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## Le plus ça change: recollections of a retiring health economist - Chalmers Oration 2009

Dr John Deeble AO, Emeritus Fellow, The Australian National University

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# The Chalmers Oration 2009

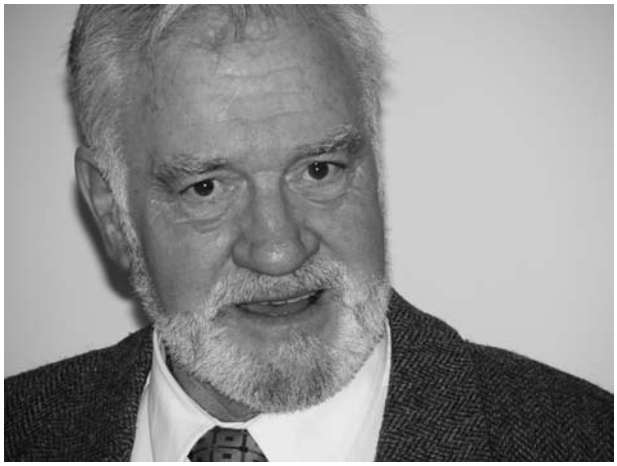
Flinders University Medical School

# Le plus ça change: recollections of a retiring health economist

Dr John Deeble AO

Emeritus Fellow
The Australian National University

23 July 2009



**Dr John Deeble AO**, Emeritus Fellow,
The Australian National University

# Introduction

Thank you Professor Worley. It is indeed a great honour to give the 2009 Chalmers Oration. Given the distinction of my predecessors, it is also a considerable challenge. When you asked me to speak, you set no borders on the content. It would have been much easier if you had, because technical subjects define themselves. But I am sure that a discourse on academic health economics is not what you want to hear. What I will try to do is identify one or two of what I see to be the major issues facing the Australian health care system at present, from the viewpoint of an economist who started his work as a hospital administrator over 50 years ago. I must therefore talk about money and use some economic terms, though hopefully in an understandable way.

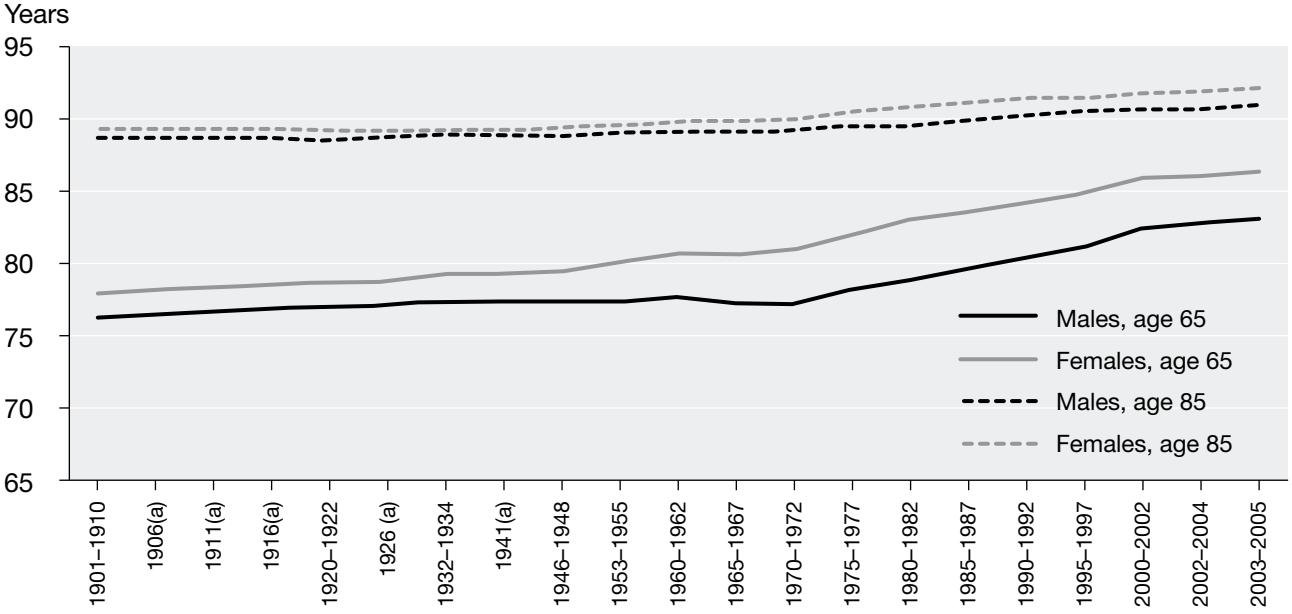
And I must be selective. The health care system is one of society's most complex creations. Its beneficiaries have a staggering range of needs and expectations and its participants come from a variety of disciplinary backgrounds. Each group has its own view of how things should be organised and what would make the system better. And there are institutional and commercial factors at work as well. Not everyone works in health care for altruistic reasons and there is no compelling reason why they should. People make their living and find a place in the world there.

