Doctors declare Australian hospital system on the brink of collapse

Alex Messenger
11 December 2008

Australia's public hospitals are so understaffed and bed shortages so serious that hospitals routinely operate for long periods at "code red", a level of overcrowding at which patients will die, says a new public hospital ‘report card' released last month. Fewer than two thirds of emergency patients are attended to within the recommended 30 minutes. About a third of emergency patients wait eight hours to be admitted to a ward.

The federal Labor government this week responded to the crisis by increasing health funding by $1 billion annually under its new five-year Australian Health Agreement with the states. But this is only a third of what is required to avoid unsafe bed occupancy levels, according to the Australian Medical Association (AMA), the country's leading medical lobby group. The AMA's report card says the $3 billion actually needed would add 3,750 hospital beds nationally. The newly announced increase in federal funding will add only 625.

The message that workers should take from the report and from the federal response, is that the Labor Party has effectively abandoned the task of providing basic services to the bulk of the population. The AMA figures are stark. The number of public hospital beds provided for each 100,000 people over 65 (a useful proxy for the hospital-using population) has decreased by 67 percent over the last 20 years. In other words, the hospital-using public is two thirds worse off than it was in 1988 in terms of hospital bed provision. The AMA also says that doctors are leaving the public hospital system and looking for work in private hospitals because they realise they cannot provide adequate care in the public system.

The core symptom of systemic distress, according to the AMA, is chronic overcrowding and vastly reduced levels of safety, especially for the elderly. Studies by the Australian College of Emergency Medicine (ACEM) show that an occupancy rate of more than 85 percent "risks systematic breakdowns, extended periods of ‘code red' and puts patients at risk of mortality and disability." The major teaching hospitals are way over this mark and are "commonly operating on a bed occupancy rate of 95 percent [with] some jurisdictions set[ing] a bed target rate of over 90 percent." Rates over 100 percent are not uncommon. However, one needs to look closely at those figures to appreciate the true scale of the disaster. The ACEM recommendation (85 percent) is for what hospitals should achieve *on average over a year*. But hospital practice (95 percent) is routinely, not on average, above that level.

The myth of universal health care

The AMA report cracks open the claim of successive Australian governments that, in contrast to the United States, Australia has a system of universal health care. (The current web site of the Commonwealth Department of Health repeats that claim.) In fact, the Australian hospital system is being torn apart by the same profit-seeking, user pays ideology that dominates US health care and which has transformed Australian education, superannuation and government administration generally over the last 25 years. Australia has a two-tier hospital system: a well-funded private one for those who can manage to pay ballooning private health insurance premiums, and for everyone else a residual system on the brink of collapse. For proof, one need only compare the trends in bed numbers. In the last decade, private hospital bed numbers have increased 16.5 percent. Public bed numbers have undergone a 1.6 percent *reduction*.

The two-tier system reinforces existing inequalities, so that the wealthier get a better class of treatment. Not only do private payers have their own hospitals, but because medical expertise is still centred in the major teaching hospitals, about 10 percent of patients in public hospitals, according to federal government figures, are actually private patients whose hospital costs are, in part, charged to their health insurer. Poorer patients lie in crowded wards, often after having waited years for elective surgery. Down the corridor, those who have paid insurance premiums receive what is, in comparison, a far better level of treatment—they are treated faster, get their own room and are allowed to choose their treating doctor. Private elective surgery patients avoid the long public waiting lists that have for decades been a source of popular outrage.

But the central political issue that Australia's semi-private hospital system raises is not simply inequality of treatment. Of even more central importance is the relationship between the public system's de-funding and the choices that individuals make in taking out private health care. The legitimate fear of ending up in a dangerous, possibly deadly, public hospital system makes private insurance a rational choice within the parameters of the current system, even if that means struggling to afford insurance premium costs. The public hospital system becomes less about providing adequate health care for all, or even for a majority, and more a mechanism for ensuring the growth of the private system and the profitability of the insurance sector. This in turn justifies the further downgrading and de-funding of the public

system.

The figures speak loudly on these matters. In the last 11 years, rates of private insurance hospital cover per head of population have increased from 30 to nearly 50 percent. The main source of that increase was a single 10 percent jump in 1999-2000 in response to the introduction of a 30 percent rebate for health insurance premiums (the federal government will refund you 30 cents for every dollar you spend on private health insurance). But the rebate cannot fully explain the current 50 percent private coverage rate. In the past five years (well after the introduction of the rebate) average premium costs have risen 33 percent. Usually, where price increases, demand drops. The fact that demand for insurance has increased means that other factors are in play. Growing apprehension about the public hospital system and its capacity to deliver adequate treatment, assisted by a federal government sales job on health insurance, is the clearest explanation.

The 30 percent health insurance rebate, now an almost unnoticed part of the health system's furniture, illuminates better than anything else the political processes at work. In 1999, the then federal Liberal government spruiked the rebate's introduction as a reward for those who had chosen not to be a burden on the public system. The intention was to encourage people to take up private health insurance. The 10 percent increase in members in 2000 indicates the policy worked. But the rebate, which now costs $3.5 billion per year, effects, via the budgetary process, a massive annual transfer of wealth from the working class to the rich and to the insurance companies.

The explosion in the annual cost of the rebate is largely explained by the insurance industry's annual ratcheting-up of premium costs. (The government makes an annual public show of "moderating" the companies' proposed increases, but these proposals are in any case ambit claims.) Over the last five years, the average annual premium increase has been 6.5 percent. Unsurprisingly, given massive public subsidies, health system parasitism is a profitable business. In 2007, MBF, which is one of 30 or so insurers and has about 20 percent of the market, announced a $223 million profit. Other insurers have been doing similarly well.

Will Labor end the billions in annual subsidies to private health insurance companies? The answer should surprise no one. At the introduction of the 30 percent rebate and in the years that followed, Labor, sensing broad popular opposition, promised to rein in the rebate. But in February of this year, three months after Labor won government, Prime Minister Kevin Rudd assured the health insurance industry that the rebate was safe. "The private health insurance rebate remains unchanged and will remain unchanged," he told reporters.

Five more years of decay

The AMA report card is an attempt to warn the Commonwealth it must dramatically increase funding for public hospitals. But the five-year agreement struck this week between the Commonwealth and states demonstrates that even careful exposure of the facts by a powerful and respected lobby group will make little or no difference to policy outcomes.

Between 1988 and 2000, the Commonwealth provided about 45 percent of public hospital funding. But that proportion has since been in steep decline, leaving state governments to meet the shortfall out of unstable state duties and fee increases for public services. Each year the states scrounge for special-purpose supplementary funds from the Commonwealth. That pattern will now continue. The Labor state premiers, sensitive to the popular opposition federal Labor will face in the looming recession, have said they are happy with what they have received. In fact, the $1 billion base funding increase is only half of what the premiers themselves were demanding before the global financial crisis began to hit.

This situation will only get worse. The state governments, cash strapped, will not increase revenue-raising to fill the gap between Commonwealth provision and actual need. Moreover, as Rudd's $10.4 billion federal government "stimulus package" has demonstrated, hospitals and other essential services will see no benefit from the federal government's ad-hoc attempts to pump-prime an economy on the skids.

Above all, the Labor government will continue the user-pays politics that has brought the public hospital system to its knees. Public hospitals will remain dangerous for patients and demoralising for employees. Chronic overcrowding will worsen and private health insurance costs will consume more and more of the monthly budget of those already just managing to meet premium costs.