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perspectives brief

no: 18

date: 08/10/2021

title

Universal Healthcare in Australia: Prof John Deeble's legacy more relevant than ever.

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Tuesday, 5th October 2021 marked the 3rd anniversary of Professor John Deeble's death. Often dubbed the 'father of Medicare' John Deeble co-authored, with Dr Dick Scotton, the original proposals for universal health insurance in Australia in 1968; which led to the establishment of Medibank in 1975 and subsequently Medicare in 1984. He was a steadfast defender of universal healthcare for nearly 50 years.

John had been troubled seeing people refuse cancer treatment because they could not afford it.

The call to champion universal healthcare is not new; but as the health system strains under the pressure of the COVID-19, maintaining John Deeble's legacy will be more critical than ever before to guide us out of the pandemic and ensure all Australians, including our most vulnerable populations have access to the care they deserve.

This perspectives brief considers the principles of universal healthcare across three scenarios: COVID-19, Long COVID and non-COVID services.

universal healthcare in Australia

The provision of universal health coverage recognises health as a fundamental human right (WHO 2017), as well as recognising health as an outcome, indicator and driver of sustainable development (UNDP 2019; Tediosi et al., 2020).

Universal healthcare is intended to achieve three related objectives:

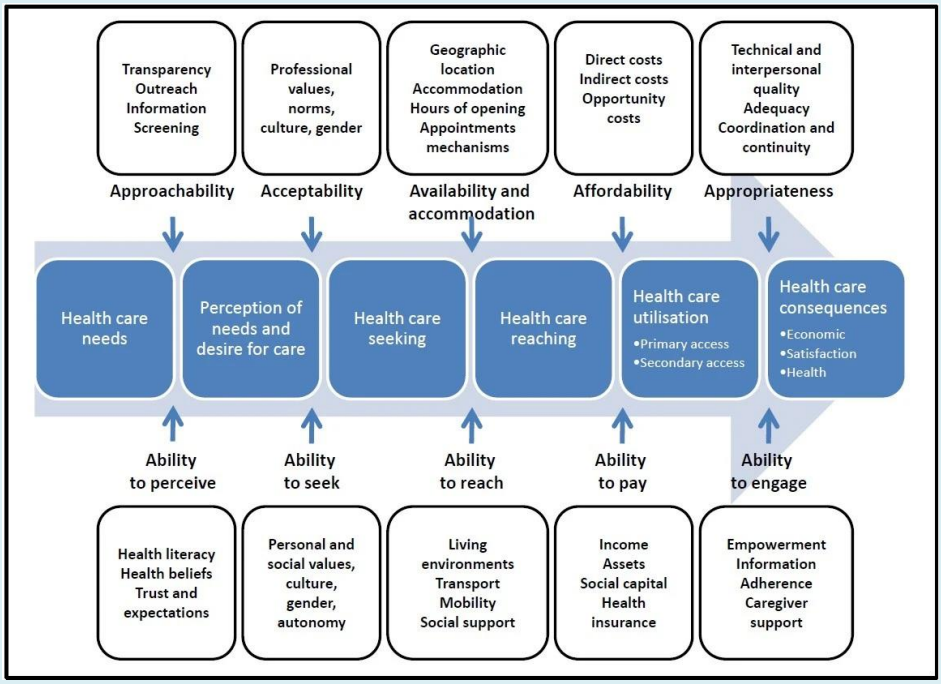
- equity in access to healthcare, where those who need care should receive it (Figure 1);
- quality healthcare, such that the health of those who receive it is improved;
- protection against financial risk related to the cost of healthcare (WHO, 2020).

Medicare, as Australia's universal health insurance scheme, supports free or subsidised health care for eligible residents. It subsidises medical, diagnostic imaging, pathology, medicines, optometry, midwifery and public hospital care and in some circumstances, allied health services (Services Australia, 2020).

However, public resources are finite and must be managed thoughtfully to ensure effective investment. While health policymakers use various strategies that attempt to emphasise sustainability to inform investment, the extent to which social values and equity are addressed varies.

Focus on the volume of healthcare activity, rather than the outcomes being achieved for wellness will continue to challenge investment decisions.

Figure 1. A conceptual framework of access to healthcare (Levesque et al., 2013).



This means that beyond funding, there are also components of the health system that impact the extent to which universal health coverage is achieved. These include the service delivery systems, workforce, facilities, communication networks, health technologies, information systems, quality assurance mechanisms, governance and regulation, and consumer engagement (WHO, 2019; AHHA 2021).

Consequently, accessible, equitable and sustainable healthcare cannot be effectively determined through the lens of any one of these components in isolation.

This has meant that despite Australia's long history of commitment to universal health coverage, health inequities still exist.

Such challenges to the health system are felt most acutely by people who are already experiencing marginalisation, disadvantage and negative social determinants of health. This includes those people who have low incomes; insecure work; live in overcrowded, insecure or high-density housing; the elderly; and those with pre-existing complex health conditions, including poor mental health, and disparities in access to digital technologies (AIHW, 2020; O' Sullivan et al., 2021).

COVID-19

While Australia's response to COVID-19 has demonstrated how health care has the potential to strengthen systems resilience and tackle threats to population health (Clay-Williams et al., 2020); it has also been a catalyst to exposing the slow erosion of Australia's universal health care system, with vulnerable populations being disproportionately affected by the pandemic (AIHW, 2021a).