But it is a social system, not a mechanical one. One of my abiding memories is of a single, short sentence by a brilliant young economist called Harry Johnson who in the mid-1960s held, concurrently, professorships at both Chicago University and the London School of Economics (and who died in tragic circumstances shortly afterwards). His Inaugural Lecture at the LSE – yes, they had such things then – was on 'The Economic approach to Social Questions'. In it he said that anyone working in this field must first and foremost understand that "things are what they are for powerful reasons". They may not be good ones but they are strong and one must identify what those reasons are. That inevitably involves politics, because that is how community decisions are made. Politics has a poor reputation everywhere and anyone who ventures into a politically contentious field is immediately suspect of either partisan bias or self-interest, or both; but it cannot be avoided. I am sure that the distinguished doctor, scientist, teacher and administrator after whom this oration is named will have faced the same realities.

# Performance of the Australian health care system

So here we go. My first and self-evident observation is that by any standards the Australian health care system appears to perform well. Our life expectancy is second only to Japan (plus the two tiny enclaves of Iceland and Luxembourg) and it is greater than in any of the other developed countries, though not by much. Health services are not, of course, the only determinants of longevity, or even the most important ones, but there are some statistics that suggest a real contribution, at least in recent years. Australian life expectancy at birth has been steadily increasing for over a century.

**Figure 1 Life expectancies at 65 years and 85 years Australia, 1901 to 2005**




(a) Pro-rated for missing years.
*Source:* AIHW population database.

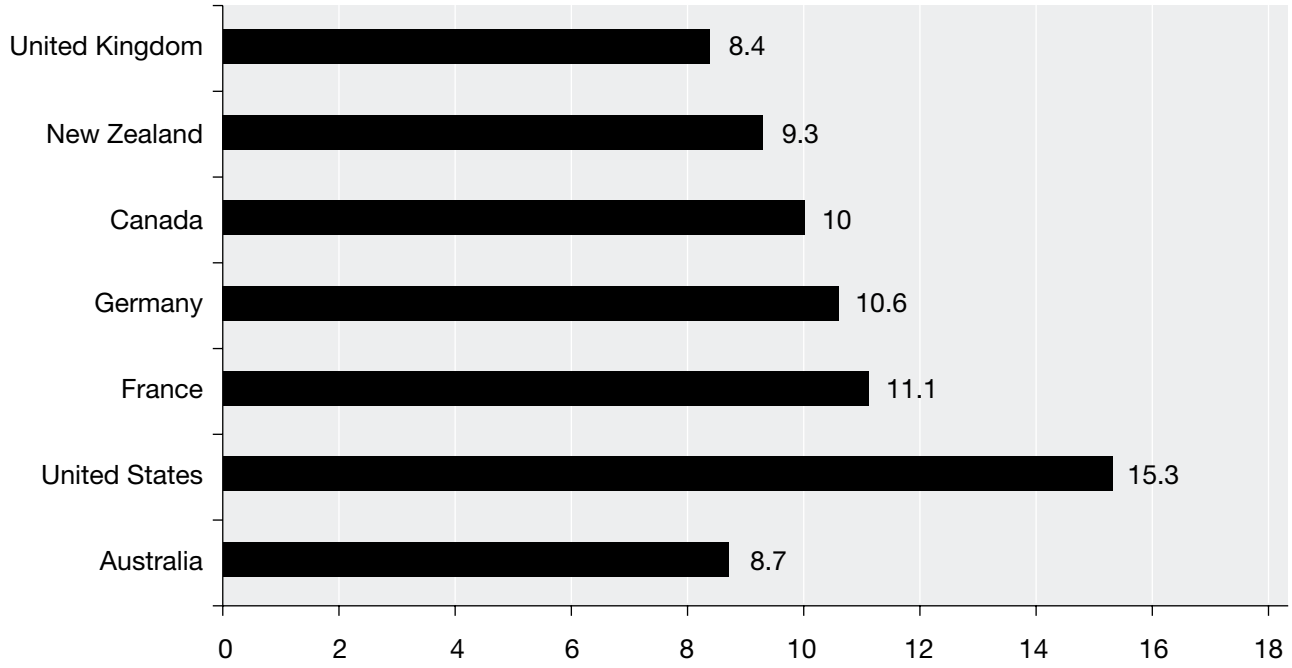
Source AIHW, *Australia's Health, 2008*, Figure 2.4

But until quite recently that came mainly from lower infant mortality and fewer deaths at younger ages. As you can see, between 1901 to 1970, expectancy at age 65 rose comparatively little – by only about two years over the seventy years. However it has increased by over twice as much since 1970 and both the quality of services and access to them must have had some effect on that.

