

# Analysis of the australian healthcare system



## INTRODUCTION

The health of people belonging to any nation is the prime topic of interest for the government of that very nation. On the same lines, it is very essential that the health system should be based on equity principle, such that no one is denied the right to utilize the benefits of the health care system. According to the National Health Reform Agreement, Australian Health care system is also founded on the concept of equity of access efficiency and effectiveness (Adityan2, 2013). It is found to be a world class system in terms of both effectiveness and efficiency. The population has a good health status, with the average life expectancy at birth of 81. 4 years (women-83. 7 and men-79. 2). This is the highest in the entire world. Still even with such statistics, there are certain groups like those of aboriginals and the Torres Islanders, who have a poor health status (AGDH, 2014). Australian government works under the scheme of medicare, which aims at providing help with high medical costs and the hospital costs. Another scheme called the Pharmaceutical Benefits Scheme (PBS) has also been implemented so that the costs of most of the medicines is subsidized. This essay describes the current scenario that prevails in the Australian democracy, regarding the status of equity of access, its effectiveness and the efficiency of the healthcare system.

Effectiveness in this regard focuses on the ratio of outputs to outcomes. These three components form the basis of an ideal health system. In other words, a health system that is effective and efficient, is able to yield estimated outcome, is able to generate profitable outputs and is easily accessible (widely distributed), is an ideal health system for any country

(NHHRC, 2009). The aim of this essay is to discuss the postulates of equity of access, effectiveness and efficiency in the Australian health care system and also throw light on the interrelationships among these concepts.

## EQUITY

According to the US health and human rights academics Braverman and Gruskinn equity is an ethical concept with the baseline of distributive justice. With respect to healthcare, equity aims to eliminate unequal opportunities that are provided, to be healthy. Such opportunities are not given to those who have membership of socially less privileged groups like the poor people, handicapped, disenfranchised racial, cultural or ethnic groups. Mostly the people living in the rural areas are treated this way. If equity has to be considered with respect to the health care practices, then all the disparities or discriminations based on races, castes, origin, etc, should be eliminated completely. Thus, equity aims at diverting the attention of authorities towards the less privileged people of the nation (Braverman et al., 2003). As depicted by this definition, the requirement for medical health care depends upon the medical and social situation of an individual. In Australia, indigenous population is the one suffering from denial from health care services. They are generally linked with the economical, social, educational and cultural causes. The World Health Organisation has described inequity as follows, "Inequities are the differences or discriminations that are unjust, unfair, unnecessary and avoidable, but still persist in our society. It is not that every inequity is unfair, but yes all inequities are a result of unfair differences among the people. In the field of healthcare, just refers to the access permission for those who are not able to pay large sums of money,

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but are in desperate need of medical aid. Inequity should be prevented in granting access to medical aids for such cases depending upon the needs of various groups ". Gavin Mooney has defined equity as " equal access to equal care for equal need" (Mooney G., 2003). It was surveyed and found that the current health care facilities do not cater to the special needs of the indigenous people. There are many barriers to equity of access like the cost of care is very high, the fees of the consumer is again high, there is low health literacy among the people, poor access to health service information by the patients living in the remote areas, timely unavailability of the doctors, prevalence of quality services only in the posh parts of the country and lastly, the discrimination in giving the treatments. The last point itself explains the loopholes in the health care system. Some of the major reasons for such inequity are as follows:

- Most of the shopkeepers have closed their outlet in remote and poorer areas because there is decline in bulk billing. Patients who are willing to pay some extra amount are treated well while the rest are just ignored and left to die.
- Generally there are no hospitals in the remote areas. But even if some are there, they are too old that they need replacement/
- Access to high technology treatments is doubtful in such areas and for such population. Richardson has shown the data statistics saying that the treatment of heart disease is thrice as common as in the insured patients.

- Also the provision of timely surgery is not applicable for public patients, as they have to wait in long queue and are treated once all the private patients have been taken care of.
- Better access to high quality services like that in dentistry and ancillary healthcare are offered to only those who either belong to the privately insured group or belong to a rich class.

