Health care: Re-framing our thinking

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"Timid" is the sharpest summary of the Interim Report of the National Hospital and Health Reform Commission.

Its recommendations and options, while including some sound technical reforms such as electronic patient records and more use of nurse practitioners, generally avoid addressing the major problems in delivery of health care. The Commission has alluded to problems, but has ducked the hard questions. In view of the high and rising cost of health care it would be reasonable to expect an inquiry of this nature to ground its work in cost-benefit analysis, but it is weak on economics.

The recommendations on primary health care simply build on the Labor Party's election commitment to superclinics. Similarly, the Commission's Option B, involving a Commonwealth takeover of public hospitals, is not new; the threat of a takeover, dependent on performance, was a Labor Party election commitment. "Denticare" has some new elements (including an extraordinary double churning of funds through taxes and private insurance), but there have been proposals for extra public funding for dental care ever since Medibank was introduced in 1975, and the notion of giving more attention to prevention and chronic care is a hardy perennial.

Rather than proposing fundamental re-design, the Commission has opted for cautious and incremental changes to current arrangements – a little tweaking here and there, a few minor re-allocations, but nothing so scary as fundamental structural change. It meekly accepts the existing "overall balance of spending through taxation, private health insurance, and individuals' out-of-pocket contributions", without questioning why such an accident of past incremental policy measures has led to an optimal balance. While it suggests some program re-arrangements, it doesn't question the existing supplier-based program structure, which compartmentalizes health funding into pharmaceutical, medical and hospital programs. And, in spite of the inequities and inefficiencies in private insurance, it does not even suggest any reforms to these arrangements, let alone question their economic justification.

Because of this cautious and incremental approach, it is hardly surprising that the report has been generally well-received by the various interest groups. It has not frightened the horses. The only exception is "Denticare", which has drawn fire from some lobby groups, probably because it is the only measure that wasn't already on the table.

Some may suggest that a little tweaking is all that's needed; we can be very complacent about health care. So long as it all goes on working tolerably well we are prepared to overlook problems such as inequities, complexity, the load of bureaucracy, waste, and the way in

which strong vested interests are diverting our health expenditure to corporate and personal profit. As Charles Lindblom pointed out many years ago, incremental change ("muddling through") is the easy path for public policy, and it is assured not to upset too many people who are comfortable with, or profiting from, the status quo.

Such timidity contrasts strongly with Australia's record of successful structural change. Even if there has been apprehension about large scale changes, we have generally accepted change well. The Howard Government's fundamental overhaul of indirect taxation and associated Commonwealth-State financial arrangements is the most recent case in point; it is doubtful if, once implemented, it involved any political cost to the government of the day. The industry policy reforms of the Hawke-Keating Government were even more radical, involving huge displacement of workers in highly protected industries, and the disappearance of many firms in clothing, footwear and light engineering. It belied the notion that a Labor Government would always be politically constrained from reducing tariffs.

While the reductions in industry protection did cause a great deal of hardship to those who lost their jobs and businesses, reform of health care should be much easier, for in health care there is a general shortage of labour. Even with radical reform, no one delivering health services should lose his or her job, and if reform can ease some of the administrative burdens, it would certainly be welcome. The only people who may lose out from reform are those bureaucrats who can demonstrate little value-added. When we think of bureaucrats we often confine our thinking to public servants in Canberra or the State capitals, but there are many others, particularly in the private health insurance funds, for we have somehow allowed the financial sector, in the form of private insurance, to attach itself to health care.

It would be easy to suggest that the Commission's cautious approach arises from conflicts of interest. Among the ten commissioners were people with close affiliations with specific interest groups – including the medical professions and the health insurers.

But that's a cynical view. There are other possible explanations. One is that they misjudged the Government's and the community's appetite for change. When the Commission was appointed the Rudd Government had been in office for only a month, and it was hard to guess where it would place itself. Also, it is reporting to a government which faces tremendous difficulties in getting even modest reforms through the Senate. If that is the case, then it's a missed opportunity, for even if a government is fearful of radical reform, it is helpful to have some strong recommendations as an initial bargaining chip. Conversely, it is difficult politically for a government to go beyond a commission's suggestions.