And superficially at least, it would seem to have been done quite efficiently. Figure 2 shows OECD figures for selected counties in 2006, in terms of health expenditures as a proportion of Gross Domestic Product (GDP). Australia ranked sixteenth in the

OECD behind the US – which was in a class of its own – Canada, and most of the western European countries, but slightly above the UK. In terms of spending per person, adjusted for the purchasing power of money, Australia was seventeenth.

**Figure 2 Health expenditures as a percentage of GDP, selected countries, 2006**




Source AIHW, *Health Expenditures Australia*, 2006–07, Table 6.1

However crude figures can be misleading. The Australian population is much younger than the European ones, mainly because its growth has been fueled by the continuing immigration of people who are comparatively young. Adjusted for age, the Australian numbers would be somewhat higher. For reasons that I will not go into here, I think that much of the scaremongering about the effects of population ageing has been exaggerated. However, one day that dilution by immigration will cease and costs per person will rise.

Of the other countries, the quite unique US figure is not because the average service use is high (overall, its public sector is weak and about 48 million people, mostly poor, have no health insurance coverage at all) but because their financing system is extremely expensive to run and all of the participants – doctors, drug companies, health insurers, etc – are even by American standards paid far more than their counterparts in any other country. Shorn of all the ideology and rhetoric, that is the major obstacle to any American reform, as President Obama is finding out. Canada has universal insurance and a system which delivers high quality care efficiently and with considerable patient choice. However drug costs are a problem and it has no national system equivalent to

the Pharmaceutical Benefits Scheme here. The PBS is, in fact, one of Australia's greatest and least heralded achievements and one which many countries that struggle with high-technology drug costs wish they had adopted first. I have worked as a World Bank consultant in Hungary, Turkey and Indonesia, and over nearly 15 years as an adviser to the Government of South Africa. All of them find drug costs crippling. South Africa even considered parallel importing from Asian countries, where drugs are cheap, until American and European pressure pushed them off it. The PBS has not just reduced the cost to people – almost fully for the most vulnerable ones – but its bargaining power has also delivered medications to the whole community at well below world market prices.

However the Australian record is not all positive. We may not have had the most expensive health care system in the world, but over the ten years from 1996 to 2006, we had the highest rate of **growth** in 'real' expenditures per person of all the comparable OECD countries. Most of it came from higher service use.

Where did the expansion come from? As recorded, spending on medications grew more rapidly than any other group, due mainly to some quite extraordinary increases in both prices and apparent volumes over the four years from 2000 to 2003. It has been relatively subdued since then. However, outside the PBS the data are not good and it is almost impossible to separate the price and volume components when established drugs are progressively replaced by newer and more expensive formulations which cannot be aligned directly with all of the items that they replaced. Spending on public health and community health services also rose by somewhat more than the average but they are a relatively minor part of total health expenditures.

That leaves the medical and hospital components which absorb nearly 60% of all health spending and which are, in any case, the subject of most policy debate. The issues are quite complex and I must use some numbers here. However I will try to summarise them and make their presentation as clear as possible. It will concentrate on the twelve years from 1996 to 2008, the second half of Medicare and one with some significant policy changes.

## Medical services

Consider the medical side first. Almost all Australian out-of-hospital care is provided by doctors in private practice and because fee-for-service payment systems require it, the information on their services is both comprehensive and detailed. It is also available for in-hospital care to private patients, 85% of whom use private hospitals. We do not

know the detailed medical content of services to public patients in public hospitals, in-patient or out-patient, although there are ways in which the overall volume can be estimated.