The Australians belonging to the White society are given the best possible treatment available in the world. While on the contrary, people belonging to the indigenous (Aboriginals and Torres Islander) population do not even have the facility to disclose their problem to a medical practitioner, leave apart getting the correct treatment. Australian Council of social Service (COSS) has implemented various strategies to overcome this gap by supporting the closing the gap priorities and promoting aboriginal health.

## EFFECTIVENESS

Effectiveness can be defined as the measure of accuracy of a therapeutic method of treatment or success of the treatment when conducting the medical practice in remote location, or in the areas where sufficient funds or facilities are not available. Use of information technology in conjunction with high speed internet, is a ray of hope for managing patient's records, health, finances, work force, advancements in medical field and delivery of services (Imran Muhammed et al., 2012). In this context, in order to introduce positive medical reforms, the government of Australia has implemented Personally Controlled Electronic Health Record (PCEHR) as the e health solution in this country. Earlier, the records of the patients were stored electronically in an electronic health recorder (EHR) system. Such systems

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were managed by a health care official and it helped a lot in maintaining records of so many people and also provided safety of personal information. But the major drawback of this system was that it was limited to the institutional access. If the family or any other person wanted to look after the patient, he/ she didn't have any access to these records (Perlin, Kolodner, & Rosswell, 2004). To avoid this problem a more patient centered model of health care system was developed (Perlin et al., 2004). This new model was termed as electronic personal health record (PHR) systems. An example of this new technology is Australia's Personally Controlled Electronic Health Record (PCEHR). PCEHR was introduced in July, 2012. PCEHR had the function of keeping all the key components of the patient's health information in one database, in form electronic records. Only registered users and their medical service providers had the access to all the records and summary of the treatments and their medical history. The main aim of developing this kind of electronic database was to help the medical practitioners to take better decisions with respect to the treatments to be given to the patients (Les Schumer, 2013). PCEHR has some basic postulates like voluntary participation, providing access under consumer (or patient's) control and a source of authentic information. PCEHR is not a substitution for clinical records. Instead depending upon the interest of the patients, they can register themselves online and choose a health care provider to create and maintain their records. People can now view their very own medical history ranging from the time, type and duration of medications, allergies and adverse reactions as well (Les Schumer, 2013).

## EFFICIENCY

Efficiency, when defined in relation to the healthcare, is a relative term. It can be used to refer to technical as well as productive efficiency or even social efficiency. The extent to which effort, cost and time can be used for the desired task or purpose, is the efficiency. It is the final stage of a logical process which comprises of three steps starting from efficacy to effectiveness and finally efficiency. Australian government aims in maximizing the health care outputs produced from a set of standard input and improving the input quality. Conversely, the government is incorporating some measures to ensure that the health care inputs in terms of cost are minimized. As mentioned there are basically three types of efficiencies that are considered in Australian health care system (James F. Burgess, 2011).

Technical efficiency: It is measured by production of outputs by utilizing fewer inputs. The potential inefficiencies prevailing in the system are long duration of stay, drugs and IV fluids that have expired and unused CPOE system. Productive efficiency: It is measured by production of outputs at minimized cost. Some of the potential inefficiencies faced by Australia are the Positron emission tomography (PET) scan vs. standard imaging for Alzheimer's diagnosis, high discharge cost and high cost of care. Social efficiency: It is measured by making an individual cope with the current ailment without harming any other person. Again the system is filled with potential inefficiencies like use of cardiac defibrillator in low risk patients and wrong scope and scale in hospitals. Palmer and Torgerson reported that efficiency is the relation between resource inputs ( which can be costs arising from labour input, capital investment and equipments) and either intermediate outputs (number of patients treated, waiting time, etc) or final

health outcomes (lives saved, life years gained, quality adjusted life years (QALYs)) with an ideal target on the final health outcomes.