Another possible explanation, however, is that those who are so intimately involved in our present health care arrangements find it difficult to step back and take a detached view. Almost everyone involved in health care works hard to see that their element – be it a retail pharmacy, an outback clinic, a health insurer – works as well as possible. But it is hard for them to see their element from the outside. It is uncomfortable for them to entertain thoughts such as the possibility that the whole architecture may need re-design.

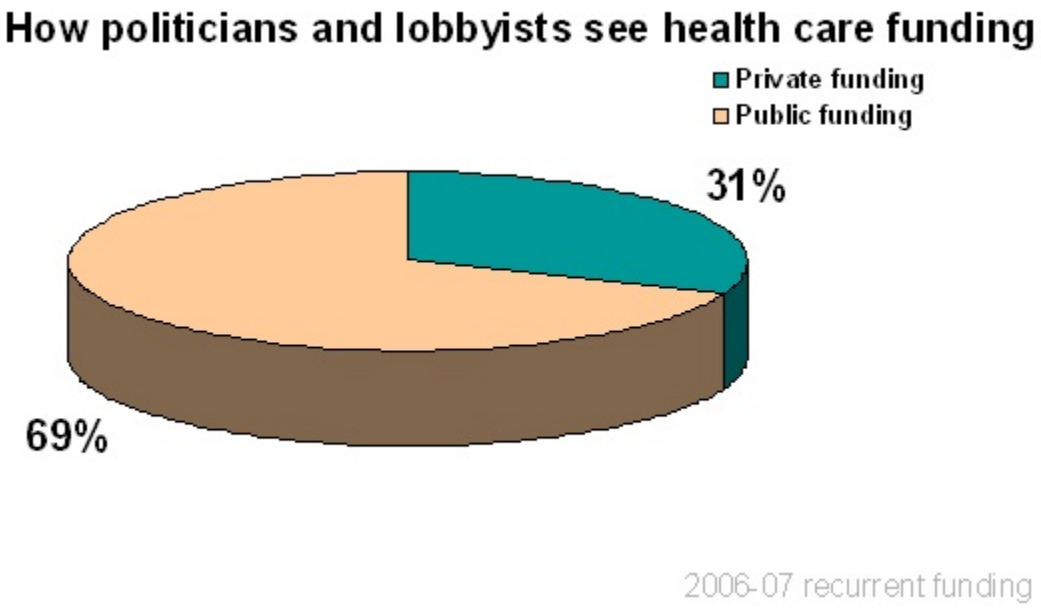
We have grown up with certain arrangements which have deep historical roots, but which have lost their relevance in many cases. For example, there was good reason for pharmacists to be separated from medical surgeries; in fact pharmacies were once specialist retail "chemists" rather than specialists in health care. But it is still hard for them to think of any

arrangement other than the stand-alone store in the local shopping center. When that model is questioned, the bogeyman of supermarket pharmacies is often raised as a defense, without any consideration of other models such as integration of pharmacy into primary health care, with pharmacists becoming an active partner in prescribing. Similarly, those who come from the private health insurance industry find it hard to imagine a health sector without private insurance; their bogeyman is Soviet-style "socialized medicine", or at best the British NHS, and they cannot contemplate a world in which there can be a thriving private sector and plenty of consumer choice without private insurance.

These impediments to broader thinking are what I would call "deficits of imagination", which stand in the way of fundamental reform. From the perspective of public policy I want to suggest some ways we can re-frame the health care debate, so as to suggest ways of thinking that may lead to genuine reform, which could see improvements in both equity and efficiency.

Re-frame 1. Think of the sharing/individual division, rather than the public/private division.