Table 1 reduces the data to its essentials. Based on Medicare statistics which cover nearly 90% of all private practice work, it shows the percentage **changes** in the number of services **per person** covered from 1996 to 2008, grouped according to consultations (GP and specialist), diagnostic services and non-diagnostic procedures. The results are quite striking. Per person, doctor consultations actually fell by 6% over the twelve years. But diagnostic services, mostly pathology and imaging, rose by a whopping 62% and procedures increased by 32%. The shift was, in many ways, only the continuation of past trends but it has accelerated significantly. We have had, in effect, an epidemic of both diagnostic investigations and procedures. Not surprisingly, that has flowed over into the hospital system, which is where most of the procedures are done.

**Table 1 Medical services per person, 1995–96 to 2007–08, by type of service**

| Service | 1995–96 | 2007–08 | % change |
|---|---|---|---|
| **Consultations** | 6.57 | 6.18 | –6 |
| **Diagnostic** | 3.36 | 5.44 | +62 |
| **Procedures** | 0.57 | 0.75 | +32 |

Source: DOHA, *Medicare Statistics*, December 2008

## Hospital use

Table 2 shows hospital separations per 1000 people for the whole Australian population over the same period, which is the way in which they are generally presented and on which perceptions of performance are formed. Again, the figures are very interesting. For the whole population, admissions to public hospitals rose by only 12%. Overnight admissions actually fell, whereas overnight admissions to private hospitals increased by 16% and their same-day admissions more than doubled.

But that is not the right story. The public system is much larger than the private one and there are denominator problems that make percentage changes misleading. But more importantly, the two systems serve quite different populations, defined partly by socio-economic and insurance status but also, and more subtly, by the type of patients that they treat. The 1996 to 2008 period saw a major shift in Commonwealth government policy towards supporting private treatment with the introduction of a Private Health

Insurance Rebate, an income-related surcharge on the Medicare levy and a massive publicity campaign. In 1996 only 34% of the population held private insurance for hospital care. In 2008 nearly 45% did. Very few public patients are treated in private hospitals – less than 0.2% – and while the number of privately insured patients who choose public patient treatment is unknown, it is unlikely to be large.

**Table 2 Acute hospital separations per 1000 population, 1995–96 to 2007–08, by type of hospital**

| Hospital type | 1995–96 | 2007–08 | % change |
|---|---|---|---|
| **Public hospitals** | | | |
| **overnight** | 115 | 111 | –4 |
| **same day** | 77 | 106 | +38 |
| **Total** | 193 | 218 | +12 |
| **Private hospitals** | | | |
| **overnight** | 43 | 50 | +16 |
| **same day** | 42 | 97 | +130 |
| **Total** | **85** | **147** | **+73** |

Sources: AIHW, *Australian Hospital Statistics*, 1999–00, 2004–05 and 2007–08

Table 3 relates the number of public patient admissions to the number of people who relied on Medicare alone and privately insured admissions to the population that held private insurance from 1995–96 to 2007–08. It shows that, contrary to all the media hype and popular impressions, not only is the Medicare-only population admitted to hospital more often than privately insured people but that while the public hospitals have **increased** their public patient admissions per person covered by about 47% over the twelve years, the admission rate of privately insured people (who are supposed to have superior access) has **hardly changed at all**.