## RELATIONSHIP BETWEEN EFFECTIVENESS AND EFFICIENCY

Efficiency is not possible without efficacy and effectiveness because both describe the extent to which the goal can be reached (Stephen Leeder, 2003). Keeping in view the Healthcare system of Australia, it is evident that even though the government is trying to reinforce new reforms into the healthcare system every now and then, yet there is lack of equity of access. The aim of such reforms is to improve the healthcare system and help it emerge as the high quality system. For this it is essential to have effective and efficient functioning of the system. But this is not the case. As said before, the health of the people in a particular nation, determines the progress or economic status of the country. And the health of people is determined by how quickly the treatment facilities are available for the patients. The aboriginals and the Torres Islanders are unable to access the medical institutions because of the discrimination and their location (which is generally outside the main city or it is a remote location). The average life span of indigenous Australians is between 10-17 years of age, which is quite lower as compared to that in the non indigenous populations. Also, the rate at which the new born babies die (in indigenous populations) is two times higher than the rate in non indigenous and they also experience frequent situations of illness as well. Thus, it is need of the hour to seal this gap between the two populations so that equal rights and equal opportunities are provided to both the classes of people, irrespective of their origin, race, tribe, etc. Thus, there is a deep connection between equity of access, effectiveness

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and efficiency. When all the populations, whether indigenous or non-indigenous, have equal access to all the medical facilities, the ratio of healthy to ill will definitely rise and the statistics will improve. But this is only possible when the medical facilities are effectively organized and made available in the remote areas too. Further, the successful execution of all these agendas will determine the efficiency of the Health care system. Thus, all the three terms go hand in hand. Without one, the other two are meaningless.

### CURRENT SCENARIO

Many clinicians and the analysts do not consider it appropriate to include economics (costs) in between the medical decisions as they consider this as unethical. But they are definitely mistaken as one of the main advantages of health economics is that everything is transparent and all the concepts of equity, effectiveness and efficiency are maintained. It has been reported that the richer countries use the public funds more in the field of healthcare as compared to those used by the underdeveloped countries (Stephen Leeder, 2003). Since the investment made in health care demonstrates a country's economic strength and its democratic values, it is both desirable and essential for a government to invest in health care. Secondly, the salaries offered to the doctors or other medical officers are very less as compared to what actually should be offered. Moreover, the funds given to the health care systems are not enough to procure the most appropriate treatments and thus this causes problems. Also since the funds are not sufficient, proper medical instruments are also not available for the treatment of chronic disorders. For an instance, there is no provision of NSAIDs which have an

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an anti-inflammatory effect on the disease. According to the Canadian social commenter John Ralston Saul, the governments that believe in corporatism, rationalism and cost reduction, as a means to improve the efficiency, become the main reason for the failure of the publically funded health care facilities (Stephen Leeder, 2003). The second scenario prevalent in Australian democracy is that even though the governments provide enough funds for the health care institutions, yet they do not guarantee equity of access. The big private sectors are generally biased and divert all the contribution from the government towards the richer institutions.

## CONCLUSION

In order to place equity on the agenda of the health care policies of the Australian government, it is important to generate awareness about what Medicare and other public agencies actually fund for healthcare. It is also necessary to take the initiative and make the government realize that the topmost priority of any healthcare system should be to provide equity of access, as only then can the policies or treatments be implemented effectively and efficiently. The Australian Bureau of statistics health insurance survey and AXA/ National Mutual Data for NSW (1998), Spencer quoted that around \$300 million of the public funds were used for dental care and allied health professional services (Stephen Leeder, 2003). Since dental care is not a luxury, but treatment of chronic illness is, therefore, the basic dental services for all the Australians should be subsidized. Secondly, the salaries received by the doctors from the bulk billed vs. the non bulk billed patients, should be redressed.

Third, (hypothetically) a new body say National Council for Equity in Healthcare should be formed, so that it is directly answerable to the Australian Parliament and aim at making the Australian Health care more equitable (Stephen Leeder, 2003). Therefore, as discussed, it is very important to reform the current medical practices so that there is efficiency in the functioning of the health care department of Australia.