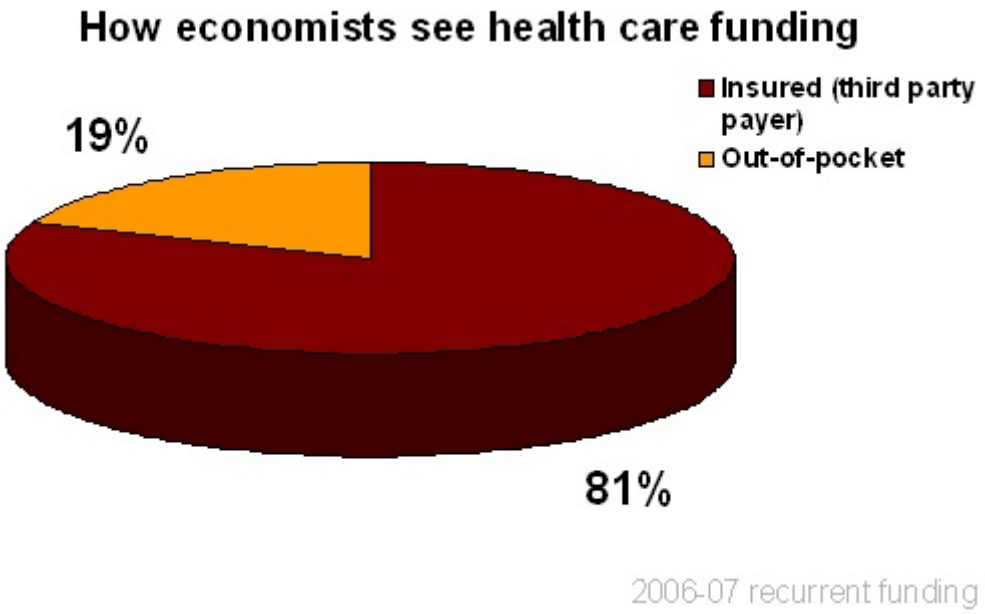
Most debate on health financing starts by looking at the division between public and private funding and provision of health care. On this model 69 percent of recurrent funding is from government, and 31 percent from non-government sources (8 percent private insurance, 4 percent other third party payers, and 19 percent individuals).



Such a division, although it tends to dominate public debate, carries little meaning. What is of more policy-related relevance is to consider what proportion comes from individuals and what proportion comes from third party sources. Most individual payments carry some of the

discipline of market forces, be those payments for non-subsidized drugs, co-payments for medical services, payments for dental services etc. By contrast, third party payments, government or non-government, are outside the discipline of consumer-provider market forces. The consumer's idea "MBF/HBA/Medibank Private will pay for it" is no different from the idea "Medicare will pay for it". Medical practitioners and others, with their patients' interests as a consideration, are likely to recommend services that put no pain on patients' pockets; the answer to the question "are you privately insured?" influences a provider's advice. (Economists know this phenomenon by the quaint term "moral hazard'.)

Private health insurance belongs on the non-market side of this divide – in the 83 percent of third party payments. Private insurers like to suggest that being "private" they bring some of the benefits of market forces into health funding, but the reality is that insurance is a mechanism people use, be it private or public insurance, to buy out of the discipline of market forces. Advocates of private insurance suggest that people who take private insurance demonstrate personal responsibility and self-reliance, but such thinking is seriously deluded, for insurance, by its very nature, is a means of handing over responsibility to another party, be it a government or a private insurer. The "no gap" policies promoted by private insurers offer a complete renunciation of personal responsibility.



The fundamental question reformers need to be asking is how we should split health care between pooled payments and individual out-of-pocket transactions. It is possible, but unlikely, that the Australian people want completely pooled payments, along the line of Britain's NHS. It is more likely that, in view of our generally rising prosperity and our greater exposure to markets over the years, we would be willing to pay more from our own pockets,

without the distortions caused by insurance, provided the markets in which we operate are fair, provided there are provisions for those without means, and provided that systems of co-payments do not skew choices away from efficient resource allocation. Sweden, for an example, has recently moved from a free system to one with a well-designed set of co-payments, and without the distortion of private insurance (which would dull the market signals of co-payments).

The Commission asserts that the present split of funding is appropriate, but puts forward no evidence in this regard. In fact, it's a question which has never been put to the public, but it should be, for it is about the very basis of the design of our health care arrangements.