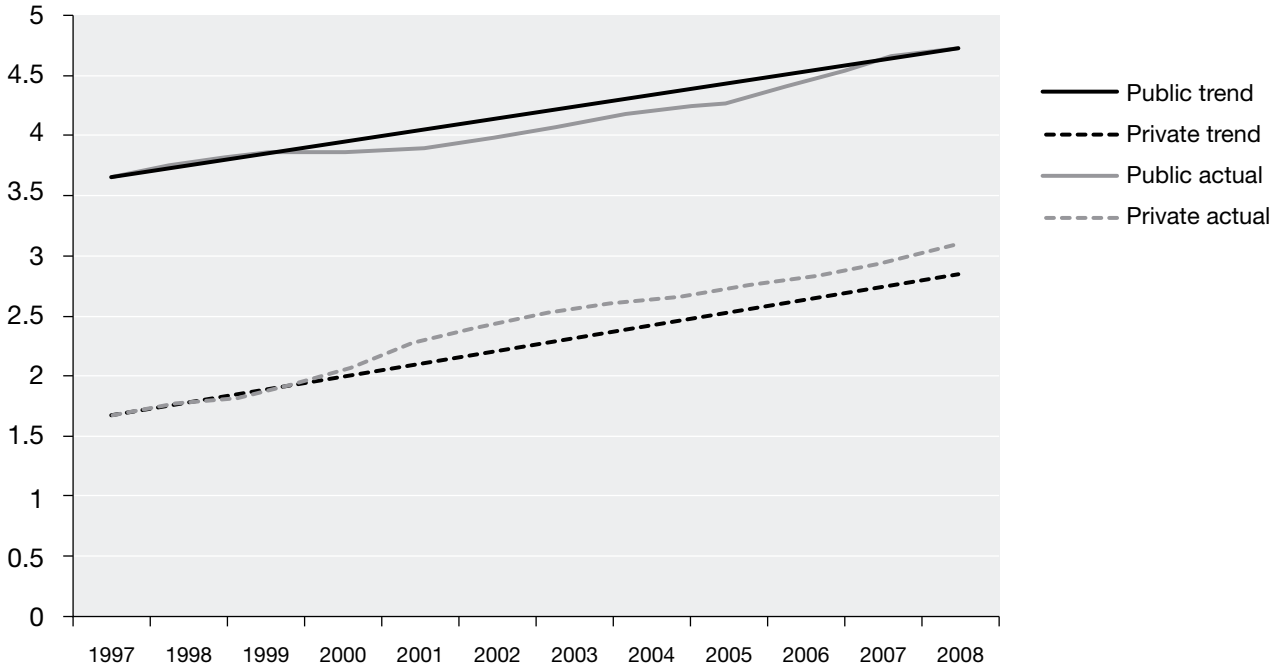
It is astonishing that despite these figures being both publicly available and clear, all of the public criticism has been directed towards the "failure" and "mismanagement" of a public hospital system which has actually performed extremely well. But the fact is that most people, most commentators and most politicians will simply not believe the evidence. If the public hospitals have done so well, they say, then why are there still waiting lists for elective surgery? The explanation is really very simple. Demand has overwhelmed them. The private insurance changes (fully introduced in 1999–2000) had very little direct effect on public hospitals – only 4% of their patients shifted and growth resumed its historical trend after 2 years (Figure 3).

**Table 3 Acute hospital separations per 1000 people covered by private insurance and those reliant on Medicare, 1995–96 to 2007–08**

| Year to 30 June | Coverage (mill) | | Separations per 1000 persons covered | |
|---|---|---|---|---|
| | PHI | Medicare | PHI | Medicare |
| **1996** | 6.23 | 11.94 | 290 | 240 |
| **1999** | 5.74 | 13,14 | 294 | 260 |
| **2001** | 8.24 | 10.92 | 218 | 318 |
| **2003** | 8.71 | 10.97 | 224 | 325 |
| **2005** | 8.70 | 11.63 | 280 | 327 |
| **2008** | 9.53 | 11.70 | 306 | 354 |
| **% change** | | | **+ 5** | **+47** |

Sources: PHIAC, *Industry Statistics*, Trends in Membership and Benefits, Dec, 2008

**Figure 3 Public and private hospital separations 1996–97 to 2007–08 (mill.)**




Sources: AIHW, *Australian Hospital Statistics*, 1999–00, 2004–05 and 2007–08

However the longer-run effects were large. The pressure is still on the public hospitals, because the funding changes completely reversed the risk profile of the insured and uninsured populations. Instead of a self-selected group of relatively high hospital users, private insurance now has a larger, younger, more affluent and healthier population for whom diagnostic investigations and elective surgery are major treatments of choice. Although they go to hospital less often, that is where much of the growth in procedures has gone and the private hospitals have accommodated it. The public hospitals now

serve a smaller population but they have more of the old and disadvantaged people, take nearly all of the emergency cases and admit many more of the complex medical patients who stay longer and occupy beds. More 'bed blockers'.

The reported data show it clearly. In its 2004–05 hospital statistics, the AIHW included an analysis of the DRGs that had showed the largest increases over the preceding four years – that is, since the full private health insurance reforms began – by type of hospital and grouped according to whether the DRGs were surgical, medical or 'other' in which the medical content was either undefined or low. In public hospitals 21% were classified as surgical, 72% were medical and 7% were 'other'. In the private hospitals, the figures were 41% surgical, 38% medical and 21% 'other'. And the proportion of patients who died in public hospitals was three times greater than in the private ones.

It is impossible to believe that these patients came from anything resembling the same populations. The public hospitals just don't have the room or resources to provide both the essential services that their clients need and do all the elective work as well. They have rural responsibilities, teaching functions and an emergency department obligation that the private hospitals do not have and one which is growing at a much faster rate than in-patient care. Emergency and out-patients take an estimated 30% of their budgets, which have been tightly constrained for years, even more so by the Commonwealth than by the States and for reasons that have little real regard for what they have to do. And relatively little has been spent on increasing their capacity, although that obviously varies between States. The last two years have seen a minor lift in public capital expenditures on health, but prior to that 'real' capital spending had hardly changed for over ten years.

