding priorities that has equity as its centrepiece.

On the first of these, we should consider a few funding additions and redistributions.

First, we should extend the principles of the Pharmaceutical Benefits Scheme and the Commonwealth Medical (previously Medicare) Benefits Schedule to cover other essential services in our healthcare system. We currently support dental and allied health professional services with public money, but preferentially for those with private insurance. We pay for a third of private health insurance premiums from public funds. From the 1998 Australian Bureau of Statistics Health Insurance Survey and AXA/National Mutual data for NSW, Spencer estimated that each year we give some $300 million of public funds for dental care of those with private insurance.[9] I believe that we should subsidise basic dental services for all Australians, as dental health is not a luxury.

Private health insurance rebates for physiotherapy, podiatry and other support services also channel public-sector funds to those who are privately insured. This runs counter to the principle of Medicare. If we consider dental and ancillary services justifiable areas of public expenditure for those with private health insurance, then we should assess what public funds provide to all other citizens in respect of these services. We should focus on equity in what we do and do not fund.

Second, the disparity in the payments that general practitioners receive from bulk-billed versus non-bulk-billed patients needs to be redressed. The Commonwealth Government is about to increase this disparity through its "Fairer Medicare" proposals.[15] This is unacceptable. I understand the complexity of the issues, and the need to increase remuneration for general practitioners, but the present proposal widens the gap between those who are bulk-billed and those who are not. We must be able to come up with something better.

Third, the Australian Health Care Agreements should take account of chronic disease management. For example, we could make more use of casemix methods in funding chronic disease management, although the AR-DRGs (Australian refined diagnosis-related groups) would have to be expanded to encompass continuing care and reflect the growing burden of chronic disease. The care of the chronically ill is an aspect of Medicare arrangements that requires substantial revision, including a full exploration of capitation rather than fee-for-service funding.

Funding of healthcare provided by all professionals, not just doctors, is critically important for people with multiple chronic health problems. Models of care for chronic illness urge team approaches with good leadership and management. Extended and coordinated care is difficult to achieve if we only pay doctors at bulk-billing rates, or, indeed, if we continue to rely on a fee-for-service basis.

Fourth, we need a coordinated plan to improve public hospital infrastructure in Australia. We need substantial additional capital funds, as well as ongoing funding. In the meantime, public hospital waiting lists, which disproportionately apply to those without private health insurance, constitute a real problem of equity.

How do we move forward? Our healthcare services change incrementally, and from time to time we need to review and consolidate them. Yet it is easy to overlook the importance to us of equity in such reviews.

This requires that we establish a process of determining what we should pay for through Medicare. For this reason, I propose the formation of a National Council for Equity in Healthcare, accountable to the Australian Parliament, with a mission to make the healthcare system more equitable. Its terms of reference would concentrate on the extent to which the resources available for healthcare are used equitably.

As part of its charter, the Council for Equity in Health Care should support community debate leading to the development of a national healthcare charter containing principles for a more equitable healthcare system. The debate would provide an opportunity for citizens, patients and carers to state their expectations clearly, and might produce some surprising results. When Gavin Mooney recently asked a citizens' jury in Perth to set priorities, it voted for equity and public health. When asked to set priorities within equity, Aboriginal health came first in the jury's agenda, ahead of rural and remote health and aged care.[16,17]

The proposed Council for Equity in Health Care could also review the contribution of the taxation system to healthcare. This is especially timely now that the GST is in place. The Australian economy is in good shape and it could sustain an increase in public spending on healthcare and health.

Although some say that there would be strong resistance among voters, a small progressive increase in the Medicare levy, to be used for the provision of more equitable healthcare, may well be acceptable. Opinion polls conducted by the major political parties have found that such an increase would be acceptable to most people in the way I have described.[18]

There are barriers to the achievement of equity that are not financial, and these deserve the careful attention of the proposed Council for Equity in Health Care. In remote Aboriginal communities, the absence of basic services compromises the universality of Medicare, and equity suffers.[19] People who live a long way from a city do not have equal

access to equal care for equal need, and may never fully do so. A previous federal Health Minister, Dr Michael Wooldridge, was correct when he said that Medicare was not the instrument to address the special needs of rural Australia. The Australian Institute of Health and Welfare has documented that Australians in large cities are bulk-billed for general practice services much more frequently than those living in remote areas.[8] One description of Medicare is that it is a metropolitan system.[20]

On the positive side, the Commonwealth Government has been energetic in seeking to improve healthcare services in rural areas. It has funded programs for medical student education and registrar training, and provided enhanced funding for services. These efforts are laudable, as are the levels of dedication of many healthcare professionals who have worked hard under less than ideal circumstances. The government is also working to open up access to Medicare and the Pharmaceutical Benefits Scheme for many rural and remote Indigenous Australian communities, and this is commendable.

There are also cultural and language barriers to equity in healthcare that can limit access to quality care. If there are not enough interpreters available in public hospitals, those who do not speak English fluently are disadvantaged. The cultural norms of the medical profession may easily prevent doctors from treating working-class patients in appropriate ways. Apart from underfunding, lack of cultural security is a major block to improving Aboriginal health.[20] The proposed National Council for Equity in Health Care should include these issues in its remit.

With increasing affluence, we can choose to invest more as a nation in the healthcare of our citizens. We can do much more to improve the degree of equity in healthcare in Australia. This is the course of a humane, caring nation with a belief in the value of civil society. We can apply business principles with benefit to many parts of healthcare. There is also a strong case for investing more in innovation and the evaluation of healthcare, and more in improving its quality and safety.

At its core, though, healthcare is about sharing and caring — sharing the load of illness and caring about ensuring access to the privilege of hope that humane medical care offers. We need political leadership, both lay and medical, that will seek to strengthen, not weaken, worthwhile achievements, and build on what this country has achieved over recent decades in providing equitable healthcare for all Australians.

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The Australian healthcare system is potentially dealing with two main problems: (a) resource allocation, and (b) performance and patient outcomes improvements. An interdisciplinary research approach in the areas of performance measurement, quality and patient outcomes improvement could be adopted to discover new insights, by using the policy implementation error/efficiency and bureaucratic capacity. Hospital managers, executives and healthcare management practitioners could use an interdisciplinary approach to design new performance measurement models, in which financial performance, quality, healthcare achieving equity. 4. system. 1. australian. 1. healthcare. 1. achieving. 1. Similar Publications.Â Please type a message to the paper's authors to explain your need for the paper. Paper: Achieving equity in the Australian healthcare system. To: Robert N Atkinson. From (Name): E-mail: Only shared with authors of paper. Please enter a personalized message to the authors. More detailed explanations for your need are more likely to get a response. Send Request. Load Form Load Form. Request PDF from Authors. We can help you find this article by emailing the authors directly. Follow us on Twitter to stay on top of the latest in scientific research. Press proceed to send the authors a message Table 20: Potential healthcare expenditure savings among Australian adults for each 1g increase in intake of grain fibre, based on level of population uptake (AUD $m). Table 21: Potential productivity cost savings from increased grain fibre intake (AUD $m). Table 22: Productivity cost savings for CVD by SES quintiles with increased intake of grain fibre (AUD $m).Â Grain consumption, the largest source of dietary fibre in the Australian diet, is in decline, despite the evidence of the health benefits associated with whole and high fibre grains and the direct association between core grains and fibre intakes among Australian adults. Consequently, dietary fibre intake is lower than recommended.