If a question were put to the public, asking how payments should be split between individual payments and pooled payments, it is a reasonable guess that the public would not want to live with the current mess of disjointed co-payments with their potential for distorting choice. And, if they understood the true costs of private insurance – how it diverts resources, how it is so administratively expensive, how it is necessarily embedded in an "illness" model rather than a "wellness" model, how it fails to achieve community rating, how it contributes to health care price inflation – they would almost certainly choose, as people of many other countries have chosen, a single national insurer for that part of their payments they want to share.

Re-frame 2. Think of funding and delivery of health separately

The private insurance industry, supported at times past by suggestive government advertising, likes to create the impression that without private insurance there would be no private hospitals. And, as an extension of this idea to individuals, there is the notion that one must have private insurance to be admitted to a private hospital.

If one accepts such a frame, private insurance appears to be essential for survival of the private hospital system. But there is no reason why private hospitals should not be placed on the same funding basis as public hospitals – most probably on a DRG basis, or on some refined modification of DRGs. (The Department of Veterans' Affairs provides a workable model, with 100 percent public funding, but with most admissions to private hospitals.) There is nothing sacred or essential about this linkage. Almost any observer of Australia's health care would acknowledge the importance of private hospitals, and would acknowledge that most health program delivery is in the private sector.

But that doesn't mean private hospitals need to be tied to private insurance. In fact, if the Commonwealth paid its subsidies now paid to private insurance direct to private hospitals, which could be an intermediate step towards full activity-based funding. (The Hawke Government unwisely dropped a bed-day subsidy it used to pay to private hospitals.) With full activity-based funding there could be genuine intersectoral competition between private and public hospitals.

Further, in bypassing insurers, there would be a large saving in administration, and there would be even greater funding for private hospitals if there were not a leakage of funds to ancillary services. While the Commonwealth had some weak arguments for supporting private insurance for private hospitals, it never had any arguments for subsidizing private

insurance for ancillary services. The present arrangements are particularly unfair on those who pay for ancillary services from their own pockets. And, in any case, ancillary cover is a particularly poor product, for, apart from ambulance services, most payments are capped, leaving the customer with the open-ended risk. It's hard to call such a product "insurance", and there is a particularly high degree of moral hazard in providing cover for low-cost discretionary services.

In sustaining the linkage between private hospitals and private insurance the Commonwealth is going against its own general policies applying in other areas. The rhetoric of the Commonwealth is that purchaser and provider arrangements should be separate. The term "purchaser/provider split" is entrenched in the language of public administration. But, for health care, the Commonwealth holds to a notion that public funds are for public hospitals, and that private insurance is for private hospitals. The idea, expressed in the 2007 election campaign, that public funding could be used to buy beds from private hospitals, seems to have been lost.

On an individual basis, the notion that one must have private insurance to be admitted to a private hospital is wrong, but it's a convenient myth to frighten people into private insurance. Many Australians, including many older Australians who have accumulated retirement savings, can afford to use private hospitals from their own pockets, but if they do exhibit such self-reliance, they are denied the incentives which apply to those who insure. In fact, since the subsidies for private insurance have been in place, there has been a sharp decline in the proportion of people funding private hospitalization from their own resources. So much for "self reliance".

In this regard it is notable that the Commission's report (Page 126) essentially states that without private insurance one cannot obtain surgery in a private hospital. Perhaps the authors themselves have been so conditioned by the industry's suggestive advertising that they have forgotten that it is still possible for people to pay for their own private hospitalization.

Re-frame 3. Think of *all* costs, not just budgetary costs

Most proposals for increased public funding of health care will meet with the claim that any increase in public funding is unaffordable.

Yet, because demand for health care is comparatively insensitive to price, we will incur expenditure on health care whether we do so through taxes, private insurance or direct payments.

An obsession with budgetary costs, as opposed to total community costs, leads governments to cost-shifting, even when the result may be a higher, and less equitable, cost burden on the community.

For example, a government concerned with controlling budgetary costs may see private insurance as a means of reducing the budgetary burden of health care. But, because private insurance incurs higher administrative costs than public tax-funded insurance, such cost-shifting actually results in an *increase* in the community's total health care costs (not to mention the extra costs associated with provider price inflation and over-servicing). Private

insurance, because it is re-distributive, is what some economists call a "privatized tax", but it is a tax hidden from detailed scrutiny, with high collection costs, with entrenched inequities, and without the strong level of accountability and administrative control which characterize official taxes.