This has occurred, in part, as a consequence of:

- the increased prevalence of non-communicable diseases and other conditions given as underlying clinical risk factors for COVID-19 among vulnerable populations (AIHW 2021b; Dept of Health, 2020);
- poor health literacy, and inconsistent and confusing public health messaging around the pandemic and vaccination rollout (McCaffery et al., 2020; O' Sullivan et al., 2021);
- established health care activities that have focussed largely on treatment, with less attention to health promotion and prevention (Raymond, 2019);
- reduced access to acute care systems for the most vulnerable and poorly integrated models of care between public health, primary care and social systems (Judkins, 2021); and
- low vaccination rates for vulnerable populations (Royal Commission, 2021; Department of Health, 2021a),

However, this rise in health inequality is not inevitable and, as Australia gradually looks ahead to recover from the pandemic, the principles of universal healthcare must be forefront in decision making considerations.

Public value, infrastructural, financial, physical and other barriers to delivering high-quality health services, both within the health sector, and between it and other sectors can be removed or minimised (Federal Financial Relations, 2020); and resources and services redirected to reach the people who require them the most.

long COVID

For the same reasons that have seen vulnerable populations disproportionately burdened by COVID-19, Long COVID, and other post-COVID related conditions, have the potential to drive health inequities in Australia .

Long COVID has affected populations regardless of whether they have had mild or even no COVID-19 symptoms, or needed ICU care to survive (Department of Health, 2021b). It is characterised by persistent ill health and symptoms for weeks and months after acute infection.

Australia has yet to establish clear reablement pathways for those suffering with Long COVID.

Internationally, efforts to funnel Long COVID care through specialist referral Long COVID clinics have for the most part, not been adequate to deal with demand for

care (Shah et al., 2021). In Australia, however, opportunities still exist to codesign care pathways that consider developing clinical guidelines, while establishing practical, effective and affordable care coordination processes across community, primary and secondary physical and mental health care services (Hensher et al., 2021); and that considers the needs of vulnerable populations

Critically, these care services must be underpinned by a systems assurance that populations more vulnerable to COVID have equitable access to appropriate Long COVID management; and that Medicare adequately supports these patients through 'safety net' and other measures to mitigate out-of-pocket costs for chronic disease management. Long COVID in particular offers important opportunities to trial novel funding models as part of new approaches to care coordination, particularly in regions where case numbers are larger.

Embedding of Long Covid management and care services within the healthcare system will become more important as rising vaccination rates impact disease mortality, and the relative contribution of Long COVID to disease burden grows over time.

Sustaining universal healthcare principles in these services requires policies that support the identification and targeting of prevention efforts focussed on vulnerable populations at high-risk of COVID; or where the social determinants of health are exacerbating the burden of COVID-19 related ill health.

non-covid health services

Globally, the pandemic has seen a reduction in care seeking for non-covid conditions, particularly in vulnerable populations or disadvantaged groups with higher rates of non-communicable disease and poorer access to services (Nature, 2021). This includes consideration of the 'shadow pandemics' of mental health, domestic violence and substance abuse.

In Australia restriction of travel, physical distancing and social isolation regulations; the cancellation of elective surgeries and other non-urgent procedures; difficulties making appointments; the interruption of supply chains and the redeployment or retention of healthcare staff have ultimately impacted the health outcomes of those populations who are most vulnerable to COVID-19.

The disruption of services created by pandemic has also created an additional patient load that threatens the ability of the health system to effectively provide services (MacKee and Sweet, 2021). For example, widespread overcrowding in hospitals has compromised safe emergency department function (ACEM, nd). This has been exacerbated by the pre-existing issues of siloed planning, poor integration of care across a patient's treatment journey and inflexible funding models.

For many vulnerable populations, the emergency department is often first contact with the health system (ACSQHC, 2019).

The health and financial impacts of missed opportunities for early diagnosis and treatment on the health system are likely to be long term - lasting far beyond the duration of the pandemic itself.

Therefore, as vaccination rates increase and COVID-19 numbers begin to reduce, those services that have been suspended must be rapidly restored. With this in mind, it will be essential to determine which of the activities we have stopped that we should not resume (AHHA, 2020).

Decisions about the resumption of service delivery must be informed by accurate and timely data, consider workforce safety, be underpinned by the tenets of universal healthcare and include contingency planning for the possible resuspension of services.

Decision makers should consult meaningfully with those that have been disproportionately affected by COVID.

With forthright views on injustice in health, Professor John Deeble had heart-felt concerns about the social and personal costs of poor health in the community.

In Australia, COVID-19 has played a role in both triggering and exacerbating inequalities in healthcare, particularly for vulnerable populations.

If we are to maintain Professor Deeble's legacy of universal healthcare, affordable, quality healthcare for all, health policies based on the principles of universal healthcare that protect the population in its entirety, including those who are more vulnerable, must be strengthened.

This will require a nationally unified and regionally controlled health system that puts people at its core.

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Suggested citation: Haddock R (2021). Universal healthcare in Australia: John Deeble's legacy more relevant than ever. Australian Healthcare and Hospitals Association, Canberra, Australia.

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