# The health and hospital reform debate

You will be pleased to know that this is the end of the numbers. I have concentrated on those systemic features in which economics has a major role to play. There are many other things that could be said about the composition of Australian health care and how both its quality and its efficiency could be improved. The National Health and Hospitals Reform Commission has labored on them for over a year. Its Interim Report ran to over 350 pages with 103 recommendations for reform in almost every field[1]. Prioritising them will be a major task. There are very many worthy suggestions that I would support, others to which I would give lower priority.

1 The NHHRC's Final report was published on 27 July 2009 with 123 recommendations.

I think, for example, that although primary medical care in this country is strong compared with many other nations, it could be improved by strengthening long-term relationships between GPs and their patients. Choice is good but it is also fragmentary, particularly in the management of chronic disease. And I would strongly support the creation of more comprehensive health care centres and the recommendations in relation to rural health. Equal access to services is meaningless if they are not there. But most of the Commission's recommendations relate to clinical and organisational matters. I have opinions about them – after 50 years in health care it would be very hard not to – but I have no special expertise in them. Neither do most economists, although that rarely stops them from commenting.

## Organising and financing hospital care

Important though they are, none of these issues will change either the structure or the economics of the health care system fundamentally. The only one that will do that is the organisation and financing of hospital care. It is **the** political problem and the most controversial in terms of both media coverage and popular concern. And it is also **the** major cost issue. Acute hospitals, and the medical services that are provided in them, absorb 40% of all health expenditures – over $36 billion in 2006–07, which was nearly twice the cost of Medicare medical benefits and the PBS combined. Australians are high hospital users. Our overnight admission rate per 1000 people is 27% higher than in the United States, 19% higher than in the UK and an astonishing 67% higher than in Canada, the countries with which we often compare ourselves (Table 4).

**Table 4 Hospital separations for acute care, per 1000 population, selected countries, 2006.**

| Country | Per 1000 population |
|---|---|
| **Australia** | 150 |
| **Canada** | 90 |
| **United States** | 118 |
| **United Kingdom** | 126 |

Sources: OECD, 2009, Canadian Institute for Health Information, *cad Analysis in Brief*, Dec 2007: US National Centre for Health Statistics, *Hospital Utilisation*, March 2009

Many people, including many health professionals would deplore that rate and regard it as a sign of failure. But that is not what the customers think. People see hospital care as essential. The more of it the better and the whole private insurance industry is predicated on offering unrestricted access to whatever hospital services they, or their

doctors, think are needed. Nearly all of the NHHRC discussion of governance and options for financial reform is really concerned with hospital funding and administration above all else.

Diagnosing the problem is relatively easy. Like most countries, we are the prisoners of our past. As pointed out earlier, we have a large public hospital system that does the most expensive and complex work, treats most of the emergency cases and provides virtually all medical education. But it grew up in another era and it was never designed to treat everyone for everything. The private system cannot do all that the public hospitals do but it can and does do procedural work well. The two systems should be complementary, not competitive, and it should not be beyond the wit of man to see that that occurs. However Australia seems to be incapable of doing so.

## The public-private mix

Solving the public-private dilemma is not a simple task, unfortunately. When Medicare and its virtually identical predecessor Medibank were introduced, the status quo was basically accepted as given. The Commonwealth simply took over the medical benefits that the private insurers used to pay and made public hospital care free through grants to the States. It was a conceptual leap forward that changed the way that costs fell on people and provided the public hospitals with much needed support. But one factor that was assumed was the continuing support of private hospital care through private insurance. It was both a pragmatic and a political decision. There was no prospect of either buying the private hospitals or even substantially subsidising them within the Commonwealth's budget restraints and no way of limiting private hospital insurance, even if any of those actions had even been contemplated, which they were not. The expectation was that while private insurance membership would fall, it would settle at about 30% of the population – the then figure in Queensland where public hospitals had been free for decades. It actually took over 20 years for the proportion to get that low, but by that time medical technology, patient expectations and the size of the private hospital sector had all increased considerably.

There have since been numerous suggestions about what should be done now, including, for example, the Commonwealth paying uniform benefits, perhaps on a DRG basis, for patients in both public and private hospitals – say 40%–50% of costs as they now do for public hospitals under the hospital agreements – leaving the States or private insurance to provide the rest (emergency and out-patients would presumably be treated separately).