As another aspect of the budgetary obsession, the Commonwealth has always been very careful to keep tight control on expenditure on PBS prescription pharmaceuticals, but it has exercised no cost control on what are known as S2 and S3 pharmaceuticals (pharmacy-only and pharmacist-only pharmaceuticals), which are sold only in pharmacies and are not subject to the full forces of retail price competition from other outlets.

Governments generally state a commitment to cost-benefit analysis as a means of evaluating programs, in line with principles articulated by the OECD and generally accepted models of sound public administration. Cost-benefit analysis involves consideration of *all* costs and *all* benefits in *all* of society; it is not confined to budgetary costs. But, in a departure from such practice, the Commonwealth generally confines its analysis of health care programs to budgetary costs alone. In fact, this narrow fiscal confinement is enshrined in the regular *Intergenerational Report*, which projects health care budgetary expenditures into future years, but is silent on the total community's health care costs (which are rising faster than budgetary outlays).

We need to be skeptical about claims that public expenditure on health care is unaffordable. There may be good reasons to do with the benefits of competition and the costs of market failure for some programs to be in the private sector and for some to be in the public sector, but fiscal affordability is unlikely to be one of them. Whatever resources we devote to health care, and it is near certain that we will be devoting more resources over time, we will have to pay for them, through taxes or other means.. Arguments that we must have private insurance to reduce future tax burdens have no basis in logic, unless one believes that there is more virtue in a privatized tax than in a government official tax. It's the total tax cost that counts, and private insurance is part of that cost.

Re-frame 4. Think of resources, not just dollars

When the Commonwealth, in a series of initiatives starting in 1997, resumed subsidies for private health insurance, its claim was that in supporting private insurance and thereby supporting private hospitals, there would be relief of pressure on public hospitals.

As we now know (and as the Senate was warned at the time), the subsidies have not had that effect. Certainly there has been some shift of activity to private hospitals, but there has also been a shift of resources to private hospitals. Specialist hospital staff, including nurses and surgeons, are in short supply, and many are attracted to where remuneration is highest. The Commission Report recognizes that this movement has occurred, but it fails to connect this to the ongoing problems of waiting times in public hospitals.

It is probable that in shifting activity to private hospitals there has been more than a 1:1 transfer of resources. There is a good deal of research which shows that for given medical conditions, a patient is likely to get more intensive service in a private hospital than in a public hospital. It is an open question whether this means private patients are over-serviced or

public patients are under-serviced, but it is clear that when there is such a shift there will be fewer patients attended overall, and some misallocation of scarce health care resources.

When governments concern themselves only with financial outlays, rather than looking at the markets where those dollars are spent, they are likely to find that increased expenditure (private or public) goes at least in part into price inflation.

Re-frame 5. Think sharing, not charity

Public funding and provision of health care bring benefits of re-distribution, largely because illness and means are negatively correlated.

This often leads observers to evaluate public health care programs only in terms of their redistributive benefits, and to argue that the well-off should be excluded from any public programs. One of the immediate public criticisms of the Commission's "Denticare" proposals was that, in being universal, it was insufficiently targeted the least well-off.

But this thinking confuses the *outcomes* of government programs with their *purposes*. Certainly health care programs have redistributive benefits. So do other areas of public expenditure, including roads, education, policing and almost all other programs. But the purpose of public programs is generally to overcome some market failure.

In the case of health care, there are many market failures and positive externalities which justify public intervention. These include the public good nature of many programs, particularly health promotion, the long-term benefits of childhood and adolescent programs, and information asymmetries between consumers and providers.

Further, there is a sound reason why people may be more willing to share health care expenses than they are to share other expenses, for, while there are certain statistical predictors, ill health or injury can strike anyone at any time. We are generally prepared to take more chances in other spheres of our lives than in health care, which is why almost every country, even those with strong individualistic cultures, have widespread insurance mechanisms. For those costs people choose to share with their fellow citizens, countries tend to choose public over private insurance not for some "socialist" reason, but simply in recognition of the fact that, compared with private insurance, public insurance is more administratively efficient, has more power to control service costs, and achieves community rating through the tax system rather than the complex and failed mechanisms of the type that have been adopted in Australia.

Re-frame 6. Think of universal *access*, not necessarily "free" for all

In a statement, open to very wide interpretation, the Commission says:

> We affirm the value of universal entitlement to medical, pharmaceutical and public hospital services under Medicare which, together with choice and access through private health insurance, provides a robust framework for the Australian health care system.

What it seems to be saying is that everyone has access to Medicare, which has many free and subsidized services, but those who have private insurance have another layer of service which somehow offers more "choice" – a term undefined. Because the incentives for private insurance are heavily biassed to the well off (particularly the one percent surcharge), the more privileged have another system.

It's a "gated community" model of health care. Everyone is entitled to the basic service, but the more fortunate, encouraged with generous subsidies, have a superior service. It means the better-off no longer have a strong stake in a shared system. Withdrawal of the well-off to their own system takes out of the shared system those who are most likely to be assertive consumers and who will exert political pressure to sustain the system's quality.

That's a strange statement to put to a government which, ostensibly, is committed to social inclusion. In the one percent tax subsidy the government has inherited one of the most skewed subsidy schemes that could ever be devised – a subsidy that not only encourages the better-off to opt out of sharing their health expenses with other citizens, but actually over-compensates them for doing so. Anyone with an income over $70 000 is subsidized to opt out, and the higher one's income, the greater the subsidy, to the point that for high income earners they are subsidized more than the cost of their policies. Not even in the heyday of manufacturing industry protection were people actually paid to buy particular products – "if your income is high enough you can have a free Holden Kingswood plus the spare change."

But, in spite of the Commonwealth's stated commitment to social inclusion, and the Commission's reference to tackling the causes of inequities, the Commission has chosen to overlook this gross inequity in our funding arrangements.

Truly universal access should mean we all have access to the same services – the same clinics, the same hospitals, private or public, and the same amount of choice (however defined). Such a principle of universal access is compatible with differential payments, such as different means-related co-payments. In that regard, the PBS with its various concessions qualifies as a universal program, but the same cannot be said of our hospitals.

Re-frame 7. Think of the customer before thinking of the supplier

Around 50 years ago a revolution swept through businesses, which changed their organizational structures to reflect customer groupings rather than technologies. A car manufacturing firm would once have had an engine division, an assembly division etc. These structures were replaced by customer-oriented divisions – light vehicles, luxury vehicles etc.

Similarly, about 20 years ago governments in Australia, led by the Commonwealth, started changing program structures and appropriations from an input basis to structures around "outputs" and "outcomes".

Health care programs, however, remain locked in an antiquated input-based structure. The main programs are medical (MBS), pharmaceutical (PBS), and shared Commonwealth/State hospital funding. These various schemes have different co-payments, different payment systems and different safety nets. Worse, the Commonwealth tends to focus on particular programs when their outlays are growing faster than others. For example, a few years ago, the

Commonwealth was panicking about the cost of the PBS, without acknowledging the possibility that growth in drug therapies may be helping save on hospital outlays.

The Commission recognizes fragmentation as a problem, and has some fine words on "connecting care". But it is short on details. It does suggest bringing primary care into health centers where different health professionals would be co-located. But co-location is about as far as it goes. For example, while pharmacists may be located in these health centers, there would remain the present demarkation divisions between medical practitioners and pharmacists. Medical practitioners would still be writing prescriptions, and pharmacists would still be meekly filling them; there is no suggestion of pharmacists working with medical practitioners to be active partners in drug prescribing. Similarly, while its Option B involves a Commonwealth takeover of hospitals, it does not indicate how, if at all, there would be integration between primary care and hospital services.

Worse, it proposes to add "Denticare" to the existing mess of programs. Rather than simply being added as new items in Medicare, "Denticare" would have its own funding, with complex and costly special arrangements to preserve the role of private insurance in funding dental services. Just why funds should be taken from a low-cost community rated tax system and churned into a high cost health insurance system is not explained.