Other variants range from a simple extension of the Commonwealth's present powers to the most radical option in the NHHRC report entitled "Medicare Select". Based largely on the Dutch and Israeli systems, this would make the Commonwealth the sole funder of health care but allow people to use their notional entitlement to government benefits to buy insurance from whatever private or public 'health plan' they chose. In effect, a 100% private health insurance rebate. All of these alternatives have major problems and I am not amongst those who think that changes in governance or a re-shuffling of responsibilities between governments would have any real effect. Cost shifting fascinates the bureaucrats and politicians but the issues are more fundamental than that. Although the States wax and wane in the quality of their administration, their problems are systemic in the populations that they serve and have very little to do with management at all.

## The private health insurance rebate

That brings us back to what we have now, the private health insurance rebate. I will talk about it at some length because it is an important issue. My position has always been clear. I support some public payments to the private providers. In any national scheme, they are both necessary and desirable. Private hospital subsidies were part of the original Medicare and their removal for budgetary reasons five years later was a major policy mistake. But it should not be indiscriminate and I have had, and continue to have, major concerns with the present rebate structure. It has been wasteful, ineffective in raising more private money for health (the net contribution of private premiums is now a lower proportion of Australia's health expenditures than it was 10 years ago), divisive in its separation of the public and private systems, inequitable in the way that it and the Medicare levy surcharge interact and grossly inflationary in some areas. For example, by subsidising medical gap insurance it has helped support the largest increase in specialist fees for a quarter of a century. The average specialist charge under private insurance is now 50% above the Medicare fee level and that is a problem for the whole system, not just private hospital care. The whole purpose of the rebate has been to maintain and support the private insurance industry and through it, the private hospitals and specialists. Cost was not a consideration.

However despite all of its faults, the rebate is **one** method of dealing with the public-private divide and a serious one that does not involve a structural change. And it is what we have. The government has promised to continue it and I understand its position. However one would hope that the program will not retain its present form indefinitely.

The current moves to phase it out for higher income people would certainly make the outcome more equitable. If private provision is seen as an integral part of the system, then equity would require that the users pay for it in the same way as those who use the public sector do – that is, through contributions related to income. At present they do not and the proposed changes would correct that anomaly. In an ideal world, I would not go through the insurers at all. The same effects could be much better achieved by paying the providers directly and in a way that would bring the public and private sectors closer together.

However the status quo has very powerful supporters and it may be politically impossible to change it at present. Some of the defects could be remedied by judicious amendment. At present, less than 60% of the rebate money goes through to the hospitals which it purports to support. The rest goes to ancillary benefits, medical gap insurance and administration. If I were King, I would abolish the rebate for all the ancillary services that Medicare does not cover (dental, allied health, alternative health, private prescription costs, etc), abolish or significantly limit it for gap medical fees, and change the legislation so that payments – which might even be at somewhat higher rates – went to the insurers, rather than, nominally, to individuals and in a way which would allow conditions to be placed on them. The savings of up to $1 billion a year should go directly to the public hospitals, which really need them. However the present rebate structure is designed to prevent that happening. It may prove impossible to even amend it now but something must be done. The present arrangements are gobbling up money at a frightening rate – about $3.6 billion a year. If nothing changes the public system will slowly but steadily decline. Nobody would gain from that.

## Financing arrangements and the delivery of care

That leads to the final issue that I want to discuss, namely the extent to which financing arrangements, which are the only devices that most democratic governments have, can actually affect the delivery of health care. We know that they do on the demand side. If costs did not matter there would be no market for insurance and no demand for governments to provide either services or health insurance cover. And we also know that while the demand for health care is not particularly sensitive to price – people see it as essential – it is very sensitive to income. The poor are much less likely to buy it than the rich, which makes its distribution a social issue that demands collective action

of some kind. What is not so clear is how much financial arrangements can influence the providers of care and in what way. Economists tend to believe that, underneath, everyone is an income maximiser and that financial tools can change behavior. So do most commentators.

However the answer is, as in most things, yes and no depending on the circumstances. At the highest level, I know of no financing system in the world that has ever changed the way that services were delivered or the way in which the providers had been paid. Custom is a very powerful influence and whatever the supposed benefits of change might be, the costs of conflict are too high. There are many people who argue that an unrestricted fee-for-service system generates excessive services and gives the providers carte blanche to do things of limited patient benefit but which are career enhancing, personally satisfying and economically rewarding. That may be true but it is an extremely difficult proposition to test. The first two motivations would be equally strong in any system and it is impossible to know what the financial impact adds. The essence of professional work is the independent exercise of skill and judgement and, in principle at least, that can be reviewed by peers. Patients seem to be satisfied with either system.