We would find it extraordinary if, when our cars needed repairs, we had to go to one establishment for short same-day jobs, to another to get parts, and to a third when we needed more extensive work. But, from a consumer's perspective, that's what our health care arrangements look like. And the private hospital arrangements are even worse; to continue the car repair analogy we would have separate contracts and would be making separate payments to the mechanics and the garage which provides the workshop space.

Some talk loosely of a health care "system", but it isn't a system by any stretch of the imagination. We have a loosely cobbled-together set of arrangements, designed at different times, reflecting practical priorities and political prejudices of the time they were designed, and designed around suppliers rather than users.

There are various ways a health care system could be designed around users, for example:

by intensity of use – chronic, acute and occasional;

by region – there are some hints in the Commission's Option B;

by demographic group – youth, aged etc;

by chronic condition – those with mental illness, diabetes etc

Occasionally there is an attempt to graft a new classification, such as mental health, on to the existing program structure, but it's difficult to achieve good design when the basic architecture is on a different, supplier-based, structure.

And "connected care" may have to go beyond what is commonly held within the boundaries of health care – a difficult task when governments have arranged their portfolio responsibilities to be largely isolated from one another. The emphasis on policy integration, which was a feature of public administration until the mid 1980s, has given way to weak

attempts at policy coordination at best. The result is that consumers facing a complex array of disconnected programs designed around providers' needs..

Of course, any break from a supplier-based structure would meet with strong opposition from provider lobbies. But that's a good reason to break the structure, for at present Commonwealth and State health departments have organizational structures which make it very easy for provider lobbies to find the right point of influence. By contrast, because patients draw on different programs for one condition, consumer groups have no one focussed point of influence.

Re-frame 8. Think one tier, not necessarily a Commonwealth takeover

The Commission sees integration in a Commonwealth takeover of primary care and possibly of public hospitals (while exempting private hospitals from any such integration).

There is a sound argument for providing all health care programs in one tier of government, but there is no strong reason why that tier should be the Commonwealth. The Commonwealth's economic role is primarily as a funder of services rather than as a provider of services. States have administrative and governance structures designed for program delivery.

It should be possible for the Commonwealth, while providing all pooled funding, to leave provision of services to the States. In such an arrangement the Commonwealth would also have a role in specifying minimum standards of access to sustain universality, in negotiating pharmaceutical prices with drug companies (so that states can buy pharmaceuticals at Commonwealth negotiated prices), and in setting quality standards.

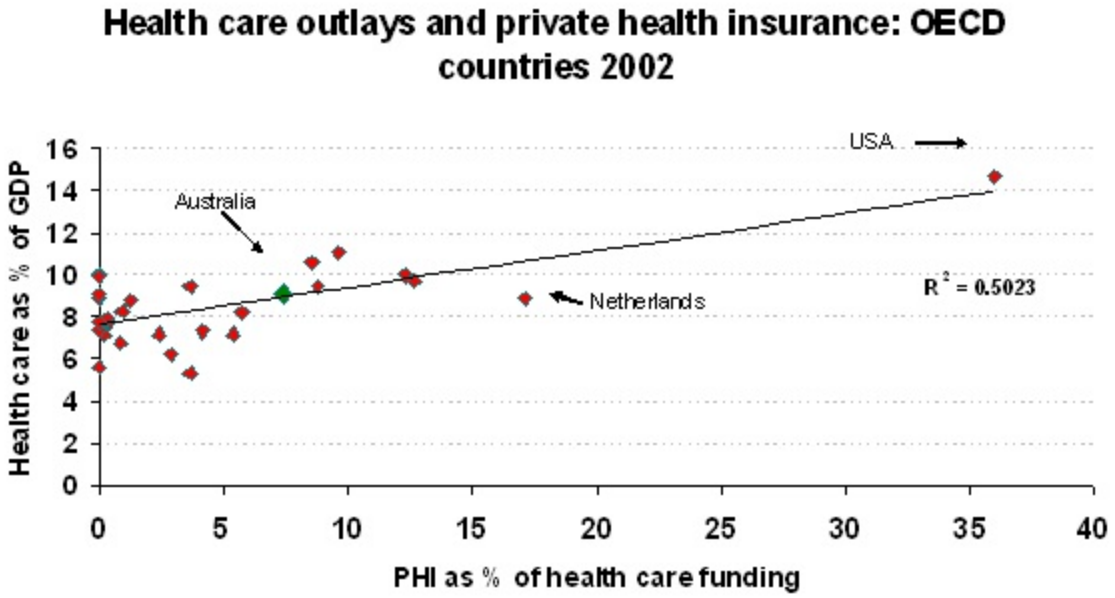
Re-frame 9. Don't think of an equity/efficiency tradeoff

Many choices in public policy involve a painful tradeoff between equity and efficiency.

But in health care, there is a great deal of scope for improving both equity and efficiency. There is waste in our present arrangements. There is still an unacceptably high level of accidents and adverse incidents. There is too much bureaucracy and duplication. There is a poor uptake of information technology. There are too many separate programs. There is too little program integration. There are misallocations, with areas of over-servicing existing alongside areas of under-servicing. There are too many delays in treatment. In all these areas we can get more out of the resources we have invested, and there is no reason why those gains should not be equitably distributed.

In particular, there could be significant gains – an annual saving of a billion dollars in bureaucratic costs alone, in phasing out private health insurance. The longer term benefits, in turning to the strong cost control of a single insurer, would be substantial. Research clearly shows that among developed countries the greater the reliance on private insurance, the more is spent on health care, with no discernable gain in health outcomes. The stand-out country in this regard is the USA, where health care, centered on private insurance, now costs 15 percent of GDP, while leaving about 50 million people uninsured and providing health outcomes

among the worst of all developed countries. Translating 15 percent of GDP into Australian terms, means that with a private insurance dominated system we would be spending another $60 billion a year on health care – *more each year than the recently announced economic stimulus package*. Ironically, in the USA, because the health insurers have been unable to contain providers' fees, the two basic government programs, Medicaid and Medicare, now cost almost as much (as a proportion of GDP) as the comprehensive single insurer programs of some European countries, and, even while our Commission seeks an expanded role for private insurance, the Americans are desperately trying to repair the damage it has caused.



The Commission did, indeed, put up something approaching a single insurer model, in Option C, but unnecessarily embellished it with a bewilderingly complex and bizarre set of managed care programs. The single insurer, in this model, would not buy health services in the way Medicare does now, but rather would churn its payments through organizations bodies providing different health plans – essentially competing health maintenance organizations with different plans on offer (not to be confused with managed care plans). It looks like an option bound for rejection, which means any rejection could be construed as a rejection of the single insurer model. In case the "socialist" bogeyman of a single insurer model doesn't work, there is the equally unattractive bogeyman of managed care plans.

The Commission could hardly have made its opposition to fundamental funding reform more obvious. Although there are many successful single-insurer models in other countries, and altthough the Commission itself has recognized the single-insurer operation of the Department of Veterans' Affairs, it has failed even to consider a single insurer as a model for national health policy. It has had a blind spot to any ideas which would remove private insurance from health care funding. In view of the performance of the financial sector over the last year, it is extraordinary that the Commission wants to protect its role in health care.

Conclusion

It's becoming clear that the Commonwealth has chosen the wrong mechanism for recommending health care reform. The Commissioners may be experienced and dedicated people, but they seem to be too established within our current health care systems to be able to take a broad perspective. Also the process has been rushed.

This is unfortunate, for Australia has an excellent mechanism for policy review, the Productivity Commission, which has skilled professional staff and commissioners drawn from different aspects of public life, whose very task is to undertake dispassionate and detached analysis of public policy. The Commission's particular strength is in economic analysis, and it has demonstrated in numerous inquiries that hard-headed economic analysis is quite compatible with the community's broad social desires.

There is still a path to better policy outcomes. In order to cut its losses and to save political face, the Commonwealth could take on board some of the easy reforms suggested by the Health and Hospitals Reform Commission, and send to the Productivity Commission a reference to undertake a basic review of health policy. It may take time, but, as the Hawke-Keating Government demonstrated in its successful reform programs, reform does take time, particularly for people to abandon old ways of thinking, to overcome fear, and to embrace change.