At the other extreme are the very micro level manipulations that can sometimes produce spectacular but unpredictable results. Let me give you two examples. Prior to the Medibank scheme in 1974, eye refractions were regarded as a medical procedure, the traditional preserve of ophthalmologists. Their fees were fairly high. The Medibank proposals were being strongly opposed in parliament and the government was looking for both institutional support and tangible benefits that it could show the public. It was therefore decided to replace the ophthalmology benefit for refraction with a non-medical and much cheaper optometric item. I remember the negotiations well – the cloak and dagger meetings with the optometrists over an agreement to bulk bill and the frigid contacts with ophthalmologists. But it happened. The optometrists signed up, the medical benefit payments stopped and the ophthalmologists immediately ceased to do any eye refractions at all, without any of the disastrous income effects that they had predicted. Success. The second example was in about 1988, when I was not involved. The Department of Health was concerned with the rapid growth in usage and cost of a GP item for the removal of warts and keratoses. It decided to remove the item, but to compensate the doctors by an increase of 20 cents in the standard consultation fee for everyone, a modest but not insignificant saving. Again, it happened, the doctors

took the money and they immediately stopped doing the procedures altogether. But they referred them all to dermatologists at a very much higher fee. Failure. The doctors won on both counts. In both cases the payment change worked. The doctors stopped doing what they were not paid for. However there were clinically acceptable alternatives available in both cases and in the GP example the mistake that the Department made was in not anticipating what that would be. It has been much harder to change items that have even minority support and, of course, the introduction of a new fee and a new service does not guarantee its take up. The explosion of procedures that I referred to earlier had nothing to do with funding policy. It came from the technologies and the professions who used them. Finance followed, but not because of any government decision. The providers had adopted them and patients saw the procedures as valuable as well. There was no choice.

There are nevertheless some areas in which financing can produce very substantial results in the **way** that services are delivered. In complex, expensive and capital-intensive institutions like hospitals, budgets obviously put limits on what they can do, although how they do it is finally determined by the people who work there and, in practice, community resistance often limits the ability of funders to intervene. But if the intervention takes place in a way which provides for a major shift of resources through convincing **patients** to voluntarily change their behavior, the task is easier. That is exactly what the private health insurance reforms in 2001 did. It was the patients who were persuaded to move by a combination of financial incentives (a lower price for health insurance), penalties (a levy surcharge) and an implied threat of limited access to public services – which I believe to have been by far the most important factor. The government never dealt directly with the private hospitals or the doctors involved; nor, necessarily, with the private health insurance funds, although I am sure that it did. People acted entirely rationally and the necessary resources followed. It was exactly the opposite situation to that at the start of Medicare when we wanted people **not to change**. I said at the beginning of this section that the demand for health care per se is very little influenced by price and that is entirely true. But this was just a question of where the services would come from and there price does become important. I have talked a lot about the PHI reforms, partly because they were important and remain so. However they were also a fascinating demonstration of economics in action. My economist friends would be delighted. Prices **do** matter after all, but not necessarily on the side of the equation for which they have often recommended them.

# Le plus ça change....

That is the business end of what I have to say. But there is one other matter to which I should refer. It relates to how extraordinarily resilient the health care system is and how it manages to absorb enormous technological developments while steadfastly resisting the structural and organisational changes that those developments require. "The more things change, the more they stay the same" and many of the arguments and disputations now are not much different to fifty years ago. And in financial terms at least, the underlying conditions are very similar. When I compiled the first Australian health expenditure accounts as part my PhD thesis in the 1960s, hospitals took 34% of all, spending, medical services took 17%, drugs and appliances 22% and public health 4%. The proportions are very little different now. But health expenditures were less than 5% of GDP then. Today they are nearly 9% of a much higher national income. The effects of technology were already being felt and one of the things which that research revealed – and the one which really underpinned the Medibank and Medicare proposals – was that the existing financing system simply could not cope with them. Private insurance would become too expensive for too many people – the US problem now. Nor would the States have been able to support their public hospitals without charging even their means-tested public patients higher and higher fees (except in Queensland, everybody other than pensioners were charged). That required changes that upset some people and which still attract some controversy now. But it is easy to overstate them. The private medical sector is almost the same as it was then and while it is hard to say exactly what the national proportion of public patients in hospital was in the 1960s and 1970s, it was about 45%. In 2008, the figure was 53%. *Le plus ça